Quality & Safety Committee

Tue 23 July 2024, 13:00 - 16:00

Virtually via Microsoft Teams

Agenda

13:00 - 13:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Committee Chair/Independent Member*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Committee Chair/Independent Member*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Committee Chair/Independent Member*

13:05 - 14:05
60 min

2. SHARED LISTENING & LEARNING

2.1. Listening & Learning Story - Boarding of Patients

Discussion *Emma James, Care Group Nurse Director, Unscheduled Care*

2.2. Spotlight Presentation - Mental Health & Learning Disabilities Quality Improvement Priorities

Discussion *Ana Llewellyn, Care Group Nurse Director*

Strategic Goals: Safe Care, Effective Care

Domains of Quality: Improving Care

2.2 QSC MHLD Spotlight-Approved GD QSC 23 July 2024.pdf (9 pages)

14:05 - 14:05
0 min

3. CONSENT AGENDA

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

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

14:05 - 14:05
0 min

4. MAIN AGENDA

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

14:05 - 14:50
45 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Report from the Clinical Executives

Discussion *Clinical Executive Directors*

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

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

5.1 Clinical Executive Directors report-Approved-Final QSC 23 July 2024.pdf (17 pages)

5.2. Care Group Highlight Reports

Discussion *Care Group Leads*

- Children & Families
- Unscheduled Care
- Planned Care
- Primary Care & Communities
- Diagnostics, Therapies, Pharmacy & Science

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

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

5.2a Highlight Report - Children & Families Care Group July 2024 QSC 23 July 2024.pdf (8 pages)
5.2b Highlight Report - USC Care Group QSC 23 July 2024.pdf (6 pages)
5.2b Appendix AMaT Actions US Care Group Highlight Report QSC 23 July 2024.pdf (5 pages)
5.2c Planned Care Highlight Report QSC 23 July 2024.pdf (7 pages)
5.2c Appendix 1 Planned Care Group Highlight Report.pdf (1 pages)
5.2c Appendix 2 Planned Care Group Highlight Report.pdf (1 pages)
5.2d Highlight report - PCC care group July 2024 QSC 23 July 2024.pdf (9 pages)
5.2e DTPS QSRE report for QSC July 24 Final-MB QSC 23 July 2024.pdf (11 pages)
5.2e Appendix 1 DTPS QSRE Report QSC 23 July 2024.pdf (1 pages)

5.3. Stroke Services Progress Report

Discussion *Lauren Edwards, Executive Director of Therapies & Health Care Sciences*

Strategic Goals: Improving Care

5.3 QS Stroke Progess Report QSC 23 July 2024.pdf (22 pages)

14:50 - 15:30
40 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 Organisational Risk Register - July 24 - Cover Paper.pdf (8 pages)
6.1b App 1 Org RR July QSC.pdf (6 pages)

6.2. Mortality Indicators and Mortality Reviews

Discussion *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Safe, Effective, Timely

6.2 Mortality Indicators and Mortality Reviews QSC 23 July 2024.pdf (8 pages)

6.3. Quality & Safety Committee Annual Self-Assessment

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

Strategic Goals: Improving Care

Domains of Quality: Safe

- 6.3 Quality Safety Committee Effectiveness Survey Themed Action Plan QSC 23 July 2024.pdf (5 pages)

6.4. Body Store Recommendations from Welsh Government

Discussion *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Safe

- 6.4a Body Storage Recommendations Update Report QSC 23 July 2024.pdf (7 pages)
- 6.4b Appendix 1 Health Board Response to Initial Assurances sought regarding Dignified Care and Security.pdf (3 pages)
- 6.4c Appendix 2 WG Recommendations regarding Body Storage Areas.pdf (3 pages)
- 6.4d Appendix 3 Fuller Inquiry checklist assessment.pdf (3 pages)

6.5. Evaluation of the success of the Falls and Pressure Damage Programme

Discussion *Richard Hughes, Deputy Director of Nursing*

Strategic Goals: Improving Care

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

- 6.5 Final Falls and PU Report QSC 23 July 2024.pdf (25 pages)

6.6. Duty of Quality Annual Report

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

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

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

- 6.6a Annual Duty of Quality Report - Cover Paper QSC 23 July 2024.pdf (4 pages)
- 6.6b Annual Duty of Quality Report 2023-24 QSC 23 July 2024.pdf (44 pages)

6.7. CTM Quality Strategy Work Plan Update

Discussion *Lauren Edwards, Executive Director of Therapies & Health Sciences*

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

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

- 6.7 Quality Strategy Action Plan Update QSC 23 July 2024.pdf (9 pages)

6.8. Health, Safety & Fire Sub Committee Highlight Report

Decision *Nicola Milligan, Independent Member/Sub Committee Chair*

Strategic Goals: Improving Care

Domains of Quality: Safe

- 6.8 Health Safety Fire Sub Committee Highlight Report 19 June 2024 QSC 23 July 2024.pdf (5 pages)
- 6.8b Appendix 1 HS&F Sub-CMt Annual Report QSC 23 July 2024.pdf (7 pages)

6.9. Quality Impact Assessment

Decision *Richard Hughes, Deputy Director of Nursing*

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

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

- 6.9a QIA Paper QSC 23 July 2024.pdf (7 pages)
- 6.9b Appendix 1 Quality Impact Assessment Report QSC 23 July 2024.pdf (27 pages)

15:30 - 15:45

7. DELIVERING OUR PLAN

15 min

7.1. Patient Safety, Quality & Experience Dashboard

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

Strategic Goals: Improving Care

Domains of Quality: Safe

7.1 Patient Safety & Quality Dashboard Report QSC 2024-07-23 draft.pdf (16 pages)

15:45 - 15:50
5 min

8. DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1. Mental Health Adult Inpatient Improvement Programme

Discussion *Ana Llewellyn, Care Group Nurse Director*

Strategic Goals: Improving Care

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

8.1 Mental Health Adult In-pt Improvement Programme QSC 23 July 2024.pdf (7 pages)

15:50 - 15:55
5 min

9. CONSENT AGENDA

9.1. FOR APPROVAL

9.1.1. Unconfirmed Minutes of the meeting held on 16 May 2024

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

9.1.1 Unconfirmed Minutes QSC 16 May 2024 Final QSC 23 July 2024.pdf (21 pages)

9.1.2. Unconfirmed Minutes of the In Committee meeting held on 16 May 2024

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

9.1.2 Unconfirmed In Committee Minutes QSC 16 May 2024 QSC 23 July 2024.pdf (2 pages)

9.2. FOR NOTING

9.2.1. Action Log

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

9.2.1 Action Log QSC 23 July 2024.pdf (9 pages)

9.2.2. Committee Annual Cycle of Business

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

9.2.2a Cover Report Committee Annual Cycle of Business QSC 23 July 2024.pdf (3 pages)
9.2.2b Quality Safety Committee Cycle of Business QSC 23 July 2024.pdf (4 pages)

9.2.3. Committee Forward Work Programme

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

9.2.3 Quality & Safety Committee Forward Work Programme QSC 23 July 2024.pdf (5 pages)

9.2.4. Healthcare Inspectorate Wales Action Plan Tracker

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

Strategic Goals: Improving Care

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

- 9.2.4a HIW Tracker Cover Report.pdf (8 pages)
- 9.2.4b App 1 - HIW Inspections Recommendations Tracker.pdf (25 pages)

9.2.5. Recognition of Acute Deterioration and Resuscitation Committee (RADAR) Committee - Annual Report

Information *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

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

- 9.2.5 RADAR Committee Mid Year Update QSC 23 July 2024.pdf (29 pages)

9.2.6. Clinical Audit Quarterly Update report

Information *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Effective, Efficient, Safe

- 9.2.6 Clinical Audit Quarterly Report QSC 23 July 2024.pdf (7 pages)

9.2.7. Annual Unpaid Carer's Report 2023/24

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

Strategic Goals: Improving Care

Domains of Quality: Person Centred

- 9.2.7 Carers End of Year progress report QSC 23 July 2024.pdf (5 pages)

15:55 - 16:00
5 min

10. CLOSE OUT BUSINESS

10.1. Any Other Business

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

10.2. Highlight Report to Board - Verbal

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

10.3. How did we do in this meeting - Verbal

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

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

Is there anything we should do more or less of?

Have we managed our time well and allowed open and balanced discussion?

Have we considered our values and acted in a way that supports embedding our values across CTM? Have we maintained a strategic focus?

Have we received sufficient assurance from a range of sources?

Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

10.4. Identification of Future Spotlights and Thematic Presentations

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

16:00 - 16:00
0 min

11. PRIVATE/IN COMMITTEE SESSION

No items identified for In Committee discussion

16:00 - 16:00
0 min

12. DATE AND TIME OF NEXT MEETING

Wednesday 18th September at 2:00pm

Agenda Item 2.2	23rd July 2024	Quality and Safety Committee	Spotlight Presentation Mental Health and Learning Disabilities

FOI Status:	Please select: Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Ana Llewellyn, Nurse Director
Presented By:	Ana Llewellyn, Nurse Director
Approving Executive Sponsor:	Greg Dix, Executive Director of Nursing and Midwifery
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	MHLD Care Group Quality Safety Risk and Experience Group

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	The Care Group Quality Priorities all relate directly to quality, safety and patient experience.
Related Health and Care Standard	Safe Care Effective Care
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No – no service change recommendations in this report
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No If Yes please include brief detail.
Link to Strategic Goals	Please Select: Improving Care

Mental Health Quality Priorities

1. **Mental Health In-Patient Improvement** – focus on ligature
2. **Older Adult Mental Health Falls Collaborative** – sharing progress and next steps
3. **Physical Health Improvement** – new priority for 2024/2025
4. **Lived Experience** – new priority for 2024/2025
5. **HMP Parc Mental Health Improvement** – new priority for 2024/2025
6. **A Mental Health Quality Management System** – a focus on Quality Control

SRO: Ana Llewellyn; **Clinical Lead:** Sophie Bassett/Caroline Humphreys; **iCTM Improvement Lead:** Paul Gimson

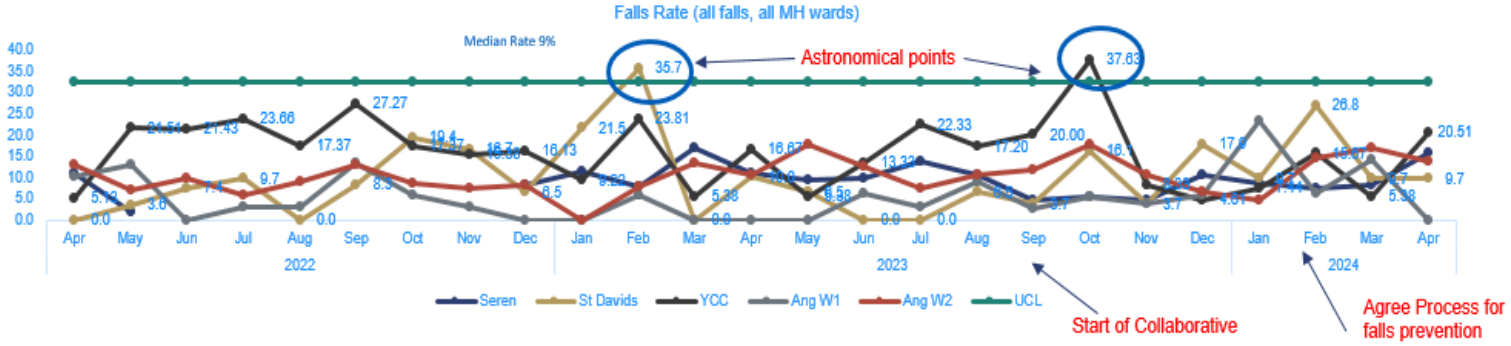
2. Older Adult Mental Health: Falls Improvement Collaborative

Rationale and Origins of the Programme

- Incidents of falls some of the highest in the Health Board on Older Adult Mental Health wards
- Initially a Quality Improvement project in Angelton led by Sophie Bassett, Lead Nurse
- Launched as an official Safe Care Collaborative in September 2023 across all Older Adult Mental Health wards

Initial Aims

- To reduce the number of inpatient falls by 15% in 5 Mental Health Older Adult wards in CTM by end of 2024
- Secondary aims: To reduce the number of avoidable inpatient falls; To increase the capacity and capability of front line clinical teams to improve care using QI methods.



Progress and Achievements

→ Baseline data gathered and analysed

→ King's Fund Environmental Audits completed per each ward

→ 3 full day learning sessions completed

→ Audit tool of the Falls Prevention Process tested

→ External stakeholders from other teams participated of the learning sessions

→ Reduction in variation and outcome

→ Staff engagement

Next Steps

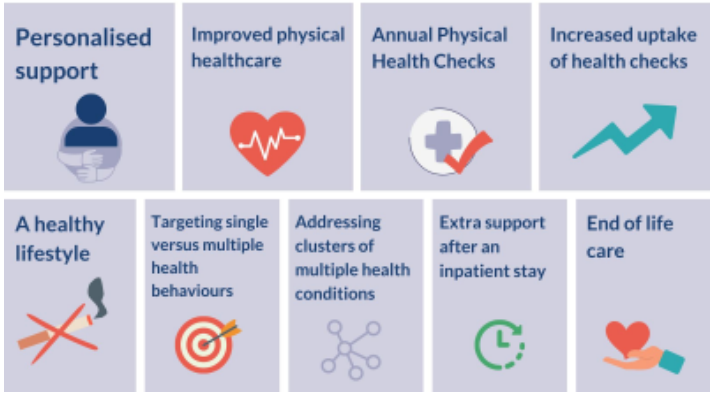
→ Completing Audit Tool by an external iCTM member to sense check the data and usability of the tool

→ Engagement with families to consider next step priorities

→ Further consider the use of the audit on AMAT – Health Board wide work in order to spread and scale the work further

SRO: Dr Mary Self; **Clinical Lead:** Dr Cara Maiden;
MHLD Improvement Lead: Maria Alvey

3. Physical Health Improvement



National Institute for Health and Care Research

2023

Rationale

- People with severe and enduring mental illness are 4.9 times more likely to die before the age of 75
- More likely to die prematurely due to liver disease, respiratory disease, cardiovascular disease and cancer (RCPsych)
- Health inequalities – social determinants, access to services, reasonable adjustments, lifestyle
- Some psychiatric medications increase physical health risks

Aim

- To improve physical health monitoring
- To improve access to health education
- To improve pan-CTM physical and mental health pathways

Plan

- Care Group Improvement Programme chaired by Medical Director and reporting to Quality Safety Risk and Experience Group
- Initial scoping of activity in the care group.

Adult Community Mental Health Team Project

- Four workstreams:
  - Clozapine monitoring
  - Lithium monitoring
  - Anti-psychotic monitoring
  - Eating disorder physical health monitoring
- Update on operational policies
- Focus on review of practice and reducing variation

4. Lived Experience

Our ambition is to plan, deliver and monitor MHLD services with service users' views, needs and experiences at the heart of what we do.

- Lived Experience Framework Developed with a broad scope including:
  - PROMS / PREMS
  - Recovery Colleges
  - Peer support roles
  - Listening into action including advocacy, complaints, routine service user feedback
  - Engaging people in care group activities e.g. recruitment, learning and strategic groups etc
  - Reward and Recognition
- First Meeting of Lived Experience Board 5th August
  - Workstreams to be agreed with people with lived experience through our third sector partners so that we "Start the Journey Together"
- Monthly meetings with third sector partners arranged to support the creation of forums where people can share their lived experience and encourage membership of the Lived Experience Board

Progress to date

- MHLD staff attended HEIW Co-Production Event in Merthyr 25/06/24
- Lived experience posts in place in therapies waiting list project for veterans MHLD and Eating Disorder Services
- HEIW funding secured for Band 7 Recovery College Peer Lead post, will go to advert immediately

SRO: Dr Mary Self; **Clinical Lead:** Brahms Robinson

5. HMP Parc Mental Health Improvement

Rationale

- In April 2023 the small secondary care mental health in-reach team transitioned from Swansea Bay Health Board
- The prevalence of mental health problems in the prison population is 10 times higher than in the general population
- Prisoners are more likely to have experienced health inequalities – social determinants, lifestyle, trauma

Aim

- To review pathways for people with mental health needs in the prison
- To understand HMP Parc secondary care mental health demand and capacity
- To improve pan-CTM physical and mental health pathways

Plan

- Care Group Improvement Programme developed and reporting to Quality Safety Risk and Experience Group
- To report to HMP Parc Operational and Partnership Board
- To work in partnership with Primary Care Community Care Group

Recent Areas of Focus

- Review of all high risk prisoners – joint planning with all agencies
- Intensive intervention to address mental health hospital delays
- Plan to develop model for formal ADHD assessment, diagnosis and treatment by 30th July

6. Maturing A Quality Management System: Focus on Quality Control

What is Quality Control?

Quality Control focuses on operations: monitoring the system of production for stability, detecting emerging process problems (special causes), and taking steps to address them.

- Quality Control under-developed in Mental Health and Learning Disabilities Care Group
- Using the lens of the Quality Management System including control in all discussions and improvement activity
- Development of Care Group Quality Dashboard with Mental Health specific metrics by end September 2024
- Increased use of mental health audit on AMaT – visually available as close to the work as possible
- Increased use of mental health huddles
- Increased use of Safety Walkarounds – gemba
- Focus on development of standard practice

Good news: Mental Health Quality Improvement

NHS Wales Team Culture Award
Impact of Implementing Our 4Cs Philosophy and Culture at Ty Llidiard Tier 4 CAMHS Inpatient Unit

NHS Wales Safe Care Award
The Falls Collaborative

Recommendation:	**The Board or Committee are asked to:**
	• *Note on the ongoing development of quality priorities in the Mental Health and Learning Disabilities Care Group.*

GIG CYMRU NHS WALES | 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	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Richard Hughes-Deputy 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
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	
CTM UHB	Cwm Taf Morgannwg University Health Board
IPC	Infection Prevention Control
SOPs	Standard Operating Procedures
UKAS	UK Accreditation Service
SBUHB	Swansea Bay University Health Board
DTPS	Diagnostics, Therapy, Pharmacy Service
QSRE	Quality, Safety, Risk and Experience
CD	Clinical Director
FCP	First Contact Practitioner
BMA	British Medical Association
WAG	Welsh Assembly Government
NICE	National Institute of Clinical Excellence
Q&S	Quality & Safety
NCACORP	National Clinical Audit and Outcome Review Plan
POW	Princess of Wales
ERCP	Endoscopic Retrograde Cholangio-Pancreaotography
PCH	Prince Charles Hospital
C&VUHB	Cardiff & Vale University Health Board
HEIW	Health Education Improvement Wales
AHPs	Allied Health Professionals
POCT	Point of Care testing
ISO	International Standardisation Organisation
HIW IR(ME)R	Healthcare Inspectorate Wales Ionising Radiation (Medical Exposure) Regulations
HIW	Healthcare Inspectorate Wales
VBHC	Value Based Health Care
OT	Occupational Therapy
RGH ITU	Royal Glamorgan Hospital-Intensive Care Unit
WISE	Wellness Improvement Service
AUSTOMS	Australian Therapy Outcome Measure
VR	Virtual Reality
R&D	Research & Development
PDI	Patient Dignity Inventory
SLT	Speech & Language Therapy
HSJ	Health Service Journal
PHM	Population Health Management
TBC	To Be confirmed
DHCW	Digital Health & Care Wales
GP	General Practitioner
IG	Information Governance

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 Therapies & 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

Nursing & Midwifery-CTM UHB Director of Nursing and Midwifery

This Executive Summary presents a comprehensive overview of the current landscape at CTM University Health Board (UHB), highlighting the pivotal achievements and ongoing challenges the Nursing Directorate faces.

Our commitment to advancing patient care, staff well-being, and operational efficiency remains steadfast as we navigate a dynamic healthcare environment.

This summary outlines our recent successes in demonstrating our dedication to innovation, quality improvement, and effective leadership. Simultaneously, it acknowledges the challenges, requiring strategic focus and collaborative efforts to provide high-standard healthcare services continuously. Through this summary, we aim to clearly understand our progress, the hurdles we face, and the strategies employed to overcome them, reflecting our dedication to excellence in nursing and healthcare delivery within CTM UHB.

Specific Matters for Consideration:

2.1.1 Nursing and Midwifery Delivery Plan Launch

The Nursing and Midwifery Delivery Plan for 2024-2027 is a collaborative endeavour shaped by the invaluable input of our nurses, midwives, and healthcare support staff across the Health Board. More than a mere set of goals, this living document embodies our collective commitment to elevate the standards of nursing and midwifery practice through continuous learning, improvement, and innovation. At its heart lies a steadfast dedication to understanding and meeting

the diverse needs of our staff and the communities we serve, fostering stronger professional relationships and delivering exceptional care. The plan has been designed and sponsored by the nursing senior leadership team for formal launch in July 2024.

Vision and Mission

Our vision is to set new benchmarks in nursing and midwifery excellence, guided by a mission to empower our professionals to achieve their fullest potential. We are guided by six core principles:

1. **Improving Population Health**: We will maximise opportunities to enhance the health of our workforce and the communities we serve, integrating preventative measures into our care strategies.
2. **Listening and Learning**: We commit to listening to our population, patients, families, carers, and colleagues, learning from their experiences to continuously improve our services.
3. **Safe and Compassionate Care**: We pledge to provide safe and compassionate care across our entire population, ensuring consistent high standards in every interaction.
4. **Workforce Excellence**: We will recruit, attract, and retain a competent and skilled nursing and midwifery workforce, nurturing talent and supporting professional growth.
5. **Professional Development**: We will invest in continuous professional development to ensure our workforce remains competent and knowledgeable, capable of delivering the highest quality care.
6. **Sustainability and Equity**: We strive to create an environment that is sustainable and reduces inequalities, improving health outcomes while optimizing costs across the healthcare system.

Implementation Approach

This plan has been meticulously crafted through extensive consultation with stakeholders at all levels of our organisation. By listening to the aspirations and insights of our frontline staff, we have tailored initiatives that resonate with the realities of clinical practice and administrative roles alike. Regular feedback loops and performance metrics will ensure accountability and enable continuous refinement of our strategies.

2.1.2 Listening and learning event

In June 2024, CTM hosted a transformative listening and learning event that reflected on the learning opportunities and how we might structure our care and service provision for patients in the future. Through TED-style talks, contributors delved into critical topics like communication, pressure damage prevention, and inpatient fall reduction.

Effective communication emerged as pivotal, fostering patient trust and enhancing team dynamics. Real-world successes in pressure damage and falls reduction underscored our commitment to patient safety and continuous improvement.

Central to the event were powerful stories shared by staff and patients, highlighting the human side of healthcare and emphasising compassion and personalised care. Their narratives provided invaluable insights into enhancing our practices.

The event was attended by various professionals, including allied professionals, non-clinical managers, nurses, and midwives. Encouraged by the positive feedback, we plan to expand our outreach to include more professions in future events.

Feedback from the event has been overwhelmingly positive. Encouraged by this success, we plan to host two live, in-person events annually, supplemented by two virtual sessions. This approach further supports information sharing and collaboration, ensuring continuous learning and improvement.

The event's success is a testament to our dedicated staff, whose commitment to patient-centred care sets new standards of excellence. It has sparked a renewed sense of purpose and unity, paving the way for a brighter, safer healthcare future.

Thank you to all contributors and participants for sharing their stories and contributing to this transformative journey towards compassionate healthcare.

2.2 Present Challenges

2.2.1 Balancing Clinical Capacity and Financial Controls

The healthcare landscape is increasingly challenging, with sustained inpatient admissions and patient acuity levels. Despite these challenges, financial constraints continue to limit our ability to adequately fund unfunded ward areas, exacerbating the strain on resources.

The surge in demand for healthcare services has necessitated careful consideration of resource allocation and financial management. The current financial climate requires us to navigate a delicate balance between meeting increasing service demands and maintaining fiscal responsibility. This balance is particularly critical in care groups with unfunded ward areas with acute financial pressures.

As we navigate these challenges, it is critical to acknowledge the complexities involved in ensuring high-quality patient care while adhering to financial constraints. The nursing leadership team recognises the need for enhanced assurance in decision-making processes related to service delivery and pay and non-pay expenditures. These decisions must demonstrate clear value for money while upholding the standards of care that our patients deserve.

Looking ahead, portfolio leads will continue to develop strategies to address these ongoing challenges. They will collaborate closely with the Executive Director of Nursing to provide comprehensive insights into the potential implications of managing fiscal responsibilities while ensuring the needs of patients are met. This collaborative approach will ensure all stakeholders understand the interdependencies in balancing financial efficiency with quality care.

2.2.2 Emerging IPC Issues

CTM has faced significant challenges balancing urgent and ward-based care with increasing levels of COVID-19 and outbreaks of norovirus and Clostridioids difficile, necessitating swift and proactive measures to safeguard patient safety and maintain operational efficiency.

Among these challenges, general hospitals have implemented robust IPC strategies to mitigate the spread of infections and minimise disruption to patient care. IPC teams and care group leaders have worked to enhance surveillance activities, conduct regular CTM-wide IPC huddles, and collaborate closely with public health colleagues. These efforts have been further strengthened by facilities support and adherence to updated IPC protocols, ensuring a proactive response to emerging issues.

Furthermore, transparency and accountability remain paramount. CTM actively utilises all reporting and governance mechanisms to inform NHS Wales Executive and other stakeholders of the challenges, strategies, and ongoing efforts to optimise patient safety and healthcare delivery.

2.2.3 Clinical area estate and facilities concerns

The estate conditions within clinical areas in CTM have become a pressing concern for nursing leaders. Issues such as damaged flooring, deteriorating interior walls, storage limitations, and inconsistent cleaning standards have highlighted significant challenges affecting patient care and operational efficiency. The Executive Director of Nursing, the Deputy Executive Director of Nursing, and other nursing leaders have voiced growing apprehension over these infrastructural deficiencies, emphasising the need for immediate attention.

In response, the Deputy Executive Director of Nursing and the Assistant Director of Nursing are working closely with facilities and estates leadership teams to actively identify priority issues requiring urgent remediation to minimise the impact on patient care delivery. Despite the scale and complexity of the challenges, ongoing engagement and coordinated efforts are underway to assess and tackle estate issues comprehensively across all CTM hospitals.

Efforts are focused on enhancing dialogue and joint planning between nursing leadership, estates, and facilities teams to implement targeted interventions and allocate resources effectively.

Sustained collaboration and proactive management will remain essential in achieving long-term improvements in the estate infrastructure across CTM hospitals.

3.0 Conclusion

In conclusion, this period at CTMUHB 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 CTMUHB continues to be a leader in the healthcare sector.

Section 3.1 Medical Directorate-CTMUHB Medical Director

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

This section covers the following achievements:

- BMA/WAG agreement to end industrial action
- Launch of the Clinical Effectiveness Committee
- Clinical Directors Induction Day

3.1.1 Achievements

BMA/WAG agreement to end industrial action

An agreement has been made between the BMA and Welsh Government around an improved pay offer to all grades of medical staff. The BMA has recommended this to their members and has been put to a vote with the closing day for this being the 26th June.

Launch of the Clinical Effectiveness Committee

The Clinical Effectiveness Committee has been introduced to be an effective and efficient forum for high-level clinicians, leaders and managers to support continuous quality improvement in clinical care in CTMUHB.

It will monitor the implementation of the clinical audit program and implementation of NICE/national guidelines/standards to ensure best practice across the Health Board. It will provide support and strategic direction for the Health Board's national and local clinical audit programme, receiving assurance reports from the subgroups and following analysis escalate issues or provide assurance to the Q&S committee and Board.

It will contribute to the production of the Annual Quality report to be presented to the Board of Directors, provide Assurance to the Quality & Safety Committee on

the delivery, performance and improvements associated with the National Clinical Audit and Outcome Review Plan (NCACORP) for Wales.

An annual program of themed meetings will enable appropriate senior professionals to monitor clinical effectiveness across all CTMUHB for assurance and, if required, implement change for improvement.

Clinical Directors Induction Day

On 25th June an induction day for all new and reappointed Clinical Directors was held in POW. This allowed the newly appointed clinical leaders to collaborate and discuss some of the pressing issues across their specialties whilst listening to a number of 'hot topics' at the moment. Primary and Secondary Care Interface, Medical Workforce Productivity and Medical Job Planning were all areas discussed during the day.

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:

- Orthopaedics - outlier data for Mortality and revision POW
- Coroner Cases Endoscopic Retrograde Cholangio-Pancreaotography (ERCP)
- Stroke Services pan-CTM

Orthopaedics - outlier data for Mortality and revision POW

CTMUHB has recently been notified by the National Hip Fracture Database (NHFD) that the Princess of Wales Hospital is an outlier in terms of 30-day mortality. This comes after a notification from the National Joint Registry that POW is an outlier for hip revision operations secondary to infection. In response to this we have established a Multi-Disciplinary Team improvement group that will be led by the Clinical Director for Orthopaedics, supported by the planned care Medical Director. As part of the process Dr Anthony Johansen, an experienced orthogeriatric from C&VUHB, will be providing support to the programme of work.

Coroner Cases Endoscopic Retrograde Cholangio-Pancreaotography (ERCP)

There has been a series of potentially high-profile Coroner Cases. One aspect of focus is our Endoscopic Retrograde Cholangio-Pancreaotography (ERCP) across CTM. We are in the process of re-designing our delivery of these cases. We currently have a number of operators across the 3 sites and there is a need to consolidate this to ensure higher cases per individual as well as shared learning and development. The Planned Care Group are overseeing this process in collaboration with the Radiology team in DTPS.

Stroke Services pan-CTM

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 able to deliver a safe and sustainable Stroke service at PCH. We are urgently looking at ways to manage this situation and deliver Stroke services for CTM patients

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

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

4.1.1 Achievements/Good News

Good News-National

Following recent HEIW interviews for Healthcare Science Clinical Leads, four healthcare scientists were successful in obtaining part-time posts within the National Healthcare Science Programme, in the professions of Operating Department Practitioners, Physiological and Physical Sciences. These posts will help drive forward transformational service change and raise the profile of these pivotal professions.

As part of the refresh work on the National Allied Health Professions Framework, a draft HEIW AHP Workforce Development Plan has been developed based on feedback from AHP roadshows and a deliberative event, to which CTM colleagues contributed. Themes from responses have been highlighted and discussed at the national group of Clinical and Deputy Directors of Therapies and Health Science. The next steps are to review the AHP workforce development plan, liaise with relevant HEIW workstreams and incorporate changes where appropriate, reviewing time scales for delivery of the plan and a relaunch of the updated AHP workforce development plan, which will provide both national/local focus on priority areas.

Good News-Local

UK Accreditation Service (UKAS) assessment 04-26/06/24 is now complete for all Pathology departments at CTM. The team are awaiting confirmation for availability of a clinical assessor for the assessment of Cellular Pathology. A number of findings have been raised across all Pathology departments, which is not unusual for UKAS assessments. We have around 50 findings to resolve and provide evidence for by 29/07/24. Improvement actions for findings have already been agreed, the Quality Team are currently working with departments to ensure submission of evidence by the July deadline. No significant concerns were highlighted, and the team are confident regarding the submission within the required timeframe.

This was the 4-year re-assessment (more extensive than surveillance visits) and also the assessment for transition from ISO 15189:2016 to ISO 15189:2022. Key updates to the standard include a greater focus on clinical risk and the impact of

services on patients; incorporation of the requirements of ISO 22870:2016 point-of-care testing (POCT); requirements for quality and competence, and a structural reorganisation to bring the standard in line with ISO 17000-series standards (the "parent" standards of ISO 15189). The transition process requires laboratories to read the new standard, perform a gap analysis between the processes they currently have in place and the requirements of ISO 15189:2022, and provide evidence of implementation of the new requirements.

HIW IR(ME)R inspection POW: following a recent HIW IR(ME)R inspection at POW, HIW have confirmed that they have accepted our submitted improvement plan, which will now be published on HIW's website. Progress against the actions continues and an updated position will be submitted to HIW by 19/08/24.

4.1.2 Areas of Concern

National

There are concerns nationally around Health Boards preparedness for expected changed to Medical Device Regulations. National meetings are being held regularly to discuss the impact of these changes. Locally collaborations, between several of the Health Boards including SBUHB and CTMUHB, have been developed to understand the expected impact of the changes, local readiness and develop recommendations to expedite the required changes.

Local

Lack of Pathology Clinical Director: this is a key role to effective risk management in the 2022 standard. If not resolved soon, this has the potential to impact transition to the new 2022 standard. We have recorded this as a risk on the Pathology risk register. Mitigations to this risk are:

- DTPS Care Group Medical Director available for escalation and clinical concerns.
- Clinical Leads in each discipline ensure robust governance within their specialties.
- DTPS Care Group QSRE and performance review, attended by Care Group triumvirate for governance oversight and clinical advice.
- Delegated duties listed in quality manual
- Risks and failure in risk management reported to pathology performance review and care group meetings

The associated action is to appoint a Clinical Director with options continuing to be explored.

4.1.3 Allied Health Professions

Good News- Miscellaneous

Showcasing return on investment for physio projects.

- **First Contact Practitioner Physiotherapy service:**
  - **96%** of patients who attended would request to be booked with the FCP Physiotherapist rather than the GP for a future MSK problem.
  - **99%** of patients would ***recommend the service*** to family or friends.
  - £1.3m indicative savings (cost avoidance)

- **Urogynaecology Value-Based healthcare project**: indicative £63,900 cost avoidance

- **Electronic referral trauma and orthopaedics project**: almost £600k cost avoidance, with reduced time to triage and patient on correct pathway within 1-2 days, compared to many weeks with paper process.

- **OT Value-Based Healthcare (VBHC):** The Palliative Heart Failure project has now come to a close. Positive feedback has been received from the multi-disciplinary team. The use of the standardised tool, Austoms (Australian Therapy Outcome Measure), to measure the effectiveness of OT has demonstrated improvement across all functional domains, including patient mobility, ability to perform activities of daily living, and ability to get on and off furniture within the home. It has also demonstrated that the intervention of Occupational Therapy has led to an improvement in patients being able to manage their own condition. Next steps are to meet with the VBHC to discuss the project results and potential future plans and to present findings from pilot at both Heart Failure and Palliative Care Conferences.

- Animal Assisted Therapy has been introduced to RGH ITU, with plans for further roll-out across the other units. Informal feedback demonstrates that this has significantly improved the well-being of patients, staff and relatives.

- Colleagues from Nutrition and Dietetics and WISE are working in partnership to train school staff to deliver Get Cooking. Dietetics staff have delivered training to over 150 school staff to deliver the accredited and quality assured "Get Cooking" course to enable a wider reach in terms of healthy meal messaging. This would be beyond the scope of Dietetic Public Healthy Staffing and has received good engagement. Next steps are to explore with WISE how services can collaborate and align offerings.

Research and Development

- PERFORM Research Trial: OT Services have agreed to support this research trial exploring the benefits of using virtual reality (VR) headsets in the rehabilitation of patients' upper limbs post-stroke. The initial phase of the study will determine the ability of patients to use the VR headsets. This will include practical elements such as being able to don/doff the headset as well as how users interact with the device. The sample size is not yet confirmed, however, the trial is due to commence April 2025 for a period of 36 months.

- One of our CTM Health Psychologists is an author in a publication outlining the evaluation of a new psychological tool to help staff understand and work with

palliative care patients and their psychological dignity: Lloyd, A., Stubbings, D.R. & Davies, J. L. (2024) Staff perceptions of the use of the patient dignity inventory (PDI) in a Welsh palliative care service. Progress in Palliative Care.

- 2023 saw the establishment of a Weight Management Research Group in collaboration with CTM R&D and academic partners from across South and West Wales. This innovative group have proposed a Realist evaluation 'EvaluWeight' which has just received ethical approval and will inform the evaluation of the Weight Management Service. The service has also been successful in securing a research grant to understand the genetic variants in people who attend specialist weight management services.

- SLT Early Years project submitted for: 2 x HSJ awards, iCTM event poster, R&D conference. The project looked at universal/non-individualised early access to information on speech, language and communication by the CTM Speech and Language Therapy Team for Children.

  Its aims:
  - To reduce health inequality through the provision of high-quality accessible information.
  - To provide all who have contact with young children with a means to share high quality information.
  - To enable parents/carers and others to be able to confidently use the information available for the benefit of their child.

  Outcomes were:

  - ✓ Consistent evidence based curated information source available across Health Board
  - ✓ Parents now receiving access to early consistent advice therefore empowering them to support their child's language early on.
  - ✓ New non-traditional close to home providers also providing same advice i.e. libraries, dentists, opticians, soft play, Family Support.
  - ✓ Capacity to support families increased in both volume and quality, reduction in capacity needed to maintain database due to external curation

4.1.4 Sharing Good Practice and Awards

- OT Service has been invited to participate in Royal College of OT Senedd Showcase on 18 June 2024.

- Head and Neck and Prehab AHP teams attended the Moondance Cancer Awards on 13 June 2024 following successful shortlisting. This was an excellent recognition and celebration of the innovative work of these teams.

- Dietetics supported successful events across the UHB for Diabetes week, with positive feedback from Diabetes UK.

- Dietetics colleagues presented their positive progress of PIPYN at the CTM Annual Weight Leadership summit, celebrating the great work being delivered by this service for children and families in the Merthyr locality. There are plans to expand into the Rhondda Cynon Taf locality and recruitment is currently underway.

- Head and Neck team have made submissions for the Macmillan excellence awards

- SLT Acute Lead has been invited to present at the next CTM Listen and Learn event. Service improvement projects will be shared, ensuring representation at the event form a range of professions.

- VBHC Inpatient Podiatry Service has been shortlisted for the NHS Wales Timely Care Award. A virtual interview has been arranged for 5 July, which will involve a presentation on the programme.

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:

- Population Health Management (PHM) – population segmentation data flows
- Henry Programme

Risk of disruption to population segmentation data flows to GP practices due to Audit+ software withdrawal:

On 8/05/24 we received notice from DHCW on the unexpected withdrawal of the Audit+ software later in 2024 (TBC). The existing contract was going to be renewed on 1st July, but the company are now closing affecting a number of services. This software is used for general medical practices' auditing, and a variety of reporting services for practices and the wider NHS and Welsh Government, and to provide quarterly GP data to the SAIL databank. This quarterly GP data flow into SAIL is used by our PHM project to produce quarterly data flows of segmentation and related data to the GP practice portal.

There is a risk that our data flows are being disrupted and that planned projects by GP clusters for late autumn/winter 24 could be affected and potentially beyond. Conversations with DHCW staff on our project team suggest that there may be a flow still for the autumn provided staff supporting Audit+ remain in post.

Mitigation may initially be to use older data from early summer, but we await further information on plans for the interim and the long-term solution from DHCW.

5.1.1 Population segmentation data flows delayed following commercial supplier Sollis Ltd closing and amending information governance arrangements:

Following the unexpected closure of Sollis and termination of contract in March 24 we have established an extended contract with SAIL starting May 24 to provide additional analyst capacity to replace most of the data processing work Sollis used to do.

Information governance advice has been sought from SAIL, CTM IG internal and DHCW IG who are advising the practices as data controllers.

The change of processor and smaller changes to the data means the data processing agreements need to be amended, as well as the data processing impact assessment and also the privacy notice displayed in practices.

We need to invite practices to sign up to the project again with the new arrangements. We sent edited documents in early May, initially to the CTM IG team, and they are now waiting with DHCW IG due to limited capacity and the funding priority for IG advice are practices and not CTM wide work.

A new data extract in SAIL would be available but we can only start once the IG arrangements are in place which could be a few more weeks away. We had already communicated to practices that we may not be able to provide a summer extract due to the new setup and it looks increasingly unlikely to be ready due to IG.

5.1.2 HENRY Programme

Introduction

Since its local launch in 2021 The Henry Programme has provided a wide range of support for families from ages 0 to 5, including workshops, programmes, resources and online help; primarily focusing on nutrition, physical activity/play, parenting support and emotional wellbeing. Since launching the programme has endured numerous challenges to delivery.

Situation

We have taken the decision to stop providing the Henry Programme in July 2024. An internal evaluation identified challenges around sustainability, referral conversion, and course completion and content, alongside positive learning around families' needs.

Since April 2024 the 8-week programme was paused, with an interim move to focused workshops on topics identified by families, these are now closed to referrals. The programme team has been listening to families and partners to better understand need and inform future development of sustainable Level 1 healthy weight support.

Cognisant of the overlapping CTMUHB Pipyn Programme, there is a need for a clear, unified model for healthy weight provision for families in CTM.

Pipyn provides community based healthy weight support to families of children aged 3 to 7. It currently operates as a Welsh Government funded pilot in Merthyr Tydfil with funding until March 25 and will be launching in the Rhondda and Taf Ely GP clusters for two years this summer.

Next steps

The Henry Team will be working with colleagues in Dietetics to understand how best to use the learning from Henry to support the continued development of a unified model for level 1 weight management for children and families in CTM. This is within the context of a wider need for a long-term road map for Healthy Weight in CTM, integrating all healthy weight activity in the health board into a unified vision.

6. Specific Matters for Consideration

Matters for consideration are detailed in the sections above.

7. Key Risks / Matters for Escalation

7.1 There are currently no further risks which require escalation to the Quality and Safety Committee as all risks have been highlighted under each section of the report.

Assurance is provided that all matters outlined within this report are being addressed through each of the four reporting teams led by the respective Clinical Executive Director.

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	Whole-systems Perspective

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

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

Agenda Item
5.2a

Quality & Safety Committee

Highlight Report from the Children & Families Care Group

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Suzanne Hardacre, Director of Midwifery & Children & Young People Nursing • Mohammed Elnasharty, Medical Director • Carl Verrecchia, Service Director
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre, Director of Midwifery & Children & Young People 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	
ABUHB	Aneurin Bevan University Health Board
ANC	Antenatal Clinic
CNS	Clinical Nurse Specialist
CYP	Children and Young People
ED&I	Equality, Diversity and Inclusion
EWN	Early Warning Notification
HCWP 2	Healthy Child Wales Programme 2
HEIW	Health Education and Improvement Wales
HV	Health Visitor

IQPD	Integrated Performance, Quality and Delivery
IT	Information Technology
LA	Local Authority
LW	Labour Ward
NNU	Neonatal Unit
NRI	Nationally Reportable Incident
PCH	Prince Charles Hospital
PMRT	Perinatal Mortality Review Tool
RCM	Royal College of Midwives
RCN	Royal College of Nursing
QSRE	Quality, Safety, Risk and Experience
SCPHN	Specialist Community Public Health Nurse
SEHS	School Entry Hearing Service
ToR	Terms of Reference
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 Families Care Group at its meeting on 13th June 2024

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

2. Purpose of this Meeting

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

2.2 The Children & Families Care Group Quality, Safety, Risk and Experience Meeting (QSRE) will:

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

Highlight Report

Alert / Escalate	• Temporary closure of maternity and neonatal units at Princess of Wales Hospital (PoW) due to commence September 2024 due to essential maintenance to electrical supply (neonates) and air handling system (maternity). Project support and plans in place. Communication with colleagues, internal and external stakeholders, women and birthing people taking place regularly. Drop in sessions for families implemented. Early Warning Notification (EWN) submitted to Welsh Government / NHS Executive. • Health Visiting Industrial Action (Unite) – Partnership meetings taking place between Health Board, Unite and NHS Employers to seek resolution. Health Visitor Job Description evaluation has been completed (Part 1 of concerns raised), the service is working in partnership with plans in place to achieve resolution to remaining actions (Part 2). • Service Level Agreements for Special School Nursing have expired. Inequity of service provision across CTM. Meeting with Directors of Education held in April with further meeting in July. Meeting with LLAIS 27th June 2024 to provide update of current situation. Work progressing within the Children and Young People (CYP) directorate to explore core service provision to facilitate further discussions with the Local Authorities.
Advise	• Due to digitalisation of maternity records at Aneurin Bevan University Health Board (ABUHB), women and birthing people are presenting for care at CTM without access to medical or pregnancy information. Meetings between Health Boards are in place, standard operating procedures strengthened. • High profile Crown Court case in progress for four weeks from 17th June 2024. Health Board staff required to provide evidence, support in place. Early Warning Notification submitted to Welsh Government. • School Entry Hearing Service (SEHS) – Cwm Taf Morgannwg (CTM) in breach of their responsibility to implement direction from Welsh Government (WG) to handover the governance arrangements of the programme to audiology services. Progress monitored and plans for resolution being discussed at Care Group and Corporate Operational Management Board. • Healthy Child Wales Programme 2 (HCWP 2). Welsh Government (WG) guidance issued in April 2024 outlining

	expectations for the rollout of the HCWP 2, which affects school-age children. There is an expectation of implementation over a 2 year period. All Wales work streams are to be established, CTM are establishing a Project Board with key stakeholders to plan the work streams required, and to ensure that CTM HB is equipped to fully deliver the programme by April 2026. • Safeguarding – From 17th June 2024, the Clinical Nurse Specialists (CNS) for Safeguarding within CYP will be managed by corporate safeguarding lead nurse to ensure consistency and oversight. • Since the relocation of services for Integrated Sexual Health (ISH), Gynaecology and Antenatal Clinic (ANC) at Ysbyty Cwm Cynon (YCC) concerns raised with flow and patient pathway. Risk assessments in place, meeting arranged with site management on 5th July 2024. • There are 14 whole time equivalent (wte) midwifery vacancies. Five midwives appointed from NHS England, 12 further newly qualified midwives due to commence September 2024. Concerns raised with HEIW that not all streamlining posts filled (against agreed commissioning numbers). Meeting with HEIW 2nd June 2024 to discuss. Also raised at Directors of Midwifery Advisory Group on 20th June 2024.
Assure	• Review of Maternity & Neonatal Governance processes underway to ensure compliance with Duty of Quality, Healthcare Standards & Incident Management Framework. Terms of Reference (ToR) agreed at Care Group QSRE meeting on 13th June 2024. Due for completion 31st August 2024. Governance workshop held 11th June 2024, further training for teams 26th June 2024. • Leadership and Culture Plan, Communication and Engagement Plan, Learning Needs Analysis in place across Perinatal services to support cultural improvements. 'Behaviour Garage' sessions arranged for September 2024, Maternity Support Worker Away Day in development for September 2024. Action Learning Sets for Senior Leaders recommenced June 2024. Working closely with Workforce and Organisational Development Colleagues in response to HIW unannounced visit at PCH maternity January 2024. • Service level agreement for Flying Start in Bridgend being completed.

- Maternity & Neonatal update provided to NHS Executive via Integrated Quality, Performance & Delivery (IQPD) meeting on 17th May 2024.

- Information Technology (IT) – Health visitors in Bridgend are using the old Abertawe Bro Morgannwg portal to access and record patient care episodes which is resulting in dual recording systems (and workload). The legacy system will not be available after May 2025. Health visitors have indicated their preference is to return to paper based systems to standardise across CTM until a sustainable solution is sought. This concern is considered under part 2 of the Unite Industrial action. Meeting with Informatics lead on 4th July 2024 to agree solution.

- Paediatric ward at PoW – Increased temperature within the treatment room. Risk assessments and mitigation in place, risks identified on service risk register. Statement of need for capital estates work completed for consideration.

- Significant progress made with integration of the Perinatal Mortality Review Tool (PMRT) process with the Nationally Reportable Incident (NRI) Framework, supporting proportionate review and improved communication for families.

- Internal Risk audit report received. Recommendations for Children and Families Care Group shared and actioned. Additional training arranged, supported by Corporate Governance team.

- Health Inspectorate Wales (HIW) unannounced visit to Prince Charles Hospital Maternity January 2024. Local improvements made to reflect recommendations and feedback from staff survey. Senior midwifery manager leading improvements with support.

Inform

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	16
5712	Industrial action HV SCPHN members of Unite Union	15

2808	Waiting times for performance - Neurodevelopmental team	15

- 15 Steps Llais / Service User Challenge took place at Prince Charles Hospital (PCH) Maternity Unit on 24th June 2024. Positive feedback with very few actions.
- Several submissions to both Royal College of Midwives (RCM) Awards and Royal College of Nursing (RCN) Wales Awards.
- Labour Ward Co-ordinator from Prince Charles Hospital shortlisted for their work with Health Education and Improvement Wales (HEIW) – 'Labour Ward Coordinator Development Competency Framework'.
- A Children and Young People Strategic Vision is being developed with support from Strategy Group colleagues.
- Band 6 Nurse away day held pan CTM for community paediatric colleagues.
- Final draft received of CTM Infant Feeding Strategy, voice of parent and baby / infant has been included. Due to launch w/c 2nd August 2024.
- 'Behaviour Garage' training arranged for September 2nd. Two sessions: – "Inclusion with Humanity" and "Behaviour Beflections".
- Equality, Diversity and Inclusion plans in place. Care Group working towards achieving cultural competence. New Transgender guideline for maternity services developed and is out for consultation. Benchmark against Race Observatory Report complete.

Appendices	Not applicable

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: • Creating Health • Inspiring People • Sustaining our Future
	Starting Well

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies please list below: • Living Well • Growing Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below: • Culture and Valuing People • Leadership • Learning, Improving and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: • Timely • Equitable • Efficient • Effective • Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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

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

4. Recommendation

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

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

Agenda Item
5.2b

Quality & Safety Committee

Highlight Report from the Unscheduled Care Group
Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
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	10/06/2024	

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 10th June 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	Our stroke service is becoming increasingly fragile with a real risk of service collapse on one site. The Stroke Consultants within CTM cover Stroke services on two acute sites (POWH and 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 consultant gaps. There are currently 4.0 WTE Stroke Consultants and 4.8 WTE CNS in post across CTM, broken down as follows: • 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 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 able to deliver a safe and sustainable Stroke service at PCH. An options appraisal has been developed by the Clinical and Operational team which has been supported by the Executive Leadership Group. This included the proposal to progress with a locum consultant as an interim solution allowing the next 2-3months to work up a more robust plan to make the service more sustainable.
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 increased in May 2024 from 68% to 94%. This is due to the doctor strikes which had a negative impact on response times. Currently there are 26 open complaints and 6 over the 30 day compliance. The USC leadership team have provided a commitment to support, improve trajectories and have developed a mechanism to escalate when clinicians and nurses are unable to achieve 30 day compliance. This has been closely monitored by the USC Senior Leadership Team which has resulted in a significant improvement. **AMaT** A high- level report has been produced to give an oversight of the outstanding actions on AMaT allowing the Directors to drill down specific areas. Attached as an appendix 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 June 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. 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. As part of their ward assurance the Lead and Senior Nurses are expected to review AMaT as a minimum once weekly to ensure compliance with the audits and action plans. Support put in place for ward managers to utilise existing systems to raise estates work as large amount of actions pertaining to estates issues. As part of standardised 1:1 template for ward managers up to Heads of Nursing, AMaT audits are a standing agenda item.

	The 31/07/2023 HIW inspection of PCH ED and CDU required action to be taken to demonstrate suitable daily checks of emergency equipment have been conducted in accordance with the health board's policy/requirements. This action is now completed as the resuscitation trolley check has now been included on the Health Board AMaT (Audit Management and Tracking) system, with the Lead Nurses successfully undertaking a 3 times weekly assurance audit that the checks have been completed. Further developments made in relation to two further outstanding HIW actions from 17th October 2022 review of POW ED. The senior nursing teams across the three departments are collaborating on a standardised patient safety checklist. This will be built on AMaT and allow this action plan to be closed. The Cardiology team in Princess of Wales Hospital undertook a trial of a 'perfect week' approach to their elective and non-elective intake. The high level results from this are that they managed to see and treat 36 planned patients and 13 unplanned patients and that protecting RCDU without changing any working practices saved 36 bed days over a 5 day period. Utilising this space for SURG or in-patients would only create 30 bed days over a 5 day period.
Assure	The patient safety team are supporting with a thematic review of the WAST/CTMUHB Joint Investigation Framework Panel meetings case reviews. Between June 2021 and June 2024 CTMUHB and WAST have jointly reviewed 75 incidents reported to the Health Board by WAST, due to the service being unable to send ambulances to respond to calls in the community. Following review of the 75 incidents at the weekly joint review panels attended by health board and WAST colleagues we have worked in partnership to review and identify patient harm and have reported 15 Nationally Reportable Incidents (NRIs) to the NHS Executive. Each NRI incident has been reviewed using an SBAR approach (as agreed by the NHS Executive) following extensive investigation into the patient's circumstances, medical history, cause of death and Health Board data in relation to ambulance release times from ED departments and patient flow throughout the Health Board at the time of the incidents. This thematic review aims to identify the themes and trends around the 15 NRI incidents in order to identify root causes of the ambulance delays and learning from these incidents.

	To note the last NRI incident is recorded as 13/12/2023 and since the implementation of the immediate release policy The Health Board has not reported any WAST related NRI's so far in the whole of 2024 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. The site based teams are in the process of developing a 'you said, we did' project to build on these helpful patient experience measures.
Inform	The Nurse Director for USC and Planned Care have collaborated with the Heads of Nursing for each acute site to develop standardised governance processes in relation to Medication Assurance meetings, IPC site based meetings, 1:1 templates, and Professional Focus Groups. We hope that by promoting consistency and transparency this approach will facilitate effective communication and enable comparison across the Health Board and drive data-driven decision-making, all of which are essential for maintaining high standards of care and patient safety.
Appendices	Not applicable

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: 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**	Leadership
	If more than one applies please list below: Culture

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

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

5. Recommendation

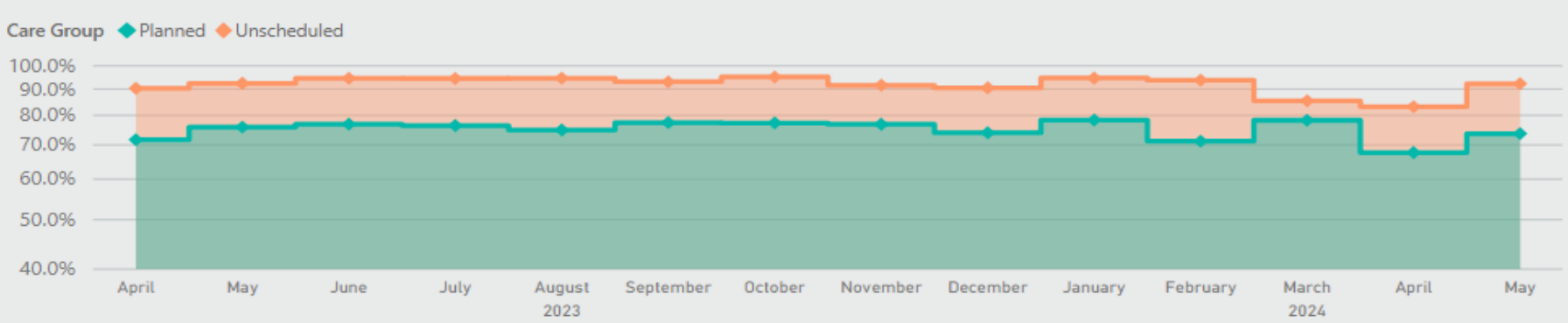
5.1 The Quality & Safety Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

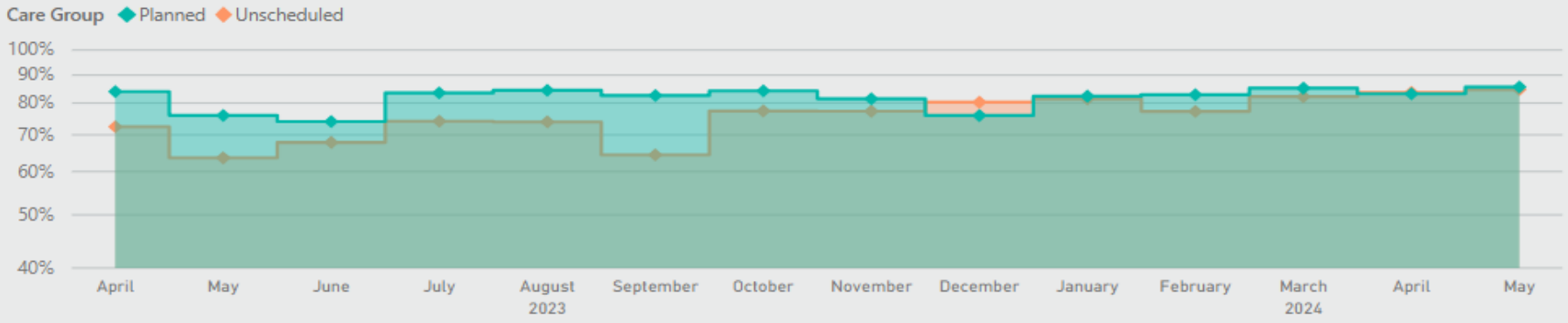
AMaT Overview & Action Assurances June 2024

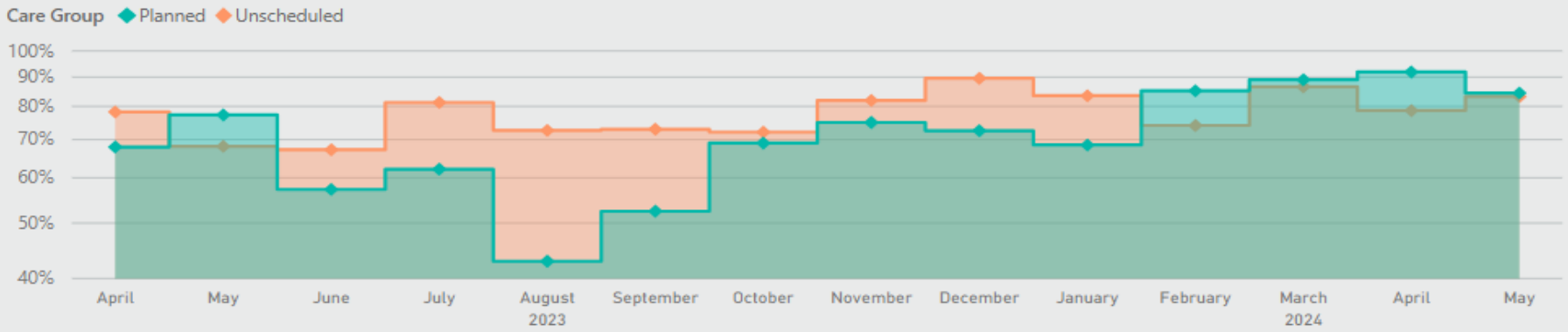
AMaT

Complaince Score (%)

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







Actions Not Opened

Prince Charles Hospital

11	8

Royal Glamorgan Hospital

1	5

Princess of Wales Hospital

33	39

Prince Charles Hospital

Actions Not Open from June 2024

23

Unscheduled Care

Core or Not: Core
Care Group: Unscheduled
Site: Prince Charles Hospital
Ward: All
Audit: All

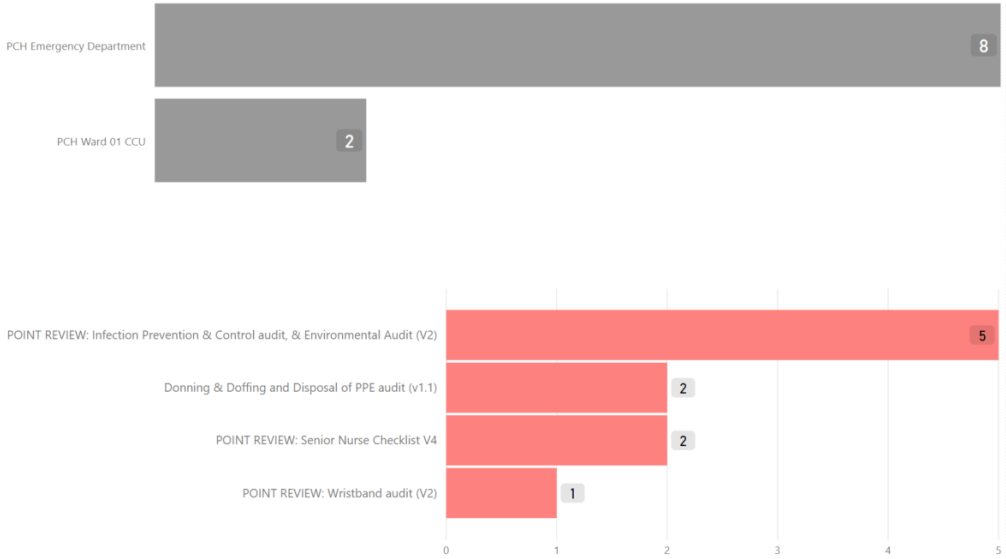
Click to Reset All Filters

Actions Not Open from June 2024

10

Total OVERDUE Actions

6



Planned Care

Core or Not: Core
Care Group: Planned
Site: Prince Charles Hospital
Ward: All
Audit: All

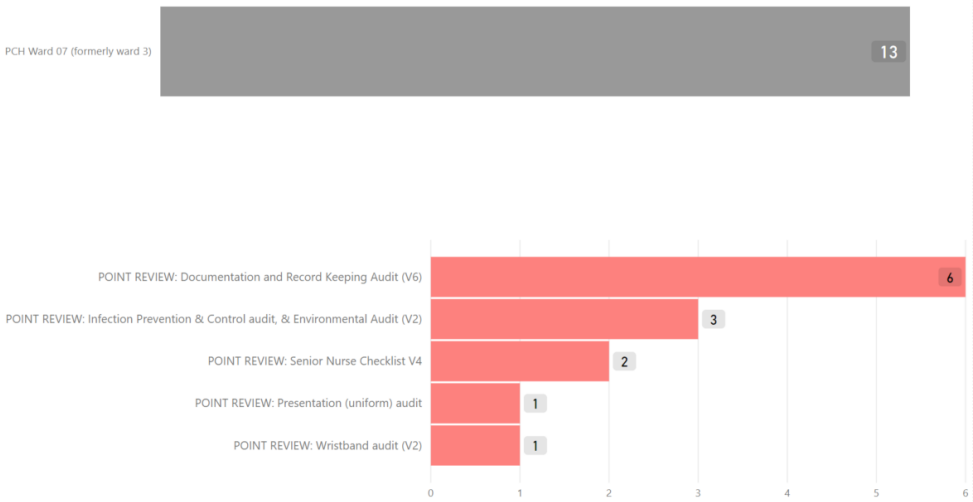
Click to Reset All Filters

Actions Not Open from June 2024

13

Total OVERDUE Actions

(Blank)



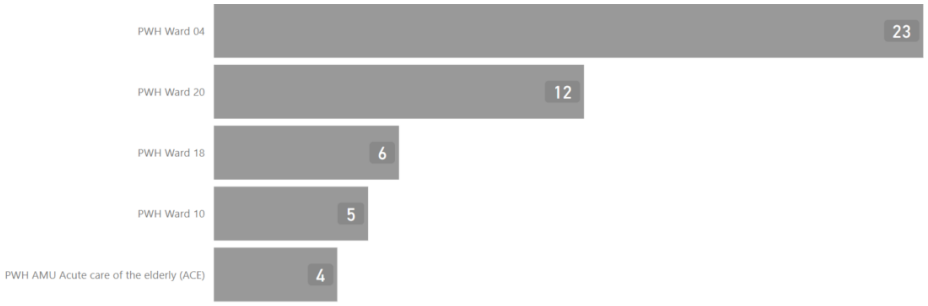
Princess of Wales Hospital

Actions Not Open from June 2024

83

Unscheduled Care

Core or Not: Core
Care Group: Unscheduled
Site: Princess of Wales Hospital
Ward: All
Audit: All



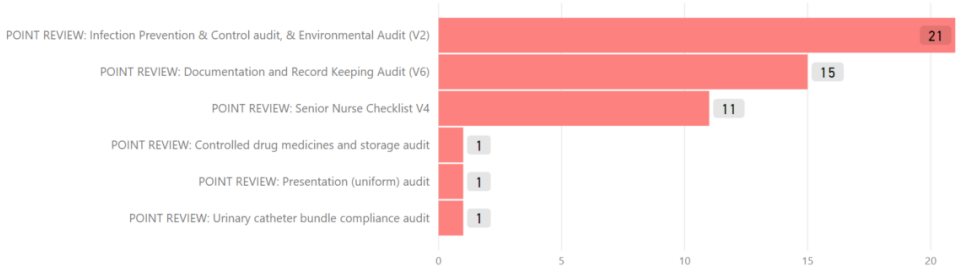
Click to Reset All Filters

Actions Not Open from June 2024

50

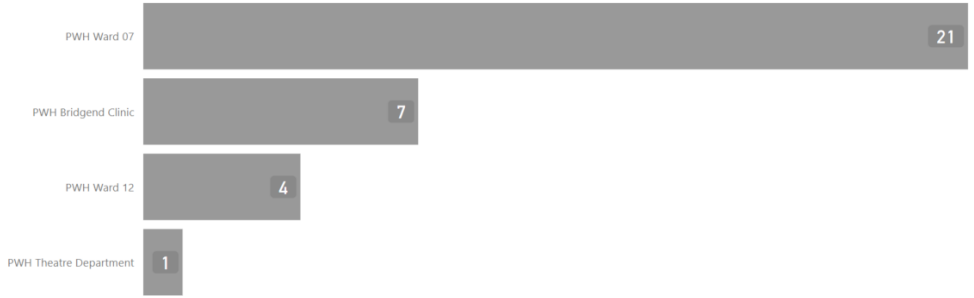
Total OVERDUE Actions

25



Planned Care

Core or Not: Core
Care Group: Planned
Site: Princess of Wales Hospital
Ward: All
Audit: All



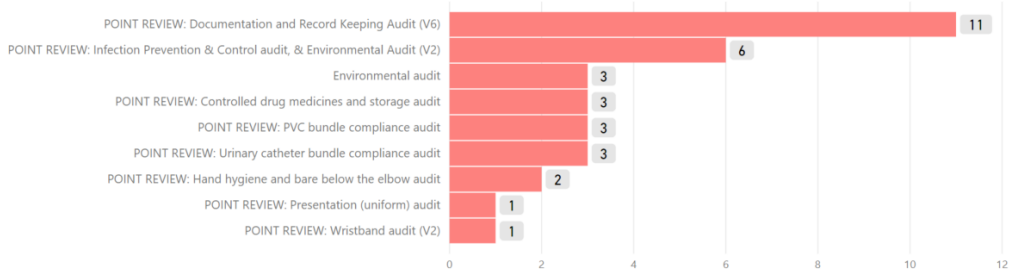
Click to Reset All Filters

Actions Not Open from June 2024

33

Total OVERDUE Actions

17



Royal Glamorgan Hospital

Actions Not Open from June 2024

6

Unscheduled Care

Core or Not: Core
Care Group: Unscheduled
Site: Royal Glamorgan Hospital
Ward: All
Audit: All

Click to Reset All Filters

Actions Not Open from June 2024

5

Total OVERDUE Actions

10

Planned Care

Core or Not: Core
Care Group: Planned
Site: Royal Glamorgan Hospital
Ward: All
Audit: All

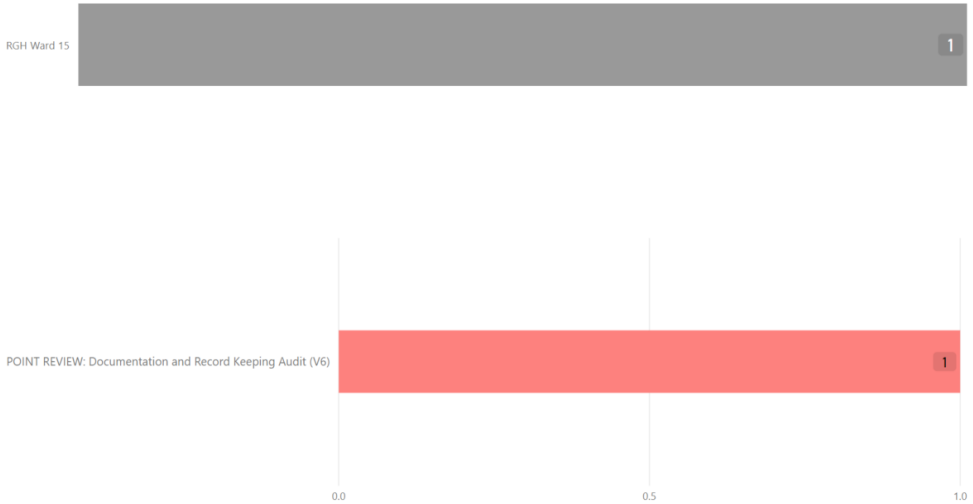
Click to Reset All Filters

Actions Not Open from June 2024

1

Total OVERDUE Actions

2



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

Agenda Item
5.2c

Quality & Safety Committee

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

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
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

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 17th June 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	**Urology** • Remains a key focus of Targeted Intervention for Cancer. The Urology Sustainability Programme has been revised with additional focus on key actions, with weekly review of demand and capacity. • Review of medical, nursing and CNS workforce and job plans has commenced with Urology Transformation Group meeting on 5th June 2024 with wider Urology medical and nursing teams.

Advise

Incidents – Care Group Overview (April & May 2024)

Incidents	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Total Number of Incidents Reported	303	233	255	288	280	267	266	278	249	249	298	274
Total Patient Safety	269	202	223	254	242	238	240	239	223	217	273	238
Total Non-Patient	21	13	23	22	26	20	26	20	16	24	10	26
Total Organisational Incidents	13	18	9	12	12	9	7	19	9	8	15	10
Total Number of Incidents Closed this month	154	243	245	293	294	309	384	371	504	273	291	282
Total Number of Open Incidents on Datix Cymru	1280	1267	1320	1438	740	1569	1491	1403	1117	1110	1120	1124
New Incident	1319	1291	1317	780	781	783	770	715	669	669	636	631
Management review/Make it safe plus	485	486	469	45	48	50	67	50	34	47	71	80
Under Investigation	320	375	396	613	602	553	545	578	365	335	321	284
Awaiting Closure	176	132	186	198	183	183	109	49	49	59	92	131
Number of Nationally Reportable Incidents	30	37	46	5	6	10	3	2	1	7	2	8
Number of Never Events reported	0	0	0	0	0	0	0	0	0	0	0	0
Number of Open Nationally Reportable Incidents	25	26	27	33	31	31	36	36	33	38	39	45

NRI's **reported** to NHS Wales Exec during Apr & May 2024: **10** in total:-

1 x Avoidable pressure damage (PoW)
6 x Treatment/Procedure Issue (1 x PoW / 5 x PCH)
3 x Ophthalmology FUNB
TOTAL NRI's Open for Planned Care = **45**

6 x Avoidable Pressure damage to be reported/closed following PU Assurance Panels:
2 x PCH (ward 5 & 8) / 3 x POW (2 x ward 9 & 8) / 1 x RGH (ward 3)

- Plans created to reduce the amount of open incidents on datix across the 3 sites, with a focus on RGH and PoW. Large number of open incidents relating to ophthalmology & cancer harm review outcomes.

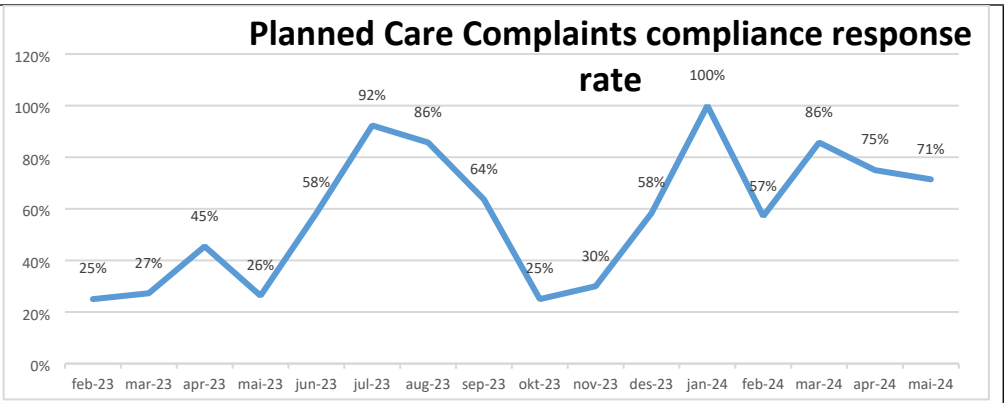
Concerns

Concerns Compliance Apr = 75%

- 8 closed; 6 within timeframe

Concerns Compliance May = 71%

- 7 closed; 5 within timeframe



Patient Experience (data via CIVICA)

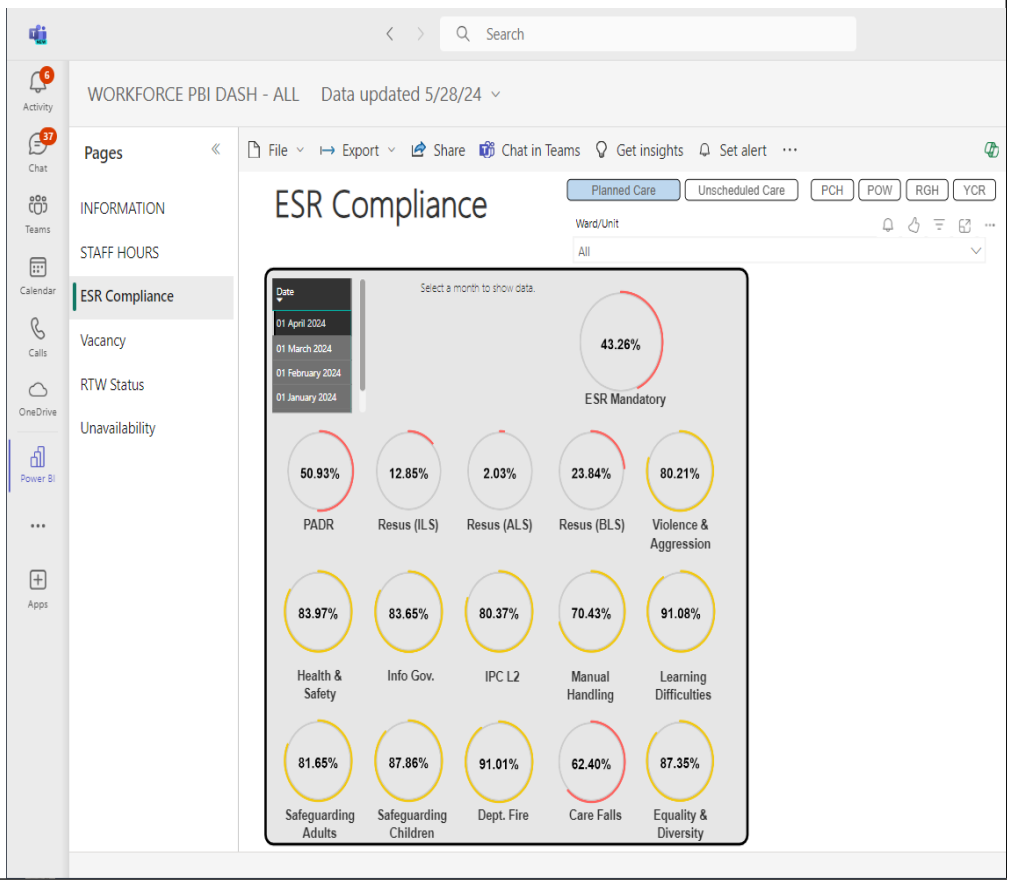
Release of updated Care Group Process for management of concerns & clinical incidents (appendices 1 and 2)

Assure

Standardisation of Governance Assurance meetings.

Heads of Nursing for acute sites with Directors of Nursing for USC and Planned have revised all the ToR, agendas and membership for key assurance meetings:

- Care Group Q&S meetings
- Medicines Management Assurance Groups
- IP&C highlight reports & Committee reports
- HoN, Lead Nurse, Senior Nurse & Ward/Dept Manager 1:1 meetings
- Professional Forum Group
- Pressure Ulcer & Falls assurance panels

	Critical Care Pet Dog Therapy commenced with weekly visit to RGH ITU. Applications in for roll out to POW and PCH. **General Surgery & Gastrointestinal Services** Ms Zoe Barber, Consultant Breast Surgeon won the Moon Dance award for Clinical Excellence
Inform	Documents Approved at Committee (available on request): • CTM Theatre Services Department Standard Operating Procedure • CTM ERCP Service Standard Operational Procedure • Acute Pancreatitis Pathway **ESR compliance Dashboard – Planned Care (April 2024)** 

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
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	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): 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.

Planned Care Group incident process

Datix incident is submited by staff member, notifcation sent to incident manager and triumvirate and patient safety team.

Severity of harm reviewed by incident manager, patient safety team and advise if rapid review meeting is required. No/Low harm incident managed by incident manager and closed.

Within 72 hours of incident, the patient safety team with arrange rapid review meeting. Key attendees: Clincial Director, Head of Nursing or Lead Nurse, Senior Nurse and Ward manager, Directorate Manager/ Deputy & Patient Safety Team.

Timeline of events to be discussed during meeting. Rapid review panel establish if there is any harm has been caused to service user. If moderate/severe to trigger Duty Of Candour and consider Nationally reporting to NHS Executive.

If potential moderate/severe harm has been caused. Investigating officer to be appointed to complete Investigation ie SBAR/ Root Cause Analysis. Family Liaison Officer (FLO) to be appointed and to contact family.

SBAR/RCA to be completed by investigating officer with support of patient safety team.

SBAR/RCA Quality assured by Head of Nursing, Clincial Director, Directorate Manager & Patient safety team.

SBAR/RCA sent to USC Directors for final approval.

For Triumvirate Leads please see attached Planned Care Organogram

Planned Care Group Concerns Process

Formal concern raised by the service user, submission to the central concerns team.

Concerns team triage concern and sends to the speciality triumvirate**
Clinical Director, Directorate Manager & Deputy DM, Lead Nurse & Head of Nursing (respective Hospital)
**Specialist Services,/General Surgiery & Gastro Intestinal/ Anaesthetics, Critical Care, Theatres & T&O

Responsible officer (RO) is allocated to the most appropraite person by triumvirate.

Response is formulated by RO and sent back to desiginated Concern Handler.
The respective Head of Nursing must be cc'd into this e-mail

Concerns handler with quality assure and send to the USC Directors for final sign off.

Once finally approved, concern handler sends to service user.

For Triumvirate Leads please see attached Planned Care Organogram

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

Agenda Item
5.2d

Quality & Safety Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
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 Health Board
ACCT	Assessment, Care and Custody Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
BBV	Blood born virus
CAVUHB	Cardiff and Vale Health Board
CDS	Community Dental Service
COPD	Chronic Obstructive Pulmonary Disease
CPE	Clinical Practice Educators
DIC	Death in custody
DNACPR	Do not attempt cardiopulmonary resuscitation
ED	Emergency Department
IV/PHT	Immunisation Vaccinations/ Public Health Team

GA	General Anaesthetic
GDS	General Dental Services
HB	Health Board
OOH	GP Out of Hours service
PCH	Prince Charles Hospital
POWH	Princess of Wales Hospital
SPC	Specialist Palliative Care
WG	Welsh Government
YCC	Ysbyty Cwm Cynon Hospital
YCR	Ysbyty Cwm Rhondda Hospital
QSRE	Quality Safety Risk Experience

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience Primary Care and Communities Care Group at its meeting on the 14th June 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	**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. **Lymphoedema Service** – Breaches on LNW guidelines for routine (12 weeks) and urgent referrals (4 weeks). Significant waiting list of over 800 new referrals and number of national concerns raised. Service review planned to address identified shortcomings. Action plan to be approved to ensure there is a clear timeframe for improvement work to be undertaken. The new patient pathway process has been implemented following support from the improvement and innovations team. An MDT meeting is arranged for the 10th July whereby an action plan and trajectory being completed.
Advise	The CTM launch of the new **All Hazards Health Protection Service** is planned on 27th June 2024, which will replace the existing IV/PHT and Specialist Immunisations Team. **Marie Curie** volunteer companion service (appendix available on request) planned to commence in July 2024, within the Merthyr Locality initially. The pilot will consist of volunteers who can deliver a befriending service to our palliative/ end of life patients where they will be able to offer emotional support, practical help and any other additional help with information and support they require. **Bridgend District Nursing manual handling compliance** – risk assessment submitted by West Network identifying low compliance with manual handling training. Low compliance a common theme across Bridgend area and attributed to service pressures. Action plan in place to focus on areas of urgent

	attention. Support from CPE team being given to increase compliance quickly. **Parc Prison** there is a new leadership model which provides assurance that a Head of Healthcare and Lead Nurse is on site full time. **Parc Prison** initiated command mode for two separate incidents • First incident followed further DIC, total of 89 patients all under an ACCT were reviewed and rag rated. Joint data base completed with G4S. • Second incident involved an act of concerted defiance and disorder by a group of patients – safety measures implemented to minimise risk to health care staff, cold de – briefs ongoing. **Wound Clinic Service –** waiting lists, particularly in YCC, increasing due to reallocation of rooms. Referrals being prioritised and plans being explored to prevent further increases. **At Home service –** Green referrals (which should be seen within 1 week) are now waiting up to 3-4 weeks before having an initial assessment. Referrals are prioritised and rotas scrutinised to ensure minimum cover of staff per day to decrease the waiting list. **BBHS -** plan to improve assessment quality across the HB and ensure there is a governance framework in place for the service **TVN -** multiple requests for team to provide additional training around pressure ulcer prevention and basic wound management, namely to external care agencies and to Heatherwood Court facility. At present there is insufficient capacity in the service to provide additional training due to operational demands. However, to continue to support the training requirements, the external care agencies have been offered places on the scheduled HB training days. **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

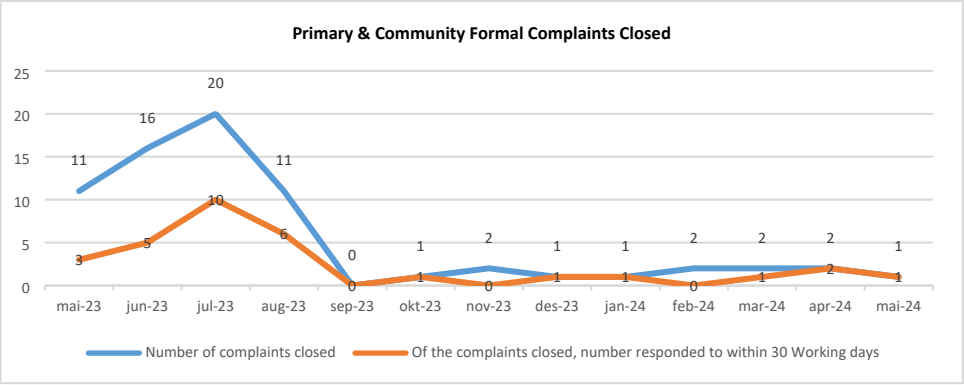
	meetings to explore how they can expedite discharges. Data to be collected and evaluated after 4-week period. **District Nursing** CIVICA scheduling data has shown some data quality issues, Senior Nurses undertaking peer reviews of data to improve quality to support demand and capacity decisions. **CDS Orthodontics** –267 patients outstanding who have been assessed and waiting to start treatment, plus 105 waiting for assessment. 362 patients who need to start treatment/ require assessment continue to wait extensively for treatment [over 2 years] due to specialist retirement in CDS. GDS will procure a temporary contract to deliver this care in practice. A new provider to start the orthodontic assessment and treatment for those patients on waiting lists is required and will be sourced from opportunities within the current budget. **Parc Prison** – a review of DNACPR documentation was undertaken and there were no significant concerns identified. An action plan has been written to strengthen the procedure within the Prison setting. **Navigation Hub including OOH** • New 111 system deployed by WAST, which now requires different approaches to patients flow and the team are still working through these changes. • Re-tendering exercise for PCH/Bridgend weekend model delayed due to awaiting new national procurement guidelines. Contract ended for 6 months.
Assure	**Parc Prison** Control Drug concerns raised with Principal pharmacist with large number of medication dispensary hatches - principal pharmacist agreed to limit quantities where possible, this has led to a decrease in medication incidents. **Parc Prison** challenges in implementing BBV testing in admissions due to staff resources –task group set up with Public Health team, aim is BBV testing will be standard admission practice on all patient's admissions – to be implemented by September 2024. **Parc Prison** Lead nurse for Mental health devising a process in collaboration with other service leads to ensure there is an ADHD pathway in place. **Parc Prison** 11 x ongoing action plans for DIC, actions identified and tracker devised to monitor progress.

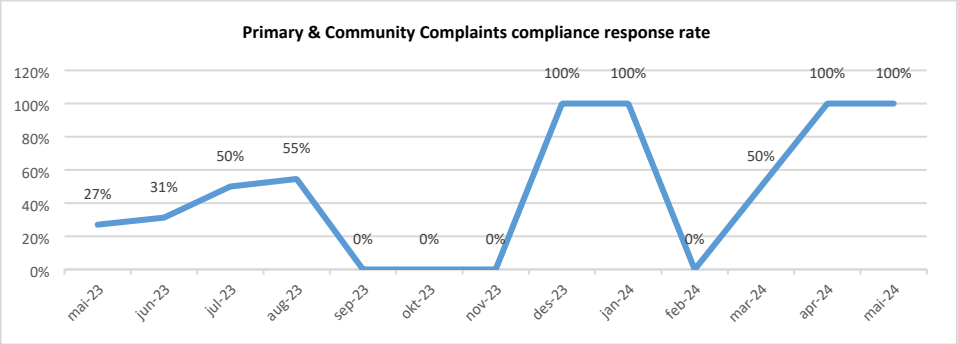
	YCC Ward 3 and **YCR** Ward B2 Ward Accreditation Visit undertaken – initial audit results positive, final report and accreditation award remains outstanding. **Respiratory Nursing -** new spirometry service for suspected COPD in Primary Care commenced 1st July. Clinics will be front loaded with an 'Innovation Sprint' using students from USW trained in Spirometry testing over 6 weeks period between August and September. Plans in place to recruit via staff bank. COPD Enhanced Care Project with the **Navigation Hub/GPOOH** in the form of a virtual ward has been completed and is being evaluated. Early data suggests positive results with prevention of readmissions for most patients. **CTM Local Gender Team:** repatriation due temporary measure until September 2024 local practice Pont Newydd will continue to provide this. Long term solution/recruitment requirements.
Inform	**Palliative Care** Y Bwthyn Newydd POWH hosted a successful open day with external agencies as well as the SPC team providing advice and showcasing the work they undertake for other team members within the organisation. **Palliative care** workshop has been delivered to Bridgend District Nurse Team leaders to review pathways, Care Decisions tool and symptom management. **Vaccination team** an award for Vaccination Saves Lives 2024 – was handed to Senior Nurse for the services due to her developing a postcard to pregnant mums regarding the benefits of vaccination in pregnancy (appendix available on request). **Parc Prison** improvement work: • Older person's health promotion day is being planned for July 2024. • Bereavement team to provide training to healthcare staff to enable them to develop a bereavement cafe in the visitors centre. • Transfers to ED – task and finish group devised, representative attending from G4S and ED team in POWH. • Ongoing All Wales document being devised for prison transfer to acute sites. **District Nursing intranet page** – new page developed to enhance information for wider UHB.

District Nursing data dashboard – work started with informatics team to provide a local CTM service dashboard to simplify national data submissions and to provide local intelligence to team leaders to support demand and capacity efforts. Anticipated to have a working draft by Autumn 2024

Optometry - Roll out of Microsoft 365 to all optometry practices has commenced, which will provide access to NHS email. Cwm Taf Morgannwg is the 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	No. audits	Current compliance	Improvement
Health & Safety	1		
Health and Care Standards	2	G 100.0%	
Infection Control	5	G 99.1%	
Medicines Management	3		
Patient Safety	14	G 94.6%	

Appendices	Award winning poster created by Senior Nurse for Immunisation and Vaccination Team with postcards in English and Welsh (appendix available on request) Marie Curie Befriending service – Pilot in Merthyr locality (appendix available on request)

4. Assessment

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

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

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

Agenda Item
5.2e

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	23/07/2024
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	Hannah Wilton- Chief Pharmacist
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AHP	Allied Health Professionals
CDs	Controlled Drugs
DI	Designated Individual
ACCT	The Assessment, Care in Custody and Teamwork process
CDAT	Community Drug & Alcohol Team
CIED	Cardiovascular Implantable Electronic Devices
DHCW	Digital Health and Care Wales
DTPS	Diagnostics, Therapies, Pharmacy & Sciences

HIW	Healthcare Inspectorate Wales
HTA	Human Tissue Authority
IABT	Independent Authorisation of Blood Component Transfusion
INR	International Normalised Ratio
ISO	International Organisation for Standardisation
LHP	Llantrisant Health Park
NOUS	Non-Obstetric Ultrasound Scan
MHRA	Medicines & Healthcare products Regulatory Agency
MRI	Magnetic Resonance Imaging
OCP	Organisational Change Policy
OMB	Operational Management Board
OOH	Out Of Hours
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
PPM	Planned Preventative Medicine
QA	Quality Assurance
RGH	Royal Glamorgan Hospital
RSI	Repetitive Strain Injury
RTT	Referral to Treat Time
SLA	Service Level Agreement
SBUHB	Swansea Bay University Health Board
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
WLI	Waiting List Initiative
MCCD	Medical Certificate of Cause of Death
HMPPS	HM Prison & Probation Services
PHW	Public Health Wales

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 17th June 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	**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 funding to support this longer term. **No Health Board MRI Pacemaker Service (Risk ID 5730)** • 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. • PCH site will offer a limited service as cardiac physiology is available on that site. • Pacing defibrillator to be purchased. Capital SON in development to support. • Follow up meeting scheduled.
Advise	**<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. **<u>Radiology</u>** **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. • Waiting list profile growing and routine waits increasing. • Options Appraisal Business Case developed to request support for additional funding/resources to tackle CT demand.

- Audit of OOH requests and justification, to understand appropriateness of demand.
- Re-vetting >8 week CT head scans and offering an alternative MRI scan where possible to balance the risk.

Non-Obstetric Ultrasound (NOUS)

Increase in >8 weeks wait due to reduced activity following cessation of PAAR pay rates. There is little appetite to undertake overtime by the sonographer workforce due to them mostly working part time hours.

The service is currently carrying 5.2WTE sonographer vacancies and unable to recruit substantively. 4.0WTE training posts have been advertised internally. Unfortunately, the 2-year Bristol course does not commence until January 2025. The team are reviewing the Birmingham course which commences in September 2024.

WLI work is being undertaken by SpR and Consultants to address current backlog growth.

A Business Case is being developed to request re-introduction of PAAR rates and additional resource to address the backlog.

Pathology

UKAS:

Assessment commenced on June 3rd and ended on June 26th. To date the Quality Management System, Haematology, Cellular Pathology, Mortuary, Blood Transfusion and Microbiology have been assessed. There have been a number of findings, which is expected as this is Pathology's 4-year re-assessment and transition to ISO 15189:2022. A number of findings have been raised across all Pathology departments, which is not unusual for UKAS assessments. **No significant concerns were highlighted** and the team are confident regarding the submission within the required timeframe.

There is concern regarding the current lack of Pathology Clinical Director as this role is integral to the management of risk in the 2022 standard. Lack of space in cellular Pathology has been raised as an issue in previous UKAS assessments, and has been discussed during this assessment. However, the assessor has been appeased by the fact that there is a potential local resolution to expand Cellular Pathology space in the near future.

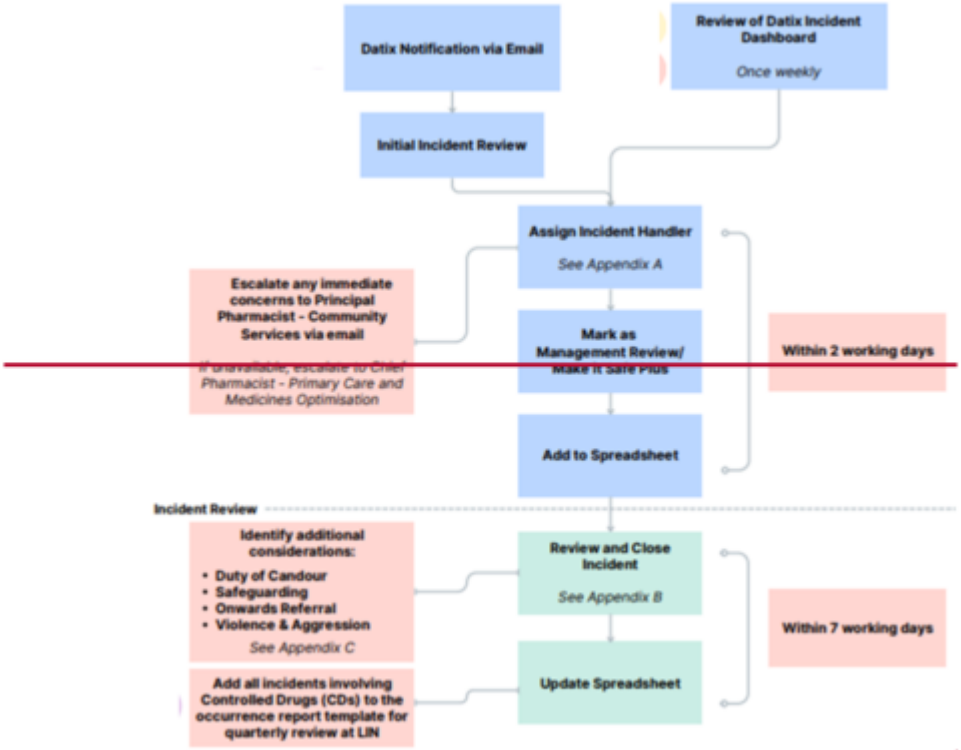
Assure

Pharmacy and Medicines Management
Controlled Drugs Management

Urgent update to controlled drugs management action plan at the request of the Audit and Risk Committee. A date of 1st September had been set to achieve 100% compliance with CD audits and updated authorised signatory lists. The Committee requested this is brought forward to the July report. Current figures for completion of CD audits are:
PCH: 100%
POW: 98% (Outstanding areas to audit Theatre Recovery)
RGH: 75.5% (Outstanding areas to audit: Theatres - 10 theaters in total booked in for next audit day on 4th July 24)

Dispensing incidents in Community Pharmacy

The medicines management team have developed a flow chart to improve handling of Community Pharmacy independent contractor Datix reports, as we do not investigate only review. Notification of CD incidents, safeguarding escalations, and Duty of Candour requirements of the third-party independent contractor have been included.



Deaths in custody in HMP Parc:

- 11 deaths in custody over the last 3 months – 4 (possibly 5) suspected drug related spice / nitizine deaths so considerable pressure and scrutiny within the establishment
- 3 potential suicides have led to review of all open ACCTs
- Pharmacy now invited to all Rapid Reviews
- All CTM staff have been offered current well-being offer with bespoke well-being offer being developed for HMP Parc CTM colleagues

Radiology

Lung Health Check Pilot won the Moondance Cancer Initiative award for 'Early Detection and Diagnosis'.

Pathology

An incident occurred in August 2023 where the Biochemistry department discovered an issue with the automated haemolysis index for folate results. This could potentially have led to erroneously high folate results dating back to 2014. Since 2014 around 290,000 folate results have been issued, these results were reviewed using several biological/analytical parameters and complex calculations. The review has narrowed the number down to 109 living patients and 220 deceased patients where an erroneous folate result may have had clinical impacted patient care.

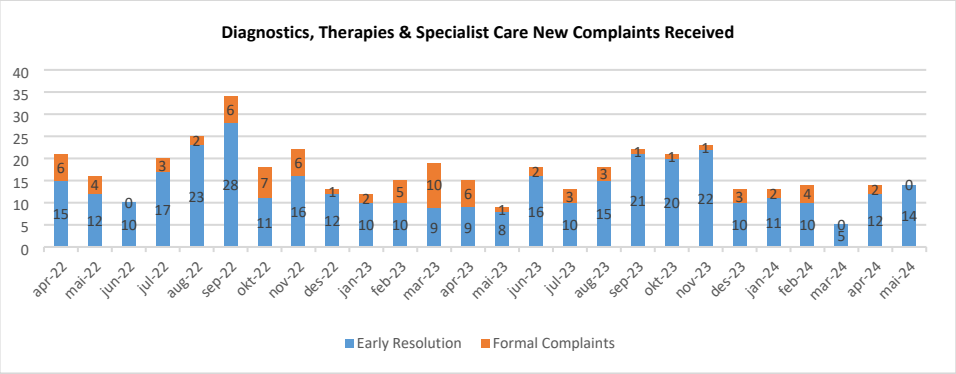
An SBAR for this incident has been completed and escalated to the DTPS Care Group and taken to ELG for final oversight and approval. ELG asked that a SBAR be taken to QSC for awareness and assurance. This report has been made available in the documents folder within Admincontrol for Members to review. Members will note that this matter was also reported in the DTPS Care Group Highlight Report presented to the March 2024 Quality & Safety Committee.

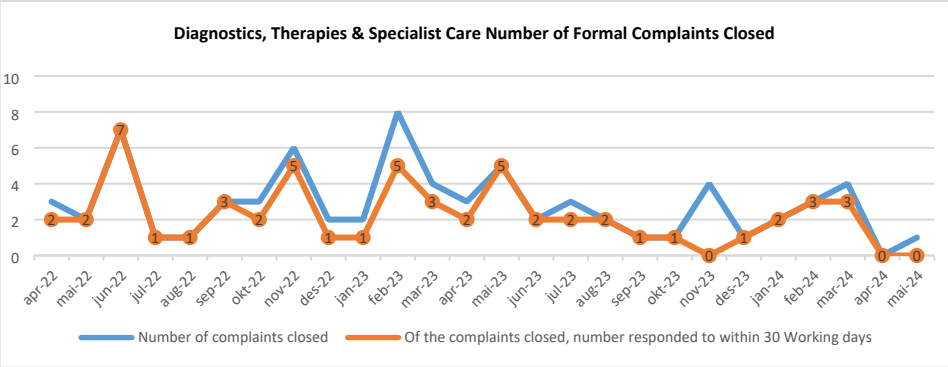
Pathology results available screens (PathRas):

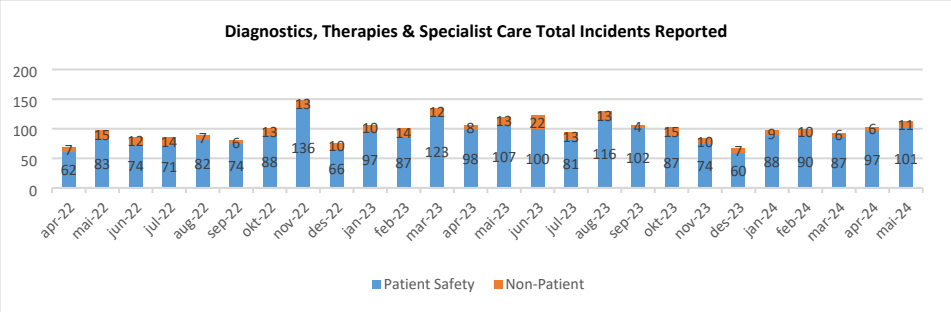
This is a real time dynamic dashboard that has been developed through innovations made by the CTM Biochemistry department. The intention is to implement in A&E departments. The dashboard will indicate when patients' blood test results are available to view on WCP, and also alert to any critical results that require immediate attention. The benefits of this dashboard include:

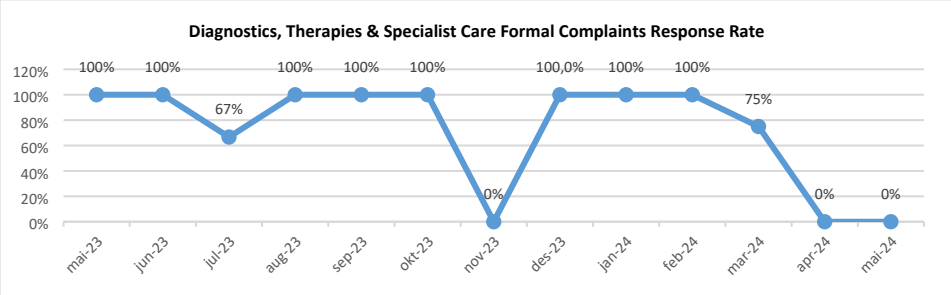
- Reduced time for critical results and treatment;
- Reduced time for non-critical results, reducing time to discharge and improving patient flow.
- Improving staff efficiency, as they will not have to continuously check WCP to check if results are available.

	ED staff have been consulted regarding the dashboard and this has been very positively received. The dashboard is currently sitting with DHCW to ensure the dashboard view is in the correct format prior to implementation.
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 %. **Pharmacy and Medicines Management** **Lovely compliment received about new frailty service at PCH:** *"Thank you to the pharmacy team on ward 3, your help and support with the complexity of my mother's discharge, it was really distressing at times seeing her so upset because we couldn't get carers to support with medication. The team went above and beyond to help me and we eventually got her home with a medicines package of care. Your support and communication to me really helped and gave me confidence that there would be an end in sight. Thank you so much!"* **Therapies** Physio 7-minute briefing following Medical Examining Officer feedback regarding team communication (Appendix 1)
Appendices	Not applicable

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: 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** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Person centred Timely Safe Equitable Efficient
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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

5. Recommendation

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

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

Physiotherapy In Patients

7 Minute Briefing

Morning Board/MDT Discussions/communication

1 Introduction

Medical Examining Officer (MEO) requested physiotherapy manager to look at the disparity from the information the physio had discussed with the family and the information the rest of the MDT were having with the family. It was not a formal concern but looking for lessons learned from the situation and why was the physio unaware of the clinical picture for the patient and planning discharge, the same day the medics were telling the family the patient was end of life.

2 Situation

- Patient admitted following extensive MCA infarct
- Long stay in hospital, further complicated by several infections
- NG Fed
- Poor physical outcome measures causing significant disability
- Medics spoke to family and reassured them that a meeting was scheduled on the Monday (4 days' time) to discuss the patients' needs on discharge, (physio involved with this).
-

3 What Changed?

Over the course of the weekend the patient's condition deteriorated and medics had a conversation with the patient's family updating them on the deterioration of their relative's condition.

- N/S had end of life discussion with family on the Saturday.
- Physio had previously planned a discussion with the family for the Tuesday

4 Communication Issues

Physiotherapist spoke to family on the Tuesday as previously planned, unaware of the change in the patient's condition and was still working on the premise of discharge for the patient.
This was obviously distressing for the family and physiotherapist apologised.

Physiotherapist relied heavily on morning board for patient updates but the board had not been updated to reflect patients' current condition.

5 Lesson Learnt

- Discussions with patients/families are not recorded on morning board
- No audit trail with morning board
- Not suitable to rely on this as main form of communication.

6 Action Plan

- Physiotherapy Team Leads need to ensure they and their teams are compliant with medical note reviews prior to each patient contact and not to rely solely on board round/MDT discussions for updates on medical conditions and status.
- Sharing learning with Physiotherapy teams

7 Further Actions

- 7-minute briefing to add to learning repository
- Leaning to be shared at Therapies Governance
- Lessons learnt and action plan shared with MEO.

(Agenda Item 5.3)	23 July 2024	Quality & Safety Committee	Stroke Services Progress Report

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	N/A
Prepared By:	Jade Gooch, Directorate Manager for Integrated Medicine
Presented By:	Lauren Edwards, Executive Director of Therapies and Health Science
Approving Executive Sponsor:	Lauren Edwards, Executive Director of Therapies and Health Science
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	• 5 day service provision impacting on patient outcomes and experience • Extremely fragile Consultant workforce • Difficult to improve key KPIs
Related Health and Care Standard	Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No - N/A
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes ACP workforce expansion to extend the service working hours to 7 days per week
Link to Strategic Goals	Please Select: Improving Care

Stroke Progress Report
Quality and Safety Committee

July 2024

CTM Stroke position

The Stroke Consultants within CTM cover Stroke services on two acute sites (POWH and 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 consultant gaps.

There are currently 4.0 WTE Stroke Consultants and 4.8 WTE CNS in post across CTM, broken down as follows:

- 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 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 able to deliver a safe and sustainable Stroke service at PCH.

Stroke services consolidated onto two sites which are PCH and POWH. We no longer offer Stroke provision at RGH and Stroke patients are transferred to PCH once accepted by a Stroke physician. At PCH and POWH we provide on-call, inpatient and outpatient care for Stroke patients.

PCH has a 24 bedded Acute Stroke Unit with dedicated rehab care being provided at YCR with 8 commissioned beds. POWH has a 22 bedded Stroke Unit providing acute and rehab care in one place with no rehab beds being provided in the community.

A recent audit shows that on average we have 7 clinically optimised patients on our stroke wards each day who do not need acute stroke care, as well as having on average 2 – 3 medical outlier patients on our stroke wards each day. This is having a significant impact on being able to deliver the right care to our Stroke patients as well as having an impact on our key performance indicators which we have to report on a monthly basis.

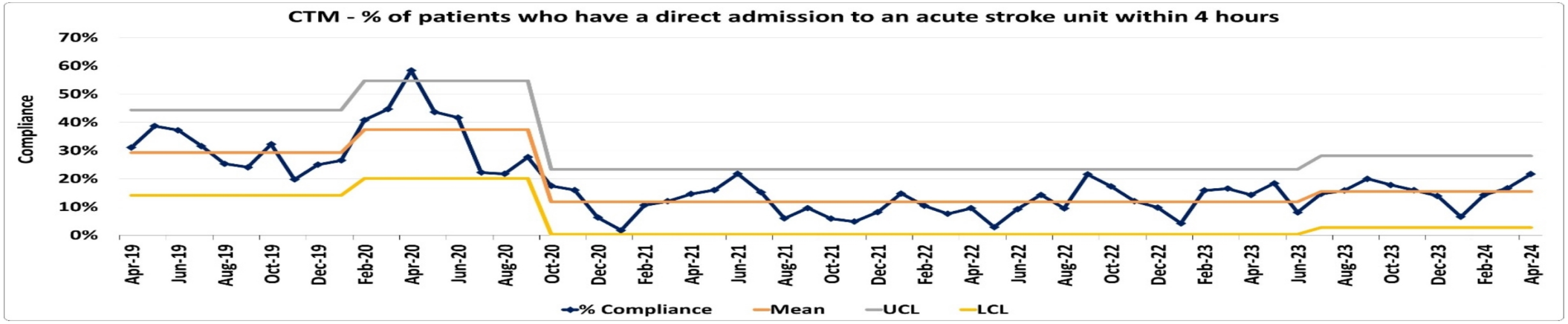
Quality Improvement Measures across PCH and POWH

The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides the Health Board with an overview of 6 national Quality Improvement Measures (QIMs), which are part of the suite of improvement measures in the SSNAP:

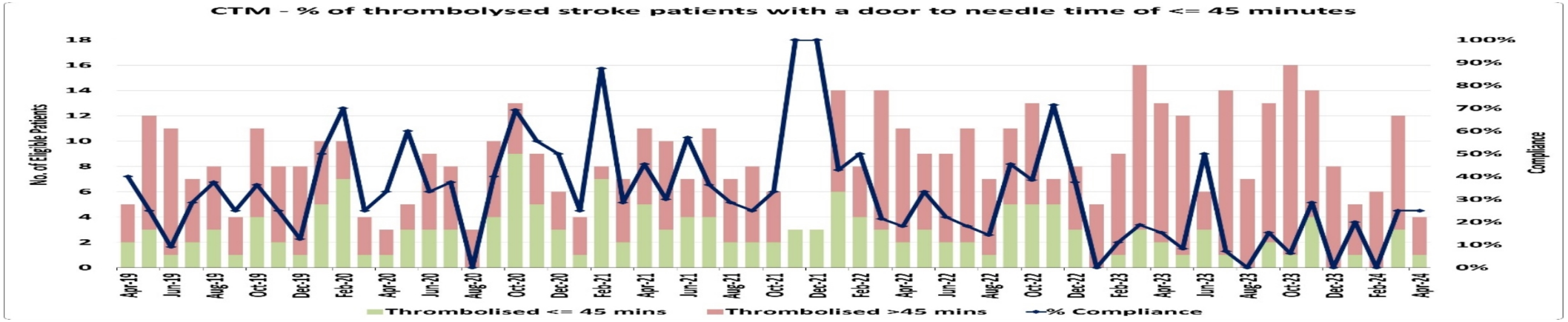
- Direct admission to an acute stroke unit within 4 hours
- Thrombolysis with a door to needle time within 45 minutes
- CT scan within 1 hour
- Assessment by a stroke consultant within 24 hours
- Patients assessed by one of OT, PT, SALT within 24 hours
- Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team

CTM UHB Unscheduled Care Group: Stroke Quality Improvement Measures (QIMs) – April 2024

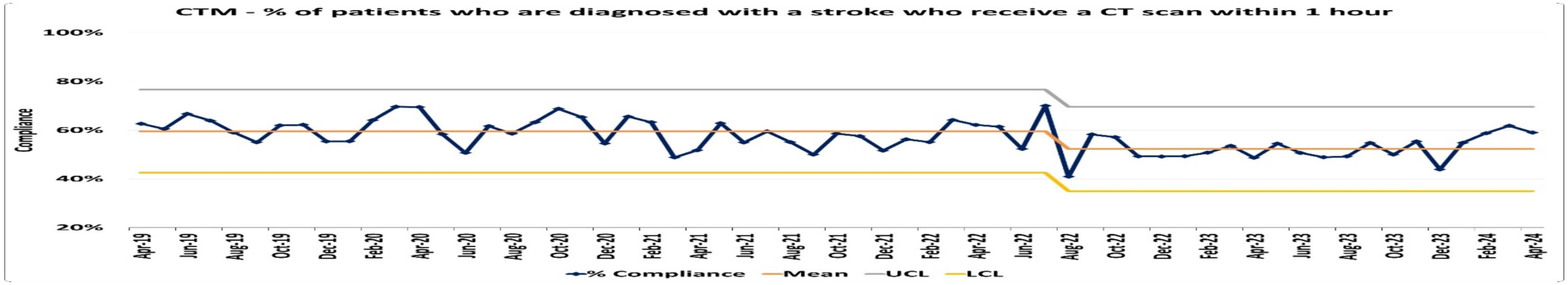
% compliance with direct admission to an acute stroke unit within 4 hours – 20.8%



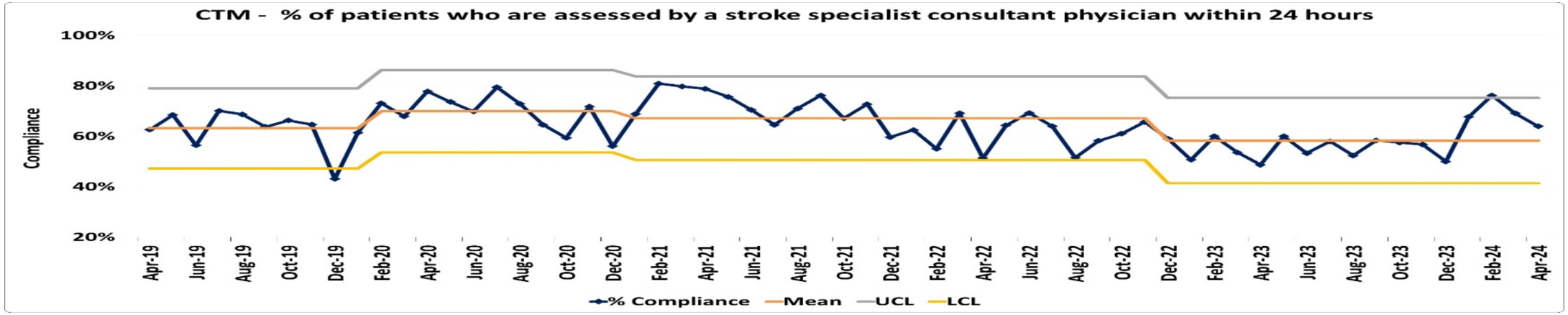
% of eligible patients thrombolysed door to needle time within 45 minutes – 25.0%



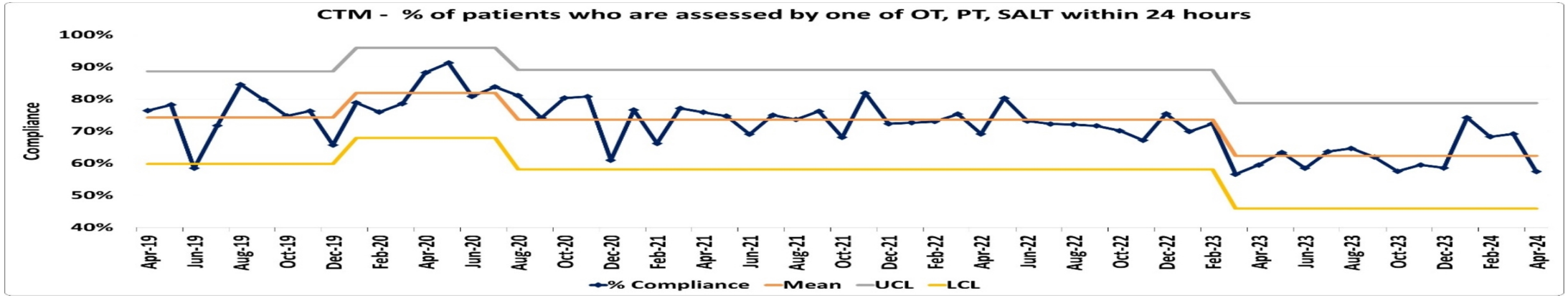
% of patients diagnosed with stroke received a CT scan within 1 hour – 59.0%



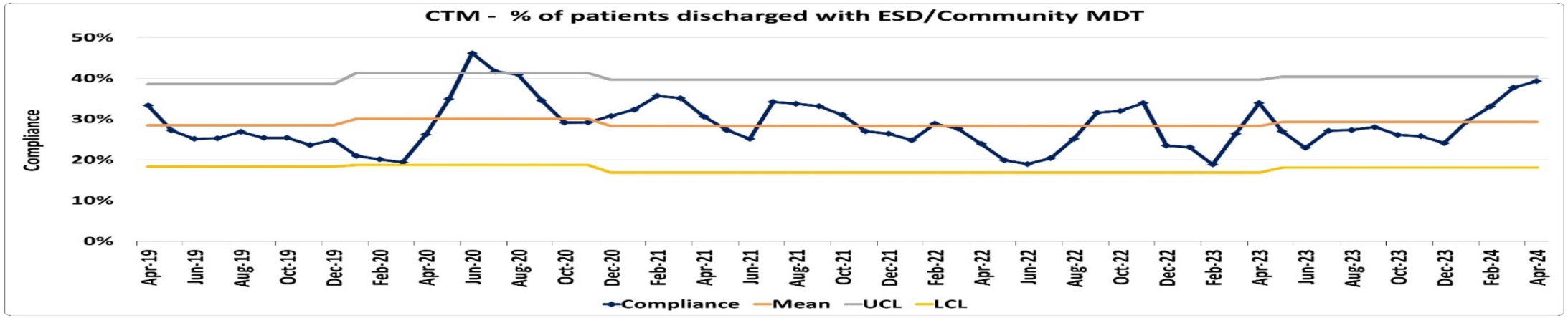
% of patients assessed by a stroke consultant within 24 hours – 63.9%



% of patients assessed by one of OT, PT, SALT within 24 hours – 57.4%



Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team – 39.3%



Stroke QIMs as per current month submitted data - May 2024		PCH	POW	YCR	CTM
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours	Total admissions	56	45	N/A	101
	No. of patients within 4 hours	21	0		21
	% Compliance	**37.5%**	**0.0%**		**20.8%**
% of thrombolysed stroke patients with a door to needle time of <= 45 mins	Total thrombolysed	10	5	N/A	15
	No of patients within 45 mins	2	0		2
	% Compliance	**20.0%**	**0.0%**		**13.3%**
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Number diagnosed	58	45	N/A	103
	No. of patients within 1 hour	39	21		60
	% Compliance	**67.2%**	**46.7%**		**58.3%**
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	58	45	N/A	103
	No. of patients within 24 hours	39	26		65
	% Compliance	**67.2%**	**57.8%**		**63.1%**
% of patients who are assessed by one of OT, PT, SALT within 24 hours	Total admissions	58	45	N/A	103
	No. of patients within 24 hours	36	35		71
	% Compliance	**62.1%**	**77.8%**		**68.9%**
% of applicable patients discharged with ESD/Community Therapy MDT (rolling 3 months)	Applicable Patients	78	89	16	183
	No. of patients with ESD/MDT	33	19	3	55
	% Compliance	**42.3%**	**21.3%**	**18.8%**	**30.1%**

How are we doing?	• During May, 20.8% (21 out of 101) stroke patients were admitted directly to an acute stroke unit within 4 hours. . Significant bed pressures across PCH & POW are impacting the transfer of patients to a stroke unit within 4 hours. We have also seen an increase in infection control breakouts throughout the hospital sites which has led to multiple beds and ward areas closed impacting further on patient flow throughout the hospital sites. As part of the perfect week, the directorate has proposed the possibility of ringfencing stroke beds to reflect the positive impact on a patient's pathway and patient experience by being able to do this. Compared to previous months, during April there was a 40% rise in stroke admissions going from a monthly average of 60 to 101 patients. The service will manage this trend going forward. • Two of the fifteen eligible patients that were thrombolysed received this within 45 minutes. A 26% increase in the number of patients who were thrombolysed in total compared to April. Although only two were thrombolysed within 45 minutes, all eligible patients were thrombolysed which is positive. There are multiple reasons for not all patients being thrombolysed within 45minutes such as; atypical presentations, patients presenting self-presenting to RGH, patients presenting outside of core hours as well as two bank holidays in May where no stroke provision is in place which will all impact on this KPI. • 58.3% of patients (60 out of 103 diagnosed patients) had a CT scan within an hour. WAST policy for transferring patients to CT continues to be an issue at PCH and POW which is impacting on performance. In addition to this, recent changes made to the in-house portering service has seen POW patients waiting increasingly longer for CT scans due to delays being transferred from A&E, AMU and ambulatory care. • 63.1% (65 out of 103) of stroke patients treated in May were seen by a specialist stroke physician within 24 hours of arrival at the hospital. The added pressure for May was having two bank holidays which will impact on patients being reviewed within the required timeframe. There were also multiple self presenting patients to RGH as well as patients attending outside of core hours. • 68.9% (71 out of 103) of stroke patients were assessed by either an Occupational Therapist, Physiotherapist or Speech and Language Therapist within 24 hours of arrival. AHPs run a Monday–Friday core hours service, which will impact on performance each month depending on the times patients present to hospital.
What are the challenges?	• Insufficient flow throughout the hospital impacted by high levels of clinically optimised patients • Fragile Stroke consultant workforce • Insufficient Clinical Nurse Specialist workforce • Self-presenters from RGH requiring an acute Stroke bed at PCH • Inability to ringfence stroke beds • Stroke service set up Monday – Friday core hours only • Lack of psychology support for patients post acute-stroke • Limited stroke rehabilitation capacity in the community

What progress has been made?	• Brainomix AI for CTs and CT angiograms has been implemented in CTMUHB. The technology has been developed to minimise delays in referral for thrombectomy . • CTM Stroke Programme Board and Stroke Operational Group established. • Extension of the Early Supported Discharge Service to cover Bridgend area, enabling specialist support for patients in the community and increased flow of stroke patients in POWH and equity of provision across CTMUHB. • Continued close working with Stroke Association to monitor service level agreement for stroke recovery service providing support in the community for stroke patients on discharge from hospital. • Community Hospitals Bed Modelling Programme in CTM UHB, including beds for stroke rehabilitation, draft project initiation document in place. • Modelling for an extended Advanced Clinical Practitioner Specialist Workforce has been undertaken • CT perfusion can now be carried out at PCH and RGH, however, limited improvement will be seen for thrombolysis and thrombectomy rates due to current workforce constraints. • IRMER training now completed for CNS workforce across CTM to support improvement of CT scanning within one hour of arrival.
What are the key priorities for improving Stroke performance and outcomes for patients?	• Recruitment into the Stroke Consultant post • Business Case to seek resource for the expansion of the ACP workforce to achieve a 7 days per week, extended service. • Business Case to seek resource to extend the Data Co-ordination role at PCH to incorporate POW to ensure robust and consistent processes, data quality, analysis and reporting across the Health Board. • Development of solution to increase the inpatient Therapy resource. • Rollout and development of the site flow plans • Full role out of the use of CT perfusion across all sites • Community bed remodelling

Stroke Entry on Risk Register

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.	Risk reviewed by SMT, stroke services options appraisal has been submitted to ELG. The Stroke consultants within CTM cover Stroke services on two acute sites (POWH and 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. Risk rating upgraded and next review due 02/08.

What is required to realise the improvement of the 4 hour target?

1. **Resource the expansion of the CNS workforce**
2. **Resource Data Co-ordinator role**
3. **Recruitment to the vacant Stroke Consultant role - long term substantive or short term locum**
4. **Progress to 7 day workforce model**
5. **Embedded in slides 13 to 17 is the action log for stroke services to support improvement**

Stroke Operational Group Action Plan

Indicator	Actions	Dependencies	Lead	Timescale	Updates	completion indicator
% compliance with direct admission to an acute stroke unit within 4 hours						
	To increase the Stroke Nursing capacity and resilience to provide 24/7 cover	Funding	CSG Manager	Mar-24	Proposal to be presented	
	To ensure Ring-fenced Stroke beds on both sites -	Improved flow	Head of Patient Flow		SOP collaboration with patient flow team and Senior Nursing team around patient flow - recent audit shows on average we have 7 clinically optimised patients on our ward each day as well as 2 - 3 medical outlier patients which is impacting the ability to ring fence beds on ASU - Ring fencing beds proposed as part of perfect week plans	
	Updated FAST campaign plans to be clarified		tbc			
	Staff recognition of stroke symptoms on presentation of patient across hospital sites		ED Senior Nurses		Red flag Training for receptionists	
	Improve CNS hours to capture more patients presenting within time window and identify eligible thrombectomy patients	Current roles filled	Lead Nurse USC	Nov 2023 - Apr 2024	Changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service agreed. To be implemented when CNS provision is backfilled.	
% of thrombolysed stroke patients with a door to needle time of <=45m	To continue exploring options to fill the vacant Stroke Consultant role @PCH	Applicant uptake	CSG Manager/tbc		Rolling advert for post live. Further impact to the service with PCH being left with one consultant due to Dr Walters going on maternity leave	
	To increase the Stroke ACP capacity and resilience to provide extended cover 7 days per week	Funding	CSG Manager	Mar-24	Proposal to be presented	
	Improve CNS hours to capture more patients presenting within time window and identify eligible thrombectomy patients	Current roles filled	Lead Nurse USC	Nov 23 - Apr 24	Changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service agreed. To be implemented when CNS provision is backfilled.	
	CT Perfusion Service implementation panCTM		Stroke Clinical Lead		CT Perfusion installed at PCH and RGH. Awaiting installation to PoW. Will not be able to fully implement pathway until additional resource is secured.	

Stroke Operational Group Action Plan

% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Extend Consultant service to 7 days - Increase Stroke Consultant numbers	Applicants	Stroke Clinical Lead		Unable to recruit to vacant posts - national shortages for Stroke consultants	
% of patients who are assessed by one of OT, PT, SALT within 24 hours	Extend therapies service to 7 days	Funding			Stroke Investment paper submitted to HB Quality & Safety Committee January 2023 included therapy staffing requirements	
% of applicable patients discharged with ESD/Community Therapy MDT	Extend ESD service pan CTM	Applicants	Head of SLT		Expansion across to bridgend currently in process following HB investment. Referral criteria/pathway being established	
Underpinning To achieve robust reporting and processes to ensure consistency across CTM	To explore options to establish a Stroke co-ordinator role/function pan CTM	Funding	CSG Manager		Proposal to be presented	

Matrix

ACTIONS	% compliance with direct admission to an acute stroke unit within 4 hours	% of thrombolysed stroke patients with a door to needle time of <=45m	% of patients who are diagnosed with a stroke who receive a CT scan witin 1 hour	% of patients who are assessed by a stroke specialist consultant physician within 24 hours	% of patients who are assessed by one of OT, PT, SALT within 24 hours	% of applicable patients discharged with ESD/Community Therapy MDT
To increase the Stroke Nursing capacity and resilience to provide 24/7 cover						
To ensure Ring-fenced Stroke beds on both sites						
Updated FAST campaign plans to be clarified						
Staff recognition of stroke symptoms on presentation of patient across hospital sites						
Improve CNS hours to capture more patients presenting within time window and identify eligible thrombectomy patients						
To continue exploring options to fill the vacant Stroke Consultant role @PCH						
To implement and rollout and review Brainomix						
To ensure all CNSs have access to training to request the CT upon admission						
Explore changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service						
Implement Biotronics 3D						
Extend Consultant service to 7 days - Increase Stroke Consultant numbers						
Extend therapies service to 7 days						
Extend ESD service pan CTM						
Underpinning						
To achieve robust reporting and processes to ensure consistency across CTM						

Stroke Strategy Action Plan

Actions	Dependencies	Lead	Timescale	Updates	completion indicator
Review current pathway for Orthoptics and explore potential for unification of service across CTMUHB	Funding	Assisstant Head of Orthoptics	Mar-24	Orthoptic stroke services continue to have different pathways across the HB and there is still a lack of unification. The new NICE guidelines 2023 recommends that people in hospital following a stroke should all be offered a specialist orthoptist assessment as soon as possible. As inpatient or urgent outpatient if discharged The CTM Head Orthoptist post still remains vacant and has not been advertised. It is not possible for Orthoptists to go to the ward currently due to a fully committed small workforce of 8 staff covering paediatric (including visual processing and visual function clinics), adult ocular motility, glaucoma and botox clinics. Plan to review options and go out to advert	
Optimisation of medication and compliance for patients on Primary Care Atrial Fibrillation (AF) and Hypertension Registers. Case Detection of patients with AF and Hypertension.	Primary Care	Health and Wellness Porgamme Manager	Ongoing	CTM UHB Value Based Health Care Business case successful as part of Regional Business Case. Work progressing on implementation. This action has moved to an ongoing monitoring phase so the review date moves accordingly.	
Updated FAST campaign plans to be clarified	PHW	tbc			
Work with Cardiff and Vale UHB to explore potential for regional working and regional enhanced stroke unit	CaV UHB / National Stroke Programme Board	Regional Stroke Programme Manager	Q1 2025/26	At the recent Programme Board meeting held on 20th February, it was agreed that the original timelines were too ambitious considering the work that needs to be undertaken, therefore a revised draft high level programme plan was presented, with the aim of developing a more detailed programme plan. Following the sad loss of the incumbent programme manager, a new programme manager has been appointed who will take up post on 8th July. Progress and next steps will be reviewed at the next programme board meeting on 27th August.	

Stroke Operational Programme Board

Actions	Dependencies	Lead	Timescale	Updates	completion indicator
Develop stroke community rehabilitation model	Funding	Head of SALT	May-24	Extension of ESD complete across Bridgend area, serving POWH. Further development of community model to feed into regional planning process	
Development of community hospital stroke rehabilitation model.	Primary Care, Mental Health and Communities Care Group	Assistant Director PC & Communities	Jul-24	Community Bed remodelling programme underway, feed into SPB.	
Track progress against HIW Action Plan.	Six Goals Programme	USC Care Group Director	Mar-24	Monitoring of plan ongoing	

Progress against the Recommendations of the HIW National Review of Flow relating to Stroke

Recommendations	Status
Recommendation 21. Health boards should review the provision of the CNS or ACP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Proposal being finalised to increase the number of ACP roles at PCH to make a more robust model. This would be replicated for POW to ensure equity.
Recommendation 25: 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 AI has been implemented in CTMUHB since December 2023
Recommendation 27: 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. Recommendation 28: 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. Recommendation 29: Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Medical SpRs and IMTs have undergone stroke simulation training. CT perfusion scanning has been implemented in PCH and RGH to help us enable extending thrombolysis hours, however, current workforce constraints across CTM is going to limit what improvements can be made.
Recommendation 30: 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. Recommendation 31: 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. Recommendation 32:WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is o ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	Thrombectomy pathways in CTMUHB need to be updated following Bristol's recent decision to increase thrombectomy availability from 6am to 12am. Current CTM workforce constraints will see minimal improvement. Interhospital transfers are managed by the "Trauma Desk" at highest priority.

Recommendations	Status
Recommendation 33: 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. Recommendation 34: Ringfenced 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 ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	4 hour target remains poor, as not able to ring fence beds due to lack of capacity and delay in seeing acute stroke patients due to reliance on patients being clerked by on call medical team and inherent delays due to business of acute medical intake and WAST policy to handover patients for CT scans.
Recommendation 35: Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to hospitals, with earlier discharge improving flow through the stroke pathway.	The ESD pathway has recently been extended to cover patients in the POWH catchment area
Recommendation 36: 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. Recent regional survey has shown considerable workforce gaps compared to national standards. No 7 day therapy service.	Recent regional survey has shown considerable workforce gaps compared to national standards. No 7 day therapy service
Recommendation 37: Health boards must consider the need for psychological support for people with stroke, and ensure that adequately trained staff are providing this support to help effectively manage patient recovery.	No psychological support.
Recommendation 38: 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.	No 7/7 service
Recommendation 39: Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	No space for adequate therapy room within the confines of ward 10
Recommendation 40: 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.	Daily Therapy Led Board Rounds

Investment Required
To be delivered through the USC CG Financial Plan

Phase one:

X3 WTE ACP roles - £229,715

Benefits:

- An increase in patients receiving thrombolysis and referred for thrombectomy
- Will increase in the percentage of patients receiving thrombolysis within 45minutes (door to needle time)
- Will improve CT scan within one hour (due to change from one hour to 20 minutes in coming months)
- Will support in providing a more equitable service 7 day service
- Nearly 40% of code 1 & code 2 Stroke calls are outside of current Stroke provision hours
- Will improve patient outcomes and experience
- Will support in achieving a more sustainable service
- Will boost staff morale and what is a current severely fragile workforce

X1 WTE band 6 SSNAP Co-Ordinator role - £50,765

Benefits:

- Will support with significant changes that are coming in from SSNAP
- Will release clinical staff from inputting data, particularly in POWH where no SSNAP role support is provided
- Enable teams to export their data at regular intervals to investigate care processes and outcomes after a stroke
- Will support in reviewing both acute and post acute measures
- Improve data quality to support developing stroke services to improve patient care

Phase two:

X4 WTE ACP roles - £298,287

Benefits:

- To provide 24/7 Stroke service provision
- Would capture all Stroke patients presenting to PCH and POWH Emergency Department
- Improve patient outcomes
- Improve patient experience
- High performance in KPIs, particularly linking to thrombolysis and thrombectomy rates, as well as patients receiving CT scan within one hour

X1 WTE Consultant - £125,000

Benefits:

- Would improve patient care and experience
- Would enable the service to build a sustainable Consultant workforce
- Would enable the Stroke service to fulfil the current a 1:6 on-call rota
- Would minimise ADH/Locum spend
- Allow daily senior reviews to all inpatients
- Would support impact when a Consultant takes leave
- Would support training of our junior workforce

To improve patient outcomes and experience further therapy investment would be required to support 7 day workforce model. Currently the service runs Monday – Friday core hours only. This significantly impacts on the ability to improve KPIs relating to patients being seen by therapy within 24 hours of admission, patients receiving formal swallow screen as well as supporting decreased length of stay if patients were able to have therapy at the weekends, releasing bed pressures on our health board.

Recommendation:	**The Board or Committee are asked to:**
	The Committee are asked to: • Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

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

Agenda Item
6.1

Quality & Safety Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
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 Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	June/July	RISKS REVIEWED
Operational Management Board	12th June 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	15th July 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
Practical Approach to Managing Risk
Risk Assessment and Scoring
Datix Risk Management Module

2.8 To date **637** members of staff trained to date since training commenced in 2021.

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

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

2.11 47 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023).

- 70% (33/47) provided a score of 5/5 in terms of content of the session
- 26% (12/47) provided a score of 4/5 in terms of content of the session
- 4% (2/47) provided a score of 3/5 in terms of content of the session

2.12 100% of the 47 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 96% of the 47 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:
- *"Useful to understand escalation processing more detail";*
- *"Very well delivered with a lot of information included";*
- *"I realised in the session that I don't have a good understanding of how risk is assessed in the organisation and potentially our team should be utilising this more so it initially started as confusing for me but is still very helpful";*
- *"Right amount of information given in the presentations and well explained by the presenter"; and*
- *"Good comprehensive information and resources to refer to".*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Diagnostics, Therapies, Pharmacy and Sciences Care Group

- Datix Risk ID 5730 – No Health Board MRI Pacemaker Service. New risk escalated to the Organisational Risk Register in June 2024. Risk score 20.

Facilities Directorate

- Datix Risk ID 5691 – CCTV System Failure in Prince Charles Hospital. New risk escalated to the Organisational Risk Register in June 2024. Risk Score of 16.

Unscheduled Care – Care Group

- Reinstated Datix Risk ID 1133 - Sustainability of the Emergency Department at the Royal Glamorgan Hospital. Risk Score of 15. Following discussion at Audit & Risk Committee the Unscheduled Care Senior Management Team agreed to reinstate this risk on the Organisational Risk Register until the Invest to Save Paper is approved at the Executive Leadership Group.

Strategy, Transformation, Planning and Commissioning Directorate

- Datix Risk ID 5821 - Provision of secondary care immunology services by external provider (this is a service that is not provided by CTMUHB). Risk Score of 20.

Public Health – Health Protection

- Datix Risk ID 5820 - Reduced Health Protection Funding allocation 2024-2025. Risk score of 12. 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.

3.2 CHANGES TO RISKS

Risk Score Increased

No risks that had been escalated to the organisational risk register were increased in score in the July iteration.

Risk Score Decreased

Diagnostics, Therapies, Pharmacy and Sciences Care Group

- Datix Risk ID 2713 – Backlog of Reporting Radiology Examinations. Risk score reduced from a 16 to an 8 on the 20th May 2024. The risk score has decreased as numbers have reduced so the service is now at a more manageable level. Additional capacity has been made available to support outsourcing arrangements. Risk will continue to be monitored via the DTPS Care Group.

- Datix Risk ID 5404 – Post Mortem Backlogs in Mortuary. Risk score reduced from a 16 to a 12. Risk score decreased as current demand has reduced and returned to seasonal normal and backlog has significantly reduced. It is anticipated that this risk may require re-escalation in winter period. Risk will continue to be monitored via the DTPS Care Group.

- Datix Risk ID 3131 – Mortuary Capacity. Risk score reduced from a 16 to a 12. Score decreased as currently capacity is being managed sufficiently although demand is higher than it normally is at this time of year (this is being noticed in other Health Board's), however there is no imminent threat of breach. It is likely that the risk will re-emerge as we move into winter months, and the risk

will be increased and escalated accordingly as we review and monitor the demand on mortuary services. Risk will continue to be monitored via the DTPS Care Group.

Patient, Care and Safety Directorate

- Datix Risk ID 4906 - Failure to provide evidence of learning from events (Incidents and Complaints). Risk score reduced form a 16 to a 12. Status of all LFERs are regularly monitored in:
  - Quality & Safety Business meeting (weekly),
  - Executive Patient Safety Meeting (weekly),
  - Quality & Safety Committee (bi-monthly).

  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.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

No risks that had been escalated to the organisational risk register were closed in the July iteration.

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

Consequence						
5			3337 3993 4080 1133	5276 5755 5730		
4			5820	4152 3133 5254 4908 4907	5646 5579 5658 5761 5417 5691	4491 4071 4103 3826 5590 5462 5821 4632
3						2808 4691
2						
1						
CxL	1	2	3	4		5
	Likelihood					

3.5 EMERGING RISKS

No emerging risks notified for inclusion in the July iteration Organisational Risk Register.

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** (C4xL4)	Updated risk developed in July 2024 specific to planned care.
1b	**Sufficient capacity to meet emergency demand**		Chief Operating Officer / Executive Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance	**20**	Updated risk developed in July 2024 specific to Unscheduled Care.
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** (C4xL4)	↔

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the Organisational Risk Register. Individual risks may have been subject to QIA.

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	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.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	4 (C4xL1)	New risk escalated to the Organisational Risk Register in June 2024.	21.03.2024	17.06.2024	22.07.2024
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.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C4xL5	4 (C4xL1)	New risk escalated to the Organisational Risk Register in June 2024.	08.07.2024	11.07.2024	11.08.2024
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. Locum arrangements have been made, however, this risk remains under review in terms of mitigation and score. No change to the risk score is considered at this review. Next review date 02/08/24.	Quality & Safety Committee	20	C4xL5	12 (C4 x L3)	↔	11.05.2021	02.07.2024	02.08.2024
5	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.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	C3xL2	↔	18.04.2024	25.06.2024	31.07.2024
6	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.	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	17.06.2024	22.07.2024
7	5276	Director of Digital	Central Support Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update May 2024 - CTMUHB have appointed internally into the 2 x fixed term band 7 clinical systems support roles for Pathology - once these posts have been backfilled these posts will be able to fully support LIMS implementation. The 1 x 8a fixed term clinical systems manager for Pathology has just gone out to advert, hoping to recruit externally - this post will provide project oversight and co-ordination. These posts will bring CTM in line with other Health Board's in terms of dedicated pathology IT support, however, Health Boards across Wales are looking for extra support in addition to this. Pathology continues to hold monthly LIMS deployment meetings with Digital Health Care Wales (DHCW) to facilitate progress. 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.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	04.07.2024	31.08.2024
8	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 June 2024 **Elective Demand-** 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 WL1 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. **Emergency Demand** There has been some improvement against trajectories for emergency demand. Specifically in total reduction of lost ambulance hours. 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 WL1 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.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	09.07.2024	09.08.2024
9	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.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	04.07.2024	02.09.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
10	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF:** The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update April 2024 Previous high risk areas of the injection/macular clinic and the diabetic retinopathy service are now in a much better position with significant delays mostly eliminated. They remain vulnerable and work is ongoing to try and make them more robust and sustainable. CTMUH B did not have a substantive glaucoma consultant from 2017 to 2023. The glaucoma service is top of the list of services to fix but in the process of fixing it, we are going to come across many, many cases of avoidable vision loss. Aside from the human cost of avoidable blindness, there is a large financial and reputational risk to the HB. The glaucoma service is currently at score of 25 on risk matrix - catastrophic consequences (blindness in high volume of patients) (5) x almost certain to occur (5). This needs to be the highest priority area in opthalmology 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.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01.04.2014	04.07.2024	30.09.2024
11	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 July 2024 - All mitigating actions are in place, no further actions can be taken, demand continues to exceed service capacity. Business case to expand service is in development. Next rv due 22.7.24.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	05.07.2024	22.07.2024
13	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. New review date 01/09/2024.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	2.7.2024	1.9.2024
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 Tilbury Douglas 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, Open View 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. Open View have managed to restore the security management system headend and power to the majority of existing site cameras. However there is further work to be undertaken and a risk of system failure remains. The outcome and recommendation from Open View the Capital Major Projects team and Tilbury Douglas is that the existing (SMP) headend system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced Tilbury Douglas will be unable to fully install the (124) new site CCTV cameras. Open View are providing a specification and estimate of cost of a new (SMP)headend so that a SON can be submitted for discretionary capital FY2024/25. System specification provided Capital SON ID 1251 submitted 17 May 24. Waiting for SON approval by ECG for funding.	Facilities have developed a case and tender spec for a suitable new CCTV head end in conjunction with ICT and estates and some discretionary capital combined with PCH scheme funding has been secured to cover the costs and is due out to Tender imminently (July 2024).	Health Safety & Fire Sub Committee Quality & Safety Committee Planning, Performance & Finance Committee	16	C4xL4	C3xL4 12	New risk escalated to the Organisational Risk Register in June 2024.	31.01.2024	24.06.2024	31.08.2024
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 July 2024 - There has been no update on progressions since the last update reported, therefore, the risk remains the same. CTMUHB continue to liase with DHCW on seeking a solution. Next review 1.8.2024.	Quality & Safety Committee Digital & Data Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	01.07.2024	01.08.2024
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 April 2024 - The Care Group have explored the mitigating action required to manage and reduce this risk and identified that the main mitigation will be the allocation of the adhoc additional lists by secondary care, however, these additional sessions are not yet confirmed. Until these sessions are confirmed this risk remains high. The Care Group are working through a plan around demand and capacity with the Planned Care – Care Group for additional theatre sessions but as indicated this has not yet confirmed. Once additional sessions are secured the risk will be reduced and be mitigated through to the backlog being resolved. Update June 2024 - Additional PMBA lists have been added pre the GAA visit, it is hoped that these lists will reduce the numbers of children requiring a GA and will be treated in a different way. E.g. sedation or LA.	Quality & Safety Committee	16	C4xL4	9 C3xL3	↔	20.04.2023	02.07.2024	31.07.2024
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.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	↔	19.12.2023	05.07.2024	18.07.2024
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 end of May 2024: Phase 2 of RCRP due to start August 2024 A national transportation group has been set up in preparation of phase 3 which is due to commence October 2024 A partnership meeting was held in April (notes attached) Health Board monthly meetings continue. Risk reviewed and remains unchanged.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	29.05.2024	31.08.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
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 April 2024 - Risk descriptor changed on this risk review. Business case finalised, and presented to Creating Health Steering Group 18.04.24. Proposal endorsed and the agreed next steps are to identify sources of funding. Next rv 25.7.24. Update July 2024 - no further changes to mitigation since April update. Review remains scheduled for the 25.7.2024.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	05.07.2024	25.07.2024
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 June 2024 Efforts to address the backlog of redress cases are ongoing. Additionally, to address the backlog, overtime arrangements now in place. The implementation of the Duty of Candour has led to a surge in redress cases. In response, team members have been reassigned to manage these cases. A trajectory of the redress cases is currently being developed and will be reviewed weekly in the Q&S Business meeting, as well as the Executive Quality & Safety meeting.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	08.07.2024	16.08.2024
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 July 2024 New reporting mechanisms have been implemented for Care Groups. Members of the Quality and Safety team now participate in governance meetings to review pending statements. A new grading system has been introduced to categorize inquests based on their risk level. This system utilizes a Red, Amber, and Green (RAG) rating to identify high-risk cases. There has been a significant upward trend in the number of inquests over recent years. Projections indicate that the volume of inquests in 2024 is expected to be twice that of the previous year. A future reviews will be undertaken in the Autumn to ascertain if the upward trajectory continues.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	08.07.2024	16.08.2024
25	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update June 2024 Efforts to address the backlog of redress cases are ongoing. Additionally, to address the backlog, overtime arrangements now in place. The implementation of the Duty of Candour has led to a surge in redress cases. In response, team members have been reassigned to manage these cases. A trajectory of the redress cases is currently being developed and will be reviewed weekly in the Q&S Business meeting, as well as the Executive Quality & Safety meeting.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	08.07.2024	16.08.2024
27	3133	Executive Director of Nursing / Deputy Chief Executive	Patient Care and Safety	Head of Clinical Education	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update July 2024 - Ongoing discussion between the Assistant Director of Nursing and the Assistant Director of Clinical Education Venables Divisional Director of Facilities to establish the most appropriate lead for this risk as the next step is to monitor compliance with training to check what impact the actions taken so far have had on this risk. It is felt that this risk should now sit with Clinical Engineering for monitoring therefore, no update action for July other than the risk has been reviewed and discussions continue. The risk will be updated in August if not before.	Quality & Safety Committee. People & Culture Committee.	16	C4 x L4	8 (C4xL2)	↔	01.05.2018	08.07.2024	16.08.2024
28	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	Update 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.	Quality & Safety Committee	16	C4 x L4	4	↔	01.06.2020	17.06.2024	22.07.2024
33	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.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	14.06.2024	30.08.2024
34	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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.	Update July 2024 - Following discussion at Audit & Risk Committee the Unscheduled Care SMT agreed to reinstate this risk on the Organisational Risk Register until the Invest to Save Paper is approved at the Executive Leadership Group. 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. This is ready to be presented to the executive team. In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff. Next review date is 30.08.2024.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	15	C5 x L3	10 (C5xL2)	Reinstated on Org Risk Register in July 2024	20.02.2014	02.07.2024	30.08.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
35	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	3.5 wte AHP/Nurses successfully appointed, starting June/July 2024 Demand and capacity modelling completed. Merging of Community and ND waiting lists to enhance capacity has taken place. Capacity available should meet demand following 3.5 wte commencing in post. However, this does not account for the average 20% increase in referrals accepted each year. This also doesn't address the backlog of patients already on W/L. (SBAR developed and presented at OMB seeking 2.0 wte B7 AHP for 2 years to clear backlog. SBAR also submitted for PCR monies) NDIP funding for 24/25 awaiting final agreement (funds to include WLI clinics, additional overtime for A4C staff, medicine costs and ADOS training).	Update 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.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	08.05.2024	08.07.2024
36	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update 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.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	09.07.2024	30.09.2024
39	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of 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 June 2024 - risk reviewed, no change The Health Board are still pursuing alternative systems as WCCIS is no longer an option as an interim system while an all Wales solution is being progressed.	Quality & Safety Committee	15	C5xL3	6	↔	07.11.2018	20.06.2024	02.09.2024
40	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update March 2024 - Still Awaiting a feasibility review on Mental Health inpatient space that will support the mitigation for this risk. Care Group Director engaging with the Capital Team on progressing this at present. No change to risk score at this stage. Update May 2024 - risk mitigation remains as reported in March 2024. No change to risk score. Next review date set for the 01.07.2024. Update June 2024 - Risk reviewed - no further change as previously reported. Risk ownership will be transferred to the Service Director for MHLD Care Group.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	20.06.2024	09.09.2024
41	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	Reduced Health Protection Funding allocation 2024-2025	**IF** the reduced allocation of Health Protection resource is insufficient to deliver a safe and sustainable service. **THEN** there may not be sufficient resources to deliver all elements of vacciantion and immunisation (which is the first line of defense against infectious disease) in accordance with the NIF. The health board response to infecious 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 insuffient 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.	Population Health & Partnerships Committee Quality & Safety Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	New risk escalated to the Organisational Risk Register in July 2024.	01.07.2024	01.07.2024	01.09.2024

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
2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	**IF** there is consistent backlog of Radiology reports **THEN** there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes **RESULTING IN** deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Update April 2024 - Review monitoring of additional funding. Vacancies. See rationale for de-escalation.	Quality & Safety Committee Planning Performance & Finance Committee	8 Decreased from a 16 on 20 May 2024	4 C4xL1	Score decreased as numbers have reduced so the service is now at a more manageable level. Additional capacity has been made available to support outsourcing arrangements. Risk will continue to be monitored via the DTPS Care Group.
5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	**IF:** the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. **THEN:** There will be delays in performing and reporting autopsies. **RESULTING IN:** * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update April 2024 - Backlogs have improved with the use of medi-link. A bank APT has left however so we are short 1 APT, we are using a locum APT 1 day per week to support the Forensic service whilst UHW is undergoing re-furbishment. See rationale for de-escalation.	Quality & Safety Committee	12 Decreased from a 16 in June 2024	8 (C4xL2)	Score decreased as current demand has reduced and returned to seasonal normal and backlog has significantly reduced. Likely to require re-escalation in Winter period. Risk will continue to be monitored via the DTPS Care Group.
3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update April 2024 - Mortuary staff resource is currently unstable due to some bank staff leaving making it difficult to efficiently move bodies. We are currently at 67% occupancy however this is including Nutwells contingency storage. Could potentially be de-escalated from the organisational risk register, however approval and further information will be required from the service manager prior to any de-escalation. See rationale for de-escalation.	Quality & Safety Committee	12 Decreased from a 16 in June 2024	8 (C4xL2)	Score decreased as currently capacity is being managed sufficiently although demand is higher than it normally is at this time of year (this is being noticed in other Health Board's), however there is no imminent threat of breach. It is likely that the risk will re-emerge as we move into Winter months, and the risk will be increased and escalated accordingly as we review and monitor the demand on mortuary services. Risk will continue to be monitored via the DTPS Care Group.
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)	Status of all LFERs are regularly monitored in: Q&S Business meeting (weekly), Executive Patient Safety Meeting (weekly), Quality & Safety Committee (bi-monthly). 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.

	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	No risks that had been escalated to the organisational risk register were closed in the July iteration.										

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

Agenda Item
6.2

Quality & Safety Committee

MORTALITY INDICATORS AND MORTALITY REVIEWS

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Esther Flavell – Clinical Lead for Mortality Review • Mark Townsend –Head of Clinical Audit and Quality Informatics • Matthew Smith –Mortality Review & Learning Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
HMR	Hospital Mortality Review
ME	Medical Examiner
DNACPR	Do Not Attempt Pulmonary Resuscitation

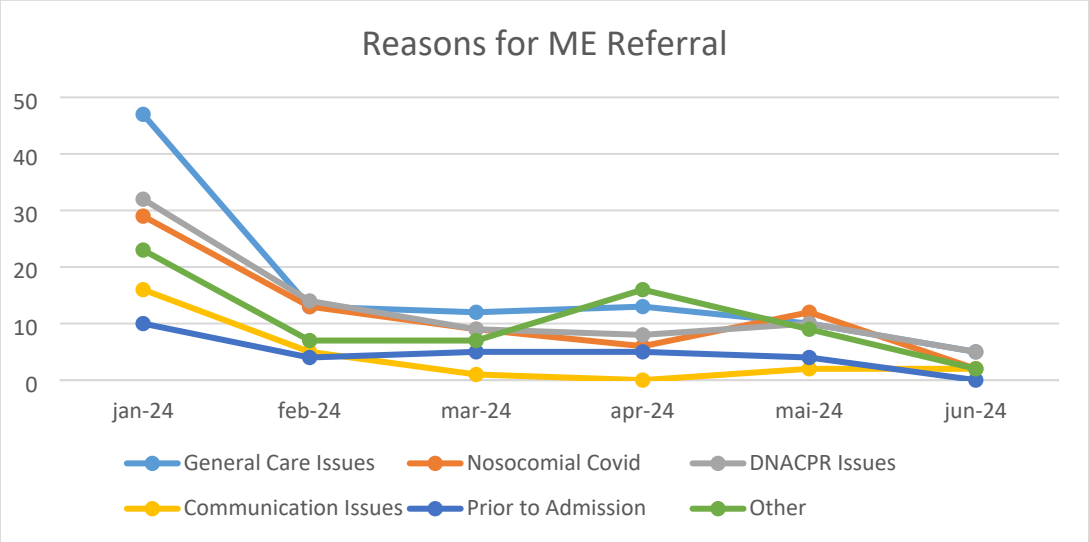
1. Situation /Background

1.1 The purpose of this report is to update the Quality and Safety Committee on compliance with the Cwm Taf Morgannwg University Health Board (CTMUHB) mortality review process in line with the All Wales Learning From Mortality Review Model Framework and to highlight the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

1.2 The table below outlines the number of ME referrals received (as of 25th June 2024), since the introduction of the DATIX Mortality Review Module on 1st April 2022, the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Under Investigation/ Action Required	Closed
CTMUHB	**2880**	**111 (4%)**	**82 (3%)**	**2687 (93%)**

1.3 Reasons for Referral are charted below (from January 2024). January is an outlier in terms of numbers. There were considerably more deaths as a whole that month and subsequently more referrals. This is not uncommon for this time of year and is consistent with previous year's data.(Please note themes are noted post Screening Panel – still 111 cases pending screening)



Learning from Mortality Reviews

1.4 Medical Examiner Service is now reviewing all of CTMUHB, in-hospital deaths. From September 2024 deaths in the community setting will also be reviewed by the Medical Examiner Service

1.5 Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued across CTMUHB. An in house target has been set of completion within 28 days of the decision made by CTMUHB Screening Panel that a HMR is required.

During the Covid pandemic, a large backlog accrued. This backlog is now all but cleared.

The tables below show the number of cases identified for HMR for each of the 3 localities since 2022-23 (as of 25th June 2024), the number where the review has been completed and the percentage completed within 28 days of screening panel.

	Number of HMR	Number Complete	Completed <28 days of Screening
2022-23	612	595 (97%)	11%
2023-24	365	359 (98%)	86%
2024-25	44	36 (82%)	97%

1.6 Stage 3 Mortality Review panel continues to be held on a monthly basis via Teams. There are currently 15 cases either waiting to be reviewed or in progress.

1.7 Each review with the medical examiner or at level 2 or 3 provides an opportunity to gather and share learning. Themes noted at Mortality Review since January 2024 include:

- Specialty teams could be contacted sooner in patients admission/Ownership of patients requiring care of more than 1 specialty
- The importance of documenting DNACPR, which will avoid putting patients with terminal illnesses through unnecessary resuscitation procedure instead of keeping comfortable and pain free
- De-escalation / celling of care should be discussed and agreed earlier in the patients admission in many cases being reviewed
- Documentation - All entries in patient's case notes should be dated and timed. This is critical when reviewing potential delays in care
- Communication with family - keep family aware of diagnosis, planned treatment, and listen to views and concerns of family – families should never feel their concerns are being dismissed
- Ensure NEWS reviewed prior to discharge. Number of occasions where patients have deteriorated after decision to discharge made resulting in failed discharges/readmissions
- Ensure IV fluids are written up and NG tubes placed promptly to avoid delays in administration
- Insufficient numbers of staff to provide 1:1 care where required

1.8 Current CTMUHB Mortality figures show that <1% of all hospital deaths have a degree of suspected avoidability due to problems in healthcare

Ongoing Development

1.9 Whole Mortality Data - Work continues to develop a Mortality Dashboard to collate all information related to Mortality across the Health Board. This is currently in trial phase as a development build.

1.10 CIVICA form under development to capture next of kin feedback noted in Medical Examiner referrals. Care Groups/Departments can view specific feedback related to their areas, facilitating targeted improvements as well as capturing compliments and the things that we do well to learn from and build upon. This should give us an understanding of a family/patient and their journey, and an opportunity to have the details of their experience within our health care system

1.11 Health and Care Quality Standards (HQS) have started being noted for each issue identified in Medical Examiner Referrals, stating which of the 6 domains of quality (safe, timely, effective, efficient, equitable and person centred) they fall under. Work is being undertaken at an All Wales level to incorporate this into the Datix Mortality module. It is hoped this will be incorporated into the October 2024 update. Whole Mortality Dashboard as mentioned in 1.9 will be amended to reflect this upon release of the update.

1.12 Thematic Review - The AMD for Mortality Review has commissioned a thematic review looking at potential issues of recognising sick patients presenting with intra-abdominal events. There have been 4 cases discussed at Stage 3 panel recently where care has been noted as less than satisfactory. These reviews will continue where a number of cases with a certain theme are found, and will provide a baseline for improving care and disseminating learning.

Baseline Population Numbers

1.13 The population CTMUHB serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2021 for population of local areas to CTMUHB

Area	Estimated pop 2021	People/km 2021
Bridgend	145,500	580
RCT	237,700	560
Merthyr	58,800	528

1.14 SHMI and HMSR are versions of RAMI (Risk Adjusted Mortality Index) used in England. We have not used RAMI as a way of measuring Mortality in Wales since the 2014 Palmer Report which stated that All Deaths should undergo review (which we were already doing). England is still sampling.

1.15 The following table shows the number of deaths per area for each month of 2023 & 2024 for each local authority area. Again, the data sets are from the ONS using their 2023 & 2024 datasets.

Deaths per region 2023(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Bridgend	150	133	171	118	155	122	144	110	130	125	145	133
RCT	313	250	238	212	217	204	206	227	202	248	260	200
MCT	72	64	60	54	51	57	60	67	53	52	63	60

ONS data for deaths per month for Wales 2023

Month	Deaths	Involving COVID	Covid Proportion of Deaths
Jan	3952	229	5.8
Feb	2989	76	2.5
March	2967	147	5.0
April	2747	104	3.8
May	2862	78	2.7
June	2494	55	2.2
July	2579	25	1.0
August	2545	45	1.8
September	2508	99	3.9
October	2841	87	3.0
November	2717	72	2.6
December	3442	80	2.3

Deaths per region 2024(taken form ONS website)

Area	Jan	Feb	March	Apr	May
Bridgend	169	142	164	158	147
RCT	294	257	227	248	240
MCT	53	65	67	67	65

ONS data for deaths per month for Wales 2024

Month	Deaths	Involving COVID	Covid Proportion of Deaths
Jan	3032	86	2.8
Feb	3072	93	3.0
March	3574	44	1.2
April	2891	27	0.9
May	3195	40	1.3

2. Specific Matters for Consideration

2.1 The Committee is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

Extrinsic:

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths
- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)
- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins
- Discussions with other health boards and ME services to improve communication and feedback

Intrinsic:

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues
- Continue to involve clinicians at an early stage for reflection
- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.
- Increase involvement of education and communication teams to share learning across the health board and embed this as part of team reflection.

3. Key Risks / Matters for Escalation

3.1 Limited clinical reviewers with appropriate MR experience available on each site remains challenging. In an attempt to address this, a trial is due to begin July 2024 of a centralised, electronic Hospital Mortality Review held weekly via Teams with patient notes and records available on the dedicated Mortality Review SharePoint site. Monthly MR training sessions continue to be available.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Dying Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *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: Effective, 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: 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 That the Committee **NOTE** the contents of the paper

6. Next Steps

6.1 Continuation of current Mortality Review Process
6.2 Continued development of Datix Mortality Module at an All Wales Level to incorporate Health and Care Quality Standards
6.3 Completion of thematic review looking at potential issues of recognising sick patients presenting with intra-abdominal events
6.4 Await final development of CTMUHB Whole Mortality Dashboard
6.5 Await development of CIVICA form to capture next of kin feedback noted in Medical Examiner referrals.
6.6 Develop robust pathways to share learning across the care groups.

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

Agenda Item
6.3

Quality & Safety Committee

OUTCOME REPORT: QUALITY & SAFETY COMMITTEE EFFECTIVENESS SURVEY

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Committee Chair/Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. PURPOSE

1.1 The Chair of the Quality & Safety Committee is required to present an annual report outlining Quality & Safety business through the financial year to the Health Board to provide an assurance on the monitoring and scrutiny undertaken of Cwm Taf Morgannwg University Health Board (CTMUHB) performance in relation to Quality & Safety. As part of this process the Committee are required to undertake an annual self-assessment questionnaire.

1.2 Members of the Quality & Safety Committee are asked to discuss and review the Committee self-assessment questionnaire relating to the activities and performance of the Quality & Safety Committee during 2023/2024.

1.3 Members should note 15 responses had been received.

2. SUMMARY REPORT

Positive Assurance	**1. Committee Effectiveness:** The majority of Members/Attendees were aware that: • There were approved Terms of Reference in place defining the role of the Committee which were reviewed annually. **2. Committee Business** There was a clear consensus that Members/Attendees considered that: • The Committee had been provided with sufficient authority and resources to perform its role effectively; • The Committee has an established Cycle of Business which was dealt with across the year; • The Committee met sufficiently frequently to deal with planned matters and with sufficient time allowed for questions and discussions; • The behaviour of all Members/attendees was courteous and professional; • In Committee meetings were convened throughout the year to assist with timeliness of information flows and it was felt that these were used appropriately for items that should not be discussed in the public domain; • They were satisfied that boundaries between this Committee and other Committees were clearly defined with appropriate cross-referral if required; • It was felt that through the Committee Highlight Report to Board, the Committee Chair provided clear and concise updates on the activities of the Committee and escalated areas of concern as appropriate;

	• It was felt that the Committee had been appropriately supported by Executive Director leads in terms of attendance, quality of papers and in their response to challenge and scrutiny.
Areas Requiring Further Assurance	**1. Committee Business** • Whilst the majority of Members were aware that the Committee prepares an annual report on its work and performance in the preceding year for consideration by the Health Board, two responders stated that they were unsure as to whether an annual report had been prepared; • Whilst the majority of members/attendees felt that the atmosphere at Committee meetings were conducive to open and productive debate, one responder stated that they felt that the Committee could sometimes have a more open discussion in relation to quality and safety issues ensuring that there is open discussion on risks and concerns as well as receiving assurance as to the mitigation of such issues; • Whilst the majority of members/attendees felt that each agenda item was **closed off** succinctly, one responder advised that they would find clearer actions on risk areas helpful when concluding items; • **Welsh Language** at meetings. There was a mixed response, however, overall Members would welcome greater use of the Welsh Language at meetings, if there was a requirement due to a member/attendee stating this as their preferred language choice; • Virtual Meetings had overall been a positive experience in that it had allowed meetings to continue to ensure robust scrutiny. It is acknowledged that some Members/Attendees considered that virtual meetings had not been a positive experience, with one responder indicating that they would prefer for some in person meetings to be held; • Whilst overall it was felt that the Committee meetings had been chaired effectively and with clarity of purpose and outcome, one responder stated that there could be more scrutiny and discussion regarding difficult safety issues, for example Coroners cases, with more assurance sought in relation to learning.
Areas Requiring Further Action	• **Committee Business** • **Committee Annual Report –** Explore the possibility of including the Committee Annual Report on the main agenda for discussion as opposed to the consent agenda to improve visibility; • **Open debates/discussions –** The Chair to reiterate that following presentation of items open debate by the Committee members is welcomed as well as seeking assurance as to mitigation and learning outcomes. The Chair will be asked to summarise areas of risk discussed when closing items.

	• **Face to Face meetings –** Explore the possibility of re-introducing some face-to-face meetings throughout the year. It has previously been suggested by the Committee Chair that we hold one meeting per year as an in person meeting with an option to join the meeting virtually for members/attendees who are unable to attend in person;

Action Plan	• Annual Report to be placed on main agenda for discussion;
	• Explore the possibility of holding one meeting per year as in person meeting with Teams option available for those unable to attend face-to-face;
	• Discussion to be held with Committee Chair regarding points made regarding:
	  ○ more open discussion was required at future meetings in relation to quality and safety issues, given the tendency could sometimes be to assure, rather than openly discussing risks and worries
	  ○ explore the possibility of identifying clearer actions in relation to risks
	  ○ Consider more scrutiny and discussion regarding difficult safety issues, for example Coroners cases, with more assurance sought in relation to learning

Appendices	Nil

3. Assessment

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

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

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

1. Recommendation

1.1 The Committee are requested to **DISCUSS** and **NOTE** this report.

2. Next Steps

2.1 The actions outlined within the report will be taken forward by the Corporate Governance Team.

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

Agenda Item
6.4

Quality & Safety Committee

An update to the Health Board regarding the Fuller Inquiry (Phase 1) and Welsh Government recommendations.

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr Paul D Davies, Designated Individual for the Human Tissue Act
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
- Executive Medical Director - Group Service Director	21/06/2024	Approved

Acronyms / Glossary of Terms	
HTA	Human Tissue Act
HTAuth	Human Tissue Authority
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
CTMUHB	Cwm Taf Morgannwg University Health Board
CCTV	Closed Circuit Television

1. Situation /Background

1.1 The Health Board is responsible for a range of clinical and support services which are involved in the removal, storage, use and disposal of human tissue in the Post Mortem sector across the three main hospital sites.

1.2 This responsibility is subject to the legal requirements of the HTA (2004) and regulated by the HTAuth.

1.3 The purpose of this report is to provide an update with regards to the outcome of the Fuller Inquiry (Phase 1) which has implication for the application of current HTA standards within the Health Board mortuary services.

1.4 In December 2021, David Fuller, an electrical maintenance supervisor with Maidstone and Tunbridge Wells NHS Trust, was convicted of 2 murders and sexual abuse of deceased people in the mortuary where he worked, under the Sexual Offences Act 2003.

1.5 Welsh Government wrote to Health Boards on 5th November 2021 seeking assurances about mortuary security in light of the distressing news report relating to David Fuller.

1.6 There were no major issues identified by the Designated Individual and a letter of assurance was provided by the Executive Medical Director on 10th November 2021 (Appendix 1).

1.7 From this initial review across Wales it was apparent that most Health Boards also managed body storage areas outside the HTA Licenced sites.

1.8 Within CTMUHB there are two such body store areas at the community hospitals of YCC (12 spaces) and YCR (8 spaces).

1.9 These body stores are not regulated by the HTAuth as they do not undertake scheduled activities in line with the Post Mortem sector and thus do not require an HTA Licence.

1.10 The Welsh Government recognised that this was potentially an area where there were variances in standards between HTA Licenced sites at District General Hospitals and the body stores within community hospitals.

1.11 Following this the Welsh Government made a number of recommendations (Appendix 2).

1.12 Those recommendations were mainly focused upon consolidating the body stores under the management of Mortuary services and levelling up standards on security, safety and dignity of the deceased.

1.13 This report to the Quality and Safety Committee will provide a status report regarding the CTMUHB response to both the Fuller Inquiry Phase 1 Report and the Welsh Government Recommendations.

2. THE HEALTH BOARD RESPONSE TO THE FULLER INQUIRY AND WELSH GOVERNMENT RECOMMENDATIONS

The HTA Licenced sites within the Health Board

2.1 There are three HTA Licenced sites within CTMUHB; PCH, RGH and POW which are overseen by the Designated Individual who has the primary legal responsibility for the assurance of standards under the Human Tissue Act (2004)

2.2 All three sites are licenced by the HTAuth to undertake scheduled activities in relation to Post Mortem activity and this includes the safe and dignified storage of the deceased.

2.3 In total there are 256 storage spaces across the three sites;

- PCH has 135, which includes 97 contingency spaces
- RGH has 59 which includes 24 contingency spaces
- POW has 60 (contingency storage if needed at RGH/PCH)

2.4 All three sites have a high level of security including;

- CCTV at all entries and exits which records for up to 31 days
- Swipe & Fob card entries and video door access
- Controlled access restricted to Mortuary staff, trained Mortuary Portering staff, Pathologists (4) and a limited number for Mortuary & Facility Managers having permitted access
- Intruder Alarm systems
- Out of Hours access is limited to admission of the deceased or Police ID viewings supervised by trained Mortuary Portering staff (working in pairs) with support from an on-call Mortuary Support Officer if required.

2.5 There is also a regular schedule of security audit at all three sites led by the Pathology Quality Department in liaison with authorising managers and the Designated Individual;

- Swipe Card Access Audit; a 3 monthly check on those staff who have swipe card access to the Mortuary Departments and their authorisation status
- Swipe Card and CCTV Audit; a 6 monthly random check of out of hours access to ensure the authorised swipe card user matches the observed staff member and their duties
- CCTV Audit; a 3 monthly audit of CCTV recording ability and the quality of the recording. The minimum standard is maintaining the ability of a CCTV system to record for at least up to 31 days.

2.6 Whilst YCC and YCR are not HTA-Licenced sites the Designated Individual has been visiting these areas and conducting inspections with Facility managers to improve standards.

2.7 The outcomes of these audits are linked into the ongoing work to consolidate both the YCC and YCR into Pathology and thus apply the relevant HTA standards for body storage.

2.8 During 2023 there was a planned HTA Inspection of the Health Board by the HTAuth and there were no major or minor shortfalls in standards relating to security or safe and dignified care of the deceased across all three HTA Licenced sites.

2.9 The Fuller Inquiry (Phase 1) was shared by Welsh Government on 4th March 2024 and the Designated Individual undertook an assessment against all 17 recommendations and the latest status is attached (Appendix 3).

2.10 On the 3rd May 2024 the HTAuth requested all Designated Individuals across all Health Boards and NHS Trusts to submit an Evidential Compliance Audit of its HTA licenced sites with regards to Mortuary security arrangements.

2.11 This request involved submitting a questionnaire and uploading a number of policies, procedures, risk assessments and audits to a secure HTA portal.

2.12 This work was duly undertaken and submitted on the 17th May 2024; there has been no follow-up requested by the HTAuth to date.

2.13 In summary, there are no major shortfalls identified for the secure, safe and dignified care of the deceased at PCH, RGH and POW Mortuary Departments licenced by the HTAuth.

The Community Hospital body stores at YCC and YCR

2.14 There are two body stores at the community hospital sites of YCC and YCR.

2.15 These sites do not require a HTA Licence however the Welsh Government recommendations (Appendix 2) expect Health Boards to consolidate the responsibility for these sites under the management of Mortuary services with oversight by the Designated Individual.

2.16 In total there are 12 storage spaces at YCC and 8 at YCR.

2.17 In terms of security there have been four shortfalls identified;

- No CCTV at YCR on the entry and exit points of the body store
- Limited CCTV coverage at YCC
- No regular audit of the CCTV system, although there is a monthly audit of controlled access permissions
- No quality control checks of HTA standards

2.18 The Pathology Directorate is currently leading a Task and Finish group to consolidate the YCR and YCC body stores under the responsibility of Mortuary services and oversight from the Designated individual.

2.19 It is expected that this will commence in August 2024.

2.20 The CCTV shortfall has been addressed through Capital Planning and new systems are being installed at both YCR and YCC.

2.21 When the community hospital body stores are consolidated under the responsibility of Mortuary services the following scheduled audits will be undertaken;

- Swipe Card and CCTV Audit; a 6 monthly random check of out of hours access to ensure the authorised swipe card user matches the observed staff member and their duties.
- CCTV Audit; a 3 monthly audit of CCTV recording ability and the quality of the recording. The minimum standard is maintaining the ability of a CCTV system to record for at least up to 31 days.
- Weekly quality control checks of dignified storage, cleanliness, temperature monitoring, equipment, record keeping and security.

2.22 A three monthly Swipe Card Access Audit check on those staff who have swipe card access to the Body Stores and their authorisation status is already in place.

2.23 In summary, there are shortfalls identified for the secure, safe and dignified care of the deceased at YCC and YCR which will be resolved through the planned consolidation of the body stores under the management of Mortuary services.

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Dying Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
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?		This paper 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: This paper is for noting
Cyfreithiol / Legal	Yes (Include further detail below)	
	HTA Compliance at POW/RGH/PCH is a legal requirement and the Designated Individual has primary legal responsibility under Section 18 of the Act.	
Enw da / Reputational	Yes (Include further detail below)	
	Non-compliance with the HTA is a reputational risk for the Health Board.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	To achieve the Welsh Government recommendations for Community Body stores there is a need to ensure consolidation of responsibility under Mortuary services. A Task and Finish group is leading this objective with a view for transfer by August 2024.	

3. RECOMMENDATIONS

3.1 The Quality and Safety Committee is requested to **NOTE** the assurances provided on security regarding the three HTA Licenced Mortuary services at the District General Hospital sites

3.2 The Quality and Safety Committee is requested to **NOTE** the ongoing work to consolidate the body stores at YCC and YCR under the responsibility of Mortuary services and the Designated Individual with the objective of improving overall HTA standards including security in light of the Fuller Inquiry recommendations.

3.3 There are no unmanageable key risks for noting.

APPENDIX 1 – HEALTH BOARD RESPONSE TO INITIAL ASSURANCES SOUGHT REGARDING DIGNIFIED CARE AND SECURITY (10/11/21)

APPENDIX 2 – WELSH GOVERNMENT RECOMMENDATIONS REGARDING BODY STORAGE AREAS (5/11/22)

APPENDIX 3 – DESIGNATED INDIVIDUAL ASSESSMENT OF HEALTH BOARD MORTUARY SERVICES AND COMMUNITY HOSPITALS AGAINST THE 17 RECOMMENDATIONS FROM THE FULLER INQUIRY PHASE 1 REPORT (April 2024)

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

Your ref/eich cyf:
Our ref/ein cyf: DH/
Date/Dyddiad: 10th November 2021
Tel/ffôn: 01443 744807
Fax/ffacs: 01443 744800
Email/ebost: Dom.Hurford@wales.nhs.uk
Dept/adran: Cyfarwyddwr Meddygol Dros DroInterim Medical Director

Professor Chris Jones
Deputy Medical Officer
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Chris.jones@gov.wales

Dear Professor Chris Jones

Thank you for your letter on 5th November seeking assurances about mortuary security in light of the distressing news report relating to David Fuller. Within the Health Board we are equally shocked and distressed by this news and whilst we are Human Tissue Act (HTA) compliant at our Licenced sites, we have immediately implemented checks of all our relevant Standard Operating Procedures (SOPs) to further enhance security and dignity protection measures. May I present the following status report for Cwm Taf Morgannwg University Health Board.

Number for Mortuaries and Body Stores in CTM

Cwm Taf Morgannwg University Health Board have three main HTA Licenced Mortuaries sited at Prince Charles Hospital, Royal Glamorgan Hospital and the Princess of Wales Hospital. Whilst all three sites have both post-mortem and body store facilities, only the Royal Glamorgan is presently conducting post-mortems as a central hub. We also host the temporary *South Wales 02 Body Store* on behalf of the Local Resilience Forum and this unit is aligned to the Prince Charles Hospital Mortuary Department. This also meets HTA Licence standards and is governed by the Health Board.

Cwm Taf Morgannwg University Health Board also have two smaller body stores in the community hospitals of Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon.

With reference to the following standards the specific assurances are;

Croeso i chi gyfathrebu â'r bwrdd iechyd yn y Gymraeg neu'r Saesneg.
Byddwn yn ymateb yn yr un iaith a ni fydd hyn yn arwain at oedi.

You are welcome to correspond with the health board in Welsh or English.
We will respond accordingly and this will not delay the response.

Cyfeiriad Dychwelyd/ Return Address:
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg, Pencadlys, Parc Navigation, Abercynon, CF45 4SN
Cwm Taf Morgannwg University Health Board, Headquarters, Navigation Park, Abercynon, CF45 4SN

Cadeirydd/Chair: Emrys Elias Prif Weithredwr/Chief Executive : Paul Mears

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg yw enw gweithredol Bwrdd Iechyd Lleol Prifysgol Cwm Taf Morgannwg
lCwm Taf Morgannwg University Health Board is the operational name of the Cwm Taf Morgannwg University Local Health Board

a. **GQ1(c):** ***Procedures on body storage which prevent practices that disregard the dignity of the deceased***

There are four main SOPs which are adhered to by trained staff to ensure that the dignity of the deceased is preserved. These include the following;

- *Handling bodies in the Mortuary*
- *Storage of bodies in the Mortuary*
- *Basic Post Mortem Procedure*
- *Release of Deceased and Associated Property*

Key criteria from these SOPs which assure good practice include;

- All bodies are shrouded or placed in body bags as appropriate
- Dignity is checked on arrival to the Mortuary using a Mortuary Checklist
- A Dignity check is conducted on release of all the deceased to ensure the person is in a dignified and acceptable state of presentation
- Our Security checks prevent unauthorised access to the mortuary which may compromise the dignity of the deceased

The Mortuary Manager is highly visible across all sites providing extra checks and updates with reference to preserving the dignity of the deceased. Periodic local inspection is also conducted by the Cellular Pathology Operational Manager and Designated Individual.

b. **PFE1(d):** ***That premises are secure (for example there is controlled access to the body storage area(s) and PM room and the use of CCTV to monitor access) (page 16 of the above document).***
c. **PFE1(e):** ***Security arrangements must protect against unauthorized access and ensure oversight of visitors and contractors who have a legitimate right of access (page 16 of the above document).***

The Health Board has a specific Policy for Mortuary Security which is followed by trained staff, namely the *Policy for Mortuary and Bereavement Security.*

Key aspects of this Policy and practice which assure security include;

- All access points to the mortuary are controlled either by security magnetic – locks operated by the authorised users or access with a Master Key
- Mortuary and Bereavement staff in possession of keys to the premises must ensure they can account for them at all times. Keys must not be lent or borrowed and any missing / lost / stolen keys must be reported as soon as detected
- A list of keys and who has them is maintained and regularly audited by the Mortuary Manager
- Keys are of a "master key" variety and cannot be readily duplicated
- All HTA Licenced sites are covered by continuous CCTV coverage in line with HTA standards and recordings are retained for 31 days for general areas; these recordings are reviewed if there is an incident or complaint
- CCTV is contemporaneously viewed through a monitor by Mortuary Staff to check the identity of people as they enter the premises
- All authorised visitors to the mortuary are accompanied at all times
- Contactors are subject to the Health Board Contractors policy.

The Mortuary Manager is highly visible across all sites providing extra checks and updates with reference to preserving security. Periodic local inspection is also conducted by the Cellular Pathology Operational Manager and Designated Individual.

1. **Body Stores at the Community Hospitals of Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda**

Whilst community hospital body stores are not HTA Licenced as they do not conduct Scheduled Activities, the Health Board expect high standards for both security and preservation of dignity to apply. Both hospital body stores are relatively recent builds and have secure swipe card and key entry for a list of authorised personnel. The Designated Individual periodically inspects these body stores to check standards are being met. There is no long term storage at these sites.

2. **Review and further assurances**

In light of this recent news managers of Mortuary Services (including Community Hospitals) will immediately be conducting the following;

- Review the list of Health Board personnel with swipe card or key access across all sites to check authorisation levels. This list is normally limited to mortuary staff, portering staff and site managers only.
- The frequency of these authorisation checks will be set to 6 monthly.
- Awareness raising sessions across Mortuary and Portering services will be conducted in light of this recent news
- A review will be conducted of all key entry access points with a view to convert to swipe card entry / magnetic locks
- An audit will be conducted to examine if personnel can be identified by swipe card entry out of hours through our IT systems

I trust this will provide the assurances you require and if you have any further questions please do not hesitate to contact me.

Yours sincerely

Dom Hurford

Cyfarwyddwr Meddygol Dros Dro
Interim Medical Director

Cc Paul Mears

Body Storage review and recommendations (November 2022)

In November 2021, Welsh Government asked all health boards to supply information on body storage facilities which fall outside of the current HTA licensing and regulatory oversight of premises where post-mortem examinations take place.

Health board returns showed there is significant variation in relation to:

- Access and security arrangements
- Quantity and capacity of body storage within health boards
- Use of standard operating procedures
- Alignment with mortuary policies and management arrangements

The Human Tissue Authority provided initial advice to the UK Government in December 2021. It has amended and recently published its updated Post Mortem sector licensing standards and guidance. NHS England has also taken forward work reviewing its Health Service Building note relating to facilities for mortuary and post-mortem.

The Fuller Inquiry has been established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed. It will also consider if procedures and practices in other hospital and non-hospital settings, where bodies of the deceased are kept, safeguard the security and dignity of the deceased. The Inquiry will publish its initial report on matters relating to David Fuller's activities at Maidstone and Tunbridge Wells NHS Trust in first half of 2023 (this has been delayed due to the volume of evidence the Inquiry has and continues to receive, and the number of witnesses to interview, is far greater than anticipated) and its final report, looking at the broader national picture and the wider lessons for the NHS and other settings in either late 2023 or during 2024. The Inquiry did publish a progress update in May 2022, which highlighted a number of areas of concern escalated to NHS England.

Given the above findings, the work undertaken by the HTA and the length of time it is likely to take for the Fuller Inquiry to conclude, Welsh Government have produced interim recommendations for health boards/trusts to implement in areas where bodies of the deceased are kept, to safeguard the security and dignity of the deceased.

In relation to building safety notices, it would appear that we have not updated these in Wales for some time and did not issue the last update which was sent out in England and Scotland. Shared services colleagues have seen a copy of the latest proposed revisions and circulated these to NHS Wales colleagues and received multiple comments. NHS Wales shared services have committed to clarifying with NHS England their timescales for publication and issuing the English version as an interim measure in Wales as swiftly as possible once it has been published.

Interim recommendations

The interim recommendations below are consistent with revised guidance issued from the HTA in relation to mortuaries/post-mortem rooms and the draft building safety notice. It is proposed that the same standards of security and oversight should apply to all NHS premises where bodies are stored.

Health boards/trusts should:

- Identify and appoint a single accountable officer for body storage facilities who can oversee implementation of the recommendations and provide updates to your board/Welsh Government
- Review and consolidate where possible their body storage arrangements, especially in community hospital settings
- Consolidate the management of body stores and where possible align them to mortuary and post-mortem services
- Apply relevant HTA post-mortem sector licensing standards and guidance to body storage areas including:

    - Documented standard operating procedures (SOP) should take account of standard and out of hours arrangements and cover for storage of bodies, record keeping, receipt and release of bodies, lone working, access and where applicable viewing of bodies, transfer of bodies.
    - Access to bodies storage facilities should be strictly controlled with clear policies and procedures which protect bodies from harm and breaches of confidentiality.
    - Policies and SOPs should be reviewed regularly
    - All staff who may access body storage facilities should be appropriately trained, for example, portering staff, site managers
    - Contractors, visiting and temporary staff should be made aware of policies and SOPs
    - Records must include records of access to the body storage (by whom and for what purpose)
    - Staff know how to identify and report incidents with i Information about incidents is shared with all staff to avoid repeat errors.
    - Risk assessments should be undertaken and reviewed on a regular basis and cover risks to the security, dignity and integrity of bodies and stored tissue.
    - Systems to track each body from admission to the body storage facility to release for burial or cremation e.g. body receipt and release details should be logged, including the date and name of the person who received/released the body and, in the case of release, to whom it was released.
    - Bodies should be identified using a minimum of three identifiers attached to the body that can be used to check the identification of the deceased. (eg. name, date of birth/death)

- Premises are secure (for example there is controlled access to the body storage area(s) and the use of CCTV to monitor access). Security arrangements should be robust, with effective mechanisms to strictly control access. Security arrangements must protect against unauthorized access and ensure oversight of visitors and contractors who have a legitimate right of access.
- Entry to body storage facilities should include swipe card access with lists reviewed and updated regularly. Records of access (electronic and paper-based) and CCTV footage should be regularly audited to ensure adherence to relevant policies and procedures. Anyone entering should have a legitimate right of access and audits should scrutinise the purpose, frequency and duration of access and be particularly alert to unusual patterns, times of entry or other unexplained or suspicious activity which must be investigated immediately.
- Staff and authorised visitors and contractors should be aware of the establishment's security arrangements. Authorised visitors and contractors should also be supervised while in the body storage areas.
- Bodies should be shrouded or in body bags whilst in storage.
- Establishments should have documented agreements with any funeral services that they may use for contingency storage.

DAVID FULLER INQUIRY PHASE 1 REPORT – RECOMMENDATIONS

Recommendation	Status - DI assessment	Further Actions Required	Lead
Recommendation 1 *Health Boards and Trusts must ensure that non-mortuary staff and contractors, including maintenance staff employed by their external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.*	The **only** non-mortuary staff with swipe access to DGH & Community Hosital sites are Trained Porters / Facility Managers who always work in pairs in and out of hours. All routine or urgent maintainance (in-house Estates & Contractor) is supervised by a mortuary member of staff (24/7) at DGH sites and supervised by a Trained Porter at Community Hospital sites (24/7). All medical, nursing and midwery staff accessing the mortuary 24/7 are supervised by a Mortuary staff member or Trained Porter. All access permissions are audited as per schedule, currently 6 months	Continue Audit Schedule	Pathology Quality Department (Audit)
Recommendation 2 *Health Boards and Trusts must assure themselves that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.*	DI has legal oversight of all practices within DGH sites but not for Community Body Stores, although advice is provided to these areas. No deceased persons are left outside the fridge unless for checking, transfer or PM. No deceased are left for any prolonged period of time outside the fridge.	Continue with current compliance	Pathology
	There is an outstanding HTA advisory item at the Princess of Wales Hospital Mortuary where there is a lack of security fencing of the ventilation plant at the rear of the building. A Capital Bid was submitted by Pathology last August 2023 and remains unfunded	Seek Captial Funding to resolve (complete) and installation planned for 24/4/24	Pathology
	There is no 24/7 refridgeration alarm system at YCC or YCR Community Hospital Body Stores which is a risk to the deceased being left in an un-refridgereted state for a long period of time if there is an equipment failure.	Funding stream has been identified and we await an installation date.	Pathology, Estates and Community
Recommendation 3 *Health Boards and Trusts must assure themselves that they are compliant with their own current policy on criminal record checks and re-checks for staff. They should ensure that staff who are employed by their facilities management provider or other contractors are subject to the same requirements.*	All new staff meeting the criteria for Criminal Record Checks are monitored by the workforce department including Trained Porters, Housekeepers and Estates Staff. There is an historic backlog of staff who never underwent a DBS check. Contractors are not subject to such checks but are supervised by Mortuary Staff at all times on site.	Health Board is currently reviewing the status of all staff. (led by Workforce)	Workforce Department
Recommendation 4 *Health Boards and Trusts must assure themselves that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within their management structure and must be adequately managed and supported.*	Compliant	None	ML
Recommendation 5 *The role of Mortuary Manager at Health Boards and Trusts should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, that requires the appropriate level of management attention.*	Compliant	None	ML
Recommendation 6			

Health Boards and Trusts must review their policies to ensure that only those with appropriate and legitimate access can enter the mortuary.	Compliant - There are a number of Policies & SOPs covering Security in the Mortuary to support the **Policy for Mortuary & Bereavement Security,** which include;**FAC10** Security Policy (Corporate) **FAC11** CCTV policy (Corporate) **MRA28** Risk assessment for Mortuary security and serious breach **MRA28a** Mortuary departmental security – generic CTMUHB risk assessment **MLONE SOP** -Lone working in the mortuary **MVIS SOP** – Visitors to the mortuary and PM room **MVIEW SOP** – Arrangement and preparation of a body for viewing **MBAP SOP** - Admission and clerking in procedure for all paediatric and adult deaths from hospital and community **MPOLOOH** Policy for out of hours mortuary services	None	ML
Recommendation 7 *Health Boards and Trusts must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.*	Compliant - regular audit schedule in place for DGH sites and Community Hospital sites every 6 months. PCH currently needs an upgraded ACU system to comply with audit.	Continue Audit Schedule and and complete work to update ACU system which commenced in March 2024	Pathology Quality Department
Recommendation 8 *Health Boards and Trusts should treat security as a corporate not a local departmental responsibility.*	Assured through Care Group Management structure	none	Health Board
Recommendation 9 *Health Boards and Trusts must install CCTV cameras in their mortuaries, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.*	On DGH sites there is no CCTV in the Post Mortem Room but are sited at access/entry points to the PM room. This is our current Policy and has been discussed with the HTA. Whilst PMs are in progress there is always more than one member of staff. CCTV is present at YCC although not in the body store but at entry / exit points. There is no CCTV at YCR. There is no CCTV camera in the PCH external body store. CCTV is now in place in body store at both YCC & YCR	Capital Funding stream identified for new CCTV systems in both the YCR and YCC Body Stores. Awaiting implementation date. CCTV is present at YCC although not in the body store but at entry / exit points. There is no CCTV at YCR. There is no CCTV camera in the PCH external body store. CCTV is now in place in body store at both YCVC & YCR	Pathology and Facilities
Recommendation 10 *Health Boards and Trusts must ensure that footage from their CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.*	Regular audit schedule in place at DGH sites but not at Community Hospital Body Stores.	Agree with Facilities a regular audit schedule for CCTV compliance for YCC.	Pathology and Facilities
	The CCTV monitoring point requires relocation to maintain confidentiality. PCH ACU monitoring system requires updating as currently swipe access cannot be audited. Access control has now been upgraded and audit trail is now in place.	Access control has now been upgraded and audit trail is now in place	Pathology
Recommendation 11			

Health Boards and Trusts must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.	Completed via HTA Board, Persons Designated meetings and 6 month Health Board Quality & Safety Group. Also HTA newletters uploaded on HTA Sharepoint portal.	None	DI
Recommendation 12 *Local County Councils should examine their contractual arrangements with Health Boards and Trusts to ensure that they are effective in protecting the safety and dignity of the deceased.*	There is no contractual link between the Health Board and Local Authorties regarding Mortuary services other than through the Local Resilience Forum for the Mass Fatality Plan.	None	Health Board
Recommendation 13 *We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. Health Boards and Trusts must review their governance structures and function in light of this.*	The Heath Board has a robust Clinical Governance framework recently inspected by the HTA in 2023 which is supported by the HTA Board. There is also a 6 month HTA update report to the Health Baord Quality and Safety Committee	None	Health Board
Recommendation 14 *Health Boards and Trusts must have greater oversight of licensed activity in the mortuary. They must ensure that the Designated Individual is actively involved in reporting to the Boards and Trusts and is supported in this.*	The DI has a dedicated role to the oversight of all licenced activity at the 3 DGH sites and reports quarterly to the HTA Board and 6 monthly to the Health Board on compliance. However that role has not been formalised for non-licenced sites such as Community Body Stores at this stage but envisaged for mid 2024 once resources have been agreed.	Community Hospital Body Stores must be consoldated under Pathology with the appropriate resource for the DI to take full responsibility for standards in these areas. There has been a transfer of of one Band 2 post from Facilities to Pathology which will enable progression on this. Task and Finish group has been set up with a view to complete in 3 months. DI can then take full responsibility for these additional areas.	Pathology, Facilities and Community
Recommendation 15 *Health Boards and Trusts should treat compliance with Human Tissue Authority standards as a statutory responsibility, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.*	Within this Health Board the HTA is treated as a statutory responsibility and a 6 monthly compliance update is submitted via the COO to the Health Board Quality & Safety Committee. The DI holds the legal responsibility.	None	Health Board & DI
Recommendation 16 *The Chief Nurse should be made explicitly responsible for assuring Health Boards and Trusts that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.*	The DoN and HoN are already responsible for protecting the security & dignity of the deceased and are appriased when needed though the DI and Persons Designated who are predominently at a Senior Nurse level. There is also a proactive Bereavement Strategy Group supported by the DoN office.	None	DoN, HoN, SN & DI.
Recommendation 17 *Health Boards and Trusts must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients*	Evident and covered by several SOPs, local inspections and on-going training including the care for Pregnancy Loss Remains.	None	Health Board & DI

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

Agenda Item
6.5

Quality & Safety Committee

Falls and Pressure Ulcer Report
July 2024

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Deputy Executive Director of Nursing and Paul Gimson, Assistant Director for quality Improvement
Cyflwynydd yr Adroddiad / Report Presenter	Greg Padmore-Dix, Executive director of Nursing, Midwifery & Patient Care/Deputy CEO
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	
CTMUHB	Cwm Taf Morgannwg University Health Board
CAPU	Community-Acquired Pressure Ulcers
SRO	Senior Responsible Officer

WWIC	Welsh Wound Innovation Centre
PU	Pressure ulcers
CTMUHB	Cwm Taf Morgannwg University Health Board
MH	Mental Health
SPA	Single Point of Access
PCH	Prince Charles Hospital
POW	Princess of Wales
RGH	Royal Glamorgan Hospital
WCP	Welsh Clinical Portal

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

1. Situation /Background

1.1 Cwm Taf Morgannwg University Health Board (CTMUHB) has identified falls and pressure ulcers as key patient safety priorities. This report provides an update on the current situation, recent initiatives, and recommendations for continued improvement in these areas as part of our 'harm-free care' agenda.

Two new steering groups have recently been established:

1. Falls Reduction Steering Group

2. Pressure Damage Reduction Steering Group

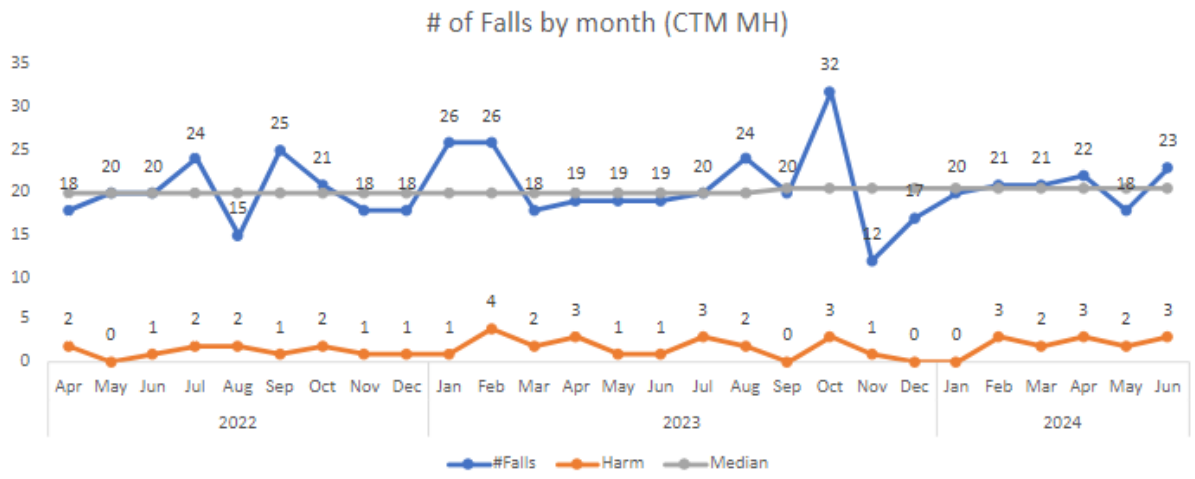
These groups form part of the 'harm-free care' agenda and aim to drive improvements by synthesising best practice guidance, policy changes, innovations, quality improvement initiatives, and data from care groups.

1.2 Falls

Falls are a significant patient safety concern, particularly in older adult mental health wards. In 2023, 247 adult inpatient falls were reported in Older Adult Mental Health Wards at CTMUHB (see graph below). Falls can lead to severe injuries, extended hospital stays, and reduced quality of life for patients.

Key points:

a) Falls Collaborative launched in 2023, building on lessons from the Community-Acquired Pressure Ulcer (CAPU) collaborative.
b) Focus on evidence-based interventions and consistent implementation across teams.
c) The Care Group Director of Nursing for Mental Health and Learning Difficulties is the Senior Responsible Officer (SRO) for the falls reduction collaborative within mental health wards.



The graph above highlights the total number of falls (blue) in the collaborative areas versus falls resulting in harm rated moderate or above (orange).

1.3 Pressure Ulcers

Pressure ulcers represent a significant challenge for healthcare systems, causing patient distress and financial strain. The estimated annual cost to NHS Wales for managing pressure ulcers is between £66.8 to £70.6 million, with CTMUHB's share estimated at £9.35 to £9.88 million[1].

Key points:

a) In 2021, CTMUHB's Executive Safety Group identified Community-Acquired Pressure Ulcers (CAPUs) as a critical safety issue.
b) The 'Community Acquired Pressure Ulcer Safety Collaborative' was initiated in Spring 2021 in partnership with the Welsh Wound Innovation Centre (WWIC)
c) The Care Group Director of Nursing for Community and Primary Care, is the SRO for the community pressure ulcer collaborative

Assessment

Falls (collaborative)

Data and Trends

While specific 2024/25 data is yet to inform a trend, the following trends have been observed:

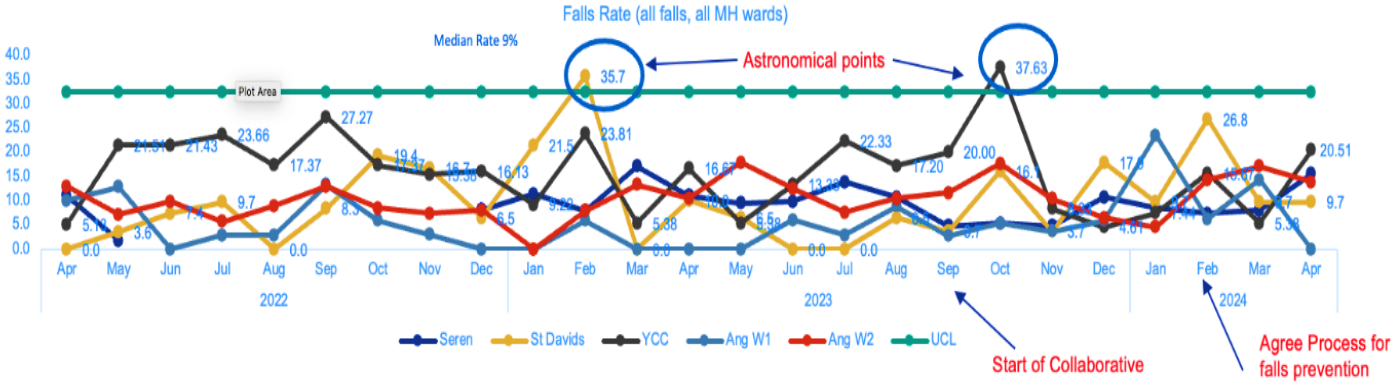
1. Incidence:

a) 247 adult inpatient falls were reported in Older Adult Mental Health Wards 2023.
b) Data from April 2022 to April 2024 shows fall rate fluctuations across different wards.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

2. Falls Rate:

a) Varies across wards, ranging from 0 to 37.63 falls per 1000 bed days, (national benchmark of 6.63 per 1000 bed days[2,3,4]).
b) The overall trend shows a stabilisation in fall rates since the start of the collaboration.



Progress and Achievements

a) Baseline data gathered and analysed.
b) King's Fund Environmental Audits were completed for each ward.
c) Four full-day learning sessions were completed.
d) The audit tool for the fall prevention process was tested.
e) External stakeholders from other teams participated in learning sessions.
f) Falls Collaborative was nominated for an NHS Wales Award.

Challenges

1. Data Accessibility:

a. Need help accessing DATIX information directly, impacting reporting and improvement monitoring.
b. Manual extraction and analysis of data are required.

2. Standardisation:

a. Need for standardised presentation of falls data, considering bed occupancy of wards (rate per 1000 bed days).

3. Engagement:

a. Challenges in getting teams to attend Pan CTM MH Falls monthly calls.

Inpatient Falls (Overall)

The data below presents monthly statistics for each hospital, including:

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

a) Number of inpatient falls

b) Total occupied bed days

c) Falls per 1,000 bed days

Hospital-Specific Data

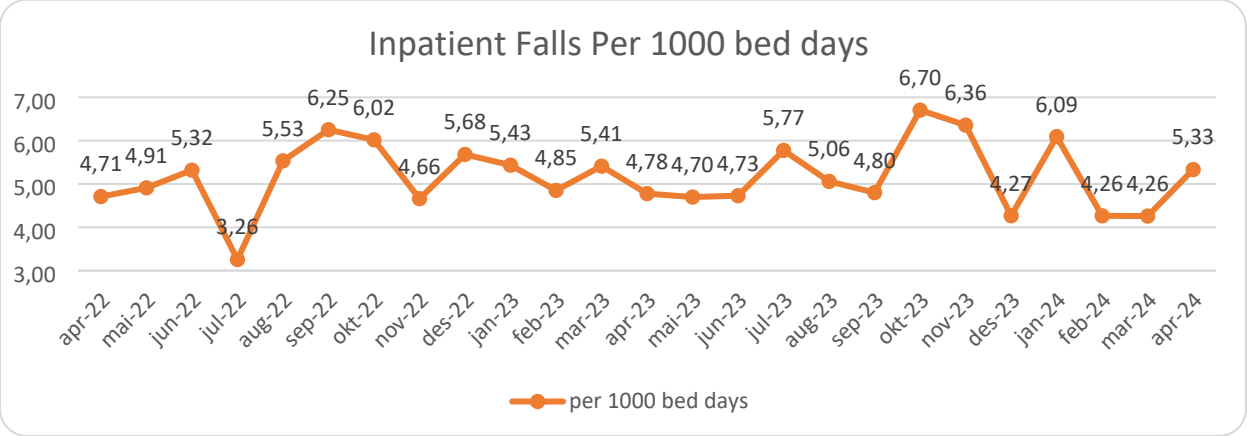
Prince Charles Hospital (graph below):

a) Total inpatient falls over the period: 1,102

b) Average falls per 1,000 bed days: 5.14

c) Highest falls per 1,000 bed days: 6.70 (October 2023)

d) Lowest falls per 1,000 bed days: 3.26 (July 2022)



Royal Glamorgan Hospital (graph below):

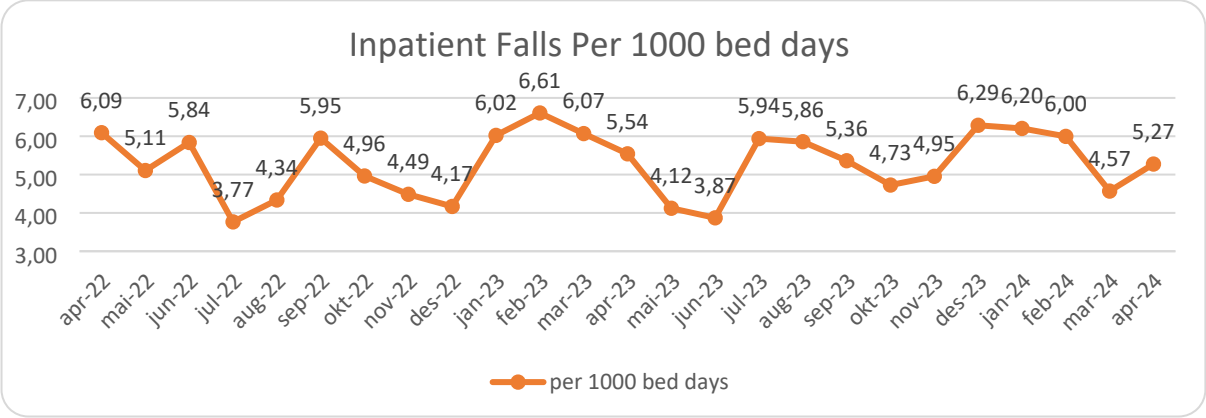
a) Total inpatient falls over the period: 1,355

b) Average falls per 1,000 bed days: 5.27

c) Highest falls per 1,000 bed days: 6.61 (February 2023)

d) Lowest falls per 1,000 bed days: 3.77 (July 2022)

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360



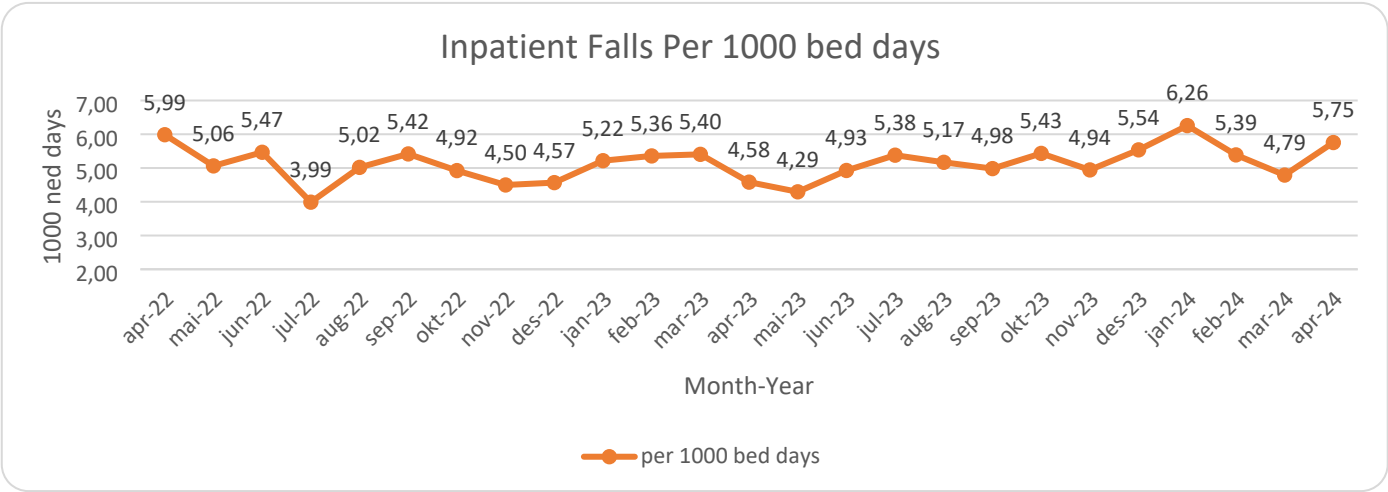
Princess of Wales Hospital (graph below)**:**

a) Total inpatient falls over the period: 1,365

b) Average falls per 1,000 bed days: 4.46

c) Highest falls per 1,000 bed days: 6.50 (April 2024)

d) Lowest falls per 1,000 bed days: 3.54 (April 2023)



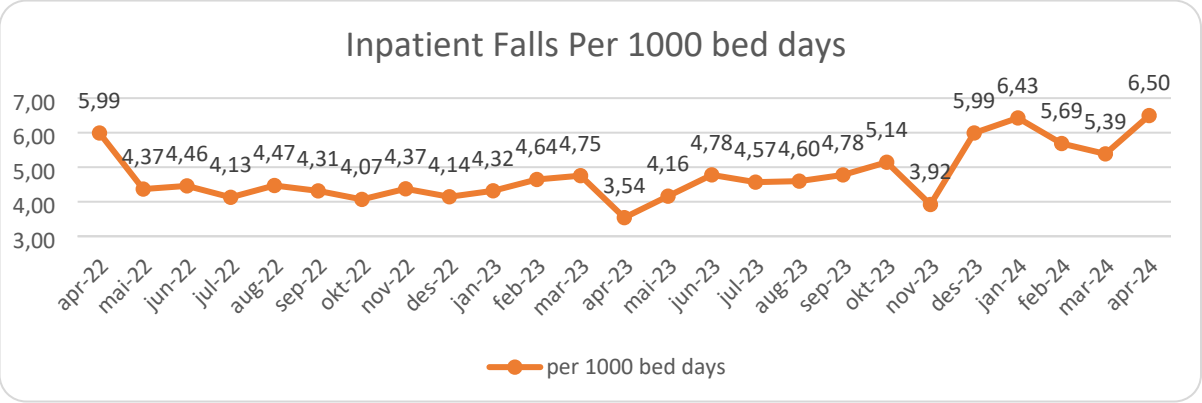
Combined Hospital Data

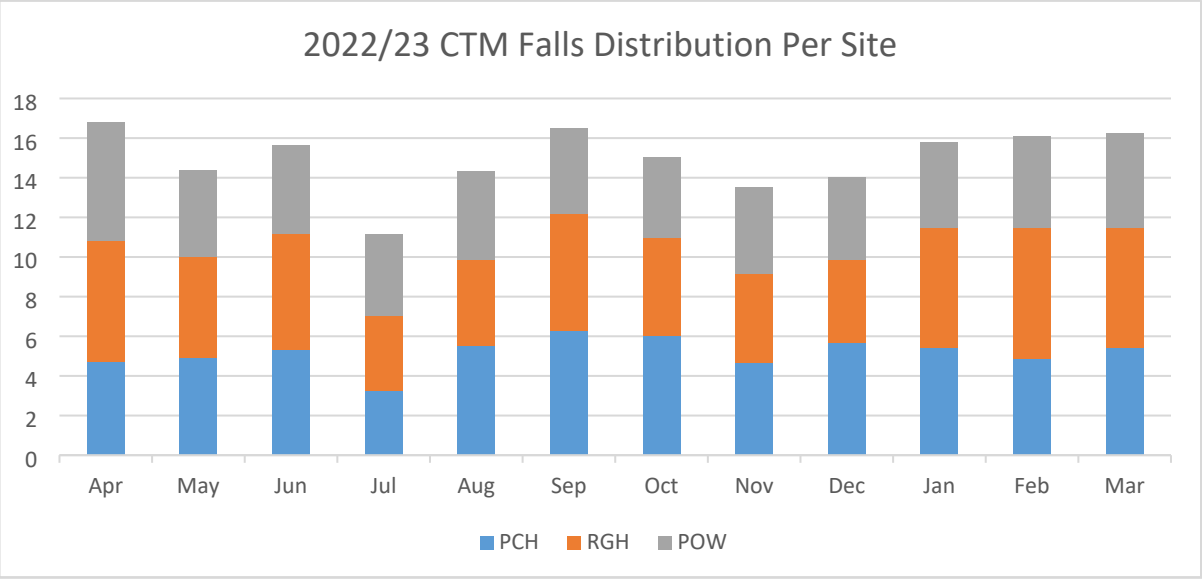
a) Total inpatient falls across all three hospitals: 3,822

b) Total occupied bed days: 379,900

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

c) Overall average falls per 1,000 bed days: 5.06





Trends and Observations

1) **Seasonal variations:** Fall rates vary seasonally, with some months consistently showing higher or lower rates across hospitals.
2) **Hospital comparison:** Royal Glamorgan Hospital has the highest total number of falls (1,355), while Prince Charles Hospital has the lowest (1,102).
3) **Fall rates:** Princess of Wales Hospital generally maintains the lowest fall rate per 1,000 bed days among the three hospitals.
4) **Fluctuations:** All hospitals show significant month-to-month fluctuations in fall rates, suggesting the influence of various factors on fall incidents.
5) **Recent trends:** Fall rates slightly increased towards the end of the data period, particularly in Princess of Wales Hospital.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

6) **Bed occupancy:** The total number of occupied bed days varies between hospitals, with Royal Glamorgan Hospital generally having the highest occupancy.

Community Pressure Ulcer Collaborative

1) Pressure ulcers (PU) are a significant healthcare challenge, causing patient distress and financial strain.
2) Annual costs for NHS Wales: £66.8 to £70.6 million; for Cwm Taf Morgannwg University Health Board (CTM): £9.35 to £9.88 million.
3) CTM's Executive Safety Group identified community-acquired pressure ulcers (CAPU) as a critical safety issue.
4) 'Community Acquired Pressure Ulcer Safety Collaborative' initiated in Spring 2021 with the Welsh Wound Innovation Centre (WWIC) partnership.

Collaborative Initiatives and Challenges

Three teams participated in the collaborative:

1) Parc Canol District Nursing Team: Improving carer education
2) Ward C3 in Ysbyty Cwm Rhondda Hospital: Using yellow wristbands for at-risk patients
3) Foundry Team: Developing PU prevention leaflet for Merthyr and Cynon

Challenges faced:

1) Data acquisition issues
2) Workforce pressures
3) Project creep
4) Incorrect methodology application
5) Mid-project focus change due to Safe Care Collaborative integration

WWIC Analysis Key Findings

1) 15.3% of community hospital patients had PU, with 64.7% developing in-hospital.
2) Most PU were superficial, but 7 patients had severe full-thickness PU.
3) Prolonged sitting (>6 hours daily) was identified as a risk factor.
4) Discrepancies in suspected deep tissue injury reporting and Datix system issues were noted.
5) Staff with training or who completed the CTM PU workbook showed higher prevention knowledge.

Key Recommendations

1. Communication:

   a) Implement digital records that are accessible by ward staff.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

b) Improve communication with A&E staff.
c) Utilise a Single Point of Access (SPA) for risk communication.
d) Create an electronic PU passport.

2. Equipment:

a) Standardise electronic ordering system.
b) Ensure equipment maintenance and availability.
c) Promote patient/relative accountability for equipment.

3. Scrutiny panels:

a) Standardise feedback methods.
b) Encourage staff attendance at panel meetings.

4. Local Authority and Private care agency staff:

a) Improve communication and joint working.
b) Enhance accountability for staff training.

5. Non-concordance:

a) Establish expert patient groups/focus groups.
b) Develop non-concordance care plans.

6. Training and education:

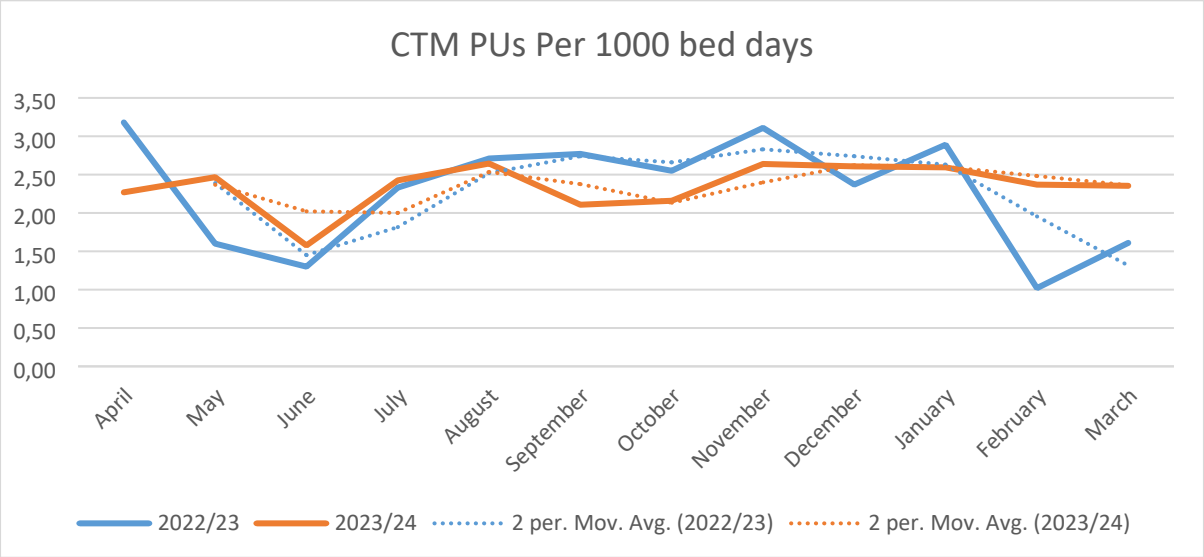
a) Implement bite-sized E-Learning modules.
b) Encourage collaborative workbook completion.
c) Enhance staff knowledge on PU equipment downgrading.

CTM has established an overarching pressure damage steering group to consider these recommendations in detail. The first meeting is scheduled for July 25th 2024.

Overview of Pressure Damage Incidents

The data presents pressure damage incidents across three hospitals - Prince Charles Hospital, Royal Glamorgan Hospital, and Princess of Wales Hospital - over 25 months from April 2022 to April 2024.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360



(Graph: PCH, RGH, PoW combined)

Key Findings

1. Total Incidents: Over the 25 months, there were 1979 reported pressure damage incidents across the three hospitals.

2. Hospital Comparison:
   b) Princess of Wales Hospital had the highest number of incidents (1041, 52.6% of the total)
   c) Prince Charles Hospital reported 498 incidents (25.2% of the total)
   d) Royal Glamorgan Hospital had the lowest with 440 incidents (22.2% of the total)

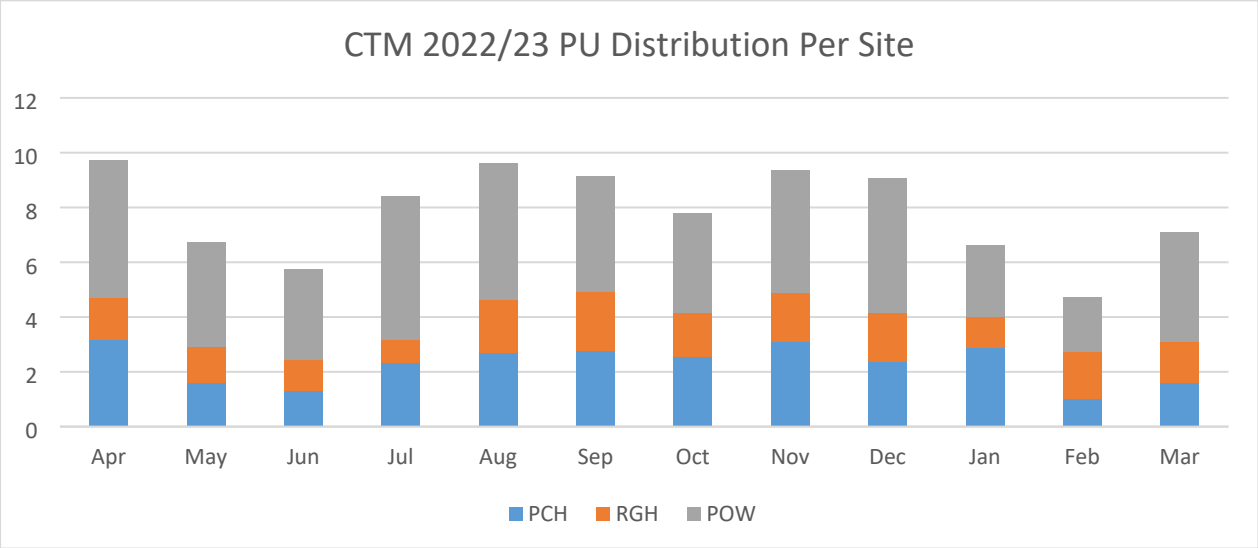
3. Temporal Trends:

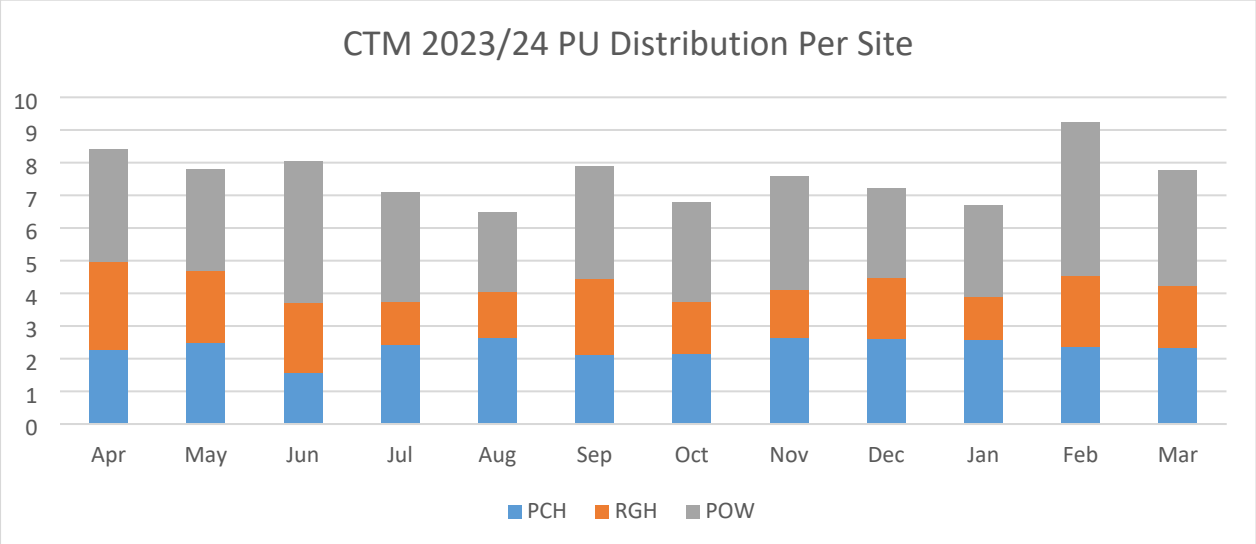
   a) The highest monthly total across all hospitals was 96 incidents in December 2022
   b) The lowest monthly total was 45 incidents in February 2023
   c) There is no clear consistent seasonal pattern, but some months (e.g., July, November, December) tend to have higher incident rates

4. Incident Rate:

   a) The overall incident rate per 1000 bed days for the entire period was 2.97
   b) The highest rate was 3.46 per 1000 bed days in April 2022
   c) The lowest rate was 1.62 per 1000 bed days in February 2023

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

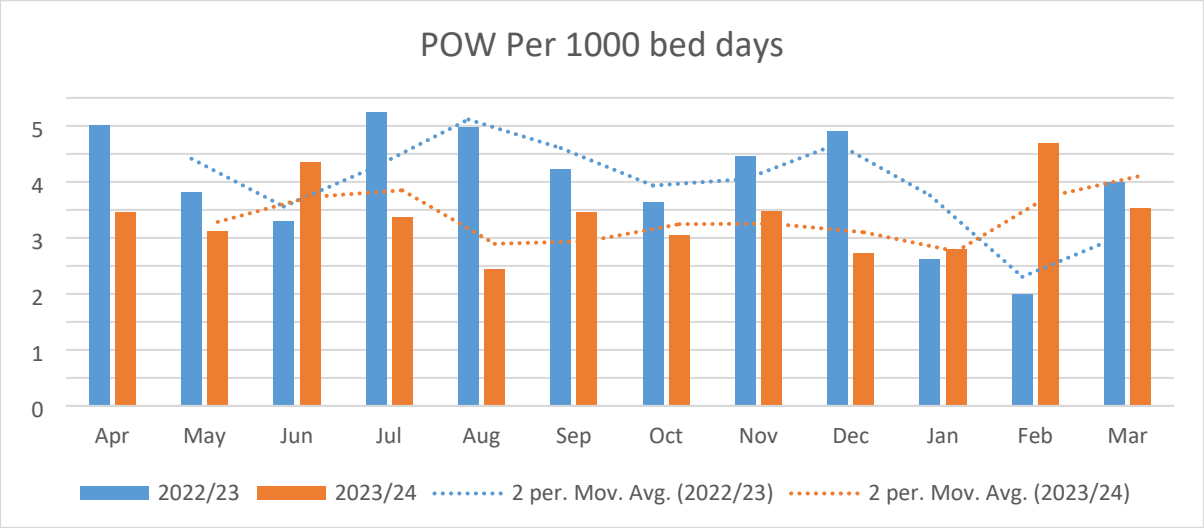




Princess of Wales Hospital

Princess of Wales Hospital reported 1,041 pressure damage incidents over the 25-month period from April 2022 to April 2024. This represents the highest number of incidents among the three hospitals analysed (Prince Charles Hospital and Royal Glamorgan Hospital were the other two).

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360



1. The incident rate per 1000 bed days shows a general downward trend from April 2022 to February 2023, reaching the lowest point in February 2023 (1.62 incidents per 1000 bed days).
    a) After February 2023, the incident rate fluctuates but generally remains between 2.15 and 3.17 incidents per 1000 bed days.

2. High Incident Rates:
    a. The highest incident rate was in April 2022 (3.46 incidents per 1000 bed days).
    b. Other high rates were observed in July 2022 (3.35) and December 2022 (3.15).

3. Low Incident Rates:

    a. The lowest incident rate was in February 2023 (1.62 incidents per 1000 bed days).
    b. Other low rates were observed in January 2023 (2.18) and April 2024 (2.56).

Quarterly Patterns

1. Q2 (Apr-Jun): Often started high but showed improvement within the quarter.
2. Q3 (Jul-Sep): Consistently high rates, particularly in July and August.
3. Q4 (Oct-Dec): Generally stable, with rates between 2.3 and 3.2 per 1000 bed days.
4. Q1 (Jan-Mar): Showed variability, with February often having higher rates than January or March.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

Comparison with Other Hospitals

When compared to Royal Glamorgan Hospital and Prince Charles Hospital:

1. Princess of Wales Hospital consistently reported higher pressure damage incidents.
2. The fluctuation patterns were similar across all three hospitals, suggesting system-wide factors affecting pressure ulcer rates.
3. Princess of Wales Hospital showed more pronounced seasonal variations, particularly in summer.

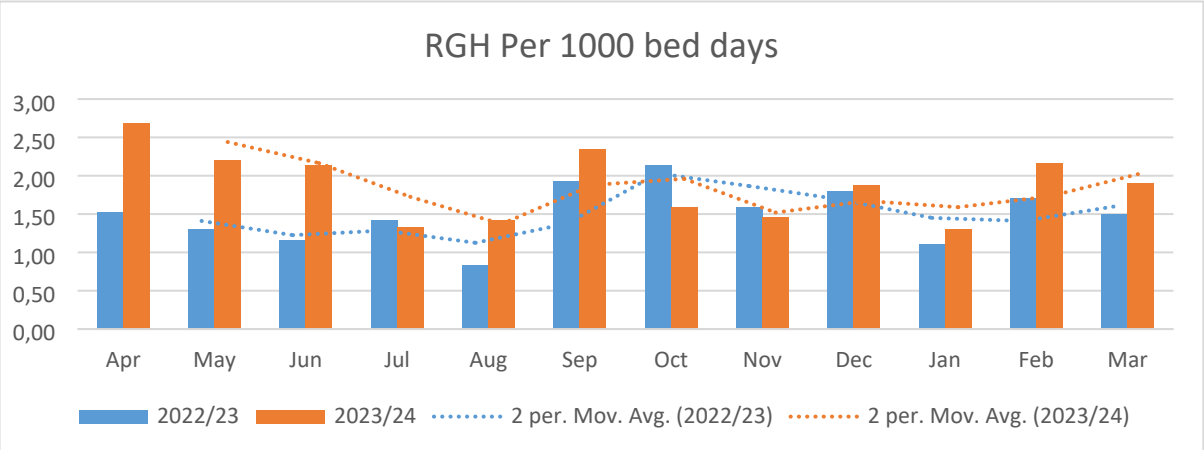
Overall Trend

While there are month-to-month fluctuations, the overall trend suggests a slight improvement in pressure ulcer rates over the two-year period. The initial high rates seen in early to mid-2022 were not repeated in 2023 or early 2024, indicating possible improvements in prevention and care strategies. However, the persistent fluctuations suggest that consistently low rates remain challenging. The data demonstrates that pressure ulcer prevention requires ongoing attention and may be influenced by various factors such as seasonal changes, staffing levels, or patient demographics.

Royal Glamorgan Hospital

Key Statistics

1. Highest Rate: 3.46 per 1000 bed days (April 2022)
2. Lowest Rate: 1.62 per 1000 bed days (February 2023)
3. Average Rate: Approximately 2.68 per 1000 bed days (calculated from the given data)



Trend Analysis

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

1. Initial High Rate: The period began with the highest recorded rate of 3.46 in April 2022.

2. Fluctuations: Throughout the two years, there were notable fluctuations in the rate:

   a. Rates varied from a low of 1.62 to a high of 3.46 per 1000 bed days.
   b. Most months fell within the 2.0 to 3.0 per 1000 bed days.

3. Seasonal Patterns: Some potential seasonal trends were observed:

   a. Spring months (April-May) often showed higher rates.
   b. Late summer/early autumn (August-September) demonstrated varying patterns.

4. Year-over-Year Comparison:

   a. 2022 average (Apr-Dec): approximately 2.97 per 1000 bed days
   b. 2023 average (Jan-Dec): approximately 2.44 per 1000 bed days
   c. This suggests a slight improvement in pressure ulcer rates from 2022 to 2023.

5. Recent Trends: The last six months of data (November 2023 to April 2024) show relatively stable rates, ranging from 2.22 to 3.17 per 1000 bed days.

Monthly Analysis

1. Highest Months:
   a. April 2022 (3.46)
   b. July 2022 (3.35)
   c. February 2024 (3.17)

2. Lowest Months:
   a. February 2023 (1.62)
   b. August 2023 (2.15)
   c. January 2024 (2.22)

Quarterly Patterns

1. Q2 (Apr-Jun): Often started high but showed improvement within the quarter.

2. Q3 (Jul-Sep): Mixed results, with high rates in July and lower rates in August or September.

3. Q4 (Oct-Dec): Generally stable, with rates between 2.3 and 3.2 per 1000 bed days.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

4. Q1 (Jan-Mar): Showed variability, with February often having higher rates than January or March.

Overall Trend

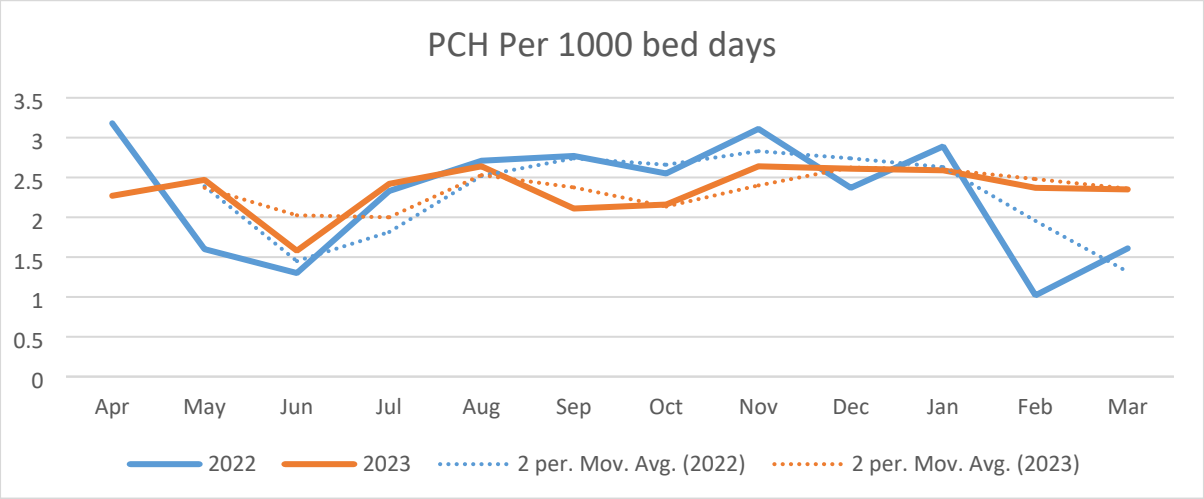
While there are month-to-month fluctuations, the overall trend suggests a slight improvement in pressure ulcer rates over the two years. The initial high rates seen in early to mid-2022 were not repeated in 2023 or early 2024, indicating possible improvements in prevention and care strategies.

However, the persistent fluctuations suggest that consistently low rates remain challenging. The data indicates that pressure ulcer prevention requires ongoing attention and may be influenced by various factors such as seasonal changes, staffing levels, or patient demographics.

Prince Charles Hospital

Key Statistics

1. Highest Rate: 3.49 per 1000 bed days (April 2024)
2. Lowest Rate: 1.62 per 1000 bed days (February 2023)
3. Average Rate: Approximately 2.68 per 1000 bed days (calculated from the given data)



Trend Analysis

1. Initial High Rate: The period began with a relatively high rate of 3.46 in April 2022.

2. Fluctuations: Throughout the two years, there were notable fluctuations in the rate:

   a. Rates varied from a low of 1.62 to a high of 3.49 per 1000 bed days.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

b. Most months fell within the 2.0 to 3.0 per 1000 bed days.

3. Seasonal Patterns: Some potential seasonal trends were observed:

   a. Spring months (April-May) often showed higher rates.
   b. Late summer/early autumn (August-September) demonstrated varying patterns.

4. Year-over-Year Comparison:

   a. 2022 average (Apr-Dec): approximately 2.97 per 1000 bed days
   b. 2023 average (Jan-Dec): approximately 2.44 per 1000 bed days
   c. This suggests a slight improvement in pressure ulcer rates from 2022 to 2023.

Recent Trends: The last six months of data (November 2023 to April 2024) show relatively stable rates, ranging from 2.22 to 3.17 per 1000 bed days.

Monthly Analysis

1. Highest Months:
   a. April 2024 (3.49)
   b. July 2022 (3.35)
   c. February 2024 (3.17)

2. Lowest Months:
   a. February 2023 (1.62)
   b. August 2023 (2.15)
   c. January 2024 (2.22)

Quarterly Patterns

1. Q2 (Apr-Jun): Often started high but showed improvement within the quarter.

2. Q3 (Jul-Sep): Mixed results, with high rates in July and lower rates in August or September.

3. Q4 (Oct-Dec): Generally stable, with rates between 2.3 and 3.2 per 1000 bed days.

4. Q1 (Jan-Mar): Showed variability, with February often having higher rates than January or March.

Overall Trend

While there are month-to-month fluctuations, the overall trend suggests a slight improvement in pressure ulcer rates over the two years. The initial high rates seen

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

in early to mid-2022 were not repeated in 2023 or early 2024, indicating possible improvements in prevention and care strategies.

However, the persistent fluctuations suggest that consistently low rates remain challenging. The data indicates that pressure ulcer prevention requires ongoing attention and may be influenced by various factors such as seasonal changes, staffing levels, or patient demographics.

Harm Free Care Agenda

The recently established Falls Reduction Steering Group and Pressure Damage Reduction Steering Group are critical components of the 'harm-free care' agenda. These groups aim to:

1. Synthesise best practice guidance from networks across Wales.
2. Incorporate policy changes and innovations within the health board.
3. Integrate quality improvement initiatives.
4. Analyse data from care groups as part of their assurance panel processes.

This holistic approach creates a comprehensive strategy for reducing falls and pressure ulcers across CTMUHB.

Recommendations

Based on the assessment of both falls and pressure ulcer initiatives, the following recommendations are proposed:

Falls Prevention

1. Data Management and Reporting:
    a. Develop a Falls data and measurement strategy, building on the learnings from the collaborative.
    b. Implement automated data extraction and reporting systems to reduce manual processes and improve data accessibility.
    c. Standardise the presentation of falls data, incorporating bed occupancy rates (falls per 1000 bed days) for more accurate comparisons across wards.

2. Best Practices Implementation:
    a. Continue to implement and monitor best practices across all sites, based on NICE guidelines, ensuring:
        1) Multifactorial risk assessments are conducted consistently.
        2) Inpatient environments are regularly assessed for fall risks.
        3) Multifactorial interventions are implemented based on individual patient needs.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

4) Patients and carers are actively involved in fall prevention strategies.

3. Collaborative Approach:

a) Maintain and enhance the community of practice within participating teams through:
   1) Regular learning sessions with action periods in between.
   2) Facilitation of shared learning within and across teams.
   3) Continued site visits from the improvement team.

4. Stakeholder Engagement:

a) Strengthen the involvement of external stakeholders in the fall prevention process, including Catering, Estates and facilities, fall community teams, Clinical Governance, and Patient Safety.
b) Develop strategies to improve attendance and engagement in Pan CTM MH Falls monthly calls.

5. Governance:

a) Establish a Falls Prevention Mental Health Panel with a committed multidisciplinary team to oversee and guide improvement efforts.

6. Spread and Sustainability:

- Continue with the Falls Collaborative and develop a plan to spread successful interventions to other high-risk areas within CTMUHB.

Pressure Ulcer Prevention

1. Communication and Information Sharing:

a. Implement a digital record system for Community Nursing teams that can be accessed by ward staff when a patient with pressure ulcer damage is admitted to the hospital.
b. Improve communication with A&E staff regarding patients admitted with pressure ulcer damage to avoid duplication and ensure seamless patient journeys.
c. During the referral process, utilise the Single Point of Access (SPA) to communicate patients' pressure ulcer risk or current pressure ulcer status.
d. Develop an electronic pressure ulcer passport to be uploaded to the Welsh Clinical Portal (WCP).

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

2. Equipment Management:

    a. Implement a standardised electronic ordering system for pressure-relieving equipment across all sites.
    b. Ensure all localities have a robust equipment servicing and maintenance program, with prompt replacement of old or faulty items.
    c. Make equipment accessible on weekends and out-of-hours to prevent delays in patient care.
    d. Develop strategies to improve accountability for equipment provided to patients and relatives, encouraging timely return when no longer required.
    e. Standardise the "Criteria for the supply of a community bed frame" across all CTM sites to ensure consistent and appropriate use of equipment resources.

3. Education and Training:

    a. Develop bite-sized e-learning modules to address staff release issues for training.
    b. Encourage collaborative use of the pressure ulcer workbook to promote reflective practice and shared learning.
    c. Enhance ward staff's knowledge and confidence in appropriately downgrading pressure ulcer equipment before patient discharge.

4. Scrutiny and Learning:

    a. Implement a standardised method for sharing lessons learned from scrutiny panels across all health board sites (e.g., newsletters, intranet updates, or "top tips of the week").
    b. Encourage all staff to attend at least one scrutiny panel meeting to improve understanding of how avoidable harm can be prevented.

5. Collaboration with External Agencies:

    a. Investigate ways to improve communication and joint working with local authorities and private care agency staff.
    b. Encourage care agencies to ensure their staff receive training and education on pressure ulcer prevention.

6. Patient Engagement:

    a. Establish new ways to encourage patient concordance, such as expert or focus groups.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

b. Develop strategies for managing non-concordance with treatment recommendations, potentially introducing a non-concordance care plan completed jointly with the patient.

Overarching Recommendations

1. Integrated Approach:

    a. Develop a comprehensive Falls and Pressure Damage patient Safety Dashboard incorporating data from both initiatives.
    b. Ensure regular communication and knowledge sharing between the Falls Reduction Steering Group and Pressure Damage Reduction Steering Group to identify synergies and shared learnings.

2. Policy and Guidance:

    a. Regularly review and update local policies and guidelines to align with the latest national guidance and best practices from networks across Wales.

3. Innovation and Quality Improvement:

    a. Encourage and support staff-led innovation projects on falls and pressure ulcer prevention.
    b. Integrate quality improvement methodologies into daily practice, providing training and resources to staff at all levels.

4. Workforce Development:

    a. Address workforce pressures by developing targeted recruitment and retention strategies for key falls and pressure ulcer prevention roles.
    b. Provide ongoing professional development opportunities to enhance staff skills in preventing, assessing, and managing falls and pressure ulcers.

5. Technology and Digital Solutions:

    a. Explore and implement digital solutions to support risk assessment, documentation, and monitoring of falls and pressure ulcers.
    b. Ensure IT systems are interoperable to facilitate seamless information sharing across care settings.

6. Patient and Family Engagement:

    a. Develop patient education materials on falls and pressure ulcer prevention that are accessible and culturally appropriate.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

b. Involve patients and families in co-designing prevention strategies and improvement initiatives.

7. Research and Evaluation:

a. Collaborate with academic institutions to research innovative approaches to falls and pressure ulcer prevention.
b. Regularly evaluate the impact of improvement initiatives using quantitative and qualitative methods.

8. Sustainability:

a. Develop long-term sustainability plans for successful interventions, ensuring they become embedded in routine practice.
b. Identify and nurture champions within each care area to drive ongoing improvement efforts.

By implementing these recommendations, CTMUHB can build on the progress made through the Falls and Pressure Ulcer collaboratives, address identified challenges, and work towards achieving sustainable reductions in falls and pressure ulcers across all care settings.

The Falls Reduction Steering Group and Pressure Damage Reduction Steering Group will play crucial roles in overseeing the implementation of these recommendations, ensuring alignment with the 'harm-free care' agenda, and providing regular updates to the Quality and Safety Committee on progress and outcomes

2. Specific Matters for Consideration

2.1 This report provides an overview of the current situation, recent progress, and falls and pressure ulcer prevention challenges at Cwm Taf Morgannwg University Health Board. Establishing dedicated steering groups and implementing collaborative approaches demonstrate the organisation's commitment to improving patient safety.

While notable achievements have been made, including the nomination of the Falls Collaborative for an NHS Wales Award, challenges remain, particularly in data management, standardisation of practices, and consistent team engagement.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	This report is provided for sharing and noting the ongoing work and activity in relation to the reduction and improvement of Falls and Pressure Damage.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

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 report is provided for sharing and noting the ongoing work and activity in relation to the reduction and improvement of Falls and Pressure Damage.
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 recommendations outlined in this report provide a comprehensive framework for addressing these challenges and building on existing successes. By focusing on data-driven decision-making, best practice implementation, stakeholder engagement, and innovative approaches to education and patient involvement, CTMUHB can continue to make significant strides in reducing falls and pressure ulcers.

4.2 The Quality and Safety Committee is asked to:

1. **Note** the progress made in falls and pressure ulcer prevention initiatives.
2. **Endorse** the recommendations presented in this report.
3. Guide prioritisation and resource allocation for implementing these recommendations.
4. Agree on a schedule for regular updates from the Falls Reduction Steering Group and Pressure Damage Reduction Steering Group.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

5. Next Steps

5.1 By maintaining a focused and collaborative approach to falls and pressure ulcer prevention, CTMUHB can improve patient outcomes, reduce avoidable harm, and contribute to the overall goal of providing high-quality, safe care to the communities it serves.

1. Welsh Wound Innovation Centre. Business Case. National Wound Transformation Programme. Proposal to Welsh Government, 2023.
2. Royal College of Physicians. (2021). National Audit of Inpatient Falls (NAIF). https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif
3. National Health Service Improvement. (2017). The incidence and costs of inpatient falls in hospitals. https://improvement.nhs.uk/documents/1471/Falls_report_July2017.v2.pdf
4. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical Medicine, 17(4), 360-362. https://doi.org/10.7861/clinmedicine.17-4-360

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

Agenda Item
6.6

Quality & Safety Committee

Duty of Quality Annual Report

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Deputy Executive Director of Nursing Nigel Downes, Assistant Director Quality & Safety
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director Lauren Edwards, Executive Director of Therapies Health Sciences

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	15/07/2024	Endorsed

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The Health and Social Care (Quality and Engagement) (Wales) Act 2020 requires that Welsh NHS Bodies publish an annual report on the duty of quality capturing the steps they have taken to comply with the duty.

1.2 This is the first Duty of Quality Annual Report produced by CTMUHB and captures the period 2023-2024.

2. Specific Matters for Consideration

2.1 This annual report aims to inform the reader on how Cwm Taf Morgannwg University Health Board (CTMUHB) have implemented the duty of quality within the organisation.

The annual report is divided into the following sections:

- Chapter 1—Quality Framework within CTMUHB—this section aims to provide information on the quality arrangements and structures established within CTMUHB.
- Chapter 2—Summary of Achievements—this section will demonstrate the progress CTMUHB have made in implementing the duty.
- Chapter 3—Our plans for the future—this chapter will outline how CTMUHB continues to strive to embed duty in all aspects of our service.

3. Key Risks / Matters for Escalation

3.1 Please refer to the detail captured within the annual report included at Appendix 1.

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: All strategic goals apply.
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: All strategic areas apply.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
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: All Enablers of Quality apply.
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: All domains of quality apply – please see chapter 2 of the annual report captured at Appendix 1.
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 an annual report.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for an annual report.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	

Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 The Quality & Safety Committee are asked to **ENDORSE FOR BOARD APPROVAL** the Duty of Quality Annual Report.

6. Next Steps

6.1 The Duty of Quality Annual Report will be received at the pubic Board meeting on the 25th July for approval.

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

Cwm Taf Morgannwg University Health Board

Duty of Quality Annual Report 2023-2024

Contents

1. What this Duty of Quality Annual Report will tell you 3

2. About Cwm Taf Morgannwg University Health Board (CTMUHB) 3

3. Foreword 4

4. Chapter 1 – Quality Framework within CTMUHB 5

Defining Quality 5

Quality Strategy 5

Cwm Taf Morgannwg University Health Board Quality & Safety Framework 2022-2025 5

Quality Improvement in CTM 6

This commitment to providing ALL our people with the knowledge, skills and support to make changes will drive quality improvement initiatives throughout CTM. 6

Quality Monitoring and Performance 6

Our Quality Governance Journey 7

5. Chapter 2 – Summary of our achievements 9

Safe 10

Timely 12

Effective 19

Efficient 22

Equity 28

Patient Centred 31

6. Chapter 3 – Our Plans for the Future 40

7. How to contact us: 44

1. What this Duty of Quality Annual Report will tell you

This annual report aims to inform the reader on how we at Cwm Taf Morgannwg University Health Board (CTMUHB) have implemented the Duty of Quality within the organisation.

The annual report is divided into the following sections:

Chapter 1—Quality Framework within CTMUHB: This section aims to provide information on the quality arrangements and structures established within CTMUHB.

Chapter 2—Summary of Achievements: This section will demonstrate the progress we have made in implementing the duty.

Chapter 3—Our plans for the future: This chapter will outline how we will continue to strive to embed the duty in all aspects of our service.

2. About Cwm Taf Morgannwg University Health Board (CTMUHB)

CTMUHB was formed on 1 April 2019. It provides and commissions a full range of community-based and hospital services for the residents of Bridgend, Rhondda Cynon Taf, and Merthyr Tydfil. This includes the provision of local primary care services (GP Practices, Dental Practices, Optometry Practices, and Community Pharmacy), health centres, and community health teams.

The resident population of CTMUHB was estimated at 444,037 (StatsWales Welsh Government, November 2023). The region has high levels of deprivation, with 56.5% of the population living in the two most deprived fifths in Wales (WIMD 2019 with populations from ONS, 2020). The highest levels of deprivation lie mainly in the valleys to the north of the CTMUHB area.

CTMUHB employs 11,251.78 whole-time equivalent (WTE) staff, with a headcount of 12,789. A significant percentage of our workforce lives within CTMUHB's area, making our staff not only the core of our organisation but also representatives of the diverse communities that we serve.

CTMUHB is also responsible for making arrangements for residents to access more specialised health services where these are not provided within the CTMUHB boundary through the Joint Commissioning Committee.

Further information about CTMUHB is available on our website: Home - Cwm Taf Morgannwg University Health Board (NHS.wales)

3. Foreword

It is with pleasure that we introduce the first Duty of Quality Annual Report for 2023-2024 by CTMUHB, which summarises CTMUHB's progress in improving the quality of its services and population outcomes over the past year.

As outlined in CTMUHB's Quality Strategy for 2022-2025, our quality vision is to improve health and well-being, deliver better care, and offer better value across the diverse communities that we serve. We want to be considered an outstanding organisation by everyone: the people who use our services, their families and carers, our colleagues, our communities, and our partners.

This annual report reflects upon the Duty of Quality, which applies to all staff in NHS Wales, whether they work in clinical roles or non-clinical services.

The Duty of Quality aims to:

- Improve the quality of health services;
- Help people in Wales to have more years in good health;
- Listen more to people and patients and act on what is shared.

We need to ensure services are safe and reliable for everyone using them by meeting 12 new Health and Care Quality Standards (see below). These standards are part of the Duty of Quality brought in on 1 April 2023. The 12 standards are made up of six domains of quality (a domain is a particular area or things we want to have good quality health care):

As the Executive Director Lead for Quality and Safety, I aim to advance our commitment to placing quality at the heart of everything we do. I would like to thank you for taking the time to read this annual report, which I hope you find informative, interesting, and demonstrative of our quality ambitions.

Greg Dix

Executive Director of Nursing / Deputy Chief Executive

4. Chapter 1 – Quality Framework within CTMUHB

Defining Quality

We describe quality using the framework outlined by the Institute for Healthcare Improvement.

CTMUHB is committed to supporting the vision articulated in *A Healthier Wales* (WG, 2018): everyone in Wales should have longer, healthier and happier lives. **A clear and sustained focus on quality will help us to achieve this for the benefit of our people and our communities**.

However, defining quality alone does not guarantee success. We know that great care does not happen by accident but by design and from a commitment to working together. Key to the delivery of our plans is a *Quality Management System* approach to embed a culture where people listen, think, feel, and act 'quality'—promoting openness and learning, continuous improvement, and service transformation.

When considering quality in CTM, we focus on **people, patients, and places**.

Quality Strategy

CTMUHB has an established Quality Framework supported by a Quality Strategy for 2022-2025. Our Quality Strategy supports us to build on our achievements to date and deliver the best quality care in collaboration with our people and our communities.

The vision, Mission and pledge as set out in our Quality Strategy are outlined below:

Our Quality Vision
We want to improve health and well-being and deliver better care and better value across the diverse communities that we serve.
We want to be considered an outstanding organisation by everyone – people who use our services, their families and carers, our colleagues, our communities, and our partners.

Our Quality Mission
For our excellent people to deliver high-quality care to every person, every day, in every setting.

Our Quality Pledge
We will continuously improve by working in partnership and placing people at the centre of our work so that we can consistently deliver high-quality care for everyone.

Cwm Taf Morgannwg University Health Board Quality & Safety Framework 2022-2025

The Quality & Safety Framework (2022-2025) aimed to set out the need for a robust quality management system to implement effective change and improve care delivery. The Health and Social Care (Quality and Engagement) Act 2020 reinforces a quality-led approach in Wales by strengthening the Duty of Quality and Duty of Candour for the NHS and establishing a Citizen Voice Body to amplify public input. This legislation and the

need to demonstrate learning and recovery from COVID-19 drove the development of the Quality and Safety Framework. The framework and duties ensure that the NHS in Wales prioritises quality and safety in decision-making and service design for the population.

In the autumn of 2024 and early 2025, CTMUHB will develop an updated Quality & Safety Framework to guide the next phase of its operations. This framework will provide a roadmap for the organisation's future, building on the successes and lessons learned from previous stages.

The new framework will focus on:

- Enhancing quality standards and patient safety measures.
- Promoting continuous improvement and innovation.
- Aligning with evolving healthcare best practices and regulations.
- Engaging stakeholders, including staff, patients, and the community.

By proactively developing this framework, CTMUHB aims to position itself for success in the coming years and ensure that it continues to deliver high-quality, safe, and effective healthcare services to the community.

Quality Improvement in CTM

Over recent years, CTM has experienced significant changes and challenges relating to quality and the COVID-19 pandemic. Our organisation recognises the ongoing challenges that we face. We are committed to improving quality and have a dedicated improvement directorate (iCTM).

The iCTM directorate builds capacity for change across our organisation, coordinates improvement and innovation activity, and engages with our colleagues, patients, communities, and partners to drive the adoption and spread of the most impactful improvement and innovation options. This work is underpinned by the principles of Prudent and Value-Based Healthcare and co-creation.

This commitment to providing ALL our people with the knowledge, skills and support to make changes will drive quality improvement initiatives throughout CTM.

Quality Monitoring and Performance

Our Quality Strategy, structured around the six dimensions of quality for 2022-2025, sets out our quality ambitions and goals. We have engaged stakeholders to ensure that these align with their views and priorities.

Each year, we devise an **Annual Quality Work Plan to focus our efforts on delivering quality objectives.** The identification of these annual objectives is data-driven and risk-stratified to ensure a targeted approach to improving quality.
As an organisation, we will monitor and report our progress against the quality objectives that we have committed to achieving. We will do this at regular intervals and adapt our plans based on progress and learning.

Within CTM, we ensure that our **quality performance monitoring is 'always on'**. Our quality management system will ensure that quality performance data is readily available to provide rapid identification and response to early warning indicators.

Quality and safety are everyone's business, but senior accountability and responsibility have been strengthened within CTM through the collective responsibility shared across our four clinical Executive Directors. Our operating model ensures clearly defined structures for quality governance across the Care Groups, and professional groups have identified quality leads.

The CTM Quality and Patient Safety Governance Framework defines responsibilities from the service to the Executive levels. Our Incident Reporting and Management Framework offers clarity to ensure adequate reporting and learning from incidents. Our Listening and Learning Framework ensures that we actively seek feedback, positive or negative, as we see this as an opportunity to learn and improve quality. Resources have been strengthened by introducing strategic roles to support quality and patient safety within the nursing management team; Allied Health, Health Science and Pharmacy; and the office of the Medical Director.

CTM has established a well-defined quality governance structure, with the Quality and Safety Committee receiving assurance and scrutinising quality, patient safety, and patient experience.

In addition to the Quality and Safety Committee, an Executive Director-led Quality and Patient Safety meeting is held each week, where an 'At-A-Glance' dashboard of quality-related matrices is presented to facilitate a timely review of the previous week's quality performance. The Director of Improvement and Innovation attends this meeting so that any themes and trends are used to inform improvement interventions via CTM.

The Quality Performance Dashboard is received at all regular public meetings of the Quality & Safety Committee and Public Board meetings and is available here: https://ctmuhb.nhs.wales/about-us/our-board/board-meetings-papers/

Our Quality Governance Journey

In response to identifying weaknesses in governance around quality governance arrangements, Health Inspectorate Wales (HIW) and Audit Wales (AW) undertook an urgent review, initially published in November 2019. A report published in May 2021 details progress made since the original 2019 review. A further follow-up review was undertaken in March 2023, and the key findings from the "CTMUHB – Quality Governance Arrangements Joint Review Follow-Up – August 2023" are captured below:

- "The Health Board has made significant progress in addressing the substantial concerns and recommendations in our 2019 report.
- As part of our work, we reviewed the Health Board's arrangements for overseeing the implementation of our 2019 recommendations and delivering the required improvements to maternity and neonatal services. We found that the Health Board's arrangements were adequate and transparent. Senior Executives and Independent Members have been fully involved, providing a good balance of support, scrutiny, and

challenge. The Health Board has also ensured that staff and other stakeholders have been informed of ongoing progress.

- The Health Board has a stronger strategic focus on quality and patient safety than 2019. The Health Board's new three-year Quality Strategy clearly articulates the organisation's quality vision, mission, pledge, ambitions, and goals. It also sets out the Health Board's approach to quality and what success will look like. The strategy and the new three-year Quality and Patient Safety Framework provide a good foundation to support the delivery of the new Duty of Quality and Duty of Candour, which came into effect in April 2023. At the time of our work, the Health Board was developing an Annual Quality Work Plan to set out the quality objectives to support the delivery of the strategy. Whilst this is a positive development, finalising the plan at pace must remain a priority for the Health Board to ensure corporate and operational teams fully understand their role in delivering the quality ambitions and goals of the organisation. The Health Board also needs to put robust arrangements in place to monitor the delivery of the plan and strategy to ensure they are improving quality outcomes as intended".

The full report is available here: Cwm Taf Morgannwg University Health Board - Quality Governance Arrangements Joint Review Follow-up (audit. wales)

No further follow-up reviews are planned. Progress against any remaining recommendation actions will be monitored through self-assessment and the Audit Tracker received by the Audit & Risk Committee.

5. Chapter 2 – Summary of our achievements

Enhancing Quality of Care

CTMUHB has made several improvements and developments, some of which will be outlined within this report, to improve the quality of service provided to patients, families, and service users. These improvements align with the Duty of Quality legislation and aim to enhance the overall experience for those who rely on CTMUHB's services.

Key Developments

- CTMUHB has implemented several initiatives, including those included in this report, to ensure compliance with the Duty of Quality requirements.
- These changes focus on improving the quality of care and service delivery across various departments and programs.
- CTMUHB has made a concerted effort to identify areas for improvement, such as CTMUHB's concerns process, and has taken proactive steps to address them.

Improved Patient Experience

- The changes made by the CTMUHB are designed to enhance the overall experience for patients, families, and service users.
- By prioritising quality of care, CTMUHB aims to provide a more personalised, efficient, and effective service to those in need.
- Patients should expect high-quality care that meets their needs and preferences.

Commitment to Excellence

- CTMUHB is committed to providing its patients and community the best possible care and service.
- By implementing these changes and developments, the board demonstrates its dedication to meeting legislative requirements and exceeding expectations.
- CTMUHB's focus on quality of care provides evidence of its commitment to continual improvement and its desire to impact the lives of those it serves positively.

This annual report will summarise CTMUHB's progress in enhancing the quality of its services and population outcomes over the past year. The report will focus on progress across the six key quality domains:

1. Safe
2. Timely
3. Effective
4. Efficient
5. Equity
6. Person Centred

Safe

Infection Prevention and Control

Healthcare-Associated Infections

The Welsh Government sets annual targets for Health Boards in Wales to reduce healthcare-associated infections (HCAIs). These targets are based on five key surveillance organisms: Clostridioides difficile, MRSA, MSSA, E. coli, and Pseudomonas aeruginosa.

The Infection Prevention and Control (IPC) team produces monthly infographics for each care group to monitor progress and trends. In the most recent financial year, CTMUHB achieved its HCAI improvement goal for Pseudomonas aeruginosa. Additionally, reductions were observed in MSSA and E. coli bacteraemia compared to the previous year.

The Welsh Government's strategy for dealing with HCAIs aims to change the culture across all healthcare organisations to one in which no preventable HCAI is tolerated. This involves strengthening leadership at all levels to improve infection prevention and control (IPC) and antimicrobial stewardship and measuring success in eliminating preventable HCAIs.

The Infection Prevention and Control Team investigates all preventable infections, and multidisciplinary meetings are held to identify learning to inform practice and influence patient care. These are widely shared.

A significant proportion of infections are deemed to be community-acquired, and there will be a focus in 2024 to restructure the IPC Team to meet the demands of the CTM population. Clinical engagement is critical to introduce targeted interventions to improve patient care.

The Board approved the Infection Prevention and Control Strategy in May 2024, the development of the CTM IPC Strategy 2024/27 exemplifies our commitment to inclusive, collaborative decision-making. Through interviews, group discussions, and iterative refinement, we have crafted a strategic roadmap that reflects the collective wisdom of our diverse stakeholder community. As we embark on implementation, we remain dedicated to collaboration, agility, and continuous improvement, ensuring the successful execution of our strategic objectives in the dynamic landscape of intellectual property and commercialisation. A copy of the IPC Strategy is available here: 30 May 2024 - Cwm Taf Morgannwg University Health Board (NHS.wales)

Acute Respiratory Infections (ARI)

CTMUHB realigned its testing strategy in response to the revised national framework, widespread vaccination, and changing public health conditions. The winter months they proved challenging due to increased Acute Respiratory Illness (ARI), including COVID-19, Influenza, and other respiratory pathogens. Hospital admissions with ARI peaked, and hospitals operated at maximum capacity, further complicated by staff sickness.

The Infection Prevention and Control (IPC) Team managed individual cases of ARI and infection outbreaks, but decisions to close wards were often overruled. A risk-based approach was adopted to maintain patient flow through the hospitals.

Point-of-care testing was introduced in the acute hospital sites' Emergency departments and paediatric wards to inform patient management.

A new COVID-19 variant was identified during the summer, and its impact on transmissibility and severity is being monitored.

Decontamination

A decontamination officer has been appointed to lead the decontamination efforts at CTMUHB. An external audit conducted last year provided reasonable to substantial assurance regarding the decontamination arrangements, processes, and systems across CTMUHB. The plan is underway to centralise endoscope decontaminating at the Princess of Wales Hospital.

Pressure damage

Reducing the pressure, PCH ICU

The Intensive Care Unit (ICU) at Prince Charles Hospital has significantly improved its ability to prevent device-related pressure ulcers in adult patients. This initiative, led by ICU staff nurses, focused on increasing staff knowledge and implementing preventive measures.

The project was initiated following an audit that revealed 13 pressure ulcers reported over eight months due to medical devices, averaging 1.6 monthly pressure damage incidents. Recognising the severity of this issue, two ICU nurses attended the Health Board's Pressure Ulcer Prevention training and became Pressure Ulcer Champions. They also participated in weekly Scrutiny panel sessions, highlighting a knowledge gap among staff regarding preventing device-related pressure ulcers.

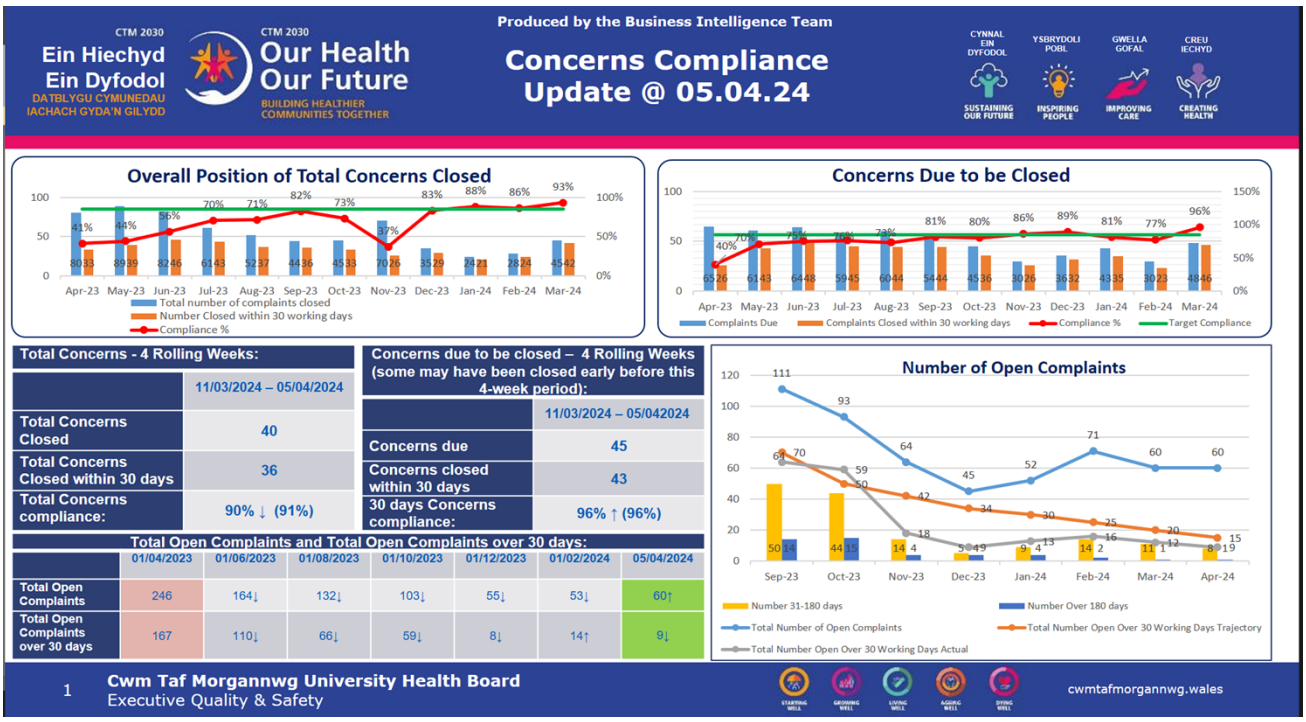
To address this, the team developed educational materials in collaboration with Tissue Viability Nurses, Professional Development Nurses, and Equipment Co-ordinators. These included two informative posters and a quick reference booklet containing up-to-date information on preventing, treating, and managing pressure ulcers. The materials were piloted in the ICU and are set to be launched in other areas of Prince Charles Hospital.

The effectiveness of this initiative was evident in the results of staff surveys conducted before and after implementing these resources. In January 2023, only 7% of ICU nurses could identify pressure damage caused by medical devices. By September 2023, this figure had increased to 56%, demonstrating a significant improvement in staff knowledge. More importantly, the incidence of device-related pressure ulcers within the ICU decreased from 1.6 to 0.4 per month over five months following the launch of the educational poster.

This project has increased staff knowledge and, potentially improved patient outcomes and reduced hospital stays. The success of this initiative has prompted plans for further

improvements, including developing quick guide posters for preventing pressure and moisture-associated skin damage, facilitating additional Pressure Ulcer Prevention training, and creating an easy-access trolley with necessary equipment and dressings.

The ICU team's efforts demonstrate that device-related pressure ulcers in critically ill patients can be significantly reduced through targeted education and prevention strategies. This successful model has the potential to be shared with other ICUs and clinical areas throughout the Health Board, contributing to overall improvements in patient care and outcomes.



Community Pressure Ulcer Collaborative

The Community Acquired Pressure Ulcer Safety Collaborative, initiated in Spring 2021, has made significant strides in addressing the challenges posed by pressure ulcers (PU) in CTMUHB. This collaborative effort, partnering with the Welsh Wound Innovation Centre (WWIC), has yielded several key achievements. Three teams successfully participated in the collaborative, focusing on diverse aspects of pressure ulcer prevention: Parc Canol District Nursing Team improved education for carers and agencies, Ward C3 in Ysbyty Cwm Rhondda Hospital implemented yellow wristbands to identify at-risk patients, and the Foundry Team developed a community-focused PU prevention leaflet. The collaborative fostered idea-sharing, peer support, and training delivery, despite challenges in data collection and workforce pressures.

WWIC conducted a detailed analysis, identifying 8 key workstreams to address PU issues. This comprehensive approach included data analysis to identify gaps, a PU baseline assessment in two community hospitals, a staff knowledge survey on PU prevention, a review of PU reporting and learning panels, and an evaluation of critical processes related to PU management. A collaborative prevalence survey with Arjo revealed important insights: 15.3% of patients in community hospitals had PU, with 64.7% developing them

in the hospital. Most PU were superficial, but some patients had severe full-thickness PU. Prolonged sitting times were identified as a significant risk factor, and staff with training or who completed the CTMUHB PU workbook demonstrated higher prevention knowledge.

Based on these findings, several recommendations were made to improve PU prevention and management. These include enhancing communication through digital records and improved information sharing, standardising equipment ordering and maintenance processes, improving scrutiny panel feedback and learning dissemination, strengthening collaboration with local authority and private care agency staff, developing strategies to encourage patient concordance with treatment, and implementing targeted training and education initiatives. Establishing an overarching pressure damage steering group in July 2024 marks a significant step towards implementing these recommendations and improving pressure ulcer care across CTMUHB.

Children and Families Care Group: Improving our services

The 2023-2024 period has been a significant year of progress and achievement for the Maternity and Children's Services at CTMUHB. The health board has made substantial strides in enhancing the quality and safety of its maternity and neonatal services, culminating in the de-escalation from targeted intervention to improved monitoring. This milestone reflects the sustained improvements and the health board's commitment to providing high-quality care for women and newborns across its facilities.

One critical success has been the implementation of the Maternity and Neonatal Improvement Programme, which has focused on addressing the recommendations from previous independent reviews. The programme has seen the establishment of dedicated Mat/Neo safety officers, the collection and analysis of thematic responses, and the publication of comprehensive reports. These efforts have been supported by regular site visits and collaborative meetings between senior leads and frontline staff, ensuring the improvements are well-integrated and effective across the board.

The positive outcomes of various inspections and reviews further evidence the health board's commitment to quality and safety. The Healthcare Inspectorate Wales (HIW) conducted unannounced inspections at the Tirion Birth Centre and Prince Charles Hospital, concluding that the staff are providing safe and effective care. The inspections highlighted the hard work and dedication of the staff at all levels, contributing to a positive experience for women and birthing people. These findings have reinforced the health board's reputation for delivering high standards of care.

In addition to structural and procedural improvements, patient engagement and feedback have been integral to the ongoing enhancement of services. The health board has actively sought patient-reported outcome measures (PREMS) through various phases of pregnancy and post-birth, achieving a good response rate and valuable insights. This feedback has been crucial in ensuring that the services are responsive to the needs and experiences of women and their families, fostering a culture of continuous improvement and patient-centred care.

Overall, the 2023-2024 period has marked a transformative phase for CTMUHB's Maternity and Children's Services. The successful de-escalation from targeted intervention, the positive inspection outcomes, and the robust engagement with patients all underscore the health board's dedication to quality and safety. These achievements reflect the staff's hard work and commitment and set a strong foundation for continued excellence in maternity and neonatal care in the years to come.

Improved Complaint Management

Over 2023-2024, CTMUHB has made significant progress in managing complaints more effectively. Here are the key improvements:

April 2023 Baseline

- There were 246 open complaints across CTMUHB.
- 167 out of the 246 complaints were open for over 30 working days.
- The compliance with the Welsh Government target of closing 75% of complaints within 30 working days was only 41% for April 2023.

March 2024 Improvements

- The number of open complaints across CTMUHB decreased from 246 to 60.
- Only 9 of the 60 complaints were open for over 30 working days.
- The compliance with the 30-working day target for closing complaints reached 93% in March 2024.

These improvements can be attributed to a change in the complaint management process, the challenge being met by the Care Groups, and targeted efforts throughout the year. CTMUHB has made significant strides in reducing the backlog of open complaints and improving the timeliness of complaint resolution.

CTMUHB has made significant improvements in complaint management over the past year. These enhancements can be attributed to several key factors:

- **Change in Complaint Management Process**
  The Concerns Team implemented changes which streamlined and optimised their complaint management procedures. These improvements allowed for more efficient processing of complaints from patients, relatives, and carers.

  The combination of streamlined procedures and a sustained focus on resolution has resulted in more efficient complaint handling. The changes implemented by the Concerns Team led to quicker turnaround times and better outcomes for those who raised concerns.

  Within each Care Group, the identification of accountable senior leaders, regular access to performance data, and effective forums for monitoring/escalation have resulted in significant improvement in complaint management effectiveness across the Care Groups.

  As a result of the process changes and sustained focus, CTMUHB has made substantial progress in reducing the backlog of open complaints. Complaints are now resolved

in a timelier manner than in previous years, resulting in a much improved experience for complainants. Overall, CTMUHB has transformed from underachieving in Concerns Management to becoming one of the top-performing organisations in NHS Wales. The position over the year is outlined in the graphs below:

Falls Prevention Collaborative in Cwm Taf Morgannwg

In 2023, CTMUHB experienced a high incidence of falls in Older Adult Mental Health wards, with 247 adult inpatient falls reported from five mental health wards in a year. In response, the Mental Health and Learning Disabilities Care Group Nurse Director requested the iCTM QI teams to develop a collaborative approach to reduce inpatient falls within Older Peoples Mental Health Wards. Building on lessons learned from the Pressure Damage Collaborative, this program utilised the breakthrough collaborative model, emphasising evidence-based interventions, team and management buy-in, and a strong focus on data from the outset. The overarching aim was to reduce the incidence of inpatient falls on these wards by the end of 2024.

Data challenges persisted, with the primary source being the recently changed Datix system. The Falls collaborative data was based on a manual analysis of raw data provided by the patient safety team. Recommendations include automating this process into a dashboard format and sharing it widely across the Health Board.

Key work areas included implementing best practices based on NICE guidelines, developing a community of practice within participating teams, standardising the falls prevention process, involving external stakeholders, standardising data presentation, creating a Falls Prevention MH Panel, and organising Pan CTM MH Falls monthly calls. Progress to date includes gathering baseline data, completing King's Fund Environmental Audits, conducting learning sessions, testing an audit tool, and involving external stakeholders.

The collaborative has shown promising results, with a stabilization in the number of falls and strong commitment from the teams. Developing a spot-check audit tool has been crucial in ensuring adherence to evidence-based treatment. The collaborative methodology has proven effective and may have potential applications in other areas of harm, such as Medicines Safety.

Final recommendations include developing a comprehensive fall and pressure damage data and measurement strategy, implementing recommendations from the WWIC report, and continuing the fall collaborative while spreading successful interventions to other high-risk areas. The collaborative's success has been recognised with a nomination for an NHS Wales Award, highlighting its potential impact on patient safety and care quality

Restorative, Just & Learning approach

A Restorative, Just and Learning (RJL) approach promotes openness and transparency and considers broader systemic issues when things do not go to plan. When taking a restorative approach, we do not seek to apportion blame but consider who has been hurt and how relationships and trust can be restored. The emphasis is on creating healthier working relationships, modelling civility, and ensuring a 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. Evidence shows that such an approach results in improved patient safety and experience.

The approach encourages compassionate engagement to understand what happened from multiple perspectives. It is essential to understand the factors that affect performance and behaviour. 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.

Vision for RJL 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 are 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 caused things not to go as planned rather than looking at who was to blame. Accountability will be forward-looking, promoting learning, development,** and personal growth.

CTMUHB has an Executive-led working group to support the development of the approach and three groups feeding into the working group looking at the following:

- Policies – how are we ensuring they support a therapeutic approach
- Education and training - create the capability within our leaders and managers to take a refreshing approach and intervene early
- Creating a baseline of data to understand our current staff experience and to measure the impact of any changes

In the 2023-2024 period, CTMUHB demonstrated a strong commitment to fostering a culture of openness and safety by implementing the NHS Wales Speaking Up Safely Framework. This framework, launched by the Welsh Government in Autumn 2023, aims to support all NHS Wales organisations in creating an environment where staff feel safe and empowered to raise concerns without fear of reprisal.

CTMUHB has taken several specific actions to embed this framework within its operations. These actions include conducting comprehensive training sessions for staff to ensure they understand the procedures for raising concerns and the protections available to them. Additionally, the health board has established clear protocols for reporting and overseeing concerns, ensuring that all reports are treated seriously, fairly, and promptly. The Board has also promoted transparency by regularly communicating the outcomes of raised concerns and the subsequent actions taken, thereby reinforcing trust and accountability within the organisation.

Furthermore, CTMUHB has aligned its efforts with broader NHS Wales's policies, such as the Procedure for NHS Staff to Raise Concerns and the NHS Wales Policy: Respect and Resolution, to ensure a cohesive approach to speaking up safely. By actively fostering a supportive environment and encouraging feedback and learning from staff experiences, CTMUHB has demonstrated its dedication to continuous improvement in patient care and staff wellbeing throughout the 2023-2024 period.

Seren Awards

Any member of CTMUHB staff can send a Seren Award to a colleague who has demonstrated extraordinary efforts to enhance the experience and care of colleagues, patients, carers, and visitors, embodying the core values of CTMUHB. These values include compassion, dedication, and excellence in service.

Every Seren Award nomination is automatically entered into the Seren of the Month Award competition. This prestigious accolade is presented to a colleague who has gone above and beyond to make a significant impact on CTMUHB, whether through innovative practices, exceptional patient care, or outstanding teamwork.

The selection process for the Seren of the Month Award is rigorous and transparent. Nominations are first shortlisted by a diverse staff panel, ensuring a fair and inclusive evaluation. The final decision is made by CTMUHB's Executive Directors, who carefully review each nominee's contributions to select the most deserving recipient.

The Seren Award recognises individual excellence and fosters a culture of appreciation and continuous improvement within CTMUHB. By celebrating the extraordinary efforts of our staff, we aim to inspire others to strive for excellence and uphold the highest standards of care and service.

Timely

Same Day Emergency Care (SDEC)

The Six Goals for Urgent and Emergency Care Policy sets clear expectations for the delivery of the right care in the right place, first time for physical and mental health. Same Day Emergency Care (SDEC) falls under Goal 3 of the Six Goals Policy, with the aim of reducing the number of people requiring overnight admission for a health care emergency. SDEC services support emergency departments and allow for the rapid assessment, diagnosis and treatment of people presenting with certain conditions, and discharge home same day where clinically appropriate, twelve hours a day, seven days a week.

CTM received investment for additional Allied health professional (AHP) resource in Prince Charles and Princess of Wales Hospitals. The additional AHP resource in Prince Charles Hospital has been aligned to the Stay Well at Home (SW@H) and Medical Team and aims to ensure that all patients are assessed on the same day of their admission. Where clinically appropriate, all patients that can be discharged home on the same day are supported to do so with the Occupational Therapist being able to commission care through the SW@H Team.

In the Princess of Wales Hospital, the existing therapy resource at the front door was minimal and therefore the additional resource has been utilised to create a therapy frailty service. The service aims to ensure that all patients admitted under the SDEC/Frailty pathway are assessed on the same day and aims to facilitate prompt discharge. The service at the Princess of Wales Hospital does not have the same ability to commission care as the Prince Charles Hospital Team and as such they utilise the Discharge to Recover and Assess pathway to facilitate discharge as soon as possible.
Our AHP Services are measuring their impact through internal processes to ensure services are meeting the demands of the local community.

Unscheduled Care: improving quality and access

In the 2023-2024 period, CTMUHB has achieved significant successes and improvements in emergency and acute medicine care, as well as in its Minor Injury Units (MIUs) at Ysbyty Cwm Cynon (YCC) and Ysbyty Cwm Rhondda (YCR). These advancements reflect CTMUHB's commitment to enhancing patient care quality and operational efficiency.

One notable achievement in emergency and acute medicine care is the implementation of the 'Six Goals for Urgent and Emergency Care' framework. This initiative has substantially improved patient flow and ambulance handover times. Introducing the Rapid Assessment Treatment Zone has enabled senior clinical decision-makers to perform early assessments, ensuring patients receive the right care promptly. This has significantly reduced the average time ambulances wait to hand over patients, enhancing patient experience and freeing up ambulance resources for community use.

CTMUHB made significant progress in optimising hospital care and discharge practices. Implementing the Optimal Hospital Patient Flow operational guidance and supportive guides for discharge processes (SAFER, Red2Green, and D2RA) led to more efficient patient flow and reduced unnecessary hospital stays. This was evidenced by a reduction of around 5% in emergency bed days used by people with a length of stay over 21 days, demonstrating improved efficiency and better patient outcomes.

Reopening the Minor Injury Unit at Ysbyty Cwm Cynon (YCC) marks another significant milestone. This unit had been temporarily closed, and its reopening has been met with positive feedback from the community. The MIU now provides enhanced services, ensuring that patients with minor injuries receive timely and effective care without the need to visit larger emergency departments. This improves patient satisfaction and alleviates pressure on the central Emergency Departments (ED).

The SDEC model focuses on providing timely and appropriate care by enabling patients to receive diagnosis and treatment on the same day, thereby avoiding unnecessary hospital admissions. This approach aligns with the hospital's commitment to delivering safe and clinically effective care. The implementation has involved several vital actions:

- **Improvement in Patient Flow**: The hospital has introduced a comprehensive plan to address patient flow and safety challenges. This includes regular bed meetings and the development of an ED dashboard to track and predict high-impact workflows, ensuring timely access to care.
- **Staff Training and Compliance**: To support the SDEC model, a concerted effort has been made to improve mandatory staff training, particularly in resuscitation, to ensure patient safety. This includes the appointment of a Senior Nurse for Professional Education, and the development of a training needs analysis and study plan for staff.
- **Operational Enhancements**: The hospital has collaborated with Improvement Cymru and other local staff to share expertise and design improvements in current arrangements. This collaborative effort aims to streamline operations and enhance the quality of care provided under the SDEC model.

These measures reflect Prince Charles Hospital's dedication to improving emergency care services and ensuring patients receive efficient, high-quality care. The ongoing efforts to refine the SDEC model demonstrate a commitment to innovation and excellence in healthcare delivery.

Effective

Quality Impact Assessment

The Quality Impact Assessment (QIA) was redeveloped during 2023-2024 and is a crucial tool used by CTMUHB to evaluate the potential effects of strategic decisions, service changes, and new initiatives on healthcare quality and patient safety. This updated process ensures that quality considerations are at the forefront of decision-making, aligning with the NHS Duty of Quality and the Health and Care Quality Standards.

The QIA procedure serves the following essential purposes:

- It provides a systematic approach to assessing the impact of proposed changes on patient safety, patient experience, workforce, and clinical effectiveness.
- It helps identify potential risks and develop mitigating actions to address any negative consequences on quality.
- It ensures that service changes are evidence-based and demonstrates best practices.
- It allows the Board to be assured that all essential factors are considered in service design and development.
- The QIA is structured around the six dimensions of quality.
- The QIA supports compliance with CTMUHB's Duty of Quality.

The QIA is an integral part of the CTMUHB's quality governance framework, which aims to maintain high standards of care through ongoing measurement and improvement. By

implementing this tool, CTMUHB will make informed decisions that prioritise quality and safety in healthcare delivery, ultimately benefiting patients and the community it serves.

To maintain transparency and assurance, the reporting mechanism will provide a quarterly comprehensive report detailing all QIAs evaluated by each of the Care Groups to be reported to the CTMUHB's Operational Management Board and Executive Leadership Group.

Infection Prevention and Control Team

A strategic Infection Prevention and Control (IPC) Team review is underway. The planned restructuring aims to enable the team to deliver an integrated service across secondary, community and primary care settings. The restructured team will support the care groups in identifying and driving improvements in IPC practices.

Absences and vacancies within the IPC Team have negatively impacted their ability to drive improvements in IPC practices this year. Despite every effort, the planned annual audit program could not be fully completed. These outstanding areas will be prioritised for completion next year. Support has been requested from clinical teams to address suboptimal IPC practices and environmental issues identified during IPC audits and ward visits.

The IPC Team has reintroduced a blended approach to support IPC education and training delivery. In addition to the existing eLearning packages available to staff, face-to-face training sessions have been reintroduced. This blended approach aims to enhance the effectiveness of IPC education and ensure that staff are well-equipped to maintain high infection prevention and control standards.

People's Experience Team

The People's Experience Team is dedicated to ensuring the patient's perspective is at the heart of all service enhancements and new initiatives. To further this mission, in April 2024, the People's Experience Team will join the Quality & Safety team.

This strategic alignment will allow for a more unified and practical approach. By combining the strengths and expertise of both teams, CTMUHB will be better positioned to:

- Amplify the patient voice in service improvement and design.
- Enhance the quality of care and safety standards.
- Streamline processes and communication.
- Achieve more significant synergies and impact through the patient's experience journey.

The patient will remain the central focus as we work together to deliver the highest quality healthcare experience. This collaboration represents an exciting new chapter in our ongoing commitment to patient-centred care.

In addition, several events are being planned in 2024-25:

- Engagement events to raise awareness of services within CTMUHB and community settings are being planned for Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda.
- Expansion of links in the community with third-sector stakeholders to ensure awareness of support available in this setting as it changes to meet demand.
- Facilitate an increase in volunteers to support patients/families holistically across CTMUHB footprint.
- CTMUHB is looking to celebrate 'Patient Experience Week' in April/May 24 as a first to highlight the work staff are undertaking to support patients/families/carers accessing services across the footprint.

CTMUHB Operating Model

Following the launch of the Care Group operating model in 2022, which saw the organisation transition from Integrated Locality Groups (ILGs) to Care Groups, we have delivered the second and final phase to develop and implement the care group leadership and management structures. This ensures that we continue the integrated care theme and focus on pan-CTM service delivery within CTMUHB. Additionally, we want to ensure that our busy clinical hospital sites are fully supported and that there is local ownership to ensure a high quality of service is delivered to our population. In an accurate 'One CTM' approach, we want to ensure that our patients can access safe and high-quality care across the organisation, irrespective of geographical location.

A new multi-professional senior leadership team leads each Care Group. This team, supported by professional leads and underpinned by corporate business partners, focuses on coordinating the services under their control across the organisation. The following six Care Groups have been established as part of the transition to a new operating model:

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

The organisation set up the entire leadership and management structures in April 2024.

Engagement with Universities

CTMUHB's Research and Development Department supports the setup and delivery of a broad range of commercial and non-commercial Clinical Research Portfolio (CRP) studies to maximise the opportunity for CTMUHB's population to participate in high-quality research and potentially access new treatments and therapies that may improve patients' outcomes or quality of life.

The Research and Development Department continues to meet and collaborate with its academic partners to optimise research opportunities that will impact the NHS and educational institutions. Collaborative working has supported the submission of high-quality funding applications. Recent successful collaborative grant applications include Welsh Intensive Care Society (Swansea University), Burdett Trust (University of South

Wales) and NIHR Health Determinant Research Collaborator (Cardiff University/Rhondda Cynon Taf Local Authority). CTMUHB's R&D Department provides an annual Collaborative Academic Research Funding scheme to support staff to develop new research partnerships with an academic institution to address a current healthcare challenge, and 5 projects have recently been awarded £3000 each.

Inclusion of inter-professional placement learning is a key change to the revised pre-registration healthcare professional education programmes that commenced from September 2022. Programmes are required to provide a minimum of 150 hours of placement jointly with other student healthcare professionals, for nursing, midwifery, allied health, and health care science professional programmes within Wales. CTM is the first Health board to take forward a Multi- Professional Education Facilitator (MPEF) role. This has resulted in a programme of IPE learning opportunities for students from a wide range of professions. Examples of the AHP contribution to this work will be showcased at a National IPE conference being held in July, entitled "Cultivating Collaborative Practice".

Alongside our commitment to IPE, we continue to deliver clinical placement capacity for an increasing number of pre-registration learners. We continue to explore innovative ways of increasing placement capacity to meet the growing demands for new graduates.

Efficient

Ward Assurance

Ward/Department Accreditation is an "improvement tool that evaluates the quality of patient care within a hospital, through the measurement of a series of agreed standards" (NHS Improvement 2019). Following a pilot, the program was implemented across CTMUHB in April 2024. The program aims to measure and recognise excellence in clinical areas through Bronze, Silver, and Gold awards.

CTMUHB plans to accredit 30 wards/areas by March 2025, divided into four phases. Critical aspects of the program include:

- Measuring quality using a series of agreed standards.
- Assuring the Board about care quality.
- Celebrating areas of excellence and identifying improvement opportunities.
- Engaging frontline staff in continuous quality improvement.
- Standardising key processes like patient discharge and staffing.

The accreditation process involves a comprehensive digital assessment and on-site visits by a clinical and non-clinical staff team. Achieving accreditation is recognised with a wall plaque displaying the award level. The program aims to drive quality, enhance patient and staff satisfaction, and align with CTMUHB's strategic priorities.

Nurse Recruitment

CTMUHB has implemented a comprehensive strategy to enhance healthcare staff's attraction, retention, and recruitment. CTMUHB has appointed a dedicated lead for attraction and recruitment at the forefront of this initiative, demonstrating its

commitment to improving workforce strategies. A health board-wide steering group has been established to oversee recruitment pipelines to ensure a coordinated approach across the organisation.

The 2023-2024 period has seen positive outcomes in recruitment efforts. CTMUHB has experienced an overall increase in recruitment for registered nurses and healthcare support workers in Bands 2 and 4, although there has been a slight decrease in Band 3 positions. Notably, CTMUHB has successfully recruited 40 internationally educated nurses, with an additional 11 international adaptation nurses joining the registered nursing team. These figures highlight CTMUHB's success in tapping into local and international talent pools.

To drive attraction and recruitment, CTMUHB has engaged in various initiatives, actively participating in student streaming events and showcasing opportunities such as the Lateral Move Policy, which supports career development and personal growth within the organisation. Additionally, CTMUHB has organised school career fairs and set up engagement stands at significant public events, further expanding its reach to potential candidates.

Retention is a crucial focus for CTMUHB, with several programs implemented to support staff development and career progression. CTMUHB has developed leadership programs for Band 6 and 7 staff in collaboration with the Clinical Education and Workforce Organisational Development team. A program for Band 8a and above is currently in development, demonstrating CTMUHB's commitment to nurturing leadership at all levels. CTMUHB's strategic approach emphasises employing the best people from the most expansive pool, indicating a solid commitment to diversity and inclusion in their recruitment efforts. This comprehensive strategy, encompassing targeted attraction, recruitment, and retention initiatives, showcases the Health Board's dedication to building a strong and sustainable healthcare workforce capable of meeting the evolving needs of the community it serves.

These initiatives demonstrate CTMUHB's multifaceted approach to addressing workforce challenges, aiming to build a strong and sustainable healthcare workforce through targeted attraction, recruitment, and retention strategies.

Nurse Bank

CTMUHB has developed a comprehensive staff bank modernisation plan to enhance its temporary staffing solutions and reduce reliance on agency staff. The plan focuses primarily on recruiting band 2 healthcare support workers for general and mental health areas, implementing a rolling recruitment program to ensure a steady influx of staff onto the nurse bank. In June 2024, CTMUHB introduced a new app to streamline the bank booking process, improving communication and efficiency between the staff bank and employees. To measure the effectiveness of these initiatives, CTMUHB is drafting Key Performance Indicators (KPIs) that will provide oversight of efficiency and highlight areas for further improvement. This multifaceted approach, combining targeted recruitment, technological innovation, and data-driven performance management, demonstrates CTMUHB's commitment to creating a more responsive and efficient temporary staffing solution. By strengthening its internal bank, CTMUHB aims to optimise workforce

management, potentially reduce costs associated with agency use, and maintain staffing flexibility in line with broader NHS workforce strategies.

Allied Health Professional (AHP) roles

Within CTM, there is a growing range of roles, creating an environment where career development is strongly supported in order to ensure that patients are seen by the right person at the right time and place. This is demonstrated through new and emerging roles such as; Consultant Podiatrist, Consultant Physiotherapist in MSK, Research Physiotherapist, Therapies Informatics Lead, Malnutrition Strategic Lead, Advanced Clinical Practitioners (Frailty Clinical Lead, SDEC practitioner), First Contact Physiotherapists, and Exercise Practitioners. Dietetics have developed a dietetic support worker role to work as a diabetes patient educator, delivering X-PERT groups and increasing capacity across the service. Two Physiotherapists have been successfully appointed as Clinical Directors for Strategy Groups within CTM, demonstrating the strength and value of leadership capabilities amongst AHPs.

The level 4 Therapy Assistant Practitioner Diploma was developed to support the development of Healthcare Support Workers in Band 4 therapy roles and to provide career progression. This first of its kind, multi-professional learning content is essential for the training of our workforce as HCSW Therapy roles working across multiple professions are a key component of our future workforce planning. This Once for Wales approach is being utilised to enable a provision of level three education for the smaller professions (Dietetics, Podiatry and Speech and Language Therapy), who have previously had no Level 3 training delivery models. This approach will initially focus on a level 3 Rehab assistant qualification, again, vital to support training our workforce for the roles that they will deliver aligning to development of rehabilitation services for Long-term Conditions and Cancer Prehabilitation.

With the aims to increase successful recruitment and reduce the requirement for agency staffing, an AHP recruitment drive was held in summer 2023. This featured weekend and evening open events, a digital lunchtime webinar, and a significant social media campaign including videos from a range of professionals at all grades. The recruitment drive was well received and raised the AHP profile both locally and nationally, showcasing CTM as a great place to work and develop future careers.

Safeguarding

CTMUHB has demonstrated exceptional leadership and commitment in safeguarding through comprehensive engagement with the Cwm Taf Morgannwg Safeguarding Board (CTMSB) and the implementation of key initiatives. Staff actively lead critical CTMSB subgroups and contribute significantly to multi-agency reviews, training, and audits. This high level of participation ensures that CTMUHB plays a pivotal role in shaping regional safeguarding strategies and practices. CTMUHB's strategic approach is evident in its annual development of the Safeguarding Maturity Matrix, which aligns closely with CTMSB's objectives. This alignment ensures coordinated efforts across the region and allows CTMUHB to focus its resources on priority areas identified by the safeguarding

board. Additionally, it has made significant strides in improving its services, particularly in child protection, mental capacity assessment, and mental health discharge planning. These improvements demonstrate CTMUHB's responsiveness to identified needs and commitment to enhancing patient care and safety.

Working in partnership has been a critical focus for CTMUHB, with strengthened collaborations with agencies and third-sector organisations. The successful integration of a Health IDVA role has notably improved early intervention and preventative work in domestic violence cases. This collaborative approach extends to CTMUHB's participation in multi-agency training and joint audits, fostering a culture of shared learning and continuous improvement across the safeguarding landscape. CTMUHB has also established robust mechanisms for disseminating learning from reviews and audits throughout its organisation. This includes the revision of policies, the development of targeted training programs, and the strengthening of governance structures. Innovative practices, such as introducing the 'Was Not Brought' policy and improved health representation at child protection conferences, further demonstrate CTMUHB's commitment to addressing gaps in service delivery and enhancing safeguarding practices.

These initiatives reflect CTMUHB's firm dedication to enhancing safeguarding practices, fostering multi-professional and multi-agency collaboration, and continuously improving services in response to emerging challenges and review outcomes. CTMUHB's proactive approach and strategic focus position it as a leader in safeguarding within the region, contributing significantly to the protection and well-being of vulnerable individuals in the community.

Community and Primary Care

Nursing

In 2023-2024, CTMUHB saw significant achievements in community nursing and primary care services, demonstrating a solid commitment to quality improvement and patient care. A notable success was the recognition of Andrea Dorrington, Lead Nurse for Urgent Primary Care, who won the Primary Care Nursing Award at the Royal College of Nursing (RCN) Awards 2023. This accolade highlights the health board's dedication to excellence in urgent primary care services and its focus on enhancing patient outcomes in community settings.

CTMUHB's community nursing teams also improved access to care for vulnerable populations. A Clinical Nurse Specialist, was recognised for her innovative work in partnership with the homeless charity The Wallich. She brought nursing care directly to the streets and reached individuals who might otherwise not have access to support. This initiative demonstrates CTM UHB's commitment to addressing health inequalities and providing compassionate care to all community members.

Additionally, Rhianydd Davey, an Immunisation Coordinator, received the Vaccine Save Lives Champion Award at the 2024 Public Health Wales Welsh Immunisation Conference, highlighting the health board's commitment to preventive care and public health initiatives.

These achievements reflect CTMUHB's ongoing efforts to improve the quality and accessibility of community nursing and primary care services. By focusing on urgent care, outreach to vulnerable populations, public health initiatives, and preventive care, the health board has demonstrated its dedication to meeting the diverse needs of its community and working towards its vision of building healthier communities together. These successes contribute to improving outcomes for people across the region by providing high-quality, accessible healthcare services.

Allied Health Professions

Preventative community-based care designed to support people to stay well and independent is at the heart of the Minister for Health and Social Services priorities for 2023 – 2026. Multi-professional working underpins the integrated community model and the funding for AHPs from Welsh Government received by the UHB in 2023 has allowed us to:

- Develop enhanced services to support the urgent and emergency care pathway
- Support admission avoidance
- Focus on supporting those in our communities who are frail
- Focus on the prevention of falls within our communities

The additional investment in AHPs has been used to strengthen and expand the Clinical Navigation Hub for urgent primary and community care, thus increasing its multi-professional offer to our community. The additional Occupational Therapy resource is being utilised to support the GPs working in the Navigation Hub Monday to Friday, through a duty rota system. The Occupational Therapists are able to support with the assessment of patients within their own homes alongside the medics. This allows a more holistic assessment of need that includes the psycho-social aspect of the individual. On a practical note, the OT is able to provide rapid access to equipment / minor adaptations to support the individual to remain at home. The team are currently working with the local authorities to ensure that the OTs are given Trusted Assessor access to intermediate care resource.

Additionally, in collaboration with service user population and the integrated community-based services, the team have developed a co-produced Physiotherapy-led falls prevention programme. This programme focuses on training care home staff in falls prevention, offers bespoke clinic-based assessment/intervention, and group-based falls prevention programmes to individuals at risk of falling.

Planned Care: Robotic Surgery

The introduction of the Versius robotic system at CTMUHB marks a significant advancement in surgical capabilities, particularly for colorectal and gynaecological cancer patients. Early patient experiences like Ann Jones's demonstrate the potential for improved outcomes. Key benefits include:

- Reduced post-operative pain
- Quicker recovery times

- Shorter hospital stays
- Smaller incisions leading to less scarring

The system's ability to provide greater precision and visual acuity during procedures allows surgeons to:

- Identify and protect vital structures more effectively
- Perform complex procedures with increased accuracy
- Potentially improve cancer treatment outcomes

CTM's participation in the National Robotic Assisted Surgery Programme demonstrates a commitment to providing state-of-the-art care to its community. This initiative:

- Increases access to minimally invasive surgical options for patients
- Aligns CTM with other leading health boards in Wales offering robotic surgery
- Supports the goal of creating a unified robotic program across Welsh hospitals

While long-term data is still being collected, the initial implementation of the Versius robotic system at CTMUHB shows promise in enhancing the quality of surgical care. The health board's commitment to this technology demonstrates its dedication to improving patient outcomes and maintaining high standards of care in line with national initiatives.

The Clinical Navigation Hub

The Clinical Navigation Hub, developed in collaboration with regional partners, has proven to be an exciting initiative within CTMUHB. This innovative project has significantly reduced ambulance conveyances following contact with the Welsh Ambulance Services Trust (WAST), alleviating pressure on emergency services and improving patient outcomes.

The Clinical Navigation Hub's primary objective was to reduce the number of unnecessary ambulance conveyances to acute hospitals. By offering alternative care pathways and timely medical advice, the hub has successfully diverted cases that do not require emergency department visits. This approach frees up ambulance resources and ensures that patients receive appropriate care in a more suitable environment.

Several key strategies have been instrumental in the success of the Clinical Navigation Hub:

- Alternative Care Pathways: The hub has developed a suite of services and clinical pathways that provide alternatives to acute hospital admissions. This includes remote prescriptions, directories for alternative care providers, and home visits by clinicians.
- Consultant Connect: This service enables Navigation Hub clinicians to discuss patient cases with consultants in secondary care, ensuring that appropriate management plans are implemented at home.
- Training and Communication: Ensuring that call receivers are well-trained to triage and signpost calls effectively has been crucial. A robust communication strategy has also been employed to inform WAST frontline staff of the hub's services.
- Introduction of Occupational therapists and Paramedics as part of the MDT, ensuring that all possible options for admission avoidance are explored

The Clinical Navigation Hub has achieved remarkable outcomes since its inception:

- Reduction in Ambulance Conveyances: The hub has significantly reduced the number of ambulance conveyances, easing the burden on emergency services and improving response times for life-threatening calls.
- Improved Patient Outcomes: Patients receive timely and appropriate care, often in the comfort of their homes, which enhances their overall satisfaction and health outcomes.
- Cost Efficiency: The hub has also contributed to healthcare system cost savings by reducing unnecessary hospital admissions.

Building on its success, the Clinical Navigation Hub aims to expand its services across the health board and beyond. The NHS Wales Executive is keen to support the team in sharing their innovative solutions with other health boards across Wales, ensuring that more patients benefit from this effective model of care.

Equity

Equality & Welsh Language Impact Assessments

The Equality Impact Assessment (EIA) and Welsh Language Impact Assessment (WLIA) are tools to support our thinking to ensure inclusive decisions meet our legislative requirements. It is essential that what we do does not create barriers that disadvantage or impact the participation of our under-represented groups, and where there is an impact, the tool can support us in taking positive action.

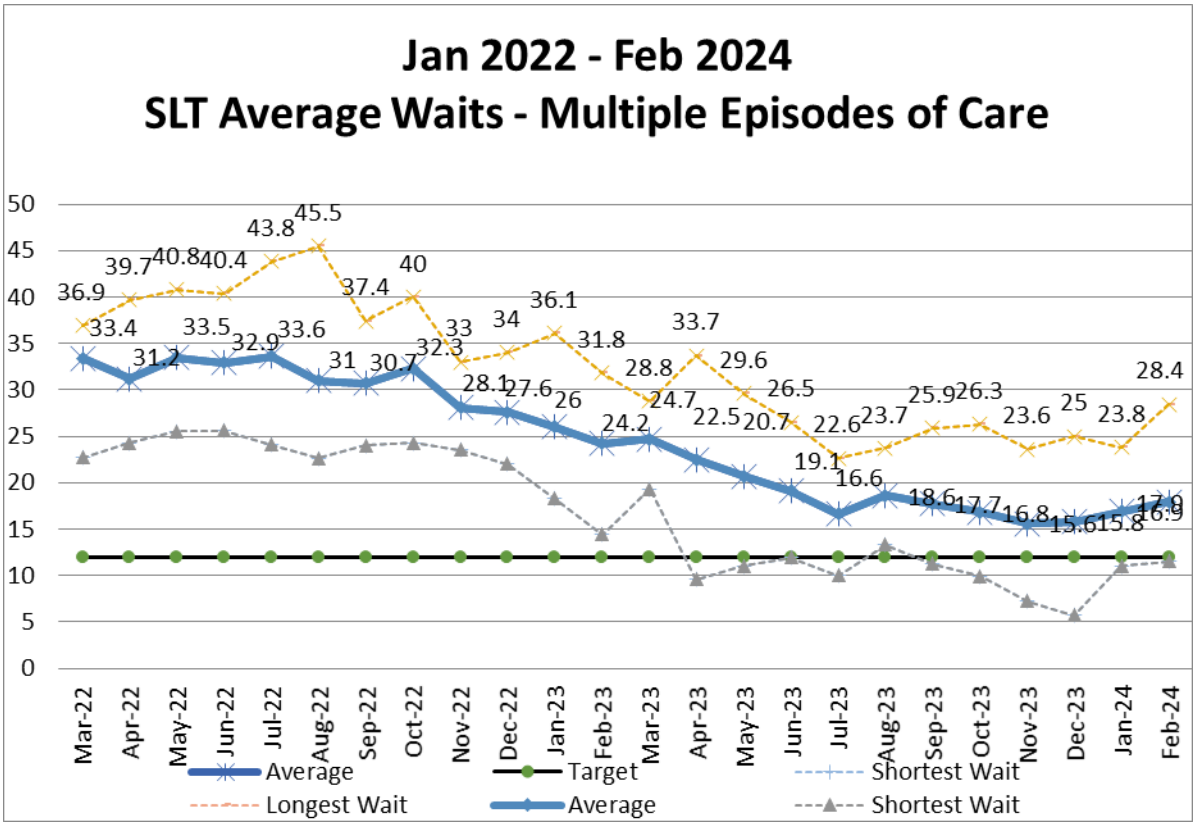
The ultimate aim is not to need an EIA or WLIA as we increase our awareness and knowledge of Welsh Language standards and Equality, Diversity, and Inclusion. The objective is to create an organisation where we think and practice inclusively and where structural inequity is addressed and broken down.

Equality and Welsh Language Impact Assessments

What	• Equality and WL Impact Assessment is process to ensure that the organisations work does not discriminate against or disadvantage protected groups, and to ensure we meet our Welsh language duties under various pieces of legislation. **It applies to any policy or service change made.**
Why	• Promote equality and address structural inequity by taking positive action and minimising risk where appropriate • Meet our requirements under the general equality duties and Welsh language legislation
When	• Any Equality and WL Impact assessment is a process - It should be undertaken at the **start, and constantly updated and revisited** when appropriate
Who	• EIAs should be carried out by t**hose responsible for developing/changing the policy/service** as they are the most familiar with the detail • All relevant parties should be involved from within and outside the health board. This may include service leads, staff, patients and particularly representatives of protected groups. i.e. Networks
Where	• You can find the EIA documents on our **SharePoint page. A-Z – OD&I and the EDI or A-Z Equality and WL Impact Assessments.** Equality & Welsh Language Impact Assessment • Sent to the CTM_Equality@wales.nhs.uk. • Drop in Sessions Booking - CTM EIA Drop-In Support Session

It is widely recognised that the Covid-19 pandemic disproportionately impacted on deprived communities and children. This inequity has been evident within our CTM communities.

The CTM paediatric SLT service secured Welsh Government funding for a project to implement the Early Years delivery plan locally, embedding universal service provision, skilling up key partners in speech language and communication knowledge in order to have maximum impact on children's outcomes. The service carried out a transformation project to address waiting lists-to reduce time between therapy episodes of care, with significant improvement in the latter, without reducing the initial assessment waits, as seen below, thus making interventions more effective and helping to address some of the health inequity faced by our population. The change in service can be seen below.



Weight management

Our CTM population has highest rate of obesity and diabetes and this impacts on all areas of health.

Adult services

CTM adult weight management services have been designed to align with the All Wales Weight Management pathway and demand for the service has been significant following

the launch at the end of 2022/2023. Level 1 and 2 patients are being seen promptly within WG therapies RTT targets, with an extensive waiting list at level 3, where patients require a more specialist intervention.

"Headstart" a level 3 group education intervention has been designed and implemented. Following implementation, capacity for the Level 3 service has increased by 250%. The Level 3 service collaborated nationally with pathway leads in planning implementation of a prescribing pathway and locally with pharmacy colleagues.

Children's services

Level 1 Children's weight management - Merthyr PIPYN

CTM Public Health Dietitians contribute to the prevention agenda at a population level, supporting healthy weights across the life course and tackling health inequalities. The team coproduced the Merthyr PIPYN service through consultation with over 150 families, supporting the implementation of healthy behaviours. The service was shortlisted for the Advancing Healthcare Awards Cymru under the category of 'Improving Access to Health and Care', features in HEIW's Early Years Prevention: A Toolkit for AHPs and was asked by Welsh Government to present and film Merthyr PIPYN as an example of best practice for the implementation of the Healthy Weight: Healthy Wales strategy.

Food and Fun

CTM Public Health Dietetics piloted a new approach to coordinating the Welsh Government funded Merthyr Food and Fun programme. The scheme saw exponential growth over 12 months to provide a total of 1660 free child places across CTMUHB within our most deprived communities, and the provision of 20,520 FREE balanced breakfast and lunches over 12 days of the summer holidays. As a result of the success of this pilot, WLGA have branded Merthyr Food and Fun as gold standard practice, showcased within the WLGA Food and Fun promotional film and staff were invited to present their work at the national WLGA Food and Fun Conference.

Patient Centred

People's Experience Team

The People's Experience team includes several teams proactively supporting patients, families, and unpaid carers. These teams ensure that the voice of the communities we support remains at the centre of what we do as a Health Board. This enables a focus on shared learning and opportunities to build on/improve our services.

To understand what our communities experience is of the care accessed across CTMUHB, there are different ways this is undertaken:

- **PALS (Patient Advisory Liaison Team)**

This team was reinvigorated across CTMUHB in January 2023 – consisting of seven staff based across the three acute sites (Princess of Wales (POW), Royal Glamorgan Hospital (RGH), Prince Charles Hospital (PCH) and supporting community hospitals as well. Support is provided in the form of:

  - Care to Share Clinics - PALS attend the wards to speak to patients and discuss their patient experience holistically.
  - Signposting to other organisations that can provide specialist information or advice.
  - Encourage patient feedback.
  - Attend meetings to support family and staff.
  - Assist service improvement by reporting on themes and trends raised by service users.

The team has held several events, and the People's Experience Roadshow was held in POW in November 2023. Several stakeholders attended to highlight the services on offer:

- Bridgend carers
- Health Board Dementia Lead
- WISE service
- Marie Curie
- Cancer Service Co-ordinator for the Health Board
- CAB for Carers – Citizens' advice
- Clinical Bereavement Lead for the Health Board.

This was well received by people visiting POW that day, and further events are planned for 2024-2025.

- **Chaplaincy Team**

The team proactively supports patients and families holistically across CTMUHB and maintains a service that operates 24 hours/seven days a week on an on-call basis for evenings/weekends in times of extreme distress.

Following the involvement of supporting bereavement services with colleagues in CTMUHB's Intensive Care Unit, an Arts and Bereavement course was created and facilitated across CTMUHB. This comprises of a six-week course exploring loss and following this a bereavement café that participants can attend if they feel further support is needed. Training to provide this course has been provided to some community leaders to take forward themselves in the community setting.

- **Veterans/Armed Forces Family**

CTMUHB signed the Armed Forces Covenant on 25 March with the CEO, Senior Executive representation, workforce reservists, Valley Veterans, and Armed Force Liaison Officers. To move this forward within the care groups, a working group representing departments/specialties across CTMUHB is in place.

An application for the Silver Employer Recognition Scheme is being worked through for submission in April 2024 to look at how as a Health Board we can highlight us as a

prospective employer within the Armed Forces Family with the expertise they hold within this.

- **Volunteer service**

Our volunteers play a huge part in supporting our patients, families and unpaid carers in a number of roles across CTMUHB:

- Good to grow Garden Therapy Volunteers & Volunteer Drivers (Y Bwythyn Newydd)
- Organ Donation Family Support Volunteer – on call for three acute sites.
- Breast Feeding Peer Support Volunteers
- Maternity Volunteers
- Ward Companion Volunteers
- Emergency Department Volunteers
- Meet and Greet Volunteers
- Patient Feedback Volunteers
- Chaplaincy Volunteers
- Bliss Volunteers - Neo Natal

Work continues to increase our volunteer numbers to provide a further holistic support element when accessing services across CTMUHB.

- **Patient feedback**

CTMUHB has a feedback mechanism in place across the sites utilising 'Have your Say' posters in the form of QR codes, paper cards and surveys via SMS (links distributed via telephone). The different mechanisms available are detailed on CTMUHB's internet but there is work underway here to look at how we can make this a more prominent feature working with colleagues in

Work continues with teams across CTMUHB to look at the feedback received and ensure this is sighted on and fed into service improvement across CTMUHB. The creation of a People's Experience Forum to look at themes and trends is also in progress with the view to this starting March 24, chaired by Executive Director of Nursing/Deputy CEO and representatives across the Care Groups and departments also.

- **World Health organisation Day 17th September 2023**

Engaging Patients for Patient Safety

"Elevate the voice of patients!"

World Patient Safety Day 2023 was undertaken on several days in the week of 17th of September under the theme "**Engaging patients for patient safety"**, in recognition of the crucial role patients, families and caregivers play in the safety of health care.

Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction and health outcomes. By becoming active members of the health care team, patients can contribute to the safety of their care and that of the health care system as a whole.

Objectives of World Patient Safety Day 2023

1. **Raise** global awareness of the need for active engagement of patients and their families and caregivers in all settings and at all levels of health care to improve patient safety.
2. **Engage** policy-makers, health care leaders, health and care workers, patients' organisations, civil society and other stakeholders in efforts to engage patients and families in the policies and practices for safe health care.
3. **Empower** patients and families to be actively involved in their own health care and in the improvement of safety of health care.
4. **Advocate** urgent action on patient and family engagement, aligned with the Global Patient Safety Action Plan 2021–2030, to be taken by all partners.

CTMUHB's active participation

The Patient Safety and Value Based Health Care Services teamed up across CTMUHB sites. Stalls were set up across the 3 main hospital sites during the week and manned by alternating members of the teams. Both staff and patients visited the stalls at each site, being provided with the opportunity to ask questions, complete a questionnaire and take part in some fun patient safety focused games. The overall feedback was positive and an opportunity for the teams to meet patients and staff.

During the Patient Safety roadshow, nearly 1,000 people were engaged across three hospital sites: Prince Charles Hospital (PCH), Princess of Wales Hospital (POW), and the Royal Glamorgan Hospital (RGH). The participants included patients, carers, family members, and staff. When asked to rate patient safety on a scale of 1 to 10, the average scores were as follows:

- PCH scored 7.98
- POW scored 8.44
- RGH scored 8.43.

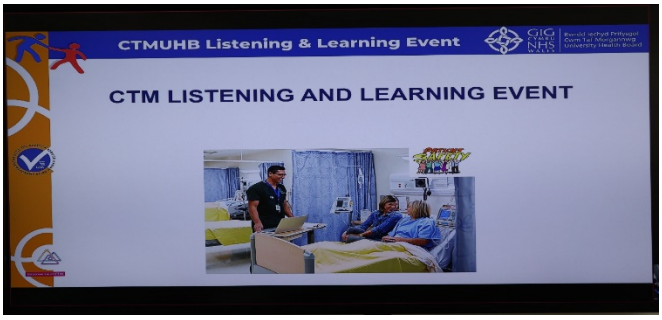
These results reflect the overall perception of patient safety at each location.

Some of the **Key comments** related to patient safety included:

- Maintain quality of life
- Keeps my mother safe
- Ensure it is in place
- To ensure protection: physically, emotionally and mentally
- Protect us
- To make my hospital stay safer
- Very important
- Excellent service, very friendly people to help you
- Makes treatment safer
- To ensure everything and everyone is safe
- Safety is important as it makes people feel safer
- Helps to keep you safer at times of need
- To ensure quality of care
- It is the most important thing.

CTMUHB are looking forward to 2024's World Health Organisation day in September. The theme **"Improving Diagnosis for Patient Safety".**

- **Listening and Learning at CTM Event May 2023**



The Listening & Learning Framework is 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. Further demonstrating how organisational 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.

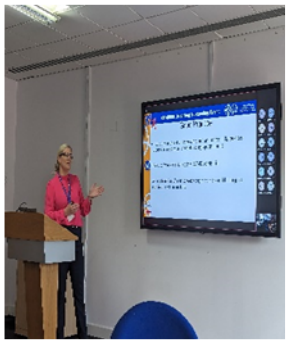
We are committed to providing equitable, safe and effective healthcare for all of our population, across all of our services. Listening, learning and improving is one vital component of our overall vision.

To support this vision, CTMUHB's Listening and Learning Event is aimed at sharing the incredible work being undertaken across our services, Learning from Events, Quality Improvement Projects, Quality Services, Communication, Health Board Incident Management Process, Concerns process and more.

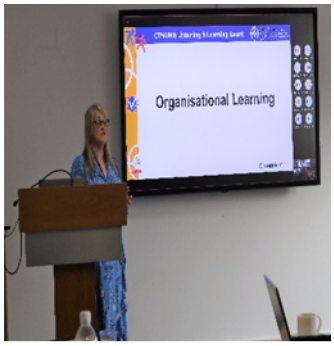
May 2023's Event covered everything from Organisational Learning to Safeguarding. With many guest speakers from internal and external sources including Welsh Risk Pool.

Some of the event topics

Listening and Learning Framework and Learning Repository



Safeguarding



Learning from events

The attendees enjoying the event

Event Feedback

The event was evaluated and some of the following feedback received:

- Very informative, needs to be spread wider to ensure the staff working on the wards are aware of this resource.
- Great information
- Very informative, very structured and enjoyed this session.
- Excellent delivery of learning and safeguarding information
- Good overview of some actual incidents
- Fabulous day. I have learnt so much.

Some really great points were also raised and reflected:

- More clinicians should be engaged.
- Could we have some patient experience stories next time please?
- These sessions are very informative and need to be shared wider. More nurses and clinicians should be involved in them to promote learning.
- Rather than focus on rare 'never' events, more focus is needed on the high-topic incident/complaint themes.

The patient safety service listened and learned from the evaluations received. 2024's event planning has considered all of the suggestions received and are looking forward to the next event. From June 2024, CTMUHB now plans to undertake the learning event biannually, alternating site, to assure the inclusion of all its staffing groups in its forward vision of the continuous sharing of learning for the sustained assurance of the delivery of equitable, safe and effective care to all of our patient population.

- **Bereavement services**

Where we were in October 2022

- No Bereavement lead
- Pregnancy loss under Gynaecology
- No single point of contact
- All hospital-funded funerals agreed with pathology
- Outdated communications
- No representation in focus groups
- No staff bereavement lead support

October 2022 to 2024

- Bereavement Link meetings quarterly attended by nurses and HCSW of all grades who are provided with updates to services for dissemination
- Staff support- Generic email address created and support given to staff if needed, 3rd sector agreement through 2wish to support all professionals
- Point of contact for families and staff
- Booklet revision- New booklet design and content created for adults and pregnancy loss
- Website and feedback area for bereavement created
- Signposting improved from 1 page to 5 pages

- PRUDIC representation- To date, no families since October 2022 have been missed from being referred to 2wish and received support within 24 hours (data from 2wish)
- Liaison for families- No family will feel like they do not know who to contact as booklets and publications are clear and non-jargon
- Staff training- The bereavement framework is constantly reviewed, and training is delivered as and when identified
- Working with USW to educate all student nurses in the care after death process, and the University has agreed to embed this into the syllabus.
- The University of South Wales is now working with CTMUHB in practical role play and is the first University in Wales to do this.

University of South Wales Prifysgol De Cymru

- First health board, internationally to have an active bereavement module on the Hydra training system that can be utilised by others.
- Notified of all sudden deaths to identify a trend if one occurs

- Working alongside WAG as the only health board representative on the panel of advisors for the new Children and Young Persons bereavement pathway.
- Helped to create and facilitate a funeral service for under 24 weeks pregnancy loss hospital communal cremation service. We are now the only health board in Wales to invite families to recognise their loss and have an outlet for grief. Since October 2022, we have invited over 250 families with a 98% contact rate and 66% attendance from those families. We were recognised by ITV Wales News for the work undertaken and commended for our passion for improving the experience for our families.

- Only Health Board in Wales to provide aching arms bereavement bears for all of our families experiencing pregnancy and baby loss in our Early pregnancy units, Emergency Departments (ED), Gynaecology wards and maternity units.

- Changed the location of all of our hospital-contracted funerals, saving the health board £2700 per funeral. To date, this has saved over £30,000.
- The Health Board has significantly improved its engagement with Third Sector organisations, providing a clearer understanding of available services and resources within its jurisdiction. This enhanced collaboration has led to a more comprehensive awareness of the local healthcare landscape, potentially improving access to and utilisation of various health-related support systems.
- Christmas memorial service delivered annually with a male voice choir and excellent attendance the last 2 years
- Baby loss awareness week- Lit up Royal Glamorgan Hospital pink and Blue and held in-person memorial events with choir. All families were invited, and there was excellent attendance and feedback.

- Reduction in Datix complaints regarding bereavement and lack of support since my appointment
- Pram donated for each ED for transportation of the baby to the mortuary. This is to alleviate the staff carrying a child for better mental health support and safety of the child.
  Fingerprint memory cards donated for all adult deaths, meaning that memory-making can be offered to all families who lose a loved one in the Health Board.

Option A

Fingerprint Memory Card

email: ctm.bereavementsupport@wales.nhs.uk

Heartfelt condolences on behalf of the Health Board

If you would like to provide feedback on the bereavement service that you have received, you can email ctm.bereavementsupport@wales.nhs.uk

Plans for the 2024-2025

- Support the changes to the ME service
- Paediatric bereavement booklet
- Cycle event for Children's Grief Awareness week across all sites to recognise that a child loses a parent every 20 minutes in the UK. Leaflets will be given out with the support available in each Health Board area for families going through grief
- National Grief Awareness Week roadshow
- Children and Young Persons' Pathway with Welsh Government to be published

6. Chapter 3 – Our Plans for the Future

Based on the this Duty of Quality Annual Report 2023-2024 and current NHS Wales policies, CTMUHB has outlined extensive plans for the future. These plans are designed to enhance the quality of healthcare services, improve patient outcomes, and ensure compliance with the Duty of Quality and Duty of Candour as mandated by the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Quality and Safety Framework

CTMUHB will continue to develop and implement its Quality and Safety Framework, guiding the organisation through the next phase of its operations. This framework will focus on:

- Enhancing quality standards and patient safety measures.
- Promoting continuous improvement and innovation.
- Aligning with evolving healthcare best practices and regulations.
- Engaging stakeholders, including staff, patients, and the community.

Quality Improvement Initiatives

The Quality Improvement Directorate (iCTM) will build capacity for change across the organisation by:

- Coordinating improvement and innovation activities.
- Engaging with colleagues, patients, communities, and partners to drive the adoption of impactful improvement options.
- Supporting the principles of Prudent and Value-Based Healthcare and co-creation.

Quality Monitoring and Performance

CTMUHB will maintain a robust quality management system to ensure continuous monitoring and improvement of healthcare services. This includes:

- Develop an Annual Quality Work Plan with SMART objectives.
- Regularly monitoring and reporting progress against these objectives.
- Using data-driven and risk-stratified approaches to target quality improvements.

Patient Experience and Engagement

The People's Experience Team will ensure patient perspectives are central to service enhancements. Key initiatives include:

- Expanding engagement events to raise awareness of services.
- Increasing volunteer support to assist patients and families.
- Celebrating Patient Experience Week to highlight staff efforts to improve patient care.

Infection Prevention and Control (IPC)

CTMUHB will focus on restructuring the IPC Team to meet the demands of the population and improve patient care. This includes:

- Strengthening leadership at all levels to enhance IPC and antimicrobial stewardship.

- Implementing a new IPC Strategy for 2024-2027 to guide efforts in preventing healthcare-associated infections.

Complaint Management

Significant improvements in complaint management will continue, with a focus on:

- Streamlining processes to reduce the backlog of open complaints.
- Ensuring timely resolution of complaints to meet Welsh Government targets.

Workforce Development

CTMUHB will enhance its workforce strategies by:

- Implementing a comprehensive staff recruitment and retention plan.
- Developing leadership programs for staff at various levels.
- Strengthening the Nurse Bank to reduce reliance on agency staff and improve temporary staffing solutions.

Safeguarding

CTMUHB will maintain its leadership in safeguarding by:

- Actively participating in the Cwm Taf Morgannwg Safeguarding Board.
- Implementing key initiatives to improve child protection, mental capacity assessment, and mental health discharge planning.
- Enhancing multi-agency collaboration and training.

Research and Development

CTMUHB's Research & Development Department will continue to support high-quality research and collaboration with academic partners. This includes:

- Facilitating new research partnerships to address healthcare challenges.
- Supporting staff in developing research projects through funding schemes.

Community and Primary Care

CTMUHB will focus on improving access to care for vulnerable populations and enhancing public health initiatives. Key achievements and future plans include:

- Recognising and supporting innovative work in urgent primary care and outreach services.
- Expanding immunisation programs and preventive care initiatives.

Technological Advancements

CTMUHB will invest in advanced technologies to improve patient care, such as:

- Implementing the Versius robotic system for minimally invasive surgeries.
- Enhancing patient safety and outcomes through precision and visual acuity in surgical procedures.

Emergency and Acute Medicine

For the 2024/25 period, CTMUHB has outlined several strategic initiatives to enhance its emergency and acute medicine services, building upon previous progress and aligning with NHS Wales' Six Goals for Urgent and Emergency Care framework.

CTMUHB will continue developing integrated care models to ensure seamless coordination between urgent primary care and emergency services. This includes strengthening Pan-Cluster Planning Groups to improve collaboration among health boards, local authorities, voluntary sectors, and allied health professionals. The board will also utilise self-reflection toolkits for clusters to evaluate and improve operational methods, ensuring effective advocacy for local population needs.

Efforts will intensify to address the significant issue of ambulance handover delays. CTMUHB plans to implement and refine operational guidance such as the SAFER, Red2Green, and D2RA processes to optimise patient flow and reduce unnecessary hospital stays. The board will continue expanding its SDEC services to provide timely and appropriate care, helping patients avoid unnecessary hospital admissions. This involves collaborating with national partners and local staff to streamline operations and enhance the quality of care provided under the SDEC model.

Special attention will be given to frail adults to prevent future urgent or emergency care episodes. CTMUHB will develop services designed to help frail adults who have experienced fractures prevent future urgent or emergency care needs. To ensure the effectiveness of these initiatives, the board will implement robust monitoring and evaluation mechanisms, including quality performance dashboards to track and predict high-impact workflows, ensuring timely access to care and identifying areas for improvement.

By focusing on these strategic initiatives, CTMUHB aims to enhance the quality, efficiency, and accessibility of its emergency and acute medicine services, ensuring better patient outcomes and alignment with national healthcare standards and policies.

Equity and Inclusion

CTMUHB will promote a Restorative, Just & Learning (RJL) approach to foster a compassionate working environment. This includes:

- Encouraging openness and transparency in addressing concerns and adverse events.
- Ensuring accountability and learning from incidents to improve employee and patient experiences.

Speaking Up Safely Framework

CTMUHB will embed the NHS Wales Speaking Up Safely Framework to support staff in raising concerns without fear of reprisal. This involves:

- Conducting training sessions to ensure staff understand the procedures for raising concerns.
- Establishing clear protocols for reporting and overseeing concerns.

Bereavement Services

CTMUHB will enhance bereavement services by:

- Providing comprehensive support to families and staff.

- Implementing training programs for staff on care after death processes.

- Continue to collaborate with third-sector organisations to improve support services.

Duty of Quality and Candour

CTMUHB is committed to upholding the Duty of Quality and Duty of Candour for the 2024/2025 period. The Health Board plans to develop an updated Quality & Safety Framework in late 2024 and early 2025 to enhance quality standards, promote continuous improvement, and align with evolving healthcare best practices. The Infection Prevention and Control Strategy for 2024/2027 will be implemented, focusing on restructuring the IPC Team better to serve the CTM population across various care settings. The People's Experience Team will join the Quality & Safety team in April 2024, facilitating a more unified approach to patient-centred care, and several engagement events are planned to raise awareness and support patients and families.

CTMUHB will continue to foster a Restorative, Just, and learning approach, emphasising compassionate and restorative principles to support staff and improve patient care. The NHS Wales Speaking Up Safely Framework will be further embedded, ensuring staff feel safe when raising concerns. Additionally, CTMUHB will participate in the 2024 World Patient Safety Day, focusing on "Improving Diagnosis for Patient Safety," and will hold biannual Listening and Learning events to share knowledge and improve care delivery.

Bereavement services will see ongoing improvements, including support for changes to the Medical Examiner service and developing a paediatric bereavement booklet. These initiatives reflect CTMUHB's dedication to enhancing the quality and safety of its services while fostering a culture of openness, learning, and compassion.

These future plans reflect CTMUHB’s commitment to continuous improvement, patient-centred care, and adherence to national healthcare standards and policies. By focusing on quality, safety, and innovation, CTMUHB aims to provide high-quality healthcare services to the diverse communities it serves.

Thank you for taking the time to read this report.

7. How to contact us:

If you require a printed version of this annual report or in alternative formats/languages please contact us using the details below:

Cwm Taf Morgannwg University Health Board Headquarters, Ynysmeurig House, Unit 3, Navigation Park, Abercynon, Rhondda Cynon Taf. CF45 4SB
01443 744800

CTM_Corporate_Governance@wales.nhs.uk

https://ctmuhb.nhs.wales

https://twitter.com/cwmtafmorgannwg

https://facebook.com/CwmTafMorgannwg/

https://www.instagram.com/cwmtafmorgannwg/

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
6.7

Quality & Safety Committee

CTM Quality Strategy Work Plan Update

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Melanie Barker – Assistant Director of Therapies and Health Science
Cyflwynydd yr Adroddiad / Report Presenter	Lauren Edwards – Executive Director of Therapies and Health Science
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg University Health Board
ELG	Executive Leadership Group
SOP	Standard Operating Procedure
AHP	Allied Health Professionals
HCS	Healthcare Scientists

1. Situation /Background

1.1 CTM's Quality Strategy sets out our quality ambitions and our quality goals, structured around the six dimensions of quality for 2022-25.

1.2 Within the Quality Strategy is the commitment to devise an Annual Quality Work Plan to focus our efforts on the delivery of SMART quality objectives.

1.3 The Quality Strategy states that identification of these annual objectives will be data-driven and risk-stratified to ensure a targeted approach to improving quality.

1.4 Within the Quality Strategy our 6 inter-dependant quality ambitions are based on the 6 dimensions of quality and shape our strategic quality goals. These in turn provide the framework for our Annual Quality Work Plan, containing SMART objectives against which we monitor and report our progress at regular intervals, adjusting our plans as required. Where appropriate, priorities have been mapped against NHS Wales Performance Framework & Guidance Document 2022-23.

2. Specific Matters for Consideration

2.1 The purpose of this paper is to update the Committee progress of delivery against agreed deliverables within the Quality Strategy.

2.2 The Committee is asked to note progress against delivery to date and future plans.

2.3 The Committee is asked to note that there are areas where progress is underway but where evidence was not available on this occasion. Work will continue to seek evidence in an efficient and comprehensive way.

2.4 The CTM Quality Strategy Action Plan contains a complete update of progress and is available on request.

2.5 Work continues on developing the best way of updating and reporting this information with ongoing discussions between CTM DoTHS Portfolio and CTM Governance Portfolio.

2.6 A snapshot of progress for each of the 6 dimensions of quality outlined in the tables below.

2.7

Quality Ambition	SAFE CARE
Strategic Quality Goals	• Develop and empower our colleagues to deliver outstanding care. • Develop a Just Culture that promotes safety through supporting people to speak up, with an effective Learning Framework
Our True North	• No avoidable harm (e.g. from falls, pressure ulcers, medication errors) • A Just and Restorative Culture across CTM • Complaints, inquests, claims and external reviews receive prompt and robust responses. • All learning is swiftly embedded with assurance regarding sustainability.

Journey to Success	Metric Being measured	Progress
Training packages developed with increasing numbers of attendances	Relaunch of CTM Leadership offers.	**In Progress**
Effective cascade of good practice	Examples of good practice shared through governance structures of CTM Transformation Portfolio.	**In Progress**
Relaunch of Falls Strategy	Recruitment progressing to Falls Programme posts. Training, induction and project work progressing Following a period of co-production the initial phased roll out of Falls Programme has been designed alongside service users in our communities	**In Progress**
Launch of Just and Restorative programme, with visible Board level and senior leadership support	Programme in the design stage collaborating across boundaries to understand our current staff experience, adjust our policies and processes and create an educational offering for the organisation which will enable us to take a restorative approach when things do not go to plan There is a project plan which aims to launch the approach and programme into CTM towards the end of this year Just and Restorative Culture Champions –stakeholders within the group are deemed to be champions/key enablers for implementation of this approach within CTM now and when we move towards the implementation stage at the end of this year.	**Delivered. Ongoing**
Positive feedback from colleagues	Established Staff Recognition Programme	**Delivered. Ongoing**
Improved responsiveness to complaints and claims	CTM continues to work on improved responsiveness to complaints and claims through improved processes. Data is reported weekly at Executive Led Quality and Safety meeting.	**In Progress**

2.8

Quality Ambition	TIMELY CARE
Strategic Quality Goals	• Improve access to urgent and emergency care. • Support people whilst they are waiting, optimising their health and wellbeing in order to achieve the best possible outcomes.

Our True North	• Everybody receives prompt care in the most appropriate setting and from the most appropriate person • Our acute hospitals experience no ambulance handover delays, no delays for assessment and admission, and no delayed discharges • Everybody on our waiting lists is optimised to achieve the best possible outcomes (waiting well, patient activation, prehab)	
Journey to Success	**Metric Being measured**	**Progress**
Successful delivery of the 6 Goals for Urgent and Emergency Care	PCH – Phase 1 of SDEC Model completed. New unit opened April 2024.	**In Progress**
↑ advanced and consultant practitioners (nursing, AHP, healthcare science, pharmacy, physician's associates)	Baseline data collected regarding ACPs in post across CTM. Advanced Clinical Practice SOP and Processes in place and panels for portfolio ratification for nursing colleagues scheduled. National discussions of suitability of rollout for AHP and HCS ongoing.	**Delivered. Ongoing.**
Regional solutions for pathology and radiology	Regional Pathology Project actively working towards regional solutions for cellular pathology in collaboration with ABUHB and CVUHB. Non-financial option appraisal of shortlisted regional options held June 2024. Regional radiology and endoscopy solutions being developed for Llantrisant Health Park; mobile MRI in use at site.	**In Progress**
Successful delivery of Planned Care Recovery & transformation programmes	Acute Clinical Services Plan in development. Significant clinical engagement. Associated governance structure in place.	**In progress**
Project to review services for: long-term conditions; rehabilitation; reablement. A supported self-management offer; shared decision making; motivational interviewing	Long Term Conditions - CTM AHPs are developing a multidisciplinary model of care for Long Term Conditions termed 'My Health, My Way' – this programme builds on existing services, enhancing a needs-based approach, where patients can access help when and where they need it, for complex long term conditions.	**In Progress**

2.9

Quality Ambition	**EFFECTIVE CARE**
Strategic Quality Goals	• Develop evidence-based models of care with our partners, making the most effective use of skills and resources.

	• Measure the impact and effectiveness of what we do, building on what works well and making brave decisions about what doesn't	
Our True North	• Consistent use of Friends and Family Test (FFT), PROMs and PREMs across our physical health and mental health services • All services developments informed by data and evidence (clinical and non-clinical) • Continuous development and transformation of our people	
Journey to Success	**Metric Being measured**	**Progress**
Feedback data shared with teams to ensure a clear understanding of what works well and opportunities for improvement	June 2024 - PDR - Your Conversation compliance is currently 64.58% This is +0.21 on the previous month. PDR Your Conversation compliance is +5.81% year on year, showing the impact that the new process and links to pay progression are having.	**In Progress**
Increased Research & Development activity	Number of open non-commercial studies: 20/21 = 32, 21/22 = 48, 22/23 = 60, 23/24 = 60. Number of open commercial studies 20/21 = 3, 21/22 = 2, 22/23 = 4, 23/24 = 5. Cwm Taf Morgannwg University Health Board Research and Development Conference 2024 scheduled for the 24th November 2024.	**In Progress**
Increased working with our academic partners	Data available to support more education activity, particularly in relation to Pharmacy student undergraduate placements, and specific work with USW re closer partnership working. Exec attendance at HEI Partnership Meetings.	**In Progress**
Consistent improvement in training compliance	June 2024 - Overall Health Board compliance for all levels of training currently sits at 71.36% This is 0.02 % on the previous month and 5.38% year on year. Compliance for level 1 currently sits at 79.29 This is 0.64% on the previous month and 3.69 % year on year.	**Delivered in year. Ongoing monitoring.**
Increased uptake of leadership courses	CTM AHP and HCS University of South Wales leadership course developed and running Nov 23-June 24. CTM leadership courses Ignite, Aspire and Inspire continue relaunched. June 24 Total Registrations:**1,024,**Total Active Learners:**903,** Conversion Rate: **71%.**	**Delivered. Ongoing**
Wellbeing offers developed in	New Wellbeing Service Pages implemented, to sign post help to need.	**In Progress**

response to local need		

2.10

Quality Ambition	EQUITABLE CARE	
Strategic Quality Goals	• New models of care are designed using population health data and reflect local need. • We regularly and effectively engage with our patients, communities and stakeholders to understand barriers to seeking early help for health needs.	
Our True North	• Population health data informs our service developments • High engagement with vaccination campaigns across all geographical locations within CTM • Low levels of smoking and obesity across our footprint • Equitable health outcomes for people experiencing mental ill health	
Journey to Success	**Metric Being measured**	**Progress**
↑ performance in Welsh-medium care provision	Welsh Language signage work commenced across the sites	**In Progress**
↑ percentage of adults losing clinically significant weight through the All Wales Weight Management Pathway	The Adult Weight Management Service is now active and offering intervention for level 2 and 3 of the All Wales Weight Management Pathway. To date, 443 patients have been offered an intervention.	**In Progress**
↑ Type 2 Diabetes prevention work	Agreement of a joint programme of work with Public Health Wales covering primary, secondary and tertiary prevention areas. Engagement with the Internal and External Stakeholder Groups, chaired by the Medical Director Engagement with the Diabetes Project in the Value Based Health Care programme	**In progress**
↑ Population Health Management approaches	PHM workshop held with good engagement. Workshop explored barriers and opportunities 48/49 GP practices have signed up to share data that allows them to see the number and identities of patients in each segment and their risk profile to enable intervention. Presentation to the National NHS Inequalities Board in December 2023 to gain agreement on key definitions of PHM and support to build core PHM capabilities.	**In Progress**
Annual ↑ in children who receive 2	Significant work being undertaken within CTM to increase uptake of MMR	**In Progress**

doses of the MMR vaccine by age 5	vaccinations. Staff MMR Vaccinations offered through CVC and Occupational Health. CVC and additional clinics to increase uptake of child MMR vaccinations.	

2.8

Quality Ambition	**EFFICIENT CARE**	
Strategic Quality Goals	• Enable our colleagues to do tasks/roles that they are best suited to do, thus cutting out waste. • Support our colleagues to stay well and reduce agency use across CTM.	
Our True North	• High-quality information and education supports people to stay well and/or seek early • Low reliance on agency staff • A highly skilled support workforce	
Journey to Success	**Metric Being measured**	**Progress**
Relaunch of the FAST campaign to support early recognition of stroke symptoms	FAST campaign relaunched across Wales In April 2023.	**Delivered**
Project SEARCH Interns transitioning to paid employment.	Total employed/volunteering: 28 Total Interns to date in CTM: 36	**In Progress**
Annual ↑ in support staff workforce who have completed level 1 competencies of the Core Skills and Training Framework	Level 1 Compliance for Equality, Diversity & Human Rights remains the highest at 84.26% followed closely by Health, Safety and Welfare at 83.10% and Safeguarding Children at 83.10%. All subjects (apart from Resuscitation) are now above 75%. Focus across the HB needs to be provided to improve Resuscitation Training which is at 57.08%.	**In Progress**

2.9

Quality Ambition	**PERSON-CENTRED CARE**	
Strategic Quality Goals	• Increase co-production across CTM, delivering care that is responsive to people's needs and wishes. • Reduce variability in how well we engage and support carers.	
Our True North	• Care is designed in partnership with patients and their families • Care is always personalised	
Journey to Success	**Metric Being measured**	**Progress**
Bereavement and dying well service developments	CTM appointed a Clinical Bereavement Lead (CBL) to oversee the implementation of the National Bereavement Framework. A strategic gap analysis was undertaken and strategic improvements implemented	Delivered
Increased patient-rated engagement measures within Ty Llidiard, CAMHS Tier 4	Specific PREM implemented to improve approach to ward round and ensure this reflected and was designed around young people	Delivered

3. Key Risks / Matters for Escalation

3.1 There are current no key risks or matters for escalation.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	Creating Health Inspiring People Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	Ageing Well Dying Well Growing Well Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
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 Data to Knowledge Leadership Learning, Improvement & Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	Effective Efficient Equitable Person Centered 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: Not required
Cydraddoldeb a'r Gymraeg	Yes: ☐	No: ☒

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

5. Recommendation

5.1 The Committee are asked to **NOTE** progress against delivery to date.

6. Next Steps

6.1 As an organisation, we will continue to monitor and report our progress against the SMART quality objectives that we have committed to achieve.

6.2 We will do this quarterly and will adapt our plans based upon progress and learning.

6.3 During Quarter 2 explore the development of a dashboard that will allow more efficient updates against progress.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
6.8

Quality & Safety Committee

Highlight Report from the Health, Safety & Fire Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Nicola Milligan, 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 Approval

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

Acronyms / Glossary of Terms	

1. 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 19 June 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 raised concerns 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 • Members raised concern in relation to workforce sustainability issues within the Fire Safety Team and within specialist areas within the Estates Team, as a result of future retirements/departures of skilled staff. • The Committee expressed concern regarding the absence of replacement batteries for core equipment, which could potentially pose a risk to the safety of staff and patients. The Chief Operating Officer will explore alternative funding sources from the core budget, as Members deemed the use of charitable funds inappropriate for this purpose.

Advise	• The Committee received the **Assistant Director of Health, Safety & Fire report** and noted the following key points; ○ The Sub Committee ratified the Manual Handling Training Strategy for Executive Leadership Group approval ○ Training Session Attendance: The high number of 'did not attend' instances during training sessions was discussed and possible actions that could be taken to address this issue were explored. • The **Health, Safety & Fire Performance Report** was received. The Committee noted the significant reduction in risks that had not yet been allocated to a Care Group and requested an update at the next meeting in relation to the remaining 19 risks that were yet to be allocated. • The Committee received the **Fire Safety Report,** which highlighted ongoing efforts to explore an apprentice scheme for training Fire Safety Officers within the Health Board. Members noted that further discussions would be held to explore options. • The **Estate Safety & Water Compliance Report** was received. The Chief Operating Officer recommended collaborative efforts with shared services partnership colleagues to address concerns related to pay rates for essential Estates colleagues • 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 July Board. • Members received a verbal update on **Overarching Care Group Health, Safety & Fire** matters**.** The Sub-Committee agreed that it would be helpful if discussions could be held in relation to future reporting of Facilities and Site Based Health, Safety and Fire matters and requested that a written report was presented to the next meeting
Assure	• Nil on this occasion
Inform	The following items were approved/noted via the consent agenda: • Unconfirmed Minutes of the meeting held on 4 March 2024 – **Approved**; • The Health, Safety & Fire Sub Committee Annual Report was received and **endorsed** for Committee approval (appendix 1) • Health, Safety & Fire Sub Committee Forward Work Programme for 2024/2025 – **Noted.**

	• The Committee **NOTED** the action log and requested an updated on Action 09.21 – 3.3 around an item within the action log.
Appendices	Health, Safety & Fire Sub Committee Annual Report

3. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not Required

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

4. Recommendation

4.1 The Quality & Safety Committee is asked to **NOTE** the highlights outlined in section 3 of this report and **APPROVE** the Health Safety & Fire Sub Committee Annual Report

Appendix 1

Health, Safety & Fire Sub Committee

Annual Report 2023-2024

HEALTH, SAFETY & FIRE SUB COMMITTEE
ANNUAL REPORT 2023-2024

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Quality & Safety Committee and reviews the work the Health, Safety & Fire Sub Committee, for the financial year 2023-2024.

During the year, I have received a wealth of support from four other CTMUHB Independent Members (IM) sitting on this Sub Committee, including Dilys Jouvenat, James Hehir (until September 2023), Geraint Hopkins, (from November 2023) and Helen Lentle, who became a Member of the Sub Committee in March 2024. Their skills and experience have helped the Sub Committee to deliver its important role in providing assurance to the Quality & Safety Committee with regard to health, safety and fire related issues.

My sincere thanks also go to Hywel Daniel, Executive Director for People and Chris Beadle Assistant Director of Health, Safety & Fire who have been the main contributors of the reports to the Sub-Committee. I would also wish to extend thanks to colleagues within the Corporate Governance Team for their support throughout the year.

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

Nicola Milligan
Chair of the Health, Safety & Fire Sub Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The purpose of the Health, Safety & Fire Sub Committee "the 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.

- Encourage strong leadership in health, safety and fire, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the sub-committee will advise the Board and the accountable officer on where and how its health, safety and fire management may be strengthened and developed further.

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

The Sub-Committee meets quarterly, with the key function to provide scrutiny on behalf of the Quality & Safety Committee on all matters relating to Health, Safety and Fire.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Sub-Committee is to support the Board through the Quality & Safety Committee with regard to its responsibilities for health, safety and fire:

- approve and monitor implementation of the annual health, safety and fire action plan;
- review the comprehensiveness of assurances in meeting the Board and accountable officers assurance needs across the whole of the health Board's activities, both clinical and non-clinical;
- the consideration of relevant CTMUHB policies for approval by the Quality & Safety Committee.

3.2 MEMBERSHIP

The membership of the Health, Safety & Fire Sub-Committee comprises of four Independent members, enabling the Sub-Committee to provide robust scrutiny and assurances to the Board as appropriate through the Quality & Safety Committee.

A summary of the Independent membership during 2023-2024 is outlined in table 1 below:

Table 1 – Composition & Membership of the Health, Safety & Fire Sub- Committee April 2023-March 2024

Name	Period
Members	
Nicola Milligan Independent Member (Chair of Committee from July 2023)	April 2023 – March 2024
Geraint Hopkins Independent Member	From November 2023 – March 2024
Dilys Jouvenat Independent Member (Chair of the Committee until June 2023)	April 2023 – March 2024
Helen Lentle Independent Member	From March 2024
James Hehir Independent Member	April 2023 – September 2023 (Term End)

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2023-2024

During the year, the Sub-Committee met on three occasions. All meetings held during 2023-2024 were quorate as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

Health, Safety & fire Subcommittee 2023-2024	15 June 2023	9 Nov 2023	4 March 2024	Total

Nicola Milligan (Chair)	Independent Member	✓	✓	✕	**2/3**
Geraint Hopkins (Vice Chair)	Independent Member	—	✓	✓	**2/2**
Dilys Jouvenat	Independent Member	✓	✓	✕	**2/3**
Helen Lentle	Independent Member	—	—	✓	**1/1**
James Hehir	Independent Member	✕	—	—	**0/1**

3.4 ATTENDEES

The Sub-Committee's work is informed by reports provided by leads within CTMUHB, colleagues from these areas are invited to attend each meeting of the Health, Safety & Fire Sub-Committee. Invitations to attend the Sub-Committee meetings are also extended, where appropriate and on an 'ad-hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. HEALTH, SAFETY & FIRE SUB COMMITTEE BUSINESS

The Health, Safety & Fire Sub-Committee provides an essential element of the Health Board's overall assurance framework. In response to the Covid-19 pandemic, all meetings continued to be held virtually via Microsoft Teams during 2023/2024 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Health, Safety & Fire Sub Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2023/2024 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards
Key risk areas from the Health, Safety & Fire Sub-Committee are highlighted at the Quality & Safety Committee by the Sub-Committee Chair via a highlight report.

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

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

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

6. GOVERNANCE

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

- Annual Review of the Terms of Reference;
- Committee Annual Report;
- Highlight Reports from the Sub-Committee to the Quality & Safety Committee meetings;
- Forward Work Programme.

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

7. ASSURANCE TO THE BOARD/QUALITY & SAFETY COMMITTEE

The Health, Safety & Fire Sub Committee considers, that on the basis of the work completed by the Sub-Committee during 2023 - 2024, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2023-2024 and beyond ensures that the Sub Committee retains scrutiny on key areas of activity.

The Forward Work Programme has continued to be presented to each meeting of the Sub-Committee during 2023/2024. This supports and helps identify the key areas of focus for the Sub-Committee and is one of the key components in ensuring that the Sub-Committee is effectively carrying out its role. It also facilitates the management of agendas and Sub-Committee business.

8. LINKS WITH OTHER COMMITTEES

The Health, Safety & Fire Sub-Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Quality & Safety Committee and Audit & Risk Committee.

As a Sub Committee of the Quality & Safety Committee, regular highlight reports are presented to the Quality & Safety Committee.

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

APPENDIX 1

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda

During 2023 – 2024 the following items were received on the Consent Agenda for Approval/Endorsement:

- Unconfirmed minutes;
- Sub Committee Terms of Reference.

During 2023 – 2024 the following items were received on the Consent Agenda for Noting/Information

- Forward Work Programme.

3. Main Agenda

During 2023-2024 the following items were received on the Main Agenda:

- Action Log & Matters Arising not Contained within the Action Log
- Estate Safety & Compliance Report with spotlight topic
- Assistant Director of Health, Safety & Fire Report
- Health, Safety & Fire Performance Report
- Fire Safety Report
- Organisational Risk Register
- Care Group, Health Safety & Fire Report / Overarching Care Group – Health, Safety & Fire Highlight Report
    - Future Care Group Attendance and Reporting – Verbal update
    - Primary Care & Community Care Group
    - Mental Health & Learning Disabilities Care Group
- Water Quality – Dewi Sant Health Park & Ysbyty George Thomas
- Health Surveillance Programme
- Health, Safety & Fire Sub Committee Annual Self Effectiveness Survey
- Estate Safety & Water Compliance Report

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

Agenda Item
6.9

Quality & Safety Committee

Quality Impact Assessment (QIA)

Dyddiad y Cyfarfod / Date of Meeting	10/07/2024
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 supporting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
ICB Membership	10/07/2024	Feedback received prior to committee
Executive Nurse Huddle	10/07/2024	Approved
ELG	15/07/2024	No additional feedback

Acronyms / Glossary of Terms	
QIA	Quality Impact Assessment
CTMUHB	Cwm Taf Morgannwg University Health Board
Q&S	Quality & Safety

OMB	Operational Management Board
ELG	Executive Leadership Group

1. Situation /Background

Introduction

1.1 The purpose of this paper is to update the Committee on the development of the Quality Impact Assessment (QIA).

1.2 The Quality Impact Assessment (QIA) is a crucial tool used by Cwm Taf Morgannwg University Health Board (CTMUHB) to evaluate the potential effects of strategic decisions, service changes, and new initiatives on healthcare quality and patient safety. This updated process ensures that quality considerations are at the forefront of decision-making, aligning with the NHS Duty of Quality (within the Health and Social Care (Quality and Engagement) (Wales) Act 2020) and the Health and Care Quality Standards.

1.3 The QIA procedure serves the following important purposes:

1.3.1. It provides a systematic approach to assessing the impact of proposed changes on patient safety, patient experience, workforce, and clinical effectiveness.

1.3.2. It helps identify potential risks and develop mitigating actions to address any negative consequences on quality.

1.3.3. It ensures that service changes are evidence-based and demonstrates best practices.

1.3.4. It assures the Board that all essential factors are considered in service design and development.

1.3.5. The QIA is structured around the six dimensions of quality.

1.3.6 The QIA supports compliance with the Health Board's Duty of Quality.

1.4 The QIA is an integral part of the Health Board's quality governance framework, which aims to maintain high standards of care through ongoing measurement and improvement. By implementing this tool, CTMUHB will make informed decisions that prioritise quality and safety in healthcare delivery, ultimately benefiting patients and the community it serves.

1.5 NHS Wales organisations are required to evaluate the impact of healthcare service decisions on the Health and Care Quality Standards. The NHS Wales Executive has distributed a 'beta version' QIA tool to NHS Wales organisations to facilitate this process. CTMUHB has reviewed the NHS Wales Executive QIA tool and incorporated additional factors relevant to the

Health Board, which has ensured a thorough assessment of potential impacts on service quality and safety of individuals to the Health Board.

2. Specific Matters for Consideration

QIA Process

2.1 The QIA process will systemically review all service change and cost improvement schemes through the quality lens, aligning to the Duty of Quality.

2.2 All QIAs must be reviewed and signed off by a clinician, with the seniority of the clinician reflecting the significance of the decision. Suppose it is agreed that the QIA will proceed. The risks and benefits identified through the QIA process should be integrated into existing monitoring processes (see section 3 below for further detail).

2.3 The QIA is a dual-stage process:

Stage 1: all service change and cost improvement schemes are screened against the following domains: Safe, Timely, Effective, Equitable, Person-centred, and staffing and resources.

Stage 2: Service change and cost improvement schemes identified as having significant risk to quality (Screening Risk Score of 12+) will proceed to a full QIA and will be reviewed by the Corporate Directorate/Care Group Senior Leadership Group (ELG), with consideration for submission to Operational Management Board (OMB) for discussion and ratification. Where a risk assessment is scored 15 or above, Corporate Directorate/Care Group Senior Leadership Teams will be required to submit it to OMB for discussion and ratification before submission for executive team approval.

3. Key Risks / Matters for Escalation

3.1 QIA Process:

The screening process is the initial step in identifying crucial risks and their potential effects on quality. As noted above, when a Screening Risk score reaches or exceeds 12, it triggers the requirement for a Full QIA. For schemes that undergo the Full QIA process, two key elements are established:

1. Mitigating actions: These are developed to address and minimise potential risks identified during the assessment.

2. Quality monitoring measures: Specific metrics and methods are implemented to track and evaluate the scheme's quality aspects continuously.

This approach ensures that high-risk projects receive thorough evaluation and ongoing oversight to maintain quality standards throughout implementation.

3.2 **Approval Procedure:**

The QIA employs a comprehensive approval process for all evaluated schemes, whether screened or fully assessed. Each QIA undergoes review and approval by the Corporate Directorate/Care Group's Senior Leadership Team. An additional signature from a clinical executive will be required for schemes reviewed and ratified by the ELG.

Monitoring Framework:

Following assessment, monitoring protocols are implemented based on the scheme's classification:

- Schemes not requiring full QIA: Managed locally through directorate-level governance and monitored through Care/Corporate Group governance structures.

- Approved complete QIAs <15: Reviewed monthly through Care/Corporate Group governance channels and quarterly by OMB.

- Approved complete QIAs >15: Reviewed monthly through Care/Corporate Group governance channels and quarterly by OMB with additional oversight by the ELG.

- Risk categorisation:

  Scores of 14 or below: Recorded on the Care Group Risk Register

  Scores of 15 or above: Entered into the Corporate Risk Register

Reporting Structure:

To maintain transparency and assurance, the following reporting mechanism is proposed:

1. High-risk schemes (scored 15 or above): Summary report submitted to the Operational Management Board (OMB), with a copy of the QIA assessment for ratification.

2. Quarterly comprehensive report: Detailing all QIAs evaluated by the Care Group or to be provided through Care Group Heads of Quality to the Q&S Business Admin Team for compilation and onward reporting to the OMB and the Executive Leadership Group (ELG).

This revised structure ensures a systematic approach to QIAs, monitoring, and reporting across all levels of CTMUHB.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health If more than one applies please list below: Improving Care Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well If more than one applies please list below: Dying Well Growing Well Living Well Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	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: Timely Effective Equitable Efficient Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Refine 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: Report relates to the Quality Impact Assessment Process.
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: Report relates to the Quality Impact Assessment Process.
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 Members of the Quality and Safety Committee are asked to **SUPPORT/NOTE** the QIA process for its adoption within the Health Board.

6. Next Steps

6.1 Once the Quality & Safety Committee is approved, the QIA Process will be published and shared on CTMUHB's SharePoint Internet Site.

Appendix 1 – QIA Adjustment of Services- CTMUHB

Please read this User Guide before

Purpose

The QIA tool enables the adjustment of

Step one - Please complete the QIA tool

Step Two - Save assessment in the template provided on tab 2

Please contact the Cwm Taf Morgannwg Patient Safety

QIA Tool Question G

Section 1. Provide a

Complete all boxes w

Section 2. Screening

The screening tool enables all schemes, which have proposed service changes, to

Section 3. Provide a

Explain the purpose of the proposal including the problem, need for

Section 4. Consider

Section 4. Consider how the scheme

For example,

Safe Care

Questions / Prompts (not exhaustive):
• What is the impact on other NHS organisations?
• What is the impact on other areas within CTMUHB?
• Is there an impact on any aspect of shared risk?

Timely Care

Questions / Prompts (not exhaustive):
• What is the impact

Equitable Care

Questions / Prompts (not exhaustive):
• Has consideration been given to patients, carers, the public and

Effective Care

Questions / Prompts (not exhaustive):
• What is the impact on implementation of evidence based practice?
• What is the impact

Efficient

Questions / Prompts (not exhaustive):
• Does it eliminate inefficiency and

Person Centred

Questions / Prompts (not exhaustive):
• What is the likely impact on self-reported experience of patients and service users?

Financial Position

Questions / Prompts (not exhaustive):

Section 5. Equality

Is an Equality Impact

Section 6. Next Steps
Following completion of the QIA, the
Section 7 . Sign off /
The QIA must be

CTMUHB
Quality Impact Assessment Tool

1. Care Group		Specific Service Area (to be adjusted)				
		Scheme Savings Value				
2. Quality Impact Screening Tool - must be completed						
Domains of Quality	**Potential / Actual Imp**	**Potential Impacts? Positive (P), Neutral (N), Adverse (A)**	**Impact Score**	**Likelihood Score**	**Score Likelihood x impact**	**Score 12 & Above = Full QIA**
Safe	Could the proposal impact on any of the following? Impact on serious incidents,	*Include Brief Summary*				*Yes/No?*
Safe	Could the proposal impact on staff safety and/or wellbeing?	*Include Brief Summary*				*Yes/No?*
Timely	Could the proposal impact on care being provided in a timely way?	*Include Brief Summary*				*Yes/No?*
Effective	Could the service change impact on evidence based practice, clinical standards	*Include Brief Summary*				*Yes/No?*

Risk Sc
1 Highly Un happen/rec
2 Unlikely: but it is po
3 Likely: It
4 Highly Lik but not a p
5 Almost Ce

Equitable	Could people be treated differently in terms of race, religion, disability, gender, sexual	*Include Brief Summary*				*Yes/No?*
Person Centred	Could the proposal impact on patient choice, dignity and respect, service user experience? Could	*Include Brief Summary*				*Yes/No?*
Staffing & Resources	Could the proposal impact on staff satisfaction, retention and recruitment, staff	*Include Brief Summary*				*Yes/No?*
Summary rating = highest individual risk score **If highest individual score is >12 please complete the Full QIA below**						*Insert Highest Score*

3. Provide a brief overview of the service to be adjusted:

4. Full QIA

4.1. QIA Duty of Quality Standards Domain: SAFE CARE

happen/rec

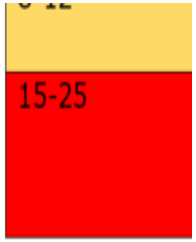
1-6

8-12

Questions / Prompts (not exhaustive):
• What is the impact on other NHS organisations? • What is the impact on other areas within CTMUHB? • Is there an impact on any aspect of shared risk? • Will the proposed scheme impact on the organisations duty to protect children, young people and adults? • What is the impact on patient safety? • What is the impact on preventable harm? • Will it affect the reliability of safety systems? • How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is reduced?

Brief Description & Actual / Potential			
Benefits :			
Risk:			
Current Risk Score (No Mitigations):	lect Opti		
Mitigation being taken:			
Mitigated Target Risk Score:	lect Opti		

4.2. QIA Duty of Quality Standards Domain: TIMELY CARE
Questions / Prompts (not exhaustive): • What is the impact on the timeliness of people's access to services across CTMUHB? • What is the impact on waiting lists?



Brief Description & Actual / Potential Adverse Impacts:			
Benefits :			
Risk:			
Current Risk Score (No Mitigations):	lect Opti		
Mitigation being taken:			
Mitigated Target Risk Score:	lect Opti		

4.3. QIA Duty of Quality Standards Domain: EQUITABLE CARE

Questions / Prompts (not exhaustive):

- **Has consideration been given to patients, carers, the public and stakeholder engagement in line with the Welsh Equality Duties including Welsh language?**
- **What is the impact on race, sex, gender reassignment, age, disability, sexual orientation, religion or belief (including those with no belief), marriage or civil partnership and pregnancy/ maternity for individual and community health access to services and experience?**

Brief Description & Actual / Potential Adverse Impacts:	
Benefits :	
Risk:	

Current Risk Score (No Mitigations):	**lect Opti**		
Mitigation / Monitoring being taken:			
Mitigated Target Risk Score:	**lect Opti**		

4.4. QIA Duty of Quality Standards Domain: EFFECTIVE CARE

Questions / Prompts (not exhaustive):

- **What is the impact on implementation of evidence based practice?**
- **What is the impact on leadership?**
- **Does it reduce or have a negative impact on variations in care provision to all groups?**
- **Does it affect supporting staff to stay well/staff experience?**
- **Does it promote self-care for people with long terms conditions?**
- **Does it impact on ensuring that care is delivered in the most clinically and cost effective setting?**

Brief Description & Actual / Potential Adverse Impacts:	
Benefits :	
Risk:	

Current Risk Score (No Mitigations):	**lect Opti**		
Mitigation / Monitoring being taken:			

Mitigated Target Risk Score:	**lect Opti**		

4.5. QIA Duty of Quality Standards Domain: EFFICIENT

Questions / Prompts (not exhaustive):

- **Does it eliminate inefficiency and waste by design?**
- **Does it lead to improvements/deterioration in care pathways?**
- **How else could this be improved?**

Brief Description & Actual / Potential Adverse Impacts:	
Benefits :	
Risk:	

Current Risk Score (No Mitigations):	**lect Opti**		
Mitigation / Monitoring being taken:			
Mitigated Target Risk Score:	**lect Opti**		

4.6. QIA Duty of Quality Standards Domain: PERSON CENTRED

Questions / Prompts (not exhaustive): • What is the likely impact on self-reported experience of patients and service users? (Response to concerns & feedback from service users). • How will it impact on the patient choice agenda? • Are there any avoidable risks associated with complaints, Clinical Negligence claims, National Reportable Incidents, poor patient and family experiences, or ability of patient to access service? • How will it impact on the compassionate care and personalised care agenda?			
Brief Description & Actual / Potential Adverse Impacts:			
Benefits :			
Risk:			
Current Risk Score (No Mitigations):	lect Opti		
Mitigation / Monitoring being taken:			
Mitigated Target Risk Score:	lect Opti		
4.7. Impact on FINANCIAL POSITION:			
Questions / Prompts (not exhaustive): • This should include increases/decreases to variable costs that are not being currently incurred (£):			

Brief Description & Actual / Potential Adverse Impacts:			
Benefits :			
Risk:			
Current Risk Score (No Mitigations):	**lect Opti**		
Mitigation / Monitoring being taken:			
Mitigated Target Risk Score:	**lect Opti**		
Proposed date of service adjustment:			
dd/mm/yyyy			
dd/mm/yyyy			
5. Equality Impact Assessment (EQIA)			
Is an EQIA assessment required?		Select option	**If YES, please complete an EQIA.**
6. Next steps			
Following completion of the QIA, the proposal for adjusting the service should now be considered and signed off by Service Group Senior			
Decision:	Next		

Select option	steps:		
7. Approval	**Signature**	**Date**	
Service Leads (clinical and operational)			
Care Group Director			
Care Group Nurse Director			
Care Group Medical Director			

oring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
likely: Will probably never cur	Not for years	1	2	3	4	5
Do not expect it to happen/recur ssible	At least annually	2	4	6	8	10
might happen/recur occasionally	At least monthly	3	6	9	12	15
kely: Will probably happen/recur, ersisting issue	At least weekly	4	8	12	16	20
ertain: Will undoubtedly	At least					

cur, maybe frequently	daily	5	10	15	20	25

	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
	Moderate	This type of risk is considered moderate and

	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

Select Optic
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19

20
21
22
23
24
25
Select Optic
Yes
No

on

on

CTMUHB
Quality Impact Assessment Scrutiny Panel

		Specific Service Area (to be adjusted)	
		Scheme Savings Value	

4. Full QIA

Likely impact (including risk) to SERVICE if adjustment of service NOT

Questions / Prompts (not exhaustive):
- **What is the impact on other NHS organisations?**
- **What is the impact on other areas within CTMUHB?**

Benefits of Adjusting the Service:			
Risk of NOT adjusting the service:			
Impact Risk Score:	lect Opti		

Likely impact (including risk) to ORGANISATION if adjustment of service NOT

Benefit of adjusting the service:			
Risk of NOT adjusting the service:			
Impact Risk Score:	lect Opti		

Likely impact (including risk) to OTHER SERVICES/DELIVERY UNITS if adjustment of service NOT supported:

Benefits :	

Risk:			
Impact Risk Score:	lect Opti		
Approval	Signature		Date

Panel's Overall Comments:

Panel's Recommendation:

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		
Likelihood:	Frequency:	1 N
1 Highly Unlikely: Will probably never happen/recur	Not for years	
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	
3 Likely: It might happen/recur occasionally	At least monthly	
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	

1-6	Low	This type of risk is co at least every six mo
8-12	Moderate	This type of risk is co should be reviewed a
15-25	High	This type of risk is co every two months. If scored 20 or above

Consequence:				
legligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1	2	3	4	5
2	4	6	8	10
3	6	9	12	15
4	8	12	16	20
5	10	15	20	25

nsidered low and should be reviewed and progress on actions updated
nths.

onsidered moderate and
nd progress on actions updated at least quarterly

onsidered high and should be reviewed and progress on actions updated, at leas

the risk should be reviewed on a monthly basis.

2
3
4
5
6
7
8
9
10
11
12
13
14

15
16
17
18
19
20
21
22
23
24
25
Select Option
Yes
No

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

Agenda Item
7.1

Quality & Safety Committee

Patient Safety & Quality Dashboard

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
Cyflwynydd yr Adroddiad / Report Presenter	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 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 01.05.24 to 30.06.24 taken from systems on 15.07.24, unless otherwise specified.

Key areas to note in this reporting period are:

- Number of Complaints managed via PTR (formal) remain relatively consistent.
- Themes from Communication related Feedback included in this report
- Compliance with the 30 working day target for responding to complaints remains over 75%.
- The Nationally Reportable Incidents submitted increased in May and June 2024.
- Increase in number of Restrictive Practice and Absconding Incidents.

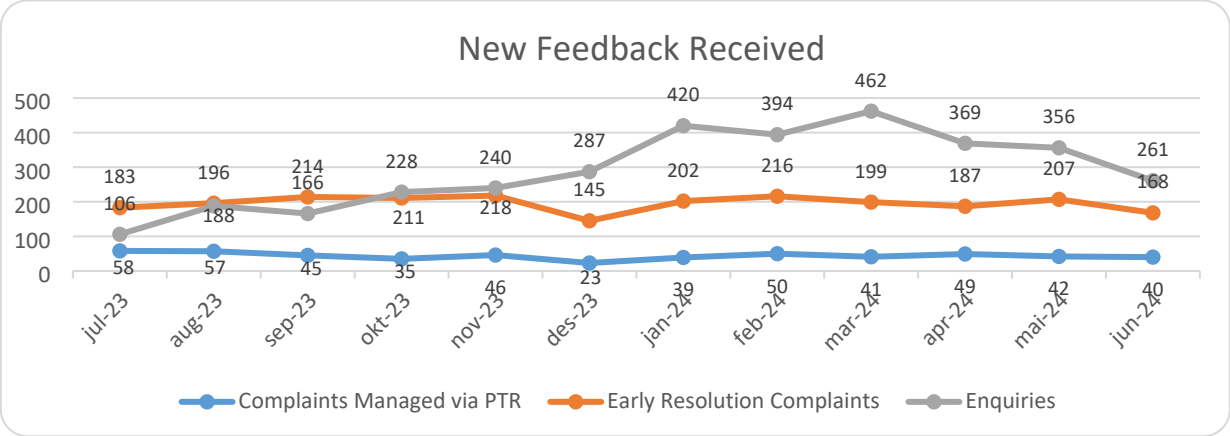
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

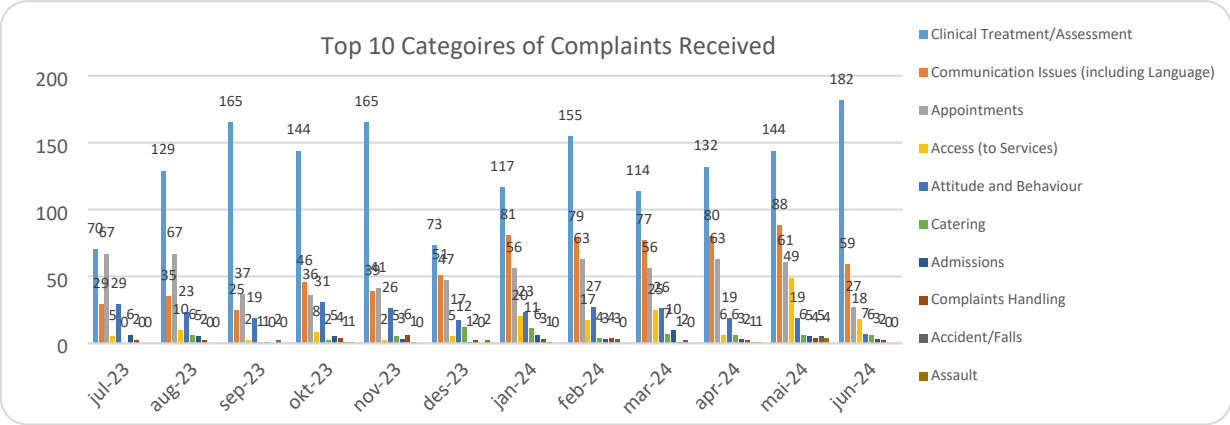
Complaints

New Complaints Received

Between the 01.05.24 and 30.06.24 the Health Board received a total of 457 complaints. Of these, 82 were categorised as formal and managed under the Putting Things Right Regulations (PTR). This remains relatively consistent with the previous two month period. The number of enquiries has decreased over the 3 month period since March 2024.



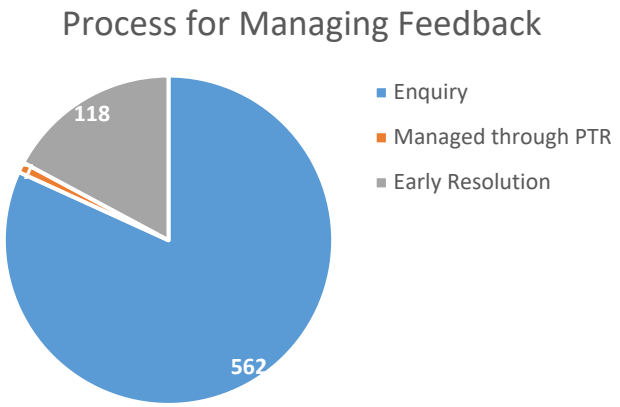
For all complaints received in May and June 2024, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (326), Communication Issues (147) and Appointments (88).



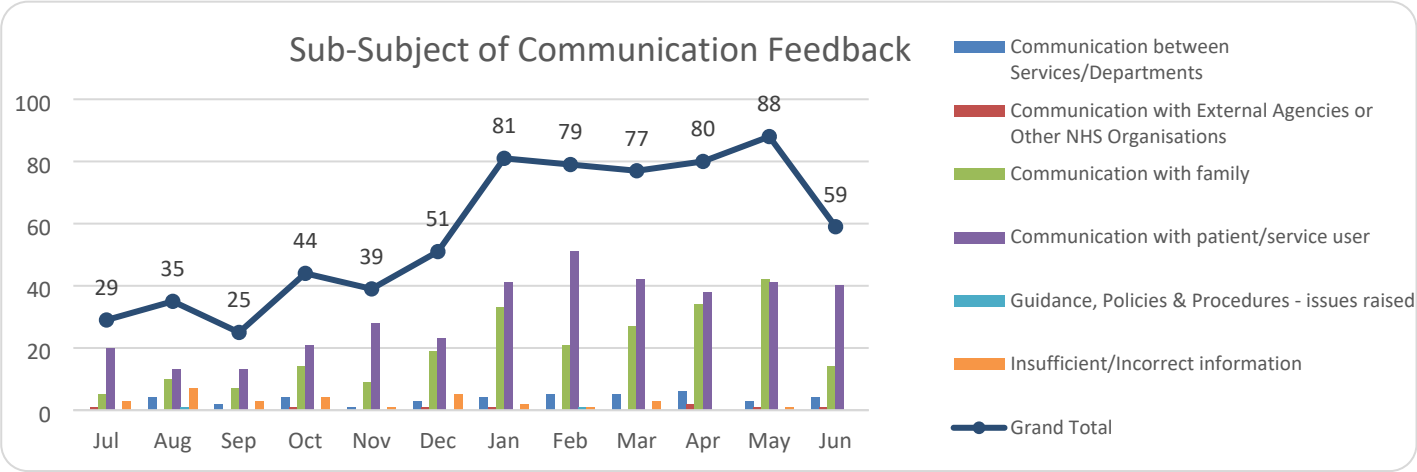
Themes from Communication related Feedback

At the last Committee meeting a request was made to provide further information in relation to feedback (Concerns & Enquiries) where the primary subject was identified as communication. A review of all feedback recorded as communication between 01.07.23 and 30.06.24 has been undertaken.

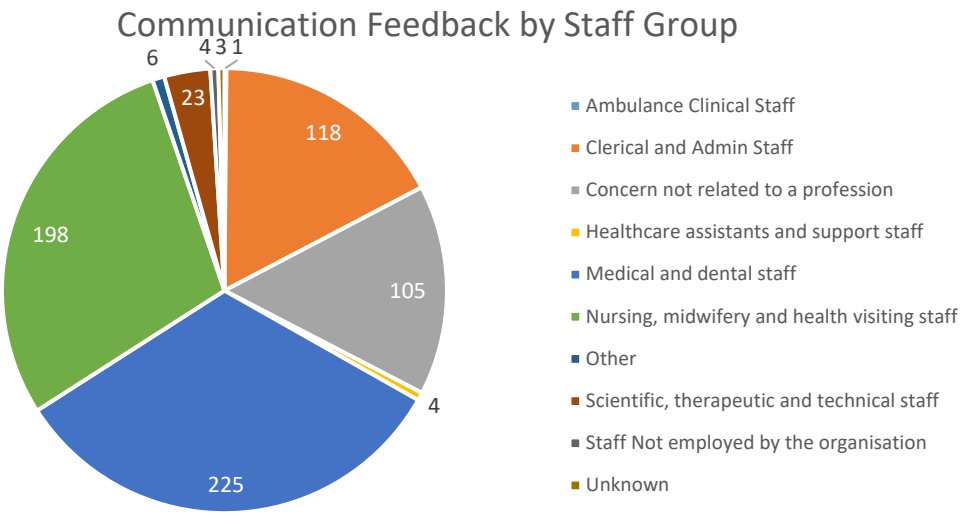
For the 12 month period 687 cases had communication recorded as the primary reason for providing the feedback. A breakdown of the process through which these were managed is reflected in the chart below.



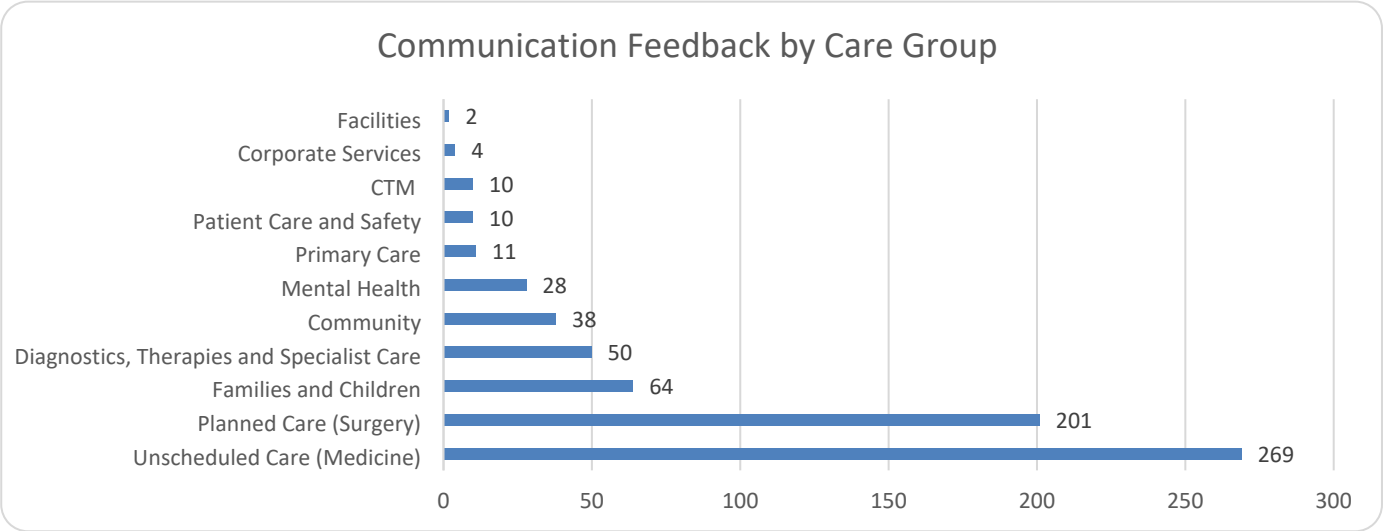
Of the 687, the main sub-subjects relate to Communication with patient/service user (371) and Communication with family (235). A breakdown of the sub-jects by first received date is provided below.



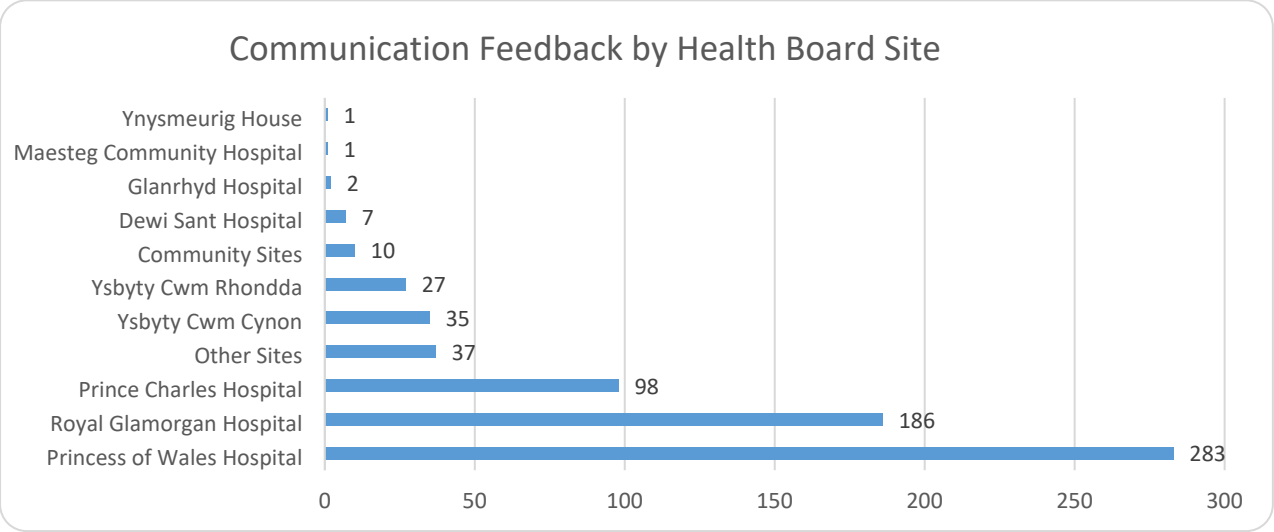
The review of the feedback received has identified that 225 cases related to Medical and Staff, with a 198 relating to Nursing, Midwifery and Health Visiting Staff and 118 to Clerical and Admin Staff. A breakdown by staff group is provided below.



Unscheduled Care (269) and Planned Care (201) have received the highest number of feedback where communication was highlighted as the primary subject. A breakdown by Care Group is provided below. For Unscheduled Care the highest number of cases is recorded for General Medicine and Urology for Planned care.

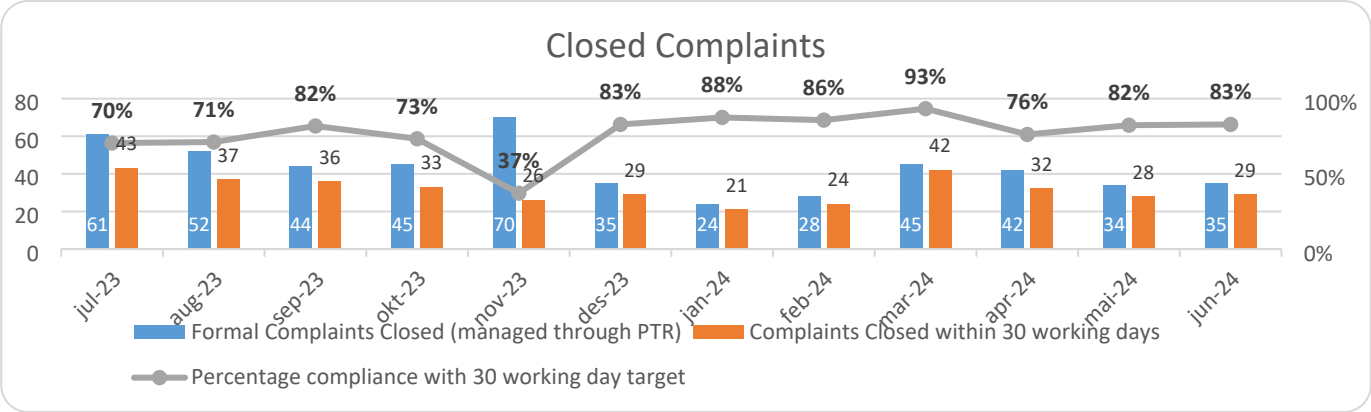


The highest number of cases where feedback is recorded as the primary subject were received in relation to Princess for Wales (283) with 51% (144) relating to Outpatients. A breakdown by Health Board site is provided below.



Closed Complaints

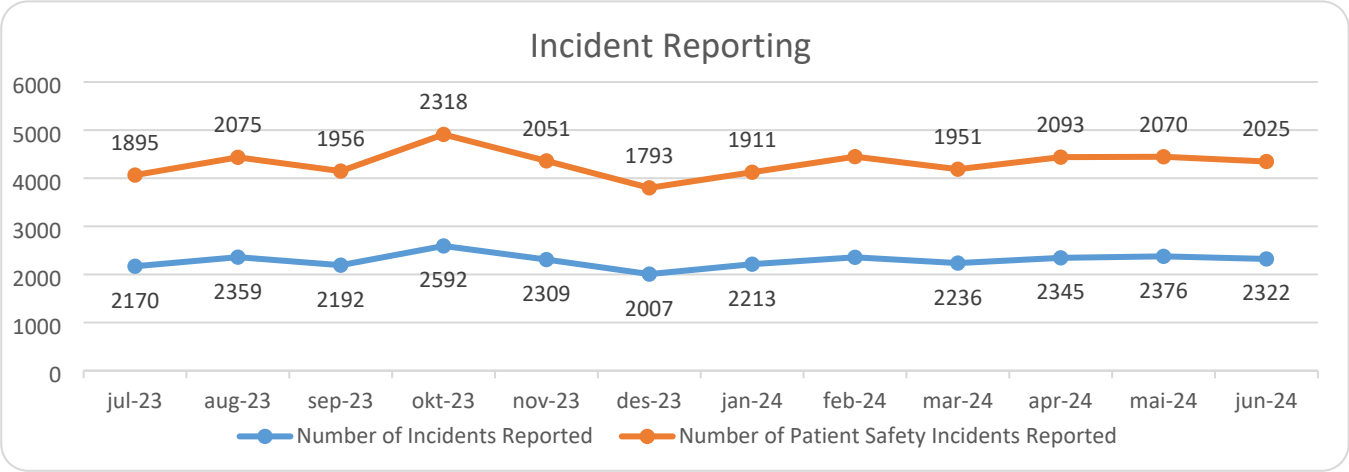
Within the period of 01.05.24 to 30.06.24, the Health Board closed a total of 69 formal complaints (managed through PTR). Whilst compliance has remained over the national target of 75% since December 2023, compliance decreased below the Health Board's internal target of 85% since April 2024. Compliance has been impacted by the availability of clinicians to provide comments and quality assure responses. Daily complaints huddles continue to take place to ensure robust escalation is in place. As at 05.07.24, the Health Board had 64 open formal complaints. Of these, 19 complaints were open over 30 working days.



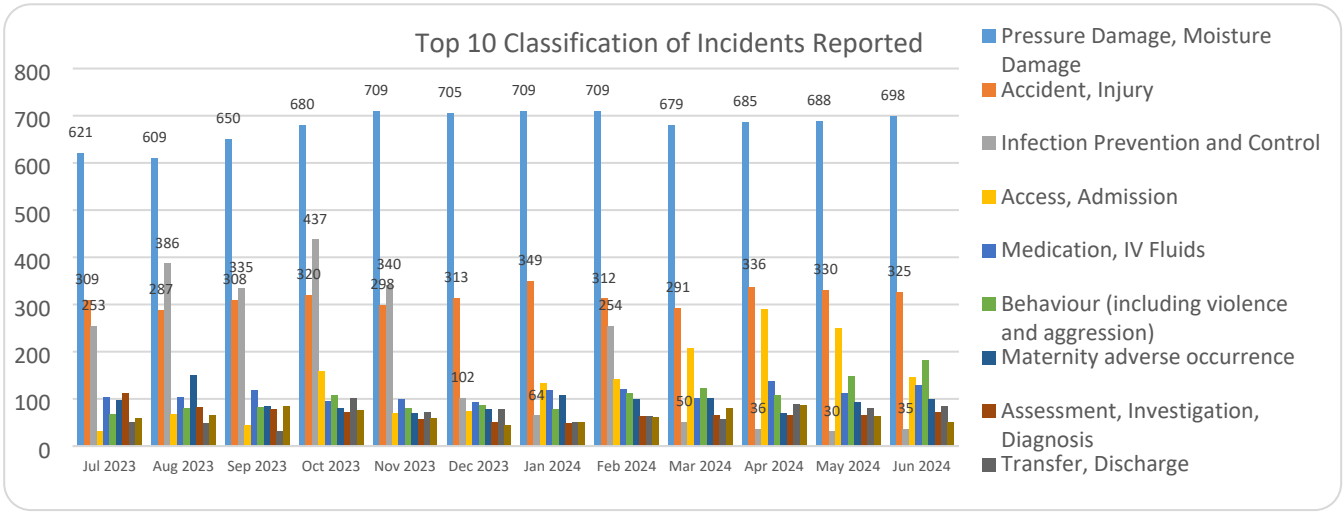
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,698 incidents were reported between 01.05.24 and 30.06.24, this represents a decrease of 117 when compared with the previous 2 months (4,581).



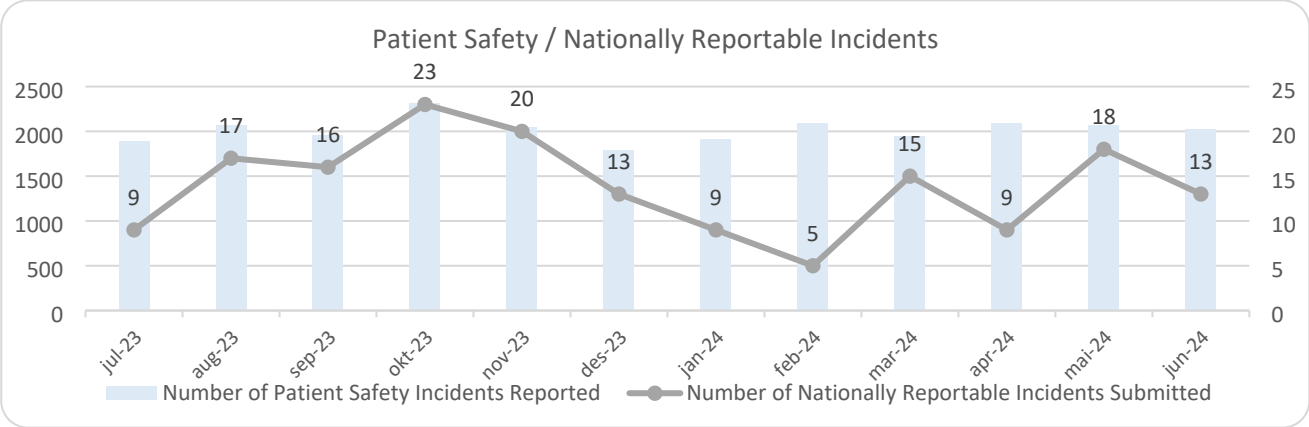
The number of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,581 incidents reported, 87% (4,095) were reported as the patient affected.



The top 3 types of incidents reported for May and June 2024, linked to a patient affected are: Pressure Damage /Moisture Lesion (1,386), Accident, Injury (655) and Access, Admission (395). This represents a change in the top 3 classifications of incidents as access, admission has replaced Infection, Prevention & Control during this time period which has identified a continued reduction since March 2024.

Nationally Reportable Incidents

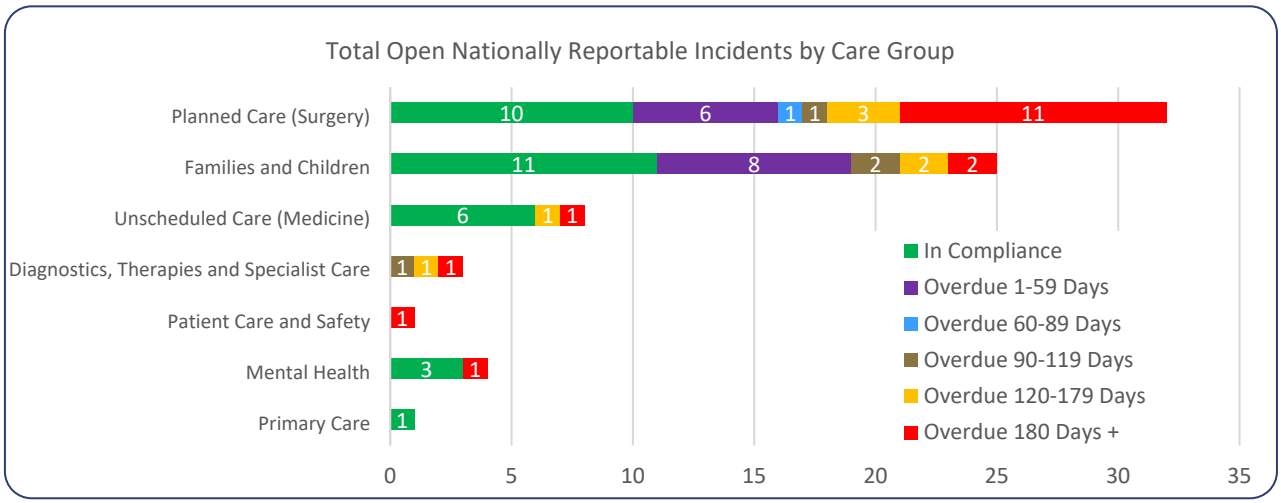
Between 01.05.24 and 30.06.24, 31 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive (formerly known as the "Delivery Unit"). This is reflected in the increase in both October 2023 (23) and Mar 2024 (15) which are linked to the notification of Ophthalmology incidents, following completion of the harm review process that occurred prior to the reporting period and pressure damage deemed avoidable following review at scrutiny panel. The increase in May 2023 relates to linked incidents within Trauma & Orthopaedics. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

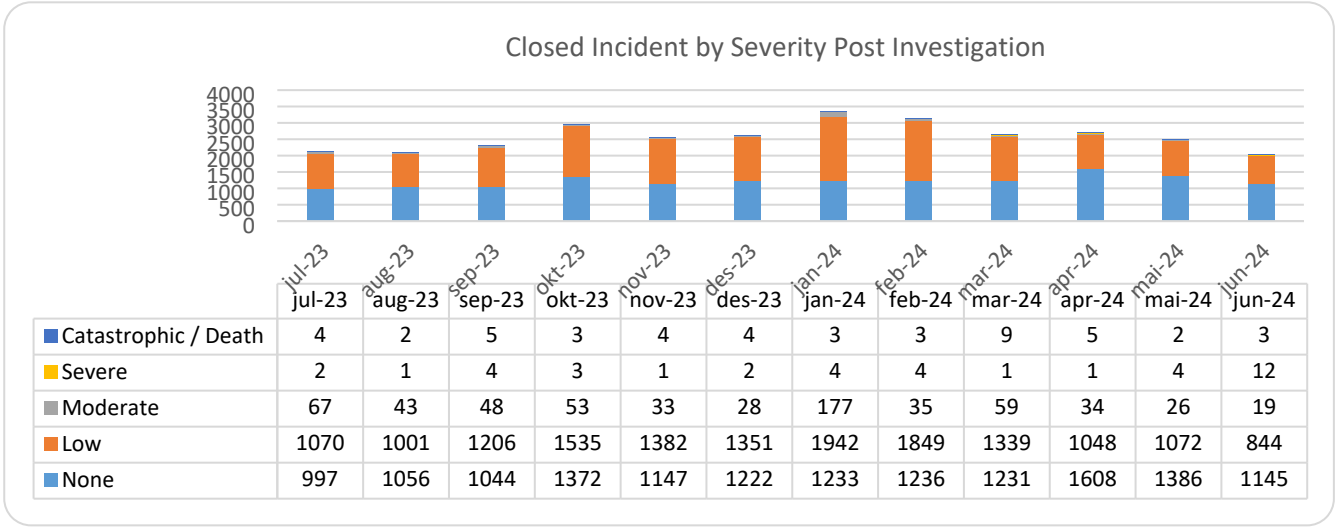
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Jun-24	Jul-24	Total
Access, Admission	1	0	0	1	1	1	2	0	2	1	2	0	9
Accident, Injury	0	0	0	0	0	0	0	1	0	0	0	0	1
Assessment, Investigation, Diagnosis	2	1	3	0	5	3	0	0	2	0	1	2	18
Behaviour (including violence and aggression)	0	0	0	0	0	0	0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

As at the 09.07.24, the Health Board currently has 74 open Nationally Reportable Incidents, of which 43 are overdue the timescale (60 days) for completion. A trajectory plan is in place to ensure investigations are concluded and an outcome provided patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



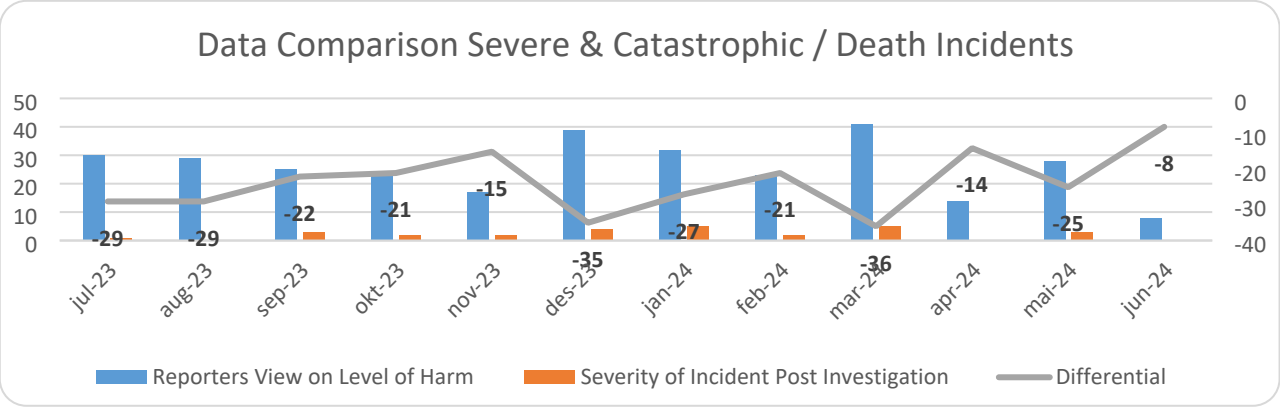
Closed Patient Safety Incidents

Between the 01.05.24 and 30.06.24 a total of 4,513 patient safety incidents were closed. Of the 4,513 patient safety incidents closed, 21 were closed with severity post investigation of severe harm (16) or catastrophic/ death (5). 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 unexpected death, 1 as clinically challenging behaviour and 1 absconding.



	jul-23	aug-23	sep-23	okt-23	nov-23	des-23	jan-24	feb-24	mar-24	apr-24	mai-24	jun-24
Catastrophic / Death	4	2	5	3	4	4	3	3	9	5	2	3
Severe	2	1	4	3	1	2	4	4	1	1	4	12
Moderate	67	43	48	53	33	28	177	35	59	34	26	19
Low	1070	1001	1206	1535	1382	1351	1942	1849	1339	1048	1072	844
None	997	1056	1044	1372	1147	1222	1233	1236	1231	1608	1386	1145

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



Duty of Candour

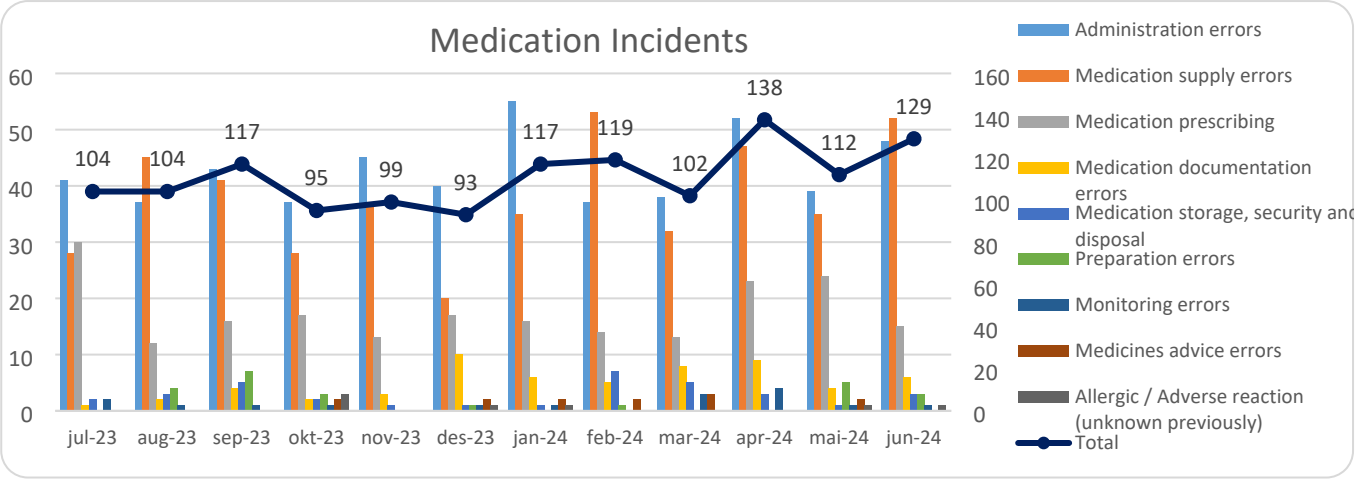
The Duty of Candour regulations where implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have ben devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have been developed to provide 'live' data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

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

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

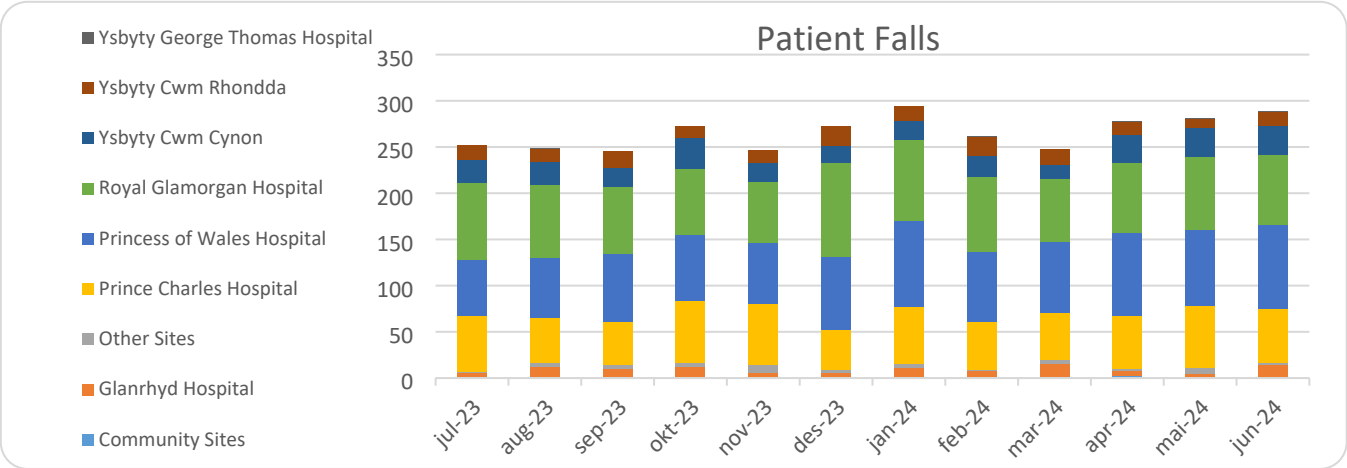
A total of 241 medication incidents were reported as occurring between 01.05.24 and 30.06.24. This is an increase of 14 when compared with the previous 2 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (87), supply errors (87), and medication prescribing errors (39).



83% of the medication incidents were reported as resulting in no (85) or low (115) harm, with the remaining reported as resulting in moderate harm (35) and severe (6) 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 570 falls, where the person affected was a patient, were reported during May and June 2024. This represents a slight increase of 41 compared with previous months. Of the falls incidents within the time period, 93% were reported as no (171) or low (358) harm. The remaining incidents were reported as moderate (40) and severe (2) harm. No incidents relating to patient falls were reported as resulting in death.

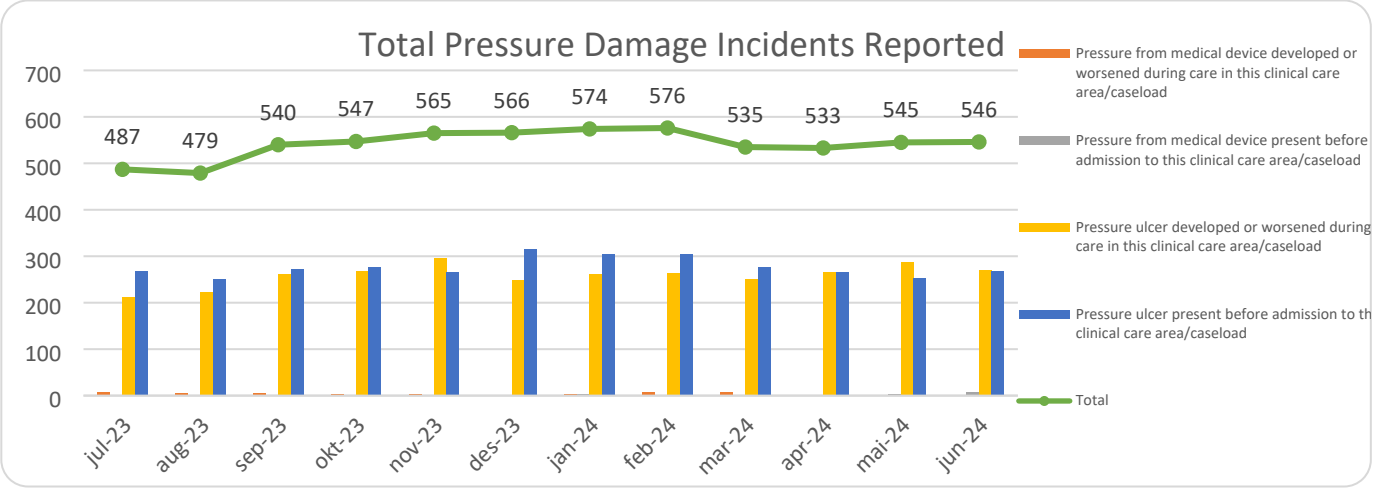


Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

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

2.3.3 Pressure Damage

Between the 01.05.24 and 30.06.24, a total of 1,068 pressure damage incidents were reported, of which 559 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (509) were reported as being present before admission to this clinical care area/caseload.



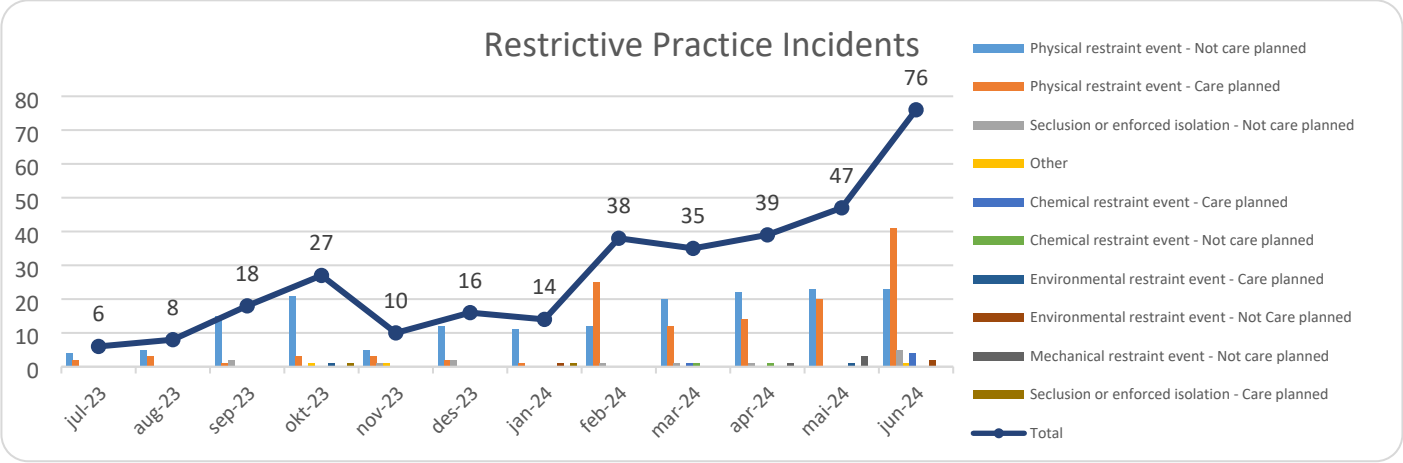
Of the 525, identified as developing or worsening during current caseload, 227 were identified as occurring within the community, which is consistent with the previous two month period.

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

2.3.4 Mental Health Metrics

<u>Restrictive Practices</u>

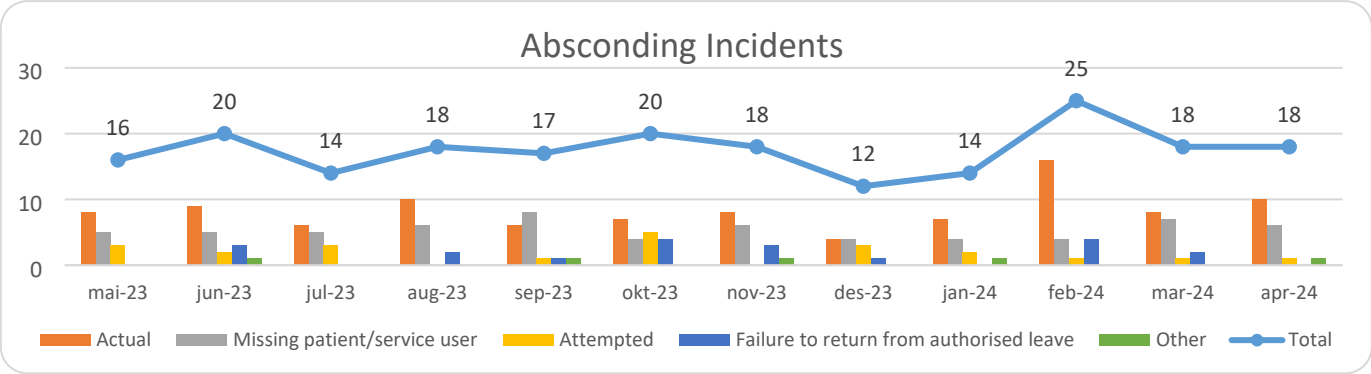
Between 01.05.24 and 30.06.243, a total of 123 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 49 incidents when compared to the previous two months.



Of the 123 incidents, 66 were reported as care planned (included in the care and treatment plan for the patient) and 56 were reported as not care planned (not included in the care and treatment plan for the patient). 1 was reported as other. The highest number of incidents were reported as occurring on the Seren Ward, Princess of Wales Hospital (42) and Seren Unit, Royal Glamorgan Hospital (30). The increase in incidents during May and June 2024 are related to a cohort of 6 patients.

Absconding incidents

During May and June 2024, a total of 46 Absconding incidents were reported, an increase of 10 when compared with the previous 2-month period. 16 were recorded as actual absconding, with the remaining recorded as missing patient / service user (18), failure to return from authorised leave (8), attempted (2), and other (2). The highest number of incidents were reported as occurring in Ward 14 at Princess of Wales Hospital (10).



3. Key Risks / Matters for Escalation

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

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

4. Assessment

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

Impact Assessment

Ansawdd *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.	

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

Agenda Item
8.1

Quality & Safety Committee

Mental Health Adult Inpatient Improvement Programme

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Ana Llewellyn, Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Mental Health In-patient Improvement Workstream Lead Meeting	18/06/2024	

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
MHLD	Mental Health and Learning Disabilities
QSRE	Quality Safety Risk Experience
SRO	Senior Responsible Officer

1. Situation /Background

1.1 This report provides committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme.

1.2 In February 2022, HIW wrote to the Health Board to advise that they would be undertaking a local review of the quality of discharge arrangements for adult patients from inpatient mental health services in CTM. This review was commissioned in response to serious incident intelligence.

1.3 The review included both fieldwork and a review of evidence, including a review of patient records. The proposed timescale for publication was August 2022, however HIW continued to seek evidence from the Health Board through to December 2022.

1.4 In June 2022 HIW identified a number of significant patient safety concerns and issued an immediate assurance improvement plan relating to: discharge governance; communication arrangements between teams (including the issue of the lack of a single electronic record); significant limitations in the involvement of patients and carers; and risk management and discharge arrangements.

1.5 The discharge review was published on 7th March and includes a further 40 recommendations: Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (hiw.org.uk)

2. Specific Matters for Consideration

2.1 The Health Board Improvement Plan was published by HIW on 6 September 2023: CTMUHB MH Discharge Review - Improvement Plan Final EN.pdf (hiw.org.uk)

2.2 An Executive-led Mental Health Inpatient Improvement Programme was developed with a number of work streams. The HIW actions were aligned to these work streams.

2.3 The initial stage of the Improvement Programme has focussed on the completion of the forty recommendations in the HIW Discharge Review.

2.4 Since the last Quality and Safety Committee a further recommendation has been completed, leaving two recommendations outstanding.

Recommendations	Number completed and approved by Improvement Board	Number with planned later timescales	Number with slipped timescales
40	**38**	**1**	**1**

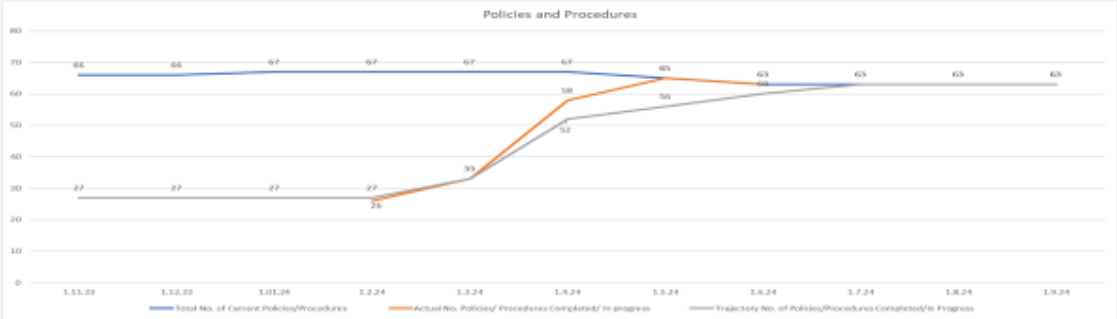
2.5 The two remaining recommendations are for further completion.

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

2.6 It has become evident that completion of all outstanding policies and procedures has been challenging to deliver due to the requirement to engage widely with partners, the challenges associated with organisational change and ensuring adherence to the Care Group and Health Board ratification processes.

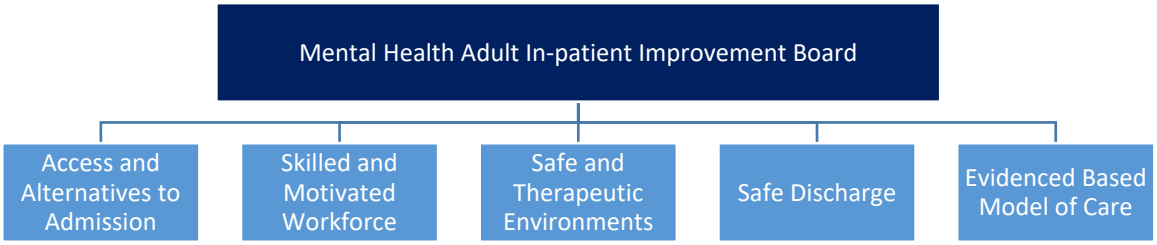
2.7 A revised timescale of September 2024 has been agreed through the Care Group QSRE and the trajectory for completion is detailed below.

Update as at 6 June 2024



Policy and Procedures (MHLD Care Group)	1.11.23	1.12.23	1.01.24	1.2.24	1.3.24	1.4.24	1.5.24	1.6.24	1.7.24	1.8.24	1.9.24	
Total No. of Current Policies/Procedures	66	66	67	67	67	67	65	63	63	63	63	
Actual No. Policies/ Procedures Completed/ In progress				26	33	58	65	63				
Trajectory No. of Policies/Procedures Completed/In Pro	27	27	27	27	33	52	56	60	63	63	63	Target
No. to be reviewed each month						4	4	4	3	0		
Progress against compliance:												
Policy and Procedures (MHLD Care Group)	1.11.23	1.12.23	1.01.24	1.2.24	1.3.24	1.4.24	1.5.24	1.6.24	1.7.24	1.8.24	30.9.24	
No. of Policies/Procedures Expired	39	39			9	9	0	0				
No. under review	3				33	37	43	41				
No. pending ratification	11					4	5	5				
No. in date	13				17	17	17	17			63	Target
Total	**66**		**67**	**67**	**67**	**67**	**65**	**63**	**63**	**63**	**63**	

2.8 At the last Quality and Safety Committee, members were advised that the Improvement Programme was undergoing a period of revision and that the programme had been redesigned into fewer workstreams as follows:

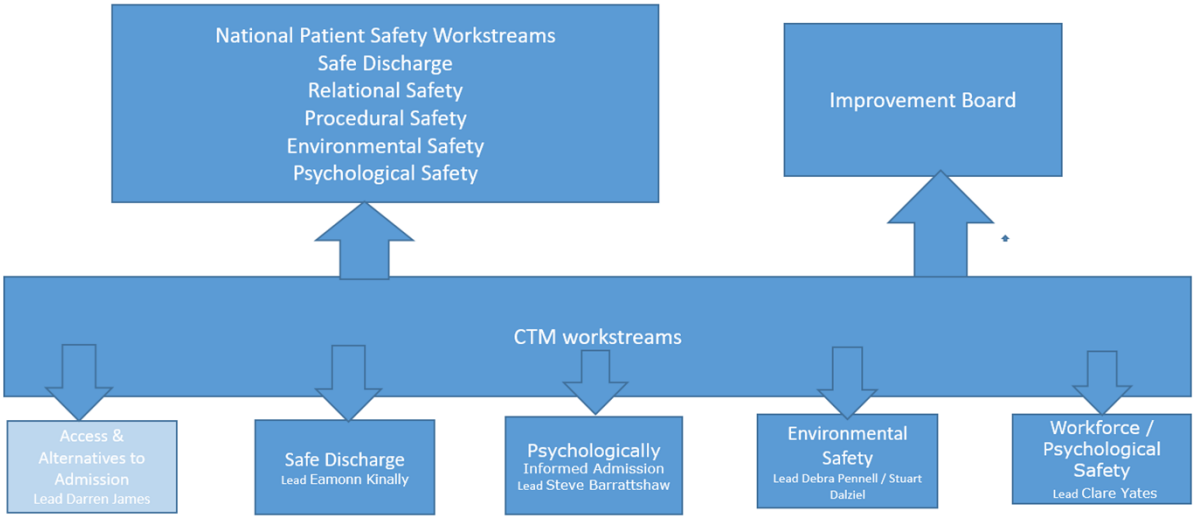


2.9 New workstream leads had been engaged in re-designing their driver diagrams and priorities for improvement. However, since the last Quality and Safety Committee, there has been further clarity on the development of the national programme and its workstreams.

2.10 The National Mental Health Patient Safety Programme met on 30th May 2024 and further clarity on workstreams and priorities have emerged. The scope of the improvement will also include older adult mental health, excluding the dementia wards.

2.11 In response to this the Health Board has made further revisions to the In-patient Improvement Programme and once again, new workstream leads have been identified to ensure leadership across adult and older adult. The

workstream leads will also engage in the national workstreams, as well as determining the Health Board's developmental priorities.



2.12 The Health Board's Access and Alternatives to Admission workstream is not in scope for the national programme. Further discussion is underway to determine where this workstream will report.

2.13 Given the more developmental nature of the programme, the Health Board's improvement programme will now move into a phase that is less transactional and one that will be more closely aligned to national timescales for delivery. It is anticipated that there will be close links to service user groups to support co-production.

3. Key Risks / Matters for Escalation

3.1 Committee members are asked to note the slippage on completing one of the recommendations in full.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
	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: Leadership Data to Knowledge Culture and Valuing People
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Person-centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No change to service design and provision
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No change to service design and provision
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	Yes (Include further detail below)
	There are public and stakeholder concerns about the quality and safety of in-patient mental health services
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)
	Improving mental health services is dependent on people – there are challenges to recruitment and retention in in-patient mental health services

5. Recommendation

5.1 Members are asked to **NOTE** the further progress of the Mental Health Inpatient Improvement Programme and the plans in place for the two outstanding recommendations.

5.2 Given that the programme now moves into a more developmental phase and priorities will be determined for year 1 of the national programme it is proposed that the frequency of reporting to Quality and Safety Committee is reduced.

6. Next Steps

6.1 The Adult Mental Health Inpatient Improvement Board, chaired by the Executive Director of Therapies and Health Science, next meets formally on 10th September 2024 and will review further progress and evidence against the HIW recommendations and progress on the programme refresh.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item Number: 9.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality and Safety Committee 16 May 2024 held via Microsoft Teams

Members Present:

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

In Attendance:

Greg Dix	Executive Director of Nursing/Deputy Chief Executive (In part)
Gethin Hughes	Chief Operating Officer
Dom Hurford	Executive Medical Director
Philip Daniels	Executive Director of Public Health
Cally Hamblyn	Assistant Director of Governance & Risk
Suzanne Hardacre	Director of Midwifery
Nigel Downes	Assistant Director of Quality & Safety
Sallie Davies	Deputy Medical Director
Helen Watkins	Deputy Director for People
Ana Llewellyn	Care Group Nurse Director
Lucie Williams	Care Group Nurse Director
Gaynor Jones	Staff Side Representative (In part)
Ceri Bear	Llais Cymru Representative
Chris Beadle	Assistant Director of Health, Safety & Fire
Julie Denley	Deputy Chief Operating Officer (In part)
Lisa Love-Gould	Clinical Director, Therapies
Mohamed Elnasharty	Care Group Clinical Director (In part)
Sharon O-Brien	Care Group Nurse Director
Neil Evans	Mental Health Practitioner (In part)
Andrea Davies	Head of Mental Health Psychology & Psychological Therapies (Observing)
Jonathan Arthur	Consultant Clinical Scientist (Observing)
Alex Brown	Care Group Medical Director
Owen Weeks	Care Group Medical Director
Emma Walters	Head of Corporate Governance & Board Business (Secretariat)

Agenda Item

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

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

1.2 Apologies for Absence

Apologies have been received from:

- Lauren Edwards, Executive Director of Therapies & Health Science;
- Hywel Daniel, Executive Director for People;
- Richard Hughes, Deputy Executive Director of Nursing;
- Emma James, Unscheduled Care Group Nurse Director;
- David Miller, Care Group Medical Director;

1.3 Declarations of Interest

There were no interests declared.

2. SHARED LISTENING AND LEARNING

2.2 Spotlight Presentation – Maternity & Neonates Metrics and Assurance Framework

S Hardacre shared the spotlight presentation with Members of the Committee which focused on the journey to sustainability within Maternity & Neonatal Services.

The Committee Chair extended her thanks to S Hardacre for sharing the presentation which highlighted the significant amount of work that had been undertaken and extended her congratulations to S Hardacre and the Team on achieving de-escalation status and being a leader across Wales in regard to shared learning. The Committee Chair added that the biggest challenge would be maintaining and sustaining the improvements that had been made and advised that the Team had demonstrated that the culture of improvement was in place.

H Lentle echoed the comments made by the Committee Chair and congratulated the Team on their achievements and for the commitment shown to improve services. H Lentle sought clarity as to whether there were any areas within the service which S Hardacre remained concerned about and which she felt required further scrutiny from Independent Members. S Hardacre indicated that an area of concern is intervention rates and the medicalisation of childbirth, as well as the impact national reports were having on midwifery practice and the midwifery profession. S Hardacre added that women were opting for different methods of birth which meant that workforce models and plans continued to evolve and needed continual revision to meet the changing requirements in relation to the ways that women were choosing to birth.

S Hardacre advised that there was evidence being seen that more women were coming back for reflections around their births, which was being seen nationally, and added that the recent All Party Parliamentary review highlighted that women were experiencing more birth trauma, which was concerning. S Hardacre provided assurance that the Team would continue to ensure they were aware of the evidence and would continue driving forward the improvements.

G Dix reiterated how proud he was of the Team who had worked incredibly hard whilst under significant scrutiny over the last five years. G Dix extended his thanks to A Llewellyn, appointed as the first Improvement Director for Maternity Services, who undertook a lot of work during the first year in that role.

G Dix suggested that it may be helpful for the Committee to closely monitor the staff cultural issues that were still in place at Prince Charles Hospital, particularly in relation to relationships with each other as opposed to relationships with Senior Managers, which was reflected in the last Healthcare Inspectorate Wales report. Members noted that this was being addressed by the Senior Management Team and S Hardacre advised that positive progress had been made in regard to developing trust and confidence in leadership and management and added that further work was required to strengthen relationships between staff peers. Assurance was provided that these areas were not r impacting on patient care or the experience of patients whilst in the service

S Hardacre advised that the team had sought external facilitation over the last 12 years to address some of the cultural areas of improvement and added that some changes had been made to the leadership team which had also helped, and advised that she would be happy to present an update on the plans in place to address staff cultural issues to a future meeting.

The Committee Chair once again extended her thanks to S Hardacre, A Llewellyn and all the Team for the achievements that had been made and

added that the Committee looked forward to seeing improvements being maintained moving forwards.

Resolution: The presentation was **NOTED.**

Action: Update on the plans in place to address staff cultural issue to be presented to a future meeting

2.1 Listening & Learning Story – Ethics

N Evans shared the Listening & Learning Story and highlighted the key matters for Members attention.

The Committee Chair thanked N Evans for sharing the presentation which provided an informative illustration of how complex some of the issues being presented to the Ethics Committee were and added that the theories were very helpful in framing and enabling the discussions that needed to be held. The Committee Chair reflected that often the expectation is that the Ethics Committee would advise on what was right or wrong, which was very rarely the case.

G Dix noted that the Ethics Committee was key to supporting colleagues with difficult clinical decisions during the Covid-19 pandemic. G Dix extended his thanks to N Evans for presenting on this item today.

A Brown also commented on the role of Ethics Committee during the Covid 19 pandemic and how complex discussion needed to be held in a timely manner as they often related to acutely unwell patients. He also reflected how often discussions are around what the legal requirements are and what the ethical course of action should be in cases where there could be disagreement amongst those involved. The Committee Chair advised that at present, an ad-hoc Ethics Committee could be arranged as quickly as possible to support the potential urgency of discussion required.

D Hurford advised that the circumstances faced during the Covid-19 Pandemic meant that a decision would be made which was then presented to the Ethics Committee to determine whether the Committee considered the correct decision had been made. D Hurford added that the process had now changed and advised that urgent high-profile cases would be prioritised for discussion at the Committee. D Hurford suggested that it would be helpful if N Evans could contact each of the Care Groups to determine whether a session on ethics could be delivered to them so that they are aware of the support available. D Hurford also added that consideration needed to be given to the role of the Caldicott Guardian within the ethics process.

The Committee Chair supported the need to raise awareness of the clinical ethics support available to staff and added that she understood that there

was a review being undertaken on the terms of reference to ensure this support is provided in the most effective way. The Committee Chair added that staff needed to be encouraged to make referrals to the Ethics Committee to access the support available and advised that Clinicians had previously found it helpful to have this framework in place, which helped to lead the discussions in a constructive way.

Resolution: The Listening & Learning Story was **NOTED.**

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 that substantive funding had now been received to ensure the commitment to bereavement care across the region, which had resulted in a substantive appointment being made into the Bereavement Clinical Lead role, which was a positive step forward. G Dix added that he was particularly impressed with the pregnancy loss pathways that had been put into place, following significant concerns previously highlighted in this area during the Independent Maternity Services Oversight Panel (IMSOP) review.

G Dix advised that he remained concerned in relation to boarding of patients and the critical crowding that was being seen within the Emergency Departments and added that there was evidence to suggest that there was an increased chance of mortality because of overcrowding. G Dix advised that he was also concerned in relation to patient deconditioning and advised that recently, there were in excess of 280 patients who were deconditioning whilst in a bed awaiting onward care. G Dix advised that consideration has been given as to how some of the risk mitigations could be heightened for patients who were being boarded and added that new individualised risk

assessments had been put into place, which were being led by Nurse Directors across the Care Groups, with visibility of boarded patients being discussed at the Safe to Start meetings.

Members noted that work was being undertaken with the NHS Executive to find a method that could be used to balance a discussion in relation to harm in hospital as a result of patients who were awaiting onward care, against harm outside of hospital. G Dix advised that this continued to be an area of concern for both him and colleagues and advised that whilst there was significant work being undertaken to try and address the issues, the situation was not improving. G Dix advised that he would continue to highlight this as an area of concern to the Committee, given that the sites were very extremely busy, and added that caring for patients in inappropriate areas such as corridors and boarding patients had regrettably led to some serious incidents occurring. G Dix advised that decisions were never made lightly to board or place a patient in a corridor and was a direct result of an over-stretched urgent care system and patients who are clinically optimised in our beds waiting for some form of community support. G Dix advised that any support that the Committee could provide in terms of addressing this would be welcomed.

The Committee Chair advised that she would ensure that the concern raised regarding boarding of patients was highlighted in the alert/escalate section of the highlight report that would be presented to the next Board meeting. The Committee Chair added that it would be helpful if an update could be presented to a future meeting on the incidents that were occurring and advised that she would also welcome a further discussion with G Dix as to what further support the Committee could provide.

N Milligan welcomed the update provided that the risk assessment process had been revised for boarded patients given some of the concerns raised previously in relation to the inconsistencies of the assessments being undertaken. N Milligan sought assurance that the assessments would be reviewed throughout the duration of a patient being in a boarded bed, as she was unsure as to whether this was being followed consistently across the Health Board. In response, G Dix advised that the Nurse Directors had recently met with Heads of Nursing to standardise the Senior Nurse Checklist, with Senior Nurses regularly reviewing the patients in boarded beds during their daily ward rounds and undertaking further discussion at the Safe to Start meetings.

G Hughes reiterated that boarding of patients was an area of concern for a number of colleagues and there was recognition of the impact this had on patients who were waiting in inappropriate spaces, patients waiting for prolonged periods of time within Emergency Departments and for patients who were delayed in being handed over in a timely way from paramedic crews. Members noted that patients waiting significant lengths of time for urgent cardiac work and elective surgery were another cohort of patients

that were equally impacted by this position. G Hughes advised that there were a number of actions which were being undertaken and added that a further update on progress would be presented to the Board.

S O'Brien provided further assurance that standardisation of boarding risk assessments was underway, with a review of the clinical criteria undertaken with Heads of Nursing utilising AMaT as an automated approach to provide visible and timely information to clinical staff and inform 'Safe to Start' meetings and documentation as appropriate.

S O'Brien provided assurance that Nurse Directors regularly walk round the wards and review risk across sites, to assess the impact on patient dignity and quality of care, for not only the boarded patients, but for all patients within the bay/ward areas.

K Palmer queried what further could be done internally and externally to further escalate this significant area of concern and noted that this is an area of attention at the All-Wales Vice Chairs meeting. K Palmer further added that whilst it was evident that the Health Board was working to address this position, she recognised that this was a significant challenge, and she fully supported this matter continuing to be escalated to the Board.

The Committee Chair advised that whilst she understood that risk assessments needed to be undertaken to be able to inform the decisions that needed to be made, she stressed the importance of this not becoming accepted as standard practice, with systems and processes being designed which allowed for the position to be managed, and suggested that a focussed discussion on this matter needed to take place at a future meeting. The Committee Chair welcomed suggestions on how much Committee members could ensure focus on this matter within other Committees and Forums internally and externally to the Health Board.

Further areas of focus were provided by the Clinical Leads on the areas of their remit which included the Medical Directorate, Therapies & Health Science and Public Health.

The Committee Chair extended her congratulations to J Arthur, Head of Audiology and his Team for the work undertaken to drive forward the national work in relation to the introduction of job planning for Healthcare Scientists, which could potentially feature in the National Healthcare Science Research and Innovation Strategy document.

N Milligan made reference to the Healthy Education and Nutrition for the Really Young (HENRY) Programme, which had been in place for some time, and referred to the cost implication for training staff for the use of resources. N Milligan advised that given that the data was no longer being captured in relation to childhood obesity, she would find it helpful if an update could be provided in the future in relation to the impact of the

HENRY Programme and programme outputs. P Daniels advised that he would be happy to provide an update to a future meeting and added that a review was being undertaken of the programme offer to determine whether there was any learning that could be added to internal expertise.

Resolution: The report was **NOTED.**

Actions: 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.

Update to be provided to a future meeting as to the nature of incidents that were occurring in relation to boarded patients.

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 a future meeting in relation to boarding of patients.

Update to be provided at a future meeting in relation to the impact of the HENRY Programme and programme outputs.

5.2 Care Group Highlight Reports

5.2a <u>Mental Health & Learning Disability Care group</u>

A Llewellyn presented the report and highlighted the matters contained within the alert/escalate section.

N Milligan advised that she appreciated there were a significant number of vacancies across the Health Board, with vacancies being particularly high in Mental Health, and sought clarity as to whether the Team knew why this was the case so that a sustainable solution could be found. A Llewellyn advised that the team were fully aware of the reasons as to why vacancies were high within Mental Health, with newly Registered Nurses advising management that they felt there was insufficient leadership and support in place. As a result of this the Nurse Establishment Review recently completed had recommended a change of a number of Band 5 posts into Band 6 posts to create additional leadership and support at ward level, which had been endorsed by the Care Group Planning, Performance, People and Finance Group. Members noted that work was now being undertaken with Executive colleagues to develop an 'Invest to Save' proposal to take this activity forward.

A Llewellyn added that the Care Group had led a recruitment drive for Healthcare Support Workers given the high usage of Bank Healthcare

Support Workers to support acuity and advised that 66 applications had been received for the posts. Members noted that given the significant challenges that had been experienced in relation to manual handling training, this would now be managed within the Care Group, with existing trained staff providing manual handling training at ward level for new starters. A Llewellyn advised that it was hoped the position would improve in future, pending approval of the 'Invest to Save' proposal.

C Bear referred to the Llais unannounced visit to Seren Ward which was referred to in the report and advised that this related to a food and drink survey that was being carried out by Llais across the Health Board. Members noted that the report would be shared with the Care Group by the 31 May 2024.

The Committee Chair advised that the Committee noted with concern the acuity and fragility of the service and the high vacancy rate and noted the actions being undertaken to address the position.

The Committee Chair referred to the unexpected deaths at Parc Prison and noted that the Care Group were part of a multi-agency review being undertaken. A Llewellyn confirmed that Mental Health were part of this review and added that not all the people who had been subject to the serious incidents were known to Mental Health Services. Members noted that the Operational Team within HMP Parc were working closely with all agencies, which included substance misuse agencies. G Hughes advised that a detailed update on Parc Prison would be presented at a Board Briefing session taking place on the 23 May 2024.

Resolution: The report was **NOTED.**

5.2b Children & Families Care Group

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

C Bear made reference to the update provided in the report regarding Special School Nursing and advised that the Llais Regional Director had been undertaking a piece of work to determine the size of the issue, and had found that there had been some organisational change processes (OCP) being undertaken, with a new nursing leadership structure being developed and submitted to Special Schools. C Bear sought clarity as to what engagement had been undertaken in relation to this. In response, S Hardacre advised that a meeting had recently been held with Directors of Education where it was confirmed that there was no change to the Senior Nurse Leadership for School Nursing. Members noted that there were challenges in relation to recruitment into Special Schools, with various different models being in place across the three Local Authority areas. S Hardacre advised that it had been determined that the Service Level

Agreements that had been in place for a number of years required review. Members noted that the Care Group were now working through the areas of improvement identified to ensure that there was an equal offer in place as to what the Health Service could provide across the Local Authorities, in addition to engaging with schools. S Hardacre advised that whilst there had been some recruitment difficulties, assurance could be provided that through the OCP process, there were no changes made to the Senior Nurse Leadership for School Nursing.

C Bear referred to the changes made in relation to the locations of where infertility clinics were being held at Princess of Wales Hospital which had been welcomed by Llais who felt that it would improve the patient experience. S Hardacre extended her thanks to C Bear for providing the feedback and advised that there was some further work to be undertaken in relation to relocation of some other services.

Resolution: The report was **NOTED.**

5.2c **Diagnostics, Therapies, Pharmacy and Sciences Care Group**

L Love-Gould presented the report and highlighted the matters contained within the alert/escalate section.

L Love Gould advised that positive feedback had been received from GP's 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. L Love-Gould suggested that this may be an area the Committee may wish to receive a further update on at a future meeting in the form of a spotlight presentation. The Committee Chair welcomed this suggestion.

The Committee Chair referred to the UKAS assessment within Pathology which would be undertaken in June 2024 and sought clarity as to what level of confidence was in place regarding the assessment and gap analysis, and whether it was felt that further work was required. L Love-Gould advised that the gap analysis had been undertaken in line with normal processes and added that no areas of concern had been highlighted through the Care Groups Quality & Safety meetings.

In response to a query raised by A Brown regarding the MRI Pacemaker Service, L Love-Gould confirmed that this service would be available to patients at Princess of Wales and Royal Glamorgan Hospitals in addition to patients at Prince Charles Hospital.

Resolution: The report was **NOTED.**

Action: 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.

5.2d **Unscheduled Care - Care Group Highlight Report**

A Brown presented the report and highlighted the matters contained within the alert/escalate section.

Resolution: The report was **NOTED.**

5.2e **Primary & Community Care- Care Group Highlight Report**

L Williams presented the report and highlighted the matters contained within the alert/escalate section. Members noted that since the report was drafted, a Team was now in place to support with Fit Test Training.

The Committee Chair welcomed the reported improvements in the Lymphoedema Service.

K Palmer referred to dental services, particularly the waiting list position within special care dentistry, and advised that it would be helpful to have an update on the work that had been undertaken by the Planned Care Group on theatre productivity. G Hughes advised that work was being undertaken to ensure that increased capacity was in place for dental services, with work being undertaken to review the flexibility of Dentist job plans. Members noted that the position was complicated for patients with learning disabilities, given that this dental service was only being run from Prince Charles Hospital and with the works being undertaken at the Hospital, this had resulted in the temporary loss of the day surgery unit. G Hughes advised that an alternative suitable environment was being sought and suggested that he provides a detailed update at the next meeting on progress being made against the plan.

K Palmer also made reference to training in Care Homes, which was a theme that spanned a number of Committee remits and topic areas, and questioned whether there was any ability for the Health Board to obtain any additional funding or support to assist with training in Care Homes. L Williams advised that a training day had been set up with Care Homes so that a better understanding could be gained in relation to the needs of the services and what support they require and added that she would be happy to provide an update on progress to a future meeting.

K Palmer welcomed the work that had been undertaken to review governance arrangements at Parc Prison.

Resolution: The Care Group Highlight Report was **NOTED**.

Actions: Detailed update to be provided at the next meeting in relation to progress being made against the plan to address the waiting list position for special care dentistry.

Update to be presented to a future meeting in relation to progress being made to address training in Care Homes.

5.2f **Planned Care Group Highlight Report**

S O-Brien presented the report and highlighted the matters contained within the alert/escalate section.

K Palmer made reference to the development of the CTM Escalation Policy and sought clarity as to where this would report. G Hughes advised that this would be presented to a variety of forums and added that he would be happy to share this with the Quality & Safety Committee if Members would find it helpful. The Committee Chair advised that she would be happy for this to be received at a future meeting for information and awareness.

The Committee Chair welcomed the work being undertaken in relation to urology and that shared learning was in place across Care Groups regarding the work undertaken.

Resolution: The Care Group Highlight Report was **NOTED**

Action: CTM Escalation Policy to be presented to a future meeting for information and awareness.

6. **GOVERNANCE, RISK AND ASSURANCE**

6.1 **Organisational Risk Register**

Some questions were raised by the Committee Chair prior to the meeting, as outlined below together with the responses:

4103 - I wondered if the risk score should be 25 given the narrative which mentions catastrophic impact on sight

Response: *Risk ID 4103 - Sustainability of a safe and effective Ophthalmology service*
Recognising the query raised by the Chair of the QSC the Planned Care - Care Group Senior Leadership Team have reviewed the risk, its mitigations and the assessment of the risk score and consider that whilst there is reference to catastrophic impact in the narrative it is considered that the mitigations that then follow have led them to confirm the impact score relating to this risk does not need to increase to a 5. This will be kept under review.

3826 - An overcrowding score is mentioned but I can't see how this in itself reduces the risk.

USC Response – "On reflection the narrative under mitigating action needs to be revisited as Carolyn is quite right that the overcrowding score will not reduce the risk. The overcrowding score will identify the risks that need to be mitigated resulting in agreed actions being undertaken or further escalation as appropriate. The update for the July iteration of the Organisational Risk Register will reflect updated narrative and the ongoing activity around ambulatory activity and also looking at the use of safety huddles."

4908 - Mentions care group governance being in locality format. This rang alarm bells for me and some further explanation would be helpful.

Response from the Assistant Director of Quality & Safety – the mitigating action has been updated to reflect the new Care Group Structure as follows:
"Governance arrangements within the Care Groups are being embedded, which has meant Governance meetings have continued to be managed via the Care Groups in a locality/site-based format – e.g. the Unscheduled Care and Planned Care Groups have held separate Governance meetings at Bridgend, Rhondda Cynon Taf, and Merthyr Tydfil.

Discussions are in place within the Unscheduled Care and Planned Care-Care Groups for these arrangements to be amended and for the Governance meetings to follow in line with Phase 2 OCP Structure.

The Mental Health Care Group are managing their Governance Meetings via the Phase 2 OCP Structures.

The Community Care Group will continue to operate their Governance meetings via a locality format, as this aligns with the Local Authorities within the Health Board.

Following the amendments noted above, the Legal Services team will review the service required to support the Care Groups.

A new report is being devised by the Business Intelligence team to further provide support on the data for each of the Care Groups"

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.

The Committee Chair welcomed the update and the significant improvements that had been made in developing the risk register.

Resolution: The report was **NOTED**

6.2 Infection, Prevention & Control Report – End of Year Update

This item was taken before agenda item 5.2c.

G Dix presented the report and provided members with an update on the key matters contained within it.

Resolution: The report was **NOTED**

6.3 Infection, Prevention & Control Strategy

This item was taken before agenda item 5.2c.

G Dix presented the report and highlighted the key matters for Members attention.

K Palmer extended her thanks to G Dix for presenting the report which she found to be helpful and sought clarity as to what engagement had been undertaken with Primary Care and GP's. G Dix advised that to meet the needs of the population, the Infection, Prevention and Control Team will need to modernise its approach in relation to the delivery of the strategy, particularly from a community perspective, given that there was currently no dedicated community or primary care resource in place.

G Dix advised that there would be an Organisational Change Process undertaken with the specialist Infection, Prevention and Control Team, which would enable the creation of a central 'Hub and Spoke' model, which would include specialist and microbiology support for the entirety of the Health Board, which would be undertaken within the Teams current financial resource. Members noted that focus would be placed on antimicrobial stewardship this year and next year, with appropriate resource in place within pharmacy to support clinicians in this area of work. G Dix advised that the focus being placed on antimicrobial stewardship would be of significant benefit to patients, given that ineffective use of antibiotics could lead to significant effects on patient care and was a contributory factor to c-difficile.

G Dix advised that once approval of the strategy had been given, an implementation plan would be developed by the team and reported annually to the Quality & Safety Committee and Board. G Dix extended his thanks to R Hughes, Deputy Director of Nursing for leading this piece of work on behalf of the Health Board.

The Committee Chair advised that she welcomed the development of the strategy and added that this had been an area of concern for some time,

particularly in relation to the resource that was available to Primary Care. The Committee Chair welcomed the suggestion made for the Quality & Safety Committee to maintain oversight of monitoring progress against the implementation plan on an annual basis and extended her thanks to R Hughes and the Team for the development of the Strategy.

Resolution: The Infection Prevention & Control Strategy was **ENDORSED FOR BOARD APPROVAL**

Action: Implementation Plan to be presented to the Quality & Safety Committee on an annual basis for monitoring of progress.

6.4 New NICE Guidance Process

D Hurford presented the report and highlighted the key matters for Members attention.

Resolution: The report was **NOTED.**

6.5 Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chairs Report

The Committee Chair presented the report and advised that as at the end of March 2024 she had been Chair of the WHSSC Quality & Patient Safety Committee. The Chair advised that she had asked for this to be included on the main agenda to ensure that the Committee are assured that processes are in place to ensure quality monitoringwas in place for the services that were commissioned on the Health Board's behalf.

N Milligan referred to the Neonatal Intensive Care Service escalation report and noted that whilst two actions had been completed in December 2023, an executive-to-executive meeting was still to be scheduled and sought clarity as to when this was likely to be arranged. S Davies advised that whilst a date had not yet been identified for the meeting, work was ongoing and active discussions were taking place.

K Palmer advised that she found the report to be helpful and sought clarity as to whether there was a list of services available that would be commissioned by the new Joint Commissioning Committee which would be a helpful learning tool for Independent Members. The Committee Chair advised that she would be happy to raise this at a meeting of the Joint Commissioning Committee taking place on 4 June 2024.

D Jouvenat sought clarity as to how the new Joint Commissioning Committee would operate in terms of governance and questioned whether they would have a Quality & Safety Committee with similar representation from Health Board's as per the previous organisations. The Committee Chair advised that clarity on this should be provided over the next few

months and added that she would be happy to seek confirmation at the meeting on 4 June 2024.

C Hamblyn advised that the Director of Corporate Governance/Board Secretary was working very closely with the Joint Commissioning Committee to finalise the Hosting agreement and Memorandum of Understanding.

Resolution: The report was **NOTED.**

Actions: 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 and whether structures would be similar as per previous hosted body organisations.

6.6 NHS Wales Joint Commissioning Committee

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

The Committee Chair advised that clarity was required as to how this Committee could triangulate information that comes from Joint Commissioning Committee monitoring, which should become clearer over the next few months.

Resolution: The report was **NOTED.**

7. DELIVERING OUR PLAN

7.1 Patient Safety, Quality & Experience Dashboard

N Downes presented the Patient Safety & Quality Dashboard to Committee Members and highlighted the key matters for Members attention.

The Committee Chair welcomed the improvements in relation to complaints and incidents as a result of the significant amount of work undertaken in these areas to address the position.

N Milligan referred to communication issues being recorded as one of the main issues highlighted in concerns being raised by patients and sought clarity as to whether there was more granular information available to enable themes and trends to be identified. N Downes confirmed that themes and trends were available and added that he would be happy to present more detail on this at a future meeting. Members noted that communication issues would be an area that would be discussed at the Listening & Learning Event that was taking place on 24 June 2024. The

Committee Chair advised that Committee Members would welcome a spotlight update on this matter, to include the actions being taken to improve the position.

K Palmer made reference to the increase in Nationally Reportable Incidents (NRIs) and queried whether the Committee should be concerned about this position. N Downes advised that the increase reported was in relation to the number of NRI's that had been closed by the Health Board and submitted to NHS Executive as opposed to there being an increase in incidents. N Downes added that a consolidation exercise of all open NRIs had been undertaken and that work in this area continues. Members noted that a concentrated effort was being made in reviewing and closing our NRIs for Ophthalmology, and there is a small team in place who were currently working on reducing 23 over the coming weeks, with a trajectory plan in place which was being monitored on a weekly basis.

K Palmer made reference to the Public Services Ombudsman reviews and sought clarity as to whether there were any lessons learnt or themes being identified. N Downes advised that a review of themes could be undertaken on the concerns received and advised that steps were taken to ensure that concerns are resolved with patients. N Downes advised that he would be happy to share this review at a future meeting.

K Palmer referred to the small improvements being made in relation to pressure damage and sought clarity as to when a significant improvement in the position would be expected. The Committee Chair advised that in addition to pressure damage, there was an improvement plan in place for falls, and it would be helpful if the Committee could be provided with an update as to whether the plans were working and having an impact so that an evaluation could be undertaken of the success of the programmes.

K Palmer referred to the four adverse incidents reported in maternity and sought clarity as to whether this was something the Committee needed to be concerned about. The Committee Chair advised that these had previously been considered by the Committee in some detail at a previous In Committee (closed) meeting due to the detail being discussed

K Palmer also referred to restricted practices and advised that whilst she understood there was a cohort of four patients, she questioned how the Committee could be provided with assurance, as opposed to reassurance, on the increased use of restrictive practices. A Llewellyn advised that an increase in acuity and levels of violence and aggression was being seen, which would be consistent with the increased use of restraint, and provided assurance that every single use of restraint was being recorded on Datix, and if restraint was inappropriately used, this would then trigger a level two investigation, which none of the reported four cases had.

In response to a question raised by K Palmer as to whether data was being shared with strategic programmes and Welsh Government, A Llewellyn advised that whilst Nationally Reportable Incident data was being received centrally, there was a Strategic Patient Safety National Programme in place for Mental Health who would be focussing on the sharing of data.

Resolution: The report was **NOTED**.

Actions: 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

Lessons learnt and identified themes from Public Services Ombudsman Reviews to be presented to a future meeting.

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.

7.2 Nursing & Midwifery Plan

A Llewellyn presented the report and highlighted the key matters for Members attention.

K Palmer welcomed the plan and sought clarity as to how the plan would be monitored moving forwards. A Llewellyn advised that the plan would be monitored through the Executive Directors of Nursing structure and added that updates could be presented to a future Committee if Members would find this helpful. The Committee Chair advised that it would be helpful if periodic updates could be presented to the Committee at the appropriate stages to highlight progress made.

The Committee Chair advised that she was pleased to see that research had been referenced within the plan alongside the involvement of carers which was also helpful.

N Milligan referred to principles four and five being the priority areas of focus, with principle four referring to embracing a diverse workforce. N Milligan referenced reports she had received from staff who had been subjected to racist behaviour where Datix reported matters were being closed, with no conversations being held with staff to address any of the issues raised. N Milligan advised that this is an area which required further focus and review and advised that she would be happy to discuss this further outside the meeting. A Llewellyn advised that she would be happy to link in with the sponsors for principles four and five to ask if they could contact N Milligan to discuss further.

Resolution: The plan was **ENDORSED**

Actions: Periodic updates to be presented to the Committee in relation to progress being made against the Nursing & Midwifery Plan

Mental Health & Learning Disabilities Care Group Nurse Director to request that the sponsors of principles four and five meet with N Milligan to discuss the concerns raised regarding staff feeling they had been subject to racist behaviour in regard to Datix Closures.

8. DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1 Mental Health Adult Inpatient Improvement Programme

A Llewellyn presented the report and provided committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme. The Committee Chair extended her thanks to A Llewellyn for presenting the comprehensive update.

Resolution: The report was **NOTED**

9. CONSENT AGENDA

9.1 FOR APPROVAL

9.1.1 Unconfirmed Minutes of the meeting held on 14 March 2024

Resolution: The Minutes were **APPROVED.**

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

Resolution: The Minutes were **APPROVED.**

9.1.3 Welsh Language Active Officer Policy

Resolution: The Policy was **APPROVED.**

9.1.4 **Quality & Safety Committee Annual Report 2023-2024**

Resolution: The Quality & Safety Committee Annual Report was **ENDORSED** for Board Approval

9.2 FOR NOTING

9.2.1 Action Log

Resolution: The Action Log was **NOTED.**

9.2.2. Committee Annual Cycle of Business

Resolution: The Annual Cycle of Business was **NOTED.**

9.2.3. Committee Forward Work Programme

Resolution: The Forward Work Programme was **NOTED.**

9.2.4. Clinical Policies Highlight Report

Resolution: The report was **NOTED.**

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

Resolution: The report was **NOTED.**

9.2.6. Cancer Services Annual Report

Resolution: The report was **NOTED.**

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

Resolution: The report was **NOTED.**

9.2.8. Human Tissue Authority Act Progress Report

Resolution: The report was **NOTED.**

9.2.9. Healthcare Inspectorate Wales Action Plan Tracker

The following question was raised regarding this item ahead of the meeting, as outlined below, together with the response provided:

Question: I note there are 154 actions past their due date and 3 new improvement plans – so my question was a general one on is there anything to worry about and need for us to focus on?

Response: In terms of the HIW Tracker I think the new approach is more transparent in identifying the gaps in the action updates and that isn't to say that work is not ongoing, but I think the tracker updates require improvement which will improve now we are transitioning to the new automated approach. In terms of risk focus – it's a little early to determine as what I have asked Claire Brown in my team to do is meet with each of the Nurse Directors in the care group to cleanse the tracker and ensure it is updated robustly over the coming months so we can provide the Committee with a more accurate reflection on progress and status.

Resolution: The report was **NOTED.**

10. CLOSE OUT BUSINESS

10.1 Any other Business

There was no other business to report.

10.2 Highlight report to Board – Verbal

The Committee Chair advised that this would be drafted by the Corporate Governance Team outside the meeting and suggested that concerns raised in relation to boarding of patients needed to be included in the alert/escalate section.

10.3 How did we do in this meeting – Verbal

The Committee Chair advised that she would welcome feedback to be shared outside the meeting as to how Members and attendees felt the meeting went.

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. The Committee Chair noted that a couple of areas had been suggested at the meeting today for future spotlighting.

11. PRIVATE/IN COMMITTEE SESSION

The Committee Chair advised that the following items would be discussed at the In Committee session being held following this meeting:

- MBRRACE-UK Perinatal Mortality Report: 2022 Births

12. DATE AND TIME OF NEXT MEETING

The next meeting would be held on Tuesday 23 July 2024 at 1:00pm

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item Number: 9.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 16 May 2024 as a Virtual Meeting via Microsoft Teams

Members Present:

Carolyn Donoghue	Independent Member (Committee Chair)
Kath Palmer	Vice Chair of the Health Board (Vice Chair)
Patsy Roseblade	Independent Member
Dilys Jouvenat	Independent Member
Nicola Milligan	Independent Member

In Attendance:

Greg Dix	Deputy Chief Executive /Executive Director of Nursing (In part)
Dom Hurford	Executive Medical Director
Suzanne Hardacre	Director of Midwifery
Nigel Downes	Assistant Director of Quality & Safety
Sallie Davies	Deputy Medical Director
Jodie Hodges	Perinatal Safety Support Champion
Bryany Tweedale	Consultant Midwife
Mohamed Elnasharty	Consultant Obstetrician & Gynaecology (In part)
Cally Hamblyn	Assistant Director of Governance and Risk
Emma Walters	Head of Corporate Governance & Board Business (Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the In Committee meeting of the Quality & Safety Committee.

1.2 Apologies for Absence

Apologies for absence were received from:

- Helen Lentle, Independent Member
- Lauren Edwards, Executive Director of Therapies & Health Science
- Hywel Daniel, Executive Director for People

1.3 Declarations of Interest

There were none.

2 MAIN AGENDA

2.1 MBRRACE-UK Perinatal Mortality Report: 2022 Births

B Tweedale and J Hodges presented the report and highlighted the key matters for Members attention in relation to the content and findings of the MBRRACE-

Unconfirmed

UK Perinatal Mortality Report: 2022 Births (CTMUHB) and the review and triangulation of data and report findings against the local CTMUHB Stillbirth Thematic Report (2022 births)

The Committee Chair extended her thanks to B Tweedale and J Hodges for presenting the report and advised that it was evident through this report that the new Care Group structure was starting to embed and work well.

It was noted that the maternity and neonatal service and Children and Family Care Group will provide regular updates to the Quality and Safety Committee by way of assurance and evidence that there is triangulation of information, learning, and that perinatal mortality cases are being reported openly and transparently.

Resolution: The Report was **NOTED**.

3. ANY OTHER BUSINESS

3.1 Human Tissue Authority (HTA) Reportable Incident

D Hurford provided an update to members in relation to an incident that had occurred in relation to pregnancy loss tissue. Members noted that a report would be presented on this matter at the July meeting of the Committee.

Resolution: The update was **NOTED**

Action: Update report to be presented to the July meeting of the Committee.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting of the Quality & Safety Committee is to be confirmed.

Unconfirmed

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.	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	**In progress** Work ongoing to improve routes of reporting into

		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	Quality Strategy Annual Plan. Updated Annual Plan to be presented to the Quality & Safety Committee in July by the Assistant Director of Therapies & Health Sciences – **On agenda**
2.1	14 March 2024	**Listening & Learning Story – Acute Oncology Service** Inequity of service across sites to be considered as part of the work being undertaken in relation to the development of the Acute Clinical Services Plan	Executive Director of Nursing/Deputy Chief Operating Officer	16 May 2024	**In progress** Awaiting response from Deputy Chief Operating Officer
2.1	14 March 2024	**Listening & Learning Story – Acute Oncology Service** 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	**In progress** Awaiting response from Deputy Chief Operating Officer
2.2	16 May 2024	**Spotlight Presentation – Maternity & Neonates**	Director of Midwifery	23 July 2024	**Completed - On agenda**

		Metrics and Assurance Framework Update on the plans in place to address staff cultural issue to be presented to a future meeting			Update included in Highlight report being presented to the July meeting of the Quality & Safety Committee
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 for the Board meeting taking place on 25 July 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 to be presented to the Quality & Safety Committee taking place on 23 July 2024
5.1	16 May 2024	**Report from the Clinical Executives** 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.	Committee Chair/Executive Director of Nursing/Deputy CEO	23 July 2024	**In progress – On agenda** Listening & Learning story in relation to Boarding of patients to be presented to the Quality & Safety Committee taking place on 23 July 2024

		Focussed discussion to take place at future meeting in relation to boarding of patients.			
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 – On agenda** Update included in the Clinical Executives Report being presented to the July meeting
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	**In progress** 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	Chief Operating Officer	18 September 2024	**In progress** Update to be provided at the meeting taking place on 18 September 2024

		in relation to progress being made against the plan to address the waiting list position for special care dentistry			
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 address training in Care Homes	Care Group Nurse Director	To be confirmed	**In progress** Awaiting confirmation on a date in which this update will be presented
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	**In progress** Update to be provided at the meeting taking place on 18 September 2024
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
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	Committee Chair	4 June 2024	**In progress** Committee Chair has received the following updates from the JCC: • The list of services are outlined in the predecessor WHSSC

		Commissioning Committee to be obtained Clarity to be sought as to governance structures within the Joint Commissioning Committee and whether structures would be similar as per previous hosted bodies organisations			joint committee annual report, and were referenced in the transition plan. Enquiries will be made with the JCC 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	Assistant Director of Quality & Safety	23 July 20224	**Completed – on agenda** Update has been included in the July iteration of the Quality Dashboard report

		communication issues to be presented to a future meeting. Update to include the actions being taken to address the position			
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	**In progress** This will be presented to the September Quality & Safety Committee
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	**On agenda** This report is on the agenda for the July meeting of the Committee
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.

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 July 2024)
6.5	21 September 2023	**CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unity Interim Learning Report** Outcome of the Demand & Capacity work to be presented to a future meeting of the Committee	Head of Covid19 Nosocomial Investigation Team	16 May 2024	**Completed** Closure report received and noted at the 16 May 2024 meeting
5.1	14 March 2024	**Clinical Executives Report** Concerns raised in relation to issues being experienced in relation to Boarding of patients to be escalated to the Board via the Committee Highlight report.	Committee Chair	30 May 2024	**Completed and Ongoing** Issue was reported in the Committee Highlight Report to May Board in the alert/escalate section. Further concerns raised at the May Quality & Safety Committee where it was agreed that the matter would continue to be escalated to the Board as an area of concern.
7.2	16 May 2024	**Nursing & Midwifery Plan** Mental Health & Learning Disabilities Care Group Nurse Director to request that the sponsors of principles four and five meet with N Milligan	Care Group Nurse Director	23 July 2024	**Completed** Assistant Director of Nursing and Peoples Experience has spoken to N Milligan about the concerns raised and meeting being

		to discuss the concerns raised regarding staff feeling they had been subject to anti-racist behaviour in regards to Datix Closures			arranged to discuss the concerns in more detail. Discussion will also be held with BAME Network Lead

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

Agenda Item
9.2.2

Quality & Safety Committee

Quality & Safety Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
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	

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

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.

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

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.

GIG CYMRU NHS WALES | 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	Executive Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi-annually	⚑						⚑					
National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement	Director of Nursing, Performance and Quality, NCCU	Annually									⚑			
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Director of Nursing	Annually	⚑ Defer to Mar 24		⚑									
Infection, Prevention & Control Report (Annual Report and Mid-Year Update) Exception reports will be presented as and when required	Executive Director of Nursing	Bi-Annually					⚑ End of year update				⚑ Annual Report		⚑ Mid Year update	
DELIVERING OUR PLAN														
Quality Dashboard Report	Executive Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
EASC Quality & Safety Highlight Report Will be superceded by new Governance Structure within the new Joint Commissioning Committee	Chief Ambulance Services Commissioner	Bi-Annually	⚑						⚑					
DELIVERING OUR IMPROVEMENT PROGRAMMES														
Stroke Services Progress Report	Executive Director of Therapies and Health Sciences	Quarterly			⚑				⚑				⚑	
Mental Health In-Patient Improvement Progress Reports	Executive Director of Therapies and Health Sciences	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														

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

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
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		⚑			
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually							⚑					
WHSSC Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	⚑				⚑				⚑			
Putting Things Right Annual Report	Director of Corporate Governance	Annually							⚑ 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											⚑	
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											⚑	

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

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
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												

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

QUALITY & SAFETY COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Request made by the Quality & Safety Committee Chair	Additional Item	Annual Quality Work Plan	Director of Nursing	Discussion held at agenda planning. Noted that an Annual Quality Report would need to be produced as opposed to an Annual Quality Work Plan. Date for presentation of the Annual Quality work plan to be confirmed
Email Request received from the Senior Nurse Community Children's Nursing Services	Additional Item	Was Not Brought Policy – For Approval	Director of Nursing	Was planned for 21 November 2023 – **To be deferred – date to be confirmed**
Email Request received from the Head of Safeguarding	Additional Item	Deprivation of Liberty Protection Safeguards Policy	Director of Nursing	Was planned for 21 November 2023 – **To be deferred – date to be confirmed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
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 Executive Medical Director	Additional Item	Body Store Recommendations from Welsh Government	Executive Medical Director	Planned for 23 July 2024 – **On agenda**
Email request received from the Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Additional Item	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
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**
Suggestion made at the meeting held on 16 May 2024 that this item would require detailed	Additional Item	Boarding of Patients	Executive Director of Nursing	Planned for 23 July 2024 – **On agenda**

discussion at a future meeting				
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
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
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**
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	Planned for 23 July 2024 – **On agenda**
Email request received from the Assistant Director of Governance & Risk following discussion at Operational	Additional Item	Impact and governance around the management of 'Medication shortages	Medical Director	Planned for 18 September 2024

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

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

Completed Activity From the Forward Work Programme:

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Request received from the Head of Nosocomial Investigation Team	Additional Item	CTMUHB Nosocomial Covid 19 Incident Management Programme - Delivery Unit (NHS Executive) Interim Learning Report	Executive Director of Nursing	**Completed** Closure report presented to the meeting held on 16 May 2024
Email request received from the Medical Directorate Business Manager	Additional Item	New NICE Guidance Process	Medical Director	**Completed** Report received and noted at the meeting held on 16 May 2024
Email request received from the Welsh Language Services Manager	Additional Item	Welsh Language Active Offer Policy	Executive Director of Nursing	**Completed** Report received and approved at the meeting held on 16 May 2024
Request made by Executive Director of Nursing at agenda planning session for this item to be added to the agenda	Additional Item	NHS Wales Joint Commissioning Committee	Executive Director of Nursing	**Completed** Report received and noted at the meeting held on 16 May 2024
Request made by Executive Director of Nursing at agenda planning session for this item to be added to the agenda	Additional Item	Infection, Prevention & Control Strategy	Executive Director of Nursing	**Completed** Report received and endorsed at the meeting held on 16 May 2024

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

Agenda Item
9.2.4

Quality & Safety Committee

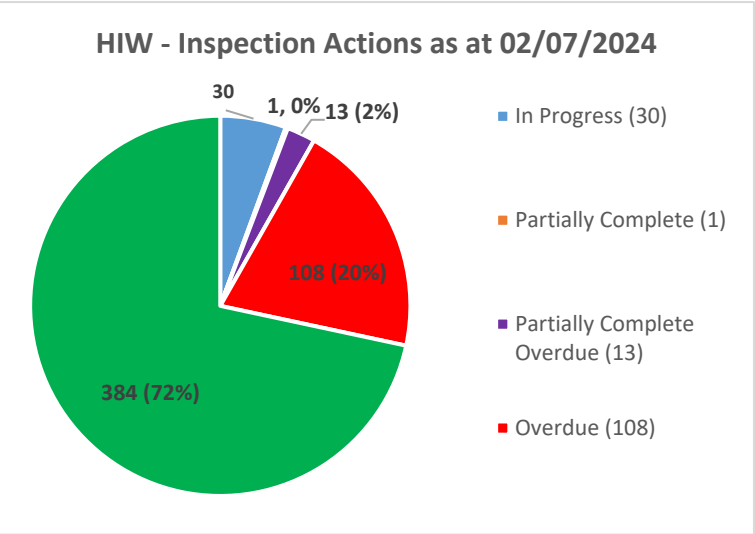
HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT July 2024

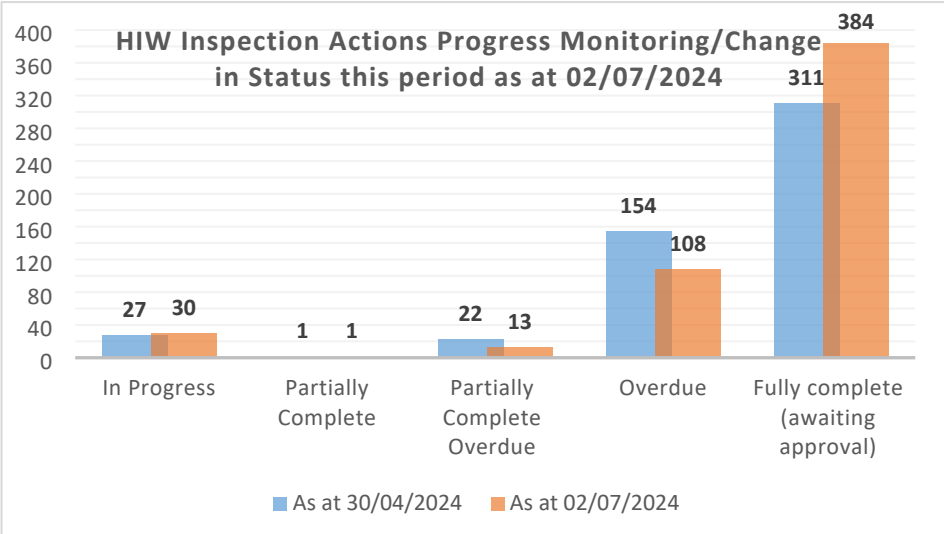
Dyddiad y Cyfarfod / Date of Meeting	23rd July 2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

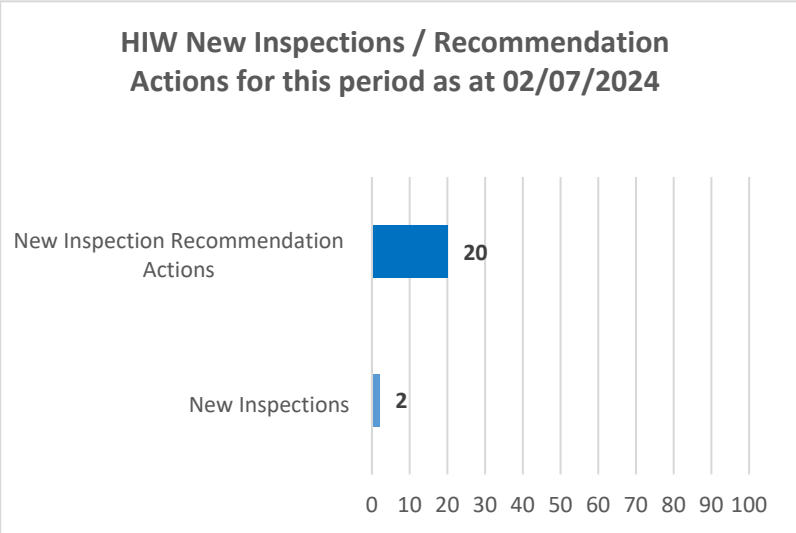
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	15th July 2024	Management sign off received.

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking







Actions by status- 02/07/2024

Total Number of Actions	Actions passed due date	Actions ongoing/partial complete	Yellow-Actions on Target to meet original or revised completion date	Actions Completed
536	108	13	31	384

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 May 2024 through to July 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 Communication has been sent out of all Heads of Quality within Care Groups to seek their support in updating the AMaT system by a prescribed date before each Quality and Safety committee. The Assurance and Compliance team and the Patient Safety team are now working closely together to ensure a smooth transition in the role of providing assurance and compliance for recording and reporting purposes. This will allow for a systematic and robust process for continuous monitoring of all the HIW inspection improvement plans and activity.

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. Engagement of Care Groups in providing updates for the report needs to be improved in order to provide assurance to the Committee.

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. Due to ongoing pressures within Care Groups this data cleanse continues to be ongoing as scheduled meetings needed to be cancelled or re-arranged due to last minute unforeseen circumstances. Priority, re-scheduled meetings are now planned within the next two weeks which will allow the team to provide the Committee with further updated assurance at the next Quality and Safety Committee meeting.

2.4 Members will note that there are a large number of Inspection actions marked as "Complete Awaiting Approval". As part of the data cleanse, these have been highlighted to Care Groups to provide a date in which these were approved by local Quality and Safety groups. These actions will now be put forward for executive approval and marked as completed and removed from the AMaT tracking system following approval within Committee.

2.5 A breakdown of the status position with regards to all actions up to the beginning of July 2024 is detailed below.

- A total of **536 actions** are reported with a further breakdown of the stages towards compliance reported in table 1 located in the dashboard at the beginning of this report.

This is further broken down as follows:

- **108** actions reported as Red with the actions being those which are incomplete and have passed the agreed due date;
- **13** actions reported as Amber which are those actions partially complete/ongoing to meet deadline date;
- **31** actions reported as Yellow which are those on target to meet original or revised completion date;
- **384** actions reported as Green completed actions. These will be put forward for approval to be closed and removed from the Tracker.

2.6 **Current Position**

- There were **2 Improvement Plans** added to the tracker during this period.
- **99 New Inspection recommendations actions** were added this period

2.7 In the last report it was noted that there were 18 overdue actions within the National Review of Mental Health Inspection (REF-2021/137) which were not displaying an update. This was escalated to the Mental Health and Learning Disabilities Care Group who have shown an increased engagement with the Head of Quality Assurance and Compliance and provided updates

to some of the outstanding actions. Engagement with the Care Group is ongoing to gain further update and input into the outstanding overdue actions.

2.8 The Committee are asked to note that updates were received after the deadline detailing progress in five of the outstanding overdue Ophthalmology Inspection actions ((HIW)2017/141). Unfortunately as these were received after the deadline to be added to AMaT and included in the dashboard report they will now be reflected in the next Quality and Safety Committee report. The Head of Quality Assurance and compliance will continue to encourage further updates for the outstanding overdue actions.

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. An in-depth data cleanse is ongoing to update and remove historic actions and complete out of date actions. Although there does not appear to be quantifiable improvements on the tracker in terms of Care Group engagement, Off tracker engagement with Care Group leads has increased with certain Care Groups. Continued engagement from Care Groups with the Head of Quality Assurance and Compliance is required in order to bring the HIW tracker and action statuses up to standard in order to provide increased assurance.

3.2 Steps have been taken to seek updates from the Care Group leads in relation to outstanding HIW improvement plans to ensure full closure and assurance of actions taken to compete all the improvement plans in an agreed and timely manner. Strict deadlines for update must be adhered to due to the requirement for manual manipulation of the data to provide updates to committee members.

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. During this last period, the Head of Quality Assurance and Compliance has

attempted to meet with Care Group Nurse Directors to gather the relevant information pertaining to the historic HIW Inspection Actions. As detailed previously, due to ongoing pressures within Care Groups and the need to rearrange scheduled meetings, this task is taking longer than anticipated. The Head of Quality Assurance and Compliance has ensured that the data cleanse meetings are rescheduled and it is anticipated that with the input from Care Group Nurse Directors that the committee will be able to review a more streamlined HIW Tracker at the next Committee Meeting.

3.4 HIW Inspection activity work continues to transition across to the Assurance and Compliance team in collaboration with the Patient Safety team. The process will be managed across the two teams to ensure less risk of process failure. It is anticipated that in doing so and with an updated process of tracking, monitoring and management of HIW inspection actions that there will be a more streamlined, improved approach to providing governance of HIW Inspection recommendations and actions.

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.

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*	Whole-systems Perspective

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))*	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: This is an overarching position update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.

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

5. Recommendation

5.1 The Quality & Safety Committee are asked to **NOTE** the contents of this report and the activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.

6. Next Steps

6.1 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	Date of Inspection	Care Group & DoN Lead	Head of Quality & Patient Safety	Recommendations	Actions
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022	30.01.2017	**Planned Care** Sharon O'Brien, Nurse Director	Lydia Thomas, Head of Quality & Patient Safety Cally Holland-Brame, Senior Nurse	22	22
Healthcare Inspectorate Wales (HIW)/2020/136	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	10.12.2020	**Unscheduled Care** Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	3	3
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08.09.2020	**Primary Care and Community** Lucie Williams, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	2	2
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	20.04.2021	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	1	1
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30.06.2021	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	17	18
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	20.07.2021	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety Sian Lewis, Lead Nurse for CHC and NHS Funded Care	2	2
Healthcare Inspectorate Wales (HIW)/2022/129	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT	01.11.2022	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	6	10
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22.03.2022	**Children & Families** Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology Sara Fox, Head of Midwifery & Gynaecology	7	7
Healthcare Inspectorate Wales (HIW)/2022/132	Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]	26.09.2022	**Children & Families** Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology Sara Fox, Head of Midwifery & Gynaecology	3	3
Healthcare Inspectorate Wales (HIW)/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	17.10.2022	**Unscheduled Care** Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	1	2
Healthcare Inspectorate Wales (HIW)/2022/36	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	14.11.2022	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	5	5
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07.03.2023	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	39	180
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital [Appendix A - Immediate Improvement Plan - PCH, E Dept & C D Unit - 31 July 01 &	31.07.2023	**Unscheduled Care** Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	2	2
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16.05.2023	**Primary Care and Community** Lucie Williams, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	7	7
Healthcare Inspectorate Wales (HIW)/2023/154	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	25.09.2023	**Children & Families** Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety	1	2
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07.09.2023	**Unscheduled Care** Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	50	50
Healthcare Inspectorate Wales (HIW)/2023/156	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	25.09.2023	**Children & Families** Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety	2	2
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13.11.2023	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	25	26
Healthcare Inspectorate Wales (HIW)/2023/158	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	20.11.2023	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	19	19
Healthcare Inspectorate Wales (HIW)/2023/159	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	19.10.2023	**Children & Families** Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology Sara Fox, Head of Midwifery & Gynaecology	5	22
Healthcare Inspectorate Wales (HIW)/2023/160	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	11.09.2023	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	20	32
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31.07.2023	**Unscheduled Care** Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	31	36
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09.01.2024	**Children & Families** Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology	2	27
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09.01.2024	**Children & Families** Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology	14	36
Healthcare Inspectorate Wales (HIW)/2024/184	Appendix A - Ysbyty Cwm Rhondda Ward B2 (Ref: 03467)	11.04.2024	**Primary Care and Community** Lucie Williams, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	3	3
Healthcare Inspectorate Wales (HIW)/2024/185	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	14.04.2024	**Diagnostics, Therapies, Pharmacies and Specialities** Sharon O'Brien	Lyida Thomas, Head of Quality & Patient Safety	17	17

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.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	**National review of Ophthalmology Services**	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		**Overdue**	April 2024 Update - DCHW-led rollout of OpenEyes still delayed, possibility of reopening tender process. OE contract with CTM in place until at least Jan 2025 (currently only Glaucoma clinics live). CTM OpenEyes Business Project Manager no longer in post (contract not renewed past March 31st), significantly impeding further rollout of OE in hospital sites as no defined support/project management. Live trial of OpenEyes in 4 glaucoma community optometry practices ongoing. National DCHW-led rollout of e-referrals also delayed, but local work ongoing to establish single inbox for email referrals from primary care into Ophthalmology. Inbox monitoring rota being established, timeline for launch dependent on primary care NHS email roll out below but expected to be live by August 2024. CTM keen to promote roll out of M365 with community optometry practices following successful pilot - provided DCHW with priority list (focusing on practices involved in shared care/WGOS4) during their rollout of NHS email (rolling out April-Aug). Previous Updates - Stage 1 – to be completed by March 2023. Stages 2 & 3 – BC dependent – objective is to start implementation in first half of 2023/24. December 2023 Update (Date of review: 12/12/23) - Roll out of Open Eyes has been delayed nationally, with CTM & C&V the only 2 HBs live with EPR for glaucoma in hospitals. The programme plan was to implement glaucoma EPR in all hospital sites nationally as stage 1, e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialties in Ophthalmology as stage 3; the timeline has been delayed with host changeover from C&V to DHCW. OpenEyes implemented in CTM hospital glaucoma clinics since March 2023. Further work on admin training and integration with hospital digital systems (WPAS & CITO) ongoing. Primary Care have worked with the DHCW programme team to provide contact details for all optometrists requiring access/relevant training, currently focusing on national pilot of NHS email addresses for community optometrists (2 per HB to start) What next? By when? By whom?
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		**Fully complete (Awaiting approval)**	April 2024 Update - EPR/E-referral - see MD1/1. Implementation plan for rollover of shared-care services to new WGOS4 pathways submitted to WG, with cross-sector discussion meeting planned 20/5/24. Once ratified, communications sessions & newsletter to update primary care optoms on changes will be delivered, as will updated patient service signposting. Dec 23 Completed - new optometry contract phased implementation began Oct'23 2- implementation of EPR across HB remains an ongoing process Dec 23 update The new national optometry contract will promote fuller conversations between patient and optometrist during WGOS service assessments, with optometrists [as part of the patient assessment]explaining how risk behaviours can effect their eye health and also enable practitioners to signpost patients to alternative services where required. EPR is already established within glaucoma clinics within HES . HB is working with national digitalisation programme to launch EPR system across primary and secondary care as a matter or urgency Actions 1. the national contract will be monitored monthly by primary care teams on an ongoing basis as part of the new contract arrangements. 2- the primary & secondary care staff will continue to engage with the national programme/DHCW to support implementation within the HB.
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		**Fully complete (Awaiting approval)**	Completed: all schemes are now established within CTM April 2024 Update - Ongoing pathways continue to monitor under existing shared-care agreements during the WGOS transition phase. Improved data sharing between secondary and primary care re: patient outcomes within these pathways being scoped. Insufficient admin resources within HES team a significant challenge for this. Currently 1.5wte Band 3-5 admin support committed to these pathways (1.0wte Band 3 post vacancy imminent, but recruitment to replace agreed) further admin support necessary to scale up pathways. WG to identify regional Planned Care Board leads to signpost secondary care to potential funding to support WGOS delivery. New HB-wide glaucoma referral refinement pathway being designed, to be live by Oct '24. Dec 23 update Data for these schemes are reviewed monthly on an ongoing basis by the primary/secondary teams and pan HB team/practice meetings are held regularly to review schemes. All schemes will begin to fall under the new optometry contract through phasing in of new contract / WGOS and monitored by primary care.
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		**Fully complete (Awaiting approval)**	April 2024 Update - ACD engagement successful across HB, HB protocol for managing failure to engage being ratified. Local discussion sessions with primary care optometry practices to be delivered once pathway changes finalised over next few months, with newsletter updates. Quarterly ECCG in progress following reinstatement in Dec '23 (next meeting May '24). Monthly cross-sector WGOS planning/implementation meetings between primary & secondary care teams for both Glaucoma and Medical Retina also taking place. Dec 23 update newsletters will continue to be sent to practices via primary care team regarding updates and new referral pathways. There will be ongoing engagement with practices due to the implementation of new contract/WGOS services and communication sent to relevant services i.e. GMS/pharmacy/secondary care on any relevant changes. Most practices are now engaged with ACD under the new contract obligations and work will continue to engage with those practices not yet engaged. HB ECCG will be the platform for primary care to share updates with secondary care on new contract/WGOS.
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		**Fully complete (Awaiting approval)**	Dec 23 update the review of quality referrals sent by optometry practices will be an ongoing process
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		**Fully complete (Awaiting approval)**	April 2024 Update - Complete. Dec 23 update this is done by the admin staff across the HB in order to ensure that optometrists are kept up to date with patients status within HES. This will be an ongoing process by the service manager to ensure that when a patient is referred by the optometrist that a copy of the clinic correspondence is sent to them for information. All new starters to be informed of the process.
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		**Fully complete (Awaiting approval)**	Dec 23 update this will be an ongoing process. Optometry Advisors will continue to work with both practices and HES to ensure the submission of high quality referrals. Implementation of the EOR system will also support /improve referral process.
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		**Overdue**	April 2024 Update - EPR rollout delays. December 2023 Update (Date of review 12/12/23) See Item 1What next? By when? By Whom?
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	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	April 2024 Update - Additional SLT (glaucoma laser procedure) leaflet being designed, along with procedure counselling guidelines from Glaucoma consultant team, to improve patient experience and laser clinic flow/efficiency. To be discussed in clinical audit meeting in June. Plan for reinstatement of local Glaucoma Patient Education Forums included in business case for potential Glaucoma Diagnostic Hubs at YCC/MCH. Dec 23 update Date of review: 03/08/2023 What next? The health board has a comprehensive selection of patient information leaflets available. In order to ensure that these meet the needs of our patients, these leaflets need to be well stocked and updated nationally through the EIDO programme to ensure that they reflect best practice. Objective to be discussed at directorate meeting to raise awareness to both clinicians and nursing staff about supplying patients with information during their clinical consultations. By when? Weekly review of leaflet stock within clinical area. Objective to be discussed at directorate meeting on 8th August 2023 By whom? Service Manager / Senior Nurse to cascade information to team. Information gathered from the clinical teams regarding what literature is available within the clinical departments. Objective to be discussed at directorate meeting to raise awareness of both clinicians and nursing staff supplying the patients with information during their clinical consultations.
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		**Overdue**	December 2023 Update (Date of review: 01/01/24) - What next? To continue to monitor the FUNB list across all sub specialties within ophthalmology By when on a weekly basis By whom service manager
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		**Overdue**	December 2023 Update - this will need ongoing review by the service manager to ensure that the most clinically urgent patients are booked with priority. Ongoing review by the service manager, this practice is currently undertaken in Bridgend but will need to be put into practice in all parts of the HB to ensure a pan CTM approach.
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 Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024		**Overdue**	December 2023 Update - this work will be ongoing to ensure lists re kept up to date and 'clean' at all times. Ongoing review by the service manager to validated and ensure correct ratio of new and follow patients in all clinic templates.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	**National review of Ophthalmology Services**	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024		**Overdue**	December 2023 Update (Date of review: 12/12/2023) - What next? Band 5 1.0 Vacancy not appointed in to - position being re-advertised on Trac. Position escalated to HON and CSGM to look for support in the short term. CSGM to determine if harm review team funding can be extended past March 2024 as the project is still ongoing. Macular cluster report due by 15/12/2023, good progressing being made towards this but absence of the Band 5 FLO support is stalling the work. By when? Closing date TBC for band 5 position. Awaiting feedback about alternate staffing to support in the short term. CSGM to feedback if funding can extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSGM September 2023 Update (Date of review: 03/08 /2023) - What next? Vacancies for harm review workforce are currently out to advert. An cluster RCA commissioning meeting is to be arranged within the next 2/52 regarding the macular service and the patients who have experienced moderate and above harm as a result of a follow up not being booked By when? to be reviewed in 2/52 with update. By whom? Senior Nurse. An SBAR for additional harm review workforce was submitted to Planned care recovery and funding was approved in July 2023 for 2 fixed term positions until the end of March 2024. These positions include 1 WTE Band 7 clinical investigator, 1 WTE band 5 governance support officer / family liaison officer. The workforce will be dedicated to support the legacy open NRI's from 2016-Feb 2022 from RTE, as well as the review all legacy and current open incidents under the Ophthalmology service. The workforce will be supporting any commissioned RCA's and will work closely with the clinical and administration teams in the review of action plans and learning from events. Date of review: 08/11/2023 What next? Band 7 1.0 Vacancy filled with 2 individuals job sharing and fixed term until the end of March 2024. Band 5 Investigation support officer currently in shortlisting phase - this role to act as the FLO for all, 2 candidates for interview, date TBC. CSGM to determine if funding can be extended further. By when? Interview for band 5 post to take place in the next 2/52. CSGM to feedback if funding can extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSGM.
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		**Overdue**	April 2024 Update - Eye drop instillation by unregistered staff in early implementation phase - nursing team signoff complete, in use. Further short term extension of 2x Band 7 0.1wte Specialist Optometrists providing significant clinic activity in Medical Retina - extended to 30/5/24 but urgent longer term/permanent extension required to maximise clinic output/booking. MDT GIRFT working group on pause following management changeover. Longstanding vacancies in Heads of Optometry and Orthoptic services - recruitment strategy in evaluation, as risk to service development without these posts. Further review is required / Action to be removed and replaced with a subsequent agreed action December 2023 Update (Date of review: 12/ 12 /23) - New clinical policy approved to allow for unregistered staff to instil eye drops, freeing up registered staff for more skilled tasks/faster clinic flow - implementation imminent. Optometry Department SBAR demonstrating value of workforce & need for expansion completed. Secured fixed term contract extension for 2 sessional optometrists supporting Medical Retina clinics for next Q (via VBHC), further extension required to maximise clinic planning. MDT workforce working group for GIRFT process due to start in Dec '23, tasked with evaluating non-medic workforce/skill mix and maximising use of MDT (to top of license). Optometrist role expansion into glaucoma laser delivery successful (training, signoff & SOP complete) - SLT WL reduced to 12/52. What next? By when? By whom?
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		**Overdue**	April 2024 Update - HES training/consultant mentoring for higher qualifications for community optometrists (to allow them to deliver enhanced services) in progress, with joint co-hosting with Cardiff University. 5 CTM consultants currently agreed to provide mentoring services over 2024/25. HEIW funding for administrative placement co-ordinator secured, to be advertised asap. December 2023 Update (Date of review: 12/12/23) - Community optometry completed funded academic course successfully, placement pending 2024 (delayed due to consultant workload). Community optometry post-grad placements widely delayed due to HES workload/lack of funding - Joint collaboration with Cardiff University to co-host placements in 2024, reducing time intensive burden on hospital site. Funding request for admin placement co-ordinator role submitted to HEIW. AMD community scheme live (June 2023), running well with consultant feedback. What next? By when? By whom?
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		**Overdue**	April 2024 Update - CD attending national CIN meetings, to develop regional strategies/shared learning. December 2023 Update - No update received.
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		**Overdue**	December 2023 Update - No update received.
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		**Overdue**	December 2023 Update - No update received.
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 collaboration and directorate meeting.	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	Complete 01/12/2023 Dec 23 update Date of review: 12 / 12 /23 ECCG re-established as of 1/12/23, regular directorate meetings ongoing What next? By when? By whom?
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		**Overdue**	April 2024 Update - CTM Optometry co-authored WG white paper on role of Hospital Optometry in NHS Wales, with specific recommendations on expanding the Welsh hospital optometry workforce and establishing a Hospital Optometry Forum in Wales. To be presented at CIN in May to identify potential resources to implement recommendations nationally, to be followed by local presentation by CTM Optometry at each HB's ECCG over next quarter, to highlight need to develop this workforce across Wales. CTM Optometry collaborated with WIRG, HEIW and ABUHB Optometry on development of UK-wide ESR updates for Optometry. New roles allowing for a defined career progression pathway for optometrists, and more accurate Areas of Work, Occupation Codes and Staff Group approved nationally by NHS Digital in March 2023, to be implemented UK-wide in the National Workforce Data Set June 2024. This will allow the optometry workforce to be more accurately captured by ESR across the NHS, aid in recruitment and offset workforce attrition for Hospital Optometry on a national scale. December 2023 Update (Date of review: 12/12/23) - Optometry SBAR detailing need for hospital optometry workforce expansion in size and clinical role completed. Funding secured from HEIW for 3 hospital optometrists to complete Higher Certificate in Medical Retina qualification (commencing March '24). Optometry-led laser service in situ in RGH, successfully brought laser WL down. What next? By when? By whom?
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		**Overdue**	April 2024 Update - GIRFT MDT working group on pause following management changeover. December 2023 Update (Date of Review: 12/12/23) - As above, await outcomes from GIRFT MDT workforce working group that will be reviewing the workforce. What next? By when? By whom?
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		**Fully complete (Awaiting approval)**	April 2024 Update - Good cross-sector representation at ongoing ECCG and local OLG meetings. Dec 23 update - Date of review: 12 / 12 / 23 4 shared-care schemes established with frequent cross-sector contact/consultant input/feedback sessions etc. Consultant Connect implemented for Glaucoma scheme (Nov '23) to allow community optoms direct access to Glaucoma team for advice & guidance. ECCG re-established 1/12/23 with good cross-sector collaboration and attendance. HB Optometry Liaison Group long established - continues bimonthly, with both primary & secondary care rep. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2020/136	10.12.2020	**Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]**	The health board must provide HIW with assurance that staffing levels are not currently impacting on the effectiveness of care being delivered to patients and that any changes resulting from the review into staffing establishments at the unit will help reduce the pressures faced on existing members of staff.	During the pandemic additional staff above the established levels for the unit have been agreed to support the pressures within the unit. However filling the shifts was problematic despite agency and bank requests being made to staff bank 6 weeks in advance. The fill rates; October 2020; 64% equivalent to 155 shifts filled and 86 shifts remain unfilled. November 2020; 62% equivalent to 131 shifts filled and 79 shifts remained unfilled. Every effort is made to fill the shifts by offering staff overtime at enhanced rates as agreed by the Health Board. The sickness levels for the unit are robustly monitored; December 2020 9.1% January 2021 10.2% February 2021 6.37% The team are hopeful with the reduced pressures from the pandemic that the sickness trajectory will continue to improve. CDU staffing establishments have been agreed for the 24 bed ward with the GP assessment area being managed separately. Posts have been filled with staff members commencing March 2021 the remaining vacancy rate will be 0.34WTE. In response to the pandemic and high acuity levels within the hospital the surge capacity within CDU has been utilised in line with the escalation policy, the use of these additional 4 beds is being monitored. Continuous quality monitoring continues through the use of a number of systems inclusive of ward based assurance audits, Datix incident reporting, Serious Incidents and patient feedback (complaints/complements). The data is triangulated and continues to indicate that there is no increase in harm or compromised care for patients.	Unscheduled Care	01.03.2021		**Fully complete (Awaiting approval)**	February 2024 Update - Complete - 14 February 2024 post Covid -19 and remodelling of services in PCH. The unit remains a 24 bedded unit with the same establishment, current vacancies 2.37 wte RN and 2.22 HCSW, the Band 7 is 100% supernumerary. 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.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	February 2024 Update - Complete 14 February 2024 post Covid-19 and remodelling of services and nursing structure-Point of Care audits have been replaced with monthly AMaT (Audit, Management and Tracker) as well as unannounced formal audits undertaken by the IPCT. To date the Environmental audit is between 94.6% and 100%. The Head of Nursing chairs the monthly acute services IPC meeting, whereby exception reports are completed by the Senior Nurse and KPI's are monitored closely. Where any deterioration in trends may be identified, targeted work is undertaken with the MDT to maintain and sustain the standards expected. IPC training of the MDT is integral to the improvement work and is monitored via the 6 weekly Workforce and Business meetings. Currently IPC Level 2 for RN=84.6%% and 72% HCSW xxxx%. ANTT RN= xxxx% . 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		Fully complete (Awaiting approval)	February 2024 Update - Complete - 14 February 2024, PDR compliance is 91% for the nursing team and this is monitored via the 6 weekly Workforce and Business meeting and clearly aligned to the nursing staff training plans.
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	**Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]**	The Health Board should ensure that the policy for infection, prevention and control is reviewed.	To present the new IPC strategy to the next IPC Committee meeting in October 2020 for approval, then for sign off.	Primary Care & Community	01.12.2020		Overdue	IPC strategy to be presented at the July 2023 IPC Committee meeting for approval.
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		Overdue	Escalation plan developed and out for consultation.
Healthcare Inspectorate Wales (HIW)/2021/135	20.04.2021	**Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]**	The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure future compliance with mandatory training.	85% of applicable staff groups will be fully compliant with mandatory training in PMVA, ILS/BLS and Fire training. Progress towards this target and future training compliance rates will be managed using ESR and monitored through line management arrangements. Deviation from the proposed improvement trajectory and failure to maintain the target levels of compliance will be escalated at Clinical Service Group Performance Review meetings. Mandatory training compliance to be included as a standing agenda item during line management sessions. Compliance to be reported on and monitored in the Clinical Service Group (CSG) Workforce and Organisational Development meeting and ILG Performance Review meeting.	Mental Health & Learning Disabilities	10.07.2021		Fully complete (Awaiting approval)	Partially Complete. • Training plan was instigated with trajectory for 85 % compliance by 10 July 2021. At time of reporting (10/7/21) compliance is April 21 July 21 ILS 6% ↑64% BLS 0% ↑38% PMVA – Mod D 20% ↑73% PMVA Mod A/B – 41% ↑87% PMVA Mod C 8% ↑67% Fire 50% ↑87% Covid risk assessment 46% ↑80% • PMVA mod A/B&C is time intensive training (6 hours per person) and clinical pressures have delayed completion. Additional pay has been used to release capacity to ensure 85 % compliance by 10th August 2021. • BLS attendance has been impacted by availability of training sessions with ward based model now established to address
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - CTP training programme has been amended to include a stronger emphasis on relapse indictors, contingency plans and crisis plans when required. Example formats are provided and discussed and again making such plans individual and person centred is reinforced. CTP lead has been targeting teams PAN CTM to improve attendance at the training sessions. This has proved to be effective with generic sessions circulated yielding poorer attendance. CTP audit in place and monitoring in place. April 2024 Update - Evidence being collated. Due for closure and ratification by MH&LD QRSE June 24.
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - CTP training programme has been amended to include a stronger emphasis on relapse indictors, contingency plans and crisis plans when required. Example formats are provided and discussed and again making such plans individual and person centred is reinforced. CTP lead has been targeting teams PAN CTM to improve attendance at the training sessions. This has proved to be effective with generic sessions circulated yielding poorer attendance. CTP audit in place and monitoring in place. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24.
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Please note this work was superseded by the rollout of 111(2) completed in April 2023 Action updated as at May 2024 - This work has been superseded by the roll out of 111#2 since April 23 in CTMUHB, providing a single point of access for citizens across the health board. Following triage of need, an agreed set of pathways are in place to ensure assessment is provided within given timeframes based on clinical need. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
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	Revised Due Date November 2024	Partially complete	June 2024 Update - Partially complete, but with outstanding work. Complete by August 2024. Action updated as at May 2024 - An initial meeting was set up between MH and PC AMD to discuss this but meeting did not take place. Ongoing communication between MH&LD MD and PC MD is in place to establish which existing forum this work can best sit to ensure action. Mitigating Actions Dedicated lithium and clozapine clinics are in place across adult and older adult CMHTs that have a consistent standard and ensure follow-up for patients who do not attend. There is an offer of physical health monitoring in all adult and older adult CMHTS. Improving the physical health of people with severe and enduring mental health problems is a priory of the MH&LD Care group, and a Physical Health Monitoring Group reporting through QSRE governance structures is in place. April 2024 Update - Partially complete, but with outstanding work. Complete by August 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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action update as at May 2024 - In Bridgend an ICF scheme implemented 3 RMNs managed by the GP cluster networks. Funding secured funding 2 of the posts substantially. Advertising shortly. Professional supervision provided by MH&LD Mental Health Practitioners are in Community Health and Wellbeing Teams in MC and RTE, additionally the TE cluster have funded x2 band 6 MHP posts within the TE area – this is due to end in March 24: awaiting feedback from the cluster development manager about future funding. Primary care professions are able to access timely advice and referral options via 111#2 professional line. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - In addition to the development of RMHN in GP surgeries to aid timely specialist advice, Consultant Connect is available. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - The roll out of 111#2 since April 23 in CTMUHB has provided a single point of access for citizens across the CTMUHB region. The professionals' line is available to colleagues in arrange of services, including PC; third sector; SWP and WAST. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24 Completed April 2023
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - Analysis completed with recommendations of extension to 3rd sector coordinator roles, but challenging to make firm conclusions around need at that time. Improved data sharing processes to GPs following crises assessment: -Bridgend Crisis Assessments and/or discharges trigger an emailed notification to GP within 24 hours/ next working day. -111(2) assessments are documented on Adastra, which is shared with relevant GP practices at the end of every working day -RTE and MC CRHTT and MHLTs have an information sharing process in place to ensure clinical and risk assessments are shared with GPs. -Ongoing pilot in RTE to ensure follow up with GP practice RMHN following crisis assessment (where no ongoing input). April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action update as at May 2024 - Funding of the development of three MH development officers was established and employed via CVCs. There are quarterly provider & commissioner meetings take place between CTMYHB and third sector. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action update as at May 2024 - A single point of access is available into CTMUHB mental health services for citizens across the CTMUHB region via the 111#2 service. Following triage of need, an agreed set of pathways are in place to ensure assessment is provided within given timeframes based on clinical need. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24 Complete April 2023
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action update as at May 2024 - As outlined above, MH practitioners are embedded in RTE and MC GP clusters. RTE cluster has also invested directly in two posts. Bridgend cluster has developed two posts that will be professionally managed within the MH&LD care group. Regular reports of activity are collated. April 2024 Update - Complete. Collating evidence and due for ratification in MH&LD QSRE June 24

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - This work has been superseded by the roll out of 111#2 since April 23 in CTMUHB, providing a single point of access for citizens across the health board. Following triage of need, an agreed set of pathways are in place to ensure assessment is provided within given timeframes based on clinical need. The professionals line is well used by SWP and WAST. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24 Completed April 2023
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QRSE June 2024. Action updated as at May 2024 - The MH&LD Care Group has worked with third sector partners to develop a website to promote local third sector services. The Website went live Q2 2022.Regular analytic reports are received to monitor most and least visited pages. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24 Completed January 2023
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - The roll out of 111#2 since April 23 in CTMUHB has provided a single point of access for citizens across the CTMUHB region. The professionals' line is available to colleagues in the third sector. Colleagues in the third sector are also able to support people to contact 111#2 directly. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24 Completed April 2023
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - The roll out of CTMUHB 111#2 in April 2023 has provided a single point of access for citizens across the CTMUHB region The professionals line is available to colleagues in arrange of services, including PC; third sector; SWP and WAST. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24 Completed April 2023
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - As outlined above, MH practitioners are embedded in RTE and MC GP clusters. RTE cluster has also invested directly in two posts. Bridgend cluster has developed two posts that will be professionally managed within the MH&LD care group. Regular reports of activity are collated. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - A Sanctuary was established in Bridgend in 2020, in partnership with Mental Health Matters. The MH&LD care group is working on the development of further sanctuary services within its transformation portfolio of work. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. Action updated as at May 2024 - The identified money was not allocated as planned as it was not felt that there was enough stability across the local CVC to collaborate well at that time. There has instead been a focus through existing contracts / organisations and the regional suicide group on men's mental health. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	**Quality Check Summary Pinewood House [Pinewood House - Quality Check]**	The health board must provide assurance on how it will meet principle nine outlined by the Chief Nursing Officer for Wales for at least two registered nurses to be rostered every shift, or if determined as not necessary, that there must be the ability to deploy a second registered nurse without delay.	Undertake a review of the night time staffing resource across the rehabilitation service in CTM and develop an options appraisal to address the risk of one registrant by night.	Mental Health & Learning Disabilities	30.11.2021		Overdue	October 2023 Update (Date of Review: 20/10/2021) - Further to discussions with the Head of Mental Health Nursing it has been advised that that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however, continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times.
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		Overdue	October 2023 Update (Date of Review: 14/10/2021) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&D department: 1) Review hierarchy lists; 2) Ensure Group alignment numbers are correct; 3) Look at appropriate required compliance and accurate records and L&D department will take forward to the subject experts on teams' behalf. Regular meetings with new L&D representatives to address and correct the issues associated with core mandatory training compliance.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	**HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maestee 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		Fully complete (Awaiting approval)	
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 (Maestee 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 (Abilify 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		Fully complete (Awaiting approval)	
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 (Maestee 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		Fully complete (Awaiting approval)	
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 (Maestee 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		Fully complete (Awaiting approval)	
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 (Maestee 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		Fully complete (Awaiting approval)	
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 (Maestee 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		Overdue	Medical staff booked in to attend 'Safeguarding People
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 (Maestee 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		Fully complete (Awaiting approval)	
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 (Maestee 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		Fully complete (Awaiting approval)	
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 (Maestee 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		Fully complete (Awaiting approval)	
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 (Maestee 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		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	**Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]**	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	Revised Completion Date 01/09/2023	Overdue	September 2023 Update - new consultant appointments enable 2 sessions of elective work to be staffed by consultant obstetricians. Awaiting 1st consultant to agree job plan 18.09.23 to commence one session a week, moving to 2 session in January 2023.
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		Overdue	September 2023 Update - recent concern from PCH identifies that learning and improvement is still required in this area.
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		Overdue	September 2023 Update - The stamps are available to all clinicians, the review of the annual record keeping audit will be completed and presented by CSfM team in November 2023 meeting.
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		Overdue	September Update (Date of Review: 08/09/23) - email sent to Medical Director of care group for advice on how to progress this recommendation.
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		Fully complete (Awaiting approval)	Sept Update - 8.9.23 email sent to OH lead to advice on progress with this recommendation. Email response from Nicola Bevan - OH Lead giving assurance. The Occupational Health service has successfully recruited into the long-standing vacancies within the service and are due to be fully established by end of September 2023. The previous substantive OH Consultant retired in April 2023 and a new provider has been procured providing two clinics per week plus 5 day clinical support if required. A new OH Physiotherapy template has also been developed to ensure there is sufficient capacity within the service to deliver the full range of Occupational Health Physiotherapy activities. As a result, the waiting times within the department have significantly reduced. In October 2023 CTM Occupational Health Service will be transitioning to a new OH software system as part of an All Wales Occupational Health initiative. One aspect of the new system will introduce an online management referral system which will improve the quality of the referrals and the communication mechanisms between managers and Occupational Health, which will increase transparency and allow the manager to monitor the progress of the referral-Action reviewed by Head of Midwifery (SF) and update to a closed and complete action.
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	Revised Completion Date 01/10/2023	Overdue	September Update (Date of Review: 08/09/23) - email sent to care group's People's Services Lead to advice on progress with this recommendation.
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	Revised Completion Date 01/10/2023	Overdue	September 2023 Update - incident report monitored by executive team. Timely review and closure for moderate harm and above incidents but low and no harm process requires further reviewing and dedicated allocation of time.
Healthcare Inspectorate Wales (HIW)/2022/132	26.09.2022	**Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]**	The health board must ensure that they obtain UNICEF reaccreditation.	Social media, weekly feeding post (appendix 1) BFI standards audit (appendix 2) BFI gap analysis (appendix 3) Recruitment of 0.4wte infant feeding midwife to support community midwifery Dashboard breast feeding data and 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		Overdue	Assessment for accreditation for UNICEF Baby Friendly to be completed by October 2023. Update 28.03.23 Assessment confirmed for December 2023. All staff will have attended 1 day update by September 2023, overseen by Infant feeding Coordinator (Maternity) - Sept 2023-Pre assessment audit completed and advised by UNICEF BFI to postpone for 3 months to drive further improvement in practice. New specialist midwife commences role 18.09.23 (vacant role for 3 months)
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	01.02.2023	Revised Completion Date Autumn 2023	Fully complete (Awaiting approval)	New record keeping audit due to be commenced Autumn 2023 - Sept Update - added to annual record keeping audit sept 23-24. Email advice from service pharmacist 7.8.23 to advise of correct prescribed method for obstetricians as requested

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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	01.02.2023		Fully complete (Awaiting approval)	Draft report received April 2023 Sept Update-CTMUHB Birth-rate plus report 2023 has been agreed by DOM and recommendations around actions will be presented to executive team in October 23
Healthcare Inspectorate Wales (HIW)/2022/133	17.10.2022	**Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]**	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Plan to work with corporate nursing team to review options of creating a digital solution for audit surveillance and daily checks to further improve oversight of status.	Unscheduled Care	01.02.2023		Overdue	June 2024 Update - We have progressed towards standardised audits on AMaT across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved. July 2023 Update - Working across CTM to ensure standardised audits are implemented.
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		Overdue	June 2024 Update - We have progressed towards standardised audits on AMaT across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	**Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton 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		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. See Appendix 9 for all estates issues and progress
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	**Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton 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		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	**Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton 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		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	**Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton 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		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	**Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton 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		Fully complete (Awaiting approval)	Sept Update-Action complete July 2023 Update-Outcome Measures working group established. Additional outcome measures training day arranged for 01/08/2023 with PHW. Appropriate OMs identified.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	**Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)**	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	The oversight of this recommendation will be via the High Quality Records Work stream.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE. September 2023 Update - Lead Nurses to meet on 18/09/2023 to review work streams and action progress. Further updates will be provided following this meeting for all actions relating to the Discharge Review.
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		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	Dec 23 update - Completed during 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 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		Fully complete (Awaiting approval)	Dec 23 update - Completed during 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 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 Work stream.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
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		Fully complete (Awaiting approval)	
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	Revised Due Date 31/01/2024	Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE. February 2024 Update - WARNN compliance 69% There is an expectation that 85% training compliance is achieved by next Improvement Board 27/02/2024. December 2023 Update - Compliance for WARRN Risk Assessment training is at 68% as at 24/11/23
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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 Work stream.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	Dec 23 update Completed during 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 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		Fully complete (Awaiting approval)	Dec 23 update Completed during 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 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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	February 2024 Update - Completed
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		Fully complete (Awaiting approval)	February 2024 Update - Completed
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		Fully complete (Awaiting approval)	February 2024 Update - Completed
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		Fully complete (Awaiting approval)	February 2024 Update - Completed
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		Fully complete (Awaiting approval)	February 2024 Update - Complete - Manual Audits to be undertaken until audit can be digitalised.
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		Fully complete (Awaiting approval)	February 2024 - Completed
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		Fully complete (Awaiting approval)	February 2024 Update - Completed
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		Fully complete (Awaiting approval)	February 2024 - Completed
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		Fully complete (Awaiting approval)	February 2024 - Completed
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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 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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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 Work stream will develop standardised discharge communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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 work streams 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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE. February 2024 Update - Reorganisation of MHLD Care Groups has commenced with shadow directorates from 01/02/2024. December 2023 Update - Reorganisation of the MHLD Care Group in progress.
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		Fully complete (Awaiting approval)	February 2024 - Complete
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	Revised Completion date 21/11/2023	Fully complete (Awaiting approval)	February 2024 Update - Complete
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	Revised Completion date 21/11/2023	Fully complete (Awaiting approval)	February 2024 Update - Complete
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	February 2024 Update - Revised completion date 27/02/2024, 69% Currently. December 2023 Update - WARRN Risk Assessment Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24
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	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	February 2024 Update - Current compliance 81% Revised completion date 27/02/2024. December 2023 Update - PMVA Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24
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	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	February 2024 Update - Current compliance 70% Revised completion date 27/02/2024. December 2023 Update - Information Governance Training compliance as at 24/11/23 is 81% Revised completion date to 31/01/24.
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	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	February 2024 Update - Current compliance 81% Revised completion date 27.02.2024
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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 Work stream.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
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		Fully complete (Awaiting approval)	
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 Work stream will develop standardised approaches for recording multi-disciplinary meetings across the Care Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
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 work streams 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		Fully complete (Awaiting approval)	February 2024 Update - Complete December 2023 Update - Reorganisation of the MHLD Care Group in progress.
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 Work stream 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		Fully complete (Awaiting approval)	
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 Work stream 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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	December 2023 Update - Audit tool developed but not yet digitised. Manual audit to be undertaken until audit can be digitised. Completed during this period.
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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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 Work stream 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		Fully complete (Awaiting approval)	
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 work streams 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		Fully complete (Awaiting approval)	
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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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		Fully complete (Awaiting approval)	February 2024 Update - Complete
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 work streams 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		Fully complete (Awaiting approval)	February 2024 Update - Complete
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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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 Work stream will develop standardised discharge recording and communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
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 work streams 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		Fully complete (Awaiting approval)	February 2024 Update - Complete
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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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 Work stream. The work stream 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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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		Fully complete (Awaiting approval)	February 2024 Update - Complete
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 Work stream. 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		Fully complete (Awaiting approval)	December 2023 Update - Completed during 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 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	Revised Completion Date 15/03/2024	Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE. February 2024 Update - Revised completion date 15/03/2024. December 2023 Update - Revised completion date. Revised timescale refers to the ratification of the new S140 policy.
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 Work stream. See response to recommendation 15	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
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 Work stream. 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 work stream and the Rehabilitation Programme.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
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 Work stream. 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 Lidiard whilst recognising that the wider care group has additional challenge in terms of scale and complexity.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
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 Work stream 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		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
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		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
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 Work stream 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		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
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 Work stream 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		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		**Overdue**	June 2024 Update - Progress to date: In-Patient Matrix devised for all in-patient and rehab units to mitigate risk of inability to access/share current patient information Matrix supports ward staff in and out of hours and gives staff contact numbers of who to contact should the patient come from another locality where a different clinical system is being used. This allows current information to be accessed/shared timely. February 2024 Update - It has been decided that WCCIS would no longer be the system implemented and that the Health Board are exploring two system options whilst awaiting a National Solution. December 2023 Update - Status relates to the Implementation of WCCIS Update to be provided to HIW 31/01/1024 The Health Board is working closely with Digital Health and Care Wales and other Health Boards in relation to implementation. However, in light of implementation challenges faced by another Health Board, discussions at a national level are ongoing in relation to the preferred digital solution to a unified patient clinical record system.
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 will start in July/ August 23 chaired by MHLD Service Director and IT/ Digital Senior manager. WCCIS Implementation Plan timescales for MHLD to be refreshed and presented to WCCIS workshop on 15th June 23.	Mental Health & Learning Disabilities	30.06.2023		**Fully complete (Awaiting approval)**	
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 Work stream 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		**Fully complete (Awaiting approval)**	WCCIS implementation aim end 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 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 Work stream. As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Work stream 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		**Fully complete (Awaiting approval)**	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
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 work stream and Safe Discharge work stream 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		**Fully complete (Awaiting approval)**	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
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		**Fully complete (Awaiting approval)**	
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 Work stream 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		**Fully complete (Awaiting approval)**	
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 work streams 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		**Fully complete (Awaiting approval)**	Reorganisation of the MHLD Care Group in progress
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 work stream , 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		**Fully complete (Awaiting approval)**	
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 Work stream 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		**Fully complete (Awaiting approval)**	
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	Revised Completion Date 21/11/2023	**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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	Revised Completion Date 21/11/2023	**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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		**Fully complete (Awaiting approval)**	June 2024 Update - Approved by QSC & QSRE.
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		**Fully complete (Awaiting approval)**	February 2024 Update - Complete
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		**Fully complete (Awaiting approval)**	February 2024 Update - Complete
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		**Fully complete (Awaiting approval)**	February 2024 - Complete
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		**Fully complete (Awaiting approval)**	February 2024 Update - Complete
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		**Fully complete (Awaiting approval)**	February 2024 Update - Complete
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		**Fully complete (Awaiting approval)**	
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		**Fully complete (Awaiting approval)**	February 2024 Update - Complete
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		**Fully complete (Awaiting approval)**	
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		**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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 Work stream will provide solutions for the monitoring of discharge follow up by community teams using different record systems.	Mental Health & Learning Disabilities	30.06.2023		**Fully complete (Awaiting approval)**	
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 Work stream.	Mental Health & Learning Disabilities	30.06.2023		**Fully complete (Awaiting approval)**	June 2024 Update - Approved by QSC & QSRE.
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		**Fully complete (Awaiting approval)**	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
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		**Fully complete (Awaiting approval)**	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
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		**Fully complete (Awaiting approval)**	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
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		**Fully complete (Awaiting approval)**	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
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		**Fully complete (Awaiting approval)**	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
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		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
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 Work stream. The PCH Crisis Assessment Space is now operational within PCH Emergency Department.	Mental Health & Learning Disabilities	30.09.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE. February 2024 Update - Discussed in Improvement Board Meeting 23/01/2024. Lead Nurse tasked to provide an update at next meeting 27/02/2024. December 2023 Update - Capital works in PCH are ongoing. The Care Group is working closely with colleagues at Prince Charles Hospital as part of the estates planning processes and to implement a substantive arrangement for crisis assessment. Capital works in PCH are due to be completed end of January 2024 which will give the care group opportunity to access to dedicated space in PCH ED. May 2023 Update - Please note this timescale is for the medium term solution. An update on substantive arrangements will be provided 30 Sept 2023.
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		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	Status relates to the substantive arrangements for unscheduled/crisis assessment in PCH
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 Work stream 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 mitgants and escalation.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
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 work stream and Safe Discharge work stream 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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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 work streams 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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	February 2024 - Reorganisation of MHLD Care Groups has commenced with shadow directorates from 01/02/2024. December 2023 Update - Reorganisation of the MHLD Care Group in progress.
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		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
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		Fully complete (Awaiting approval)	
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. Work streams 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		Fully complete (Awaiting approval)	
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%) Speciality Doctor26(100%)11 (42%)13 (50%) While there are at present significant rates of vacancy across the MH medical workforce, the Care group is successfully maintaining a cohort of Locum Doctors as a mitigating measure while the recruitment and retention programme scales up. At present (June 2023) the Care Group Medical Director is assured that there are locum doctors covering all vacant substantive posts " In addition the Medical Workforce Productivity Group has agreed timescales for delivery of actions within the Recruitment and retention; Unplanned care & Diverse workforce Work streams.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
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		Fully complete (Awaiting approval)	
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		Fully complete (Awaiting approval)	
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 Work stream.	Mental Health & Learning Disabilities	30.09.2023		Overdue	
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 work stream will review current facilities and scope out potential new areas and facilities. Whilst the work stream is further developing the OT team have been provided with temporary arrangements for therapy space, which has enabled them to continue to deliver the service, with reduced numbers for group sessions."	Mental Health & Learning Disabilities	30.09.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed 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 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		Overdue	
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 Occupational Therapy workforce is at full capacity and as such is able to meet demands for assessment, treatment and review that are presented on the Adult inpatient units.	Mental Health & Learning Disabilities	31.03.2024		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
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		Fully complete (Awaiting approval)	February 2024 Update - Consultant Clinical Psychologist is leading on this action from a psychological therapies perspective and the recommendation is on track to be completed by 31/03/2024.
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		Overdue	
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		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period - 8c Clinical Psychologist Adult Inpatient Lead commenced in post from October 2023
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		Overdue	
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		Overdue	
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		Fully complete (Awaiting approval)	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		**Overdue**	
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 Work stream. Please refer to the response to recommendation 8.	Mental Health & Learning Disabilities	31.08.2023		**Fully complete (Awaiting approval)**	February 2024 Update - Complete
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 work streams a full training needs analysis will be completed to identify further opportunities for skills development.	Mental Health & Learning Disabilities	31.08.2023		**Fully complete (Awaiting approval)**	
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	Revised Completion Date 31/10/2024	**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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		**Fully complete (Awaiting approval)**	
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		**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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	31.05.2024		**Fully complete (Awaiting approval)**	
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 Work stream. 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		**Fully complete (Awaiting approval)**	February 2024 Update - Complete
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		**Fully complete (Awaiting approval)**	
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		**Fully complete (Awaiting approval)**	
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		**Fully complete (Awaiting approval)**	June 2024 Update - Approved by QSC & QSRE.
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		**Fully complete (Awaiting approval)**	December 2023 Update - Completed during this period. Manual audits are being undertaken until audits can be digitised.
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	Revised Completed Date 21/11/2023	**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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		**Fully complete (Awaiting approval)**	
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 Terms of reference at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024		**Overdue**	June 2024 Update - Though all policies and procedures are now under review by the expert groups, the changes caused by the restructure is causing added complication as teams and services and moved and merged across locality (e.g. MH Liaison SOP). February 2024 Update - Remains in progress December 2023 Update - The HB has revised its process for the ratification of policies which will lead to more timely ratification and will enable all policies and procedures to be ratified by 01/06/24. There are 39 expired MH policies/ procedures. These have been prioritised for updates. The Mental Health Policy Review Group will monitor this review schedule at each meeting. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy.
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		**Overdue**	
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		**Fully complete (Awaiting approval)**	
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 performance arrangements. The Head of Quality and Safety will lead an operational care group governance meeting to monitor compliance with Putting Things Right, action plans and risk review timescales. Agenda item in performance meeting at senior nurse level in order to encourage escalation and culture of owning risks and mitigation as local level.	Mental Health & Learning Disabilities	30.11.2024		**Fully complete (Awaiting approval)**	
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		**Fully complete (Awaiting approval)**	December 2023 Update - Completed during 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 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	Revised Completion Date 31/10/2024	**Overdue**	February 2024 Update - Update from Business Intelligence Team that they have explored ways for a social worker to be able to access the incident module of Datix, however a solution has not been found. Action agreed: SOP to be developed to describe the process for feedback, learning and actions to be shared with social workers as applicable. Previous Update - The Mental Health Care Group is exploring a way for social workers to be able to report incidents directly through Datix with the Health Board Governance Team and ICT team. This has been delayed by issues with allowing non HB personnel access to HB and NHS systems and organisational changes to the CTM governance and Datix teams. In the meantime, a process for reporting and feeding back on social worker identified incidents in multi-agency meetings and so that learning can be shared will be implemented.
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		**Fully complete (Awaiting approval)**	
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 and 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		**Fully complete (Awaiting approval)**	
Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	**Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)**	The health board is required to provide HIW with details of the action taken to demonstrate suitable daily checks of emergency equipment have been conducted in accordance the health board's policy/requirements.	There is a plan to include the resuscitation trolley on the Health Board AMaT (Audit Management and Tracking) system, whereby it will be a requirement that the Lead Nurses in Unscheduled Care and planned Care undertake a 3 times weekly assurance audit that the checks have been completed.	Unscheduled Care	01.11.2023	Review Date - March 2024	**Fully complete (Awaiting approval)**	June 2024 Update - Complete. AMaT audit In place for assurance completed by Senior Nurses. February 2024 Update - The audit tool has been developed and awaiting final approval - Senior Nursing Leadership audit tool to provide the assurances of audits undertaken by the Ward/Department Managers. Partially Completed - review date March 2024 (AMaT tool awaiting final approval).

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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	Review Date - June 2024	Partially complete (Overdue)	February 2024 Update - CDU compliance ILS 40% (RN), BLS 68% and ED compliance ILS 43.75% , BLS 76%. It is important to note the RN's undertake ILS training and therefore BLS is not required - ESR Mandatory Training requires updating. Please note there has been 10 wte New Starters in the last 6 weeks, hence reducing the compliance rate - there is a plan to improve. Partially Completed – review date June 2024 (new recruitment has reduced trajectory of compliance-as described). Previous Update - 65% compliance aim November 2023 with 100% compliance February 2024.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	**HMP Parc Prison**	HMP Parc Prison to ensure Covid 19 swabs are performed in a timely manner.	All staff to be reminded of working within CTM COVID -19 guidelines alongside Public Health Wales advice. All staff to be reminded of the importance of providing / undertaking COVID 19 swabs when required in a timely manner	Primary Care & Community	31.05.2023		Overdue	September 2023 Update - No update received
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		Overdue	September 2023 Update - No update received
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		Overdue	September 2023 Update - No update received
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		Overdue	September 2023 Update - No update received
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 cantered care.	Primary Care & Community	31.10.2023		Overdue	September 2023 Update - No update received
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 work stream 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		Overdue	September 2023 Update - No update received
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		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/154	25.09.2023	**Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)**	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Maternity and Neonatal colleagues are piloting QR code system for checking resuscitation trolley. Children's ward plan to implement same. See further information below. Digitalisation of equipment checks presentation	Children & Families	30.11.2023	Revised Completion Date 03/03/2024	Fully complete (Awaiting approval)	April 2024 Update - The QR code daily resus checking is fully implemented on the children's ward in POW. Using the QR code has digitalised the record keeping making it easier to track, store and retrieve compliance data. December 2023 Update -By end Nov 2023.QR code still piloted in maternity. 6/12/23 Daily checks undertaken 100% November 23. Revised implementation date due to the ongoing pilot in of the QR code across a number of audits in PCH - A status review against the required action will be completed by the end of March 2024.
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	Revised Completion Date June 2024	Fully complete (Awaiting approval)	April 2024 Update - The QR code daily resus checking is fully implemented on the children's ward in POW. Using the QR code has digitalised the record keeping making it easier to track, store and retrieve compliance data. Patient safety audits continue on AMaT and compliance is reported monthly to CYP Patient safety and effectiveness group. In addition to this the daily resus trolley check is reported every morning and afternoon on the daily activity and acuity. December 2023 Update (Date of Review: 12/12/23) - As maternity colleagues continue with their pilot - Children's ward have established their own QR code .The CPD lead is responsible for ensuring staff are aware of how to record. This will be piloted in Paediatrics for 6 months commencing 1/1/24. Patient safety checks undertaken on AMaT audit monthly. Reported to patient safety and effectiveness group Implementation date revised until June 24.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	CTM UHB 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	Ongoing 2024/25	Overdue	Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	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	Ongoing 2024/25	Overdue	Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	Health boards 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	Ongoing 2024/25	Overdue	Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	Significant improvement work has been undertaken within the Unscheduled Care Group (USC) in relation to immediate release of emergency vehicles, with the introduction of the Cwm Taf Morgannwg Emergency Pressures Escalation Cards. These clearly outline triggers, escalations and actions. Since April 2023, there have been no refusals of immediate release request and the USC group continue to work in collaboration with WAST colleagues as part of the joint review process to review community delays that may have led to an adverse outcome in order to quantify harm and share learning.	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Achieved and ongoing
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	Ongoing	Overdue	
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	Ongoing	Overdue	
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	Ongoing 2024/25	Overdue	
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	des-24	Overdue	
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	2024/25	Overdue	Revised Due Date - In 2024/25 timescale dependent on resource availability Timescale In 2023/24-exact timescale dependent on resource availability

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	Health boards 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		Overdue	November launch. Full implementation 24-25.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	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	Ongoing	Overdue	
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	aug-24	In progress	Revised Review - August 2024. Ongoing implementation. Review - March 2024. Implementation October 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	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	jan-25	In progress	
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		In progress	
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	Ongoing targeted improvement	In progress	
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	Ongoing 2024/25	In progress	
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	Ongoing 2024/25	In progress	
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	
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	Ongoing, January 2025	In progress	
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	Ongoing, January 2025	In progress	
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		Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing.
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	Ongoing 2024/25	Overdue	
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	October 2024	Overdue	
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	Ongoing	Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing as workforce changes.
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	Ongoing 2024/25	In progress	
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	Ongoing	Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing.
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	Ongoing	Overdue	
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	Ongoing	Overdue	
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		Overdue	
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		Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing.
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	Ongoing 2024/25	Overdue	
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	Ongoing	Overdue	
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	Ongoing	Overdue	
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	Ongoing	Overdue	
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	Ongoing 2024/25	In progress	
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	Ongoing 2024/25	In progress	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	**National Review of Patient Flow - a journey through the stroke pathway**	Health boards 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		Fully complete (Awaiting approval)	June 2024 Update - Achieved and Ongoing cycle of improvement.
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		Fully complete (Awaiting approval)	June 2024 Update - Achieved and Ongoing.
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	Ongoing	Overdue	
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	Ongoing	Overdue	
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	Ongoing	Overdue	
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	Ongoing 2024/25	Overdue	
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	Ongoing 2024/25	Overdue	
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	Ongoing 2024/25	In progress	
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		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
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		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
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		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
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		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
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		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
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		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/156	25.09.2023	**Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]**	We recommend the health board review all relevant policies to ensure they are in line with current guidance	All Paediatric policies are available on Cwm Taf Morgannwg (CTM) SharePoint site. The Children and Young People Care Group (CYP) will re-establish a monthly policy-working group where policies will be reviewed to ensure they are in line with current guidance.	Children & Families	31.12.2023		Fully complete (Awaiting approval)	Updated HIW Improvement Plan (Appendix C) as at May 2024, Actioned April 2024 May 2024 Update - Lead Nurse for acute services has been leading group to cleanse and update guidelines and Standard operating procedures. This summer a new CTM SharePoint site will be launched to replace the current staff intranet. This will provide a more accessible platform for staff to access guidance. A flowchart is now available for the approval of new guidelines/policies. A quality assurance checking form has been developed to ensure robust governance prior to submission for approval. January 2024 Update (Date of Review: 04/01/2024) - Progress continues on Sharepoint. December 2023 Update (Date of Review: 06/12/23) - Reviews in progress April 2024. Review of all paediatric policies and procedures underway across CTMUHB. This is being cleansed on Sharepoint.
Healthcare Inspectorate Wales (HIW)/2023/156	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	Revised Due Date August 2024	Overdue	May 2024 Update - The above iteration was actioned December 2023- However the children's ward is currently undergoing refurbishment of the painting and decorating in the area new display boards are being purchased and the Health promotion elements of the action will be a priority on completion of the estates works. New timescales added. December 2023 Update - In progress 12/12/23 - Doctors have been assigned poster presentation for health promotion. Nursing staff completed this action Dec 2023. Health promotion boards on smoking cessation and healthy eating completed on health promotion board 31/12/23.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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 Angleton Clinic. This will be carried out in the Spring where plants and bulbs will be planted. The Angleton 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		Fully complete (Awaiting approval)	Action updated as at May 2024 - Completed 10/05/2024, see Appendix 8 In Progress Estimated Completion Date April 2024 See Appendix 1
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)**	The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Angleton 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		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 2
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		Fully complete (Awaiting approval)	Completed 28/1[2]/2023 See Appendix 3
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		Fully complete (Awaiting approval)	April 2024 Update - Ward 1= 92% Ward 2=91.18% Previous Update - In Progress Estimated date for completion January 2024 See Appendix 4
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 5a, 5b + 5c
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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 Angleton 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		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 6a + 6b

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 Appendix 7, 7a, 7b, 7c,7d, 7e, 7f,7g, 7h, 7i + 14
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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 Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 8a + 8b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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 Angleton 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		**Fully complete (Awaiting approval)**	April 2024 Update - CTM gardeners have completed work to the ward courtyards and will be routinely maintaining the areas. Previous Update - Completed 28/12/2023 See Appendix 8
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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 Angleton clinic to identify and address any additional maintenance issues.	A full environmental audit within Angleton Clinic will be completed to address and identify any further additional maintenance issues.	Mental Health & Learning Disabilities	01.01.2024		**Fully complete (Awaiting approval)**	Action updated as at May 2024 - Completed 10/05/2024, see Appendix 10a and 10b April 2024 Update - Environmental audit was undertaken of both wards and all environmental issues identified reported to estates and placed on the estates log. This is reviewed regularly and any outstanding issues escalated. Previous Update - In Progress. Estimated date for completion Jan 2024
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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 Angleton Clinic. Audit completed on AMAT, current compliance 85.3%	Mental Health & Learning Disabilities	28.12.2023		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 10
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 11a, 11b, 7e and 7f
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 12a + 12b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 13
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 7h + 14
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 15a +15b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 16
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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 Angleton Clinic has been put in place by the catering Lead to meet the nutritional standards and offer a variety of food for Angleton Patients.	Mental Health & Learning Disabilities	28.12.2023		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 18a,18b + 18c
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 22a + 22b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 18
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 21
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 22
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 7h + 23
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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	Revised Due Date 10/07/2024	**Overdue**	June 2024 Update - Working with Corporate and Patient Care Safety to align DATIX to new structure. Action updated as at May 2024 - Update10/05/2024 The Head of Nursing continues to work with the Datix team regarding this action. The new care group structures have created some delay. Revised completion date set for 10/07/2024. April 2024 Update - In progress. Work is ongoing between the head of nursing and the Datix team. Previous Update - In Progress Due for completion end of Jan 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angleton 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. The Cascade and Escalate Standard Operating Procedure document describes the process.	Mental Health & Learning Disabilities	28.12.2023		**Fully complete (Awaiting approval)**	Completed 28/12/2023 See Appendix 7f + 25
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	**Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)**	The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.	The Health Board has reviewed the current ward environment. With consideration of the ward footprint, clinical need and bed capacity within the Adult Mental Health Directorate it is not possible at present to provide a fully single bedroom inpatient provision. To mitigate potential impact of the present arrangements the nursing teams ensure that all shared rooms are single sex, with identified curtained private space for each person. The specific need for single rooms is identified at point of admission/assessment, with consideration of individual need i.e., gender, sexual orientation, or physical need/risk, and care plan developed as required. The nursing team identify patients who wish to have shared rooms e.g. for company. If requested, an individual room will be provided when available and if there is no other pressing clinical need.	Mental Health & Learning Disabilities	09.01.2024		**Fully complete (Awaiting approval)**	Completed
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 targeting staff due to gender. In extremis the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and CAMHS Mental Health wards, and there have been examples of recent good practice.	Mental Health & Learning Disabilities	09.01.2024		**Fully complete (Awaiting approval)**	Completed
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. Patio Photo; Evidence 2 Patio Photo; Evidence 3 There is routine discussion within the patient community groups around smoking arrangements and support by the patient groups of self-regulation of cleanliness of such areas by smokers. This is checked by ward staff regularly and extraordinary cleaning requested of facilities if required.	Mental Health & Learning Disabilities	09.01.2024		**Fully complete (Awaiting approval)**	Completed
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 insignial uniforms that identify them to those who wish to communicate in Welsh . For ease of recognition, this identifying uniform will be displayed to patients and visitors on Information Boards in each of the clinical areas. Welsh Language Notice; Evidence 4 Welsh Language Notice; Evidence 5	Mental Health & Learning Disabilities	28.02.2024		**Fully complete (Awaiting approval)**	June 2024 Update - Approved by QSRE and QSC 30th 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 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		**Overdue**	June 2024 Update - update due 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 address the environmental issues and resolve them in a prompt and timely manner.	The ward 22 damaged chair, with exposed foam filling which is not compliant with the relevant legislation has been condemned and removed with a temporary replacement now in place. A specialist furniture manufacturer has provided a quotation for new seating within the Interview room and a Statement of Need submitted. Ward 22 Interview Room Photo; Evidence 7 Psychiatric Intensive Care Unit (PICU) missing ceiling tiles have now been replaced. PICU Ceiling Photo; Evidence 8 Water damaged ceiling tiles in the Ward 22 office have all been replaced. There remain 6 water damaged tiles between the lounge & dining room awaiting replacement which have been logged with Estates Department. These have been prioritised by Estates as non-urgent, as they are considered decorative rather than safety sensitive, and the progress on replacement is monitored weekly by the Inpatient Deputy Directorate manager Ward 22 Ceiling Photo; Evidence 9 Ward 22 Ceiling Photo; Evidence 10 After consultation with a specialist furniture manufacturer the Inpatient Senior Nurse confirmed the suitability of the dining chairs currently in place in Ward 22.The dining room chairs are multipurpose and need to be moved between dining room and lounge for group discussions/activities and therefore need to be of a manageable weight. The Adult Mental Health Senior Leadership Team acknowledged that the weight of the current chair would allow them to be picked up and potentially brandished as a weapon, however this risk would not be completely eradicated unless the chairs were of a weight that would disadvantage patients with mobility restrictions and potentially increase risk of injury to staff when moving for cleaning purposes. The |nursing team mitigate risk of furniture being used in this way through individual risk assessment and maintaining observation of these areas when in use. Ward 21 bedroom rails and privacy curtains have been replaced. Ward 21 Curtain Photo; Evidence 11 There are long standing difficulties with inadequacy of wastewater/ sewage capacity within the RGH MHU site. As a result, the PICU Extra Care Area (ECA) utilises a Sani-flo macerator system to move waste from ECA to the main sewage system. This can result in issues when foreign objects are placed in toilet in ECA. Groundwork investigations report that a permanent solution to connect ECA to main sewage system would require extensive excavation works with significant capital spend and	Mental Health & Learning Disabilities	09.01.2024		**Fully complete (Awaiting approval)**	Completed
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		**Fully complete (Awaiting approval)**	Completed
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 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		**Fully complete (Awaiting approval)**	Completed

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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 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		**Fully complete (Awaiting approval)**	Completed
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		**Fully complete (Awaiting approval)**	Completed
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		**Fully complete (Awaiting approval)**	June 2024 Update - Approved by QSRE and QSC 30th 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 there are more variety of choices for patients with specific dietary requirements.	All Health Boards in Wales follow a menu which is based on The All-Wales Catering & Nutrition Standards. The Health Board Catering Service works with clinical teams to adapt the patient menus to patient specific requirements. The present patient menu changed in September 2023 to a two-week rolling menu which replaced an `a la carte' style menu. The new menu was reviewed by the All-Wales dieticians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing teams seek feedback from patients via the Inpatient Community Group and "Have Your Say" suggestion boxes (which are regularly monitored). This feedback informs discussions with the wider service i.e. Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Team recognise the need to increase the frequency of the menu review and change and are currently working on the new version for 2024.	Mental Health & Learning Disabilities	09.01.2024		**Fully complete (Awaiting approval)**	Completed
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		**Overdue**	June 2024 Update - update due 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		**Overdue**	
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 Work stream on the implementation of the Nurse Staffing Levels Act, the report makes recommendations about amendments to skill mix and enhancement of Nursing leadership roles the better to improve opportunities for recruitment and particularly staff retention. The Staffing review report will be presented to the Mental Health Nursing Workforce meeting on 25 January 2024, for consideration by Director of Nursing on subsequent actions. Considerations of staffing levels day to day are a core role of the Ward Managers and Senior Nurse, with all shift requirements monitored initially at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate staff on shift. Review of clinical need is a dynamic process that involves all members of the Nursing team, and staffing levels are increased in response to increased levels of acuity e.g. 1:1 patient observations to maintain safety or a need for intensive personal care. At this time, there is an organisational acknowledgement of the particular challenges to recruitment of unregistered nurses into Mental Health posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate. While there is a high degree of scrutiny around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership.	Mental Health & Learning Disabilities	09.01.2024		**Fully complete (Awaiting approval)**	Completed
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 local universities to maximise SSP opportunities for recruitment.	Mental Health & Learning Disabilities	09.01.2024		**Fully complete (Awaiting approval)**	Completed
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		**Fully complete (Awaiting approval)**	June 2024 Update - Approved by QSRE and QSC 30th 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. Present guidance on the use of ECA will be revised and formalised by the Senior Nurse by 31 January 2024.	Mental Health & Learning Disabilities	31.01.2024		**Overdue**	
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. The Inpatient Senior Nurse will lead on development of the Ward Transfer proforma in collaboration with a working group of qualified and Health Care Support Workers in in order to ensure that all key communications are considered, and the process addresses the concerns about miscommunication of decision.	Mental Health & Learning Disabilities	28.02.2024		**Fully complete (Awaiting approval)**	June 2024 Update - Approved by QSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	**Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)**	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	Paintwork has been re-painted.	Children & Families	28.12.2023		**Fully complete (Awaiting approval)**	April 2024 Update - Paintwork has been completed. Action can be closed. Previous update - Complete
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		**Fully complete (Awaiting approval)**	April 2024 Update - New blinds now in place. Action can now be closed. February 2024 Update - Complete–new blinds in place.
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		**Fully complete (Awaiting approval)**	April 2024 Update - Environmental audit in place on the AMAT system. Action can be closed. Previous update - Complete
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		**Fully complete (Awaiting approval)**	April 2024 Update - Added to ongoing maintenance programme. Action can be closed. Previous Update - Complete
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		**Fully complete (Awaiting approval)**	April 2024 Update - Tirion purposeful visit complete. No further environmental issues identified. Action can be closed. Previous Update - Complete

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	February 2024 Update - Complete, posters in place.
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		Fully complete (Awaiting approval)	April 2024 Update - As previous update, no Tirion core staff are welsh speakers. The specialist midwife in attendance during the HIW visit/inspection has now been given appropriate lanyard to identify her as a welsh speaker. This action can be closed. February 2024 Update - Complete, no Tirion core staff are Welsh speakers. Specialist midwife Welsh speaker now has appropriate identity.
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		Fully complete (Awaiting approval)	April 2024 Update - The Welsh Language team have undertaken a visit to the Tirion footprint, and all signs, resources and information are available in welsh. This action can be closed. Previous Update - Complete
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		Fully complete (Awaiting approval)	April 2024 Update - There is an i-Pad available at Tirion to support translation and interpreting services for those who are non-English speaking. This action can be closed. Previous Update - Complete
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		Fully complete (Awaiting approval)	June 2024 Update - This can be closed. The Welsh Language team have supported a walk-around at Tirion and we are fully compliant with Welsh language requirements. All women are supported to identify their language of choice/need at the outset of pregnancy using the All-Wales Handheld Records, and through the digital self-referral system. Where women identify additional language/communication needs there is access to use of translator/interpreting services. The Consultant Midwife for Population Health is developing a framework around the EDI agenda as part of a wider piece of work to increase awareness of, and respond to the diversity of local communities. April 2024 Update - This action is ongoing and requires financial investment to support this event. The Women's Experience Midwife is currently scoping this and looking for grants/funding to support the event. February 2024 Update - Ongoing.
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		Fully complete (Awaiting approval)	April 2024 Update - Baby Shower events have been drafted into the CTMUHB Maternity & Neonatal Engagement Plan, however this action is ongoing and requires financial investment to support future events. The Women's Experience Midwife is currently scoping this and looking for grants/funding to support the event. Previous Update - Complete
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		Fully complete (Awaiting approval)	June 2024 Update - This action can be closed. There have been 2 baby abduction drills undertaken at Tirion (including all appropriate stakeholders). The Security of the Newborn guideline has been updated and includes the auditable standard of at least annual baby abduction drill in each acute clinical area (including Tirion). This should be ratified in the next Postnatal Forum and Guideline Group and then available via Wisdom. April 2024 Update - The draft 'Security of the Newborn- guideline is currently out for consultation and due to be discussed with the intention to ratify in the next Postnatal Forum (awaiting date tbc). The draft guidelines includes an auditable standard of an annual baby abduction drill in each acute maternity setting. February 2024 Update - Final draft to be sent out for consultation on 19/02/2024 for ratification. This will include KPI for annual baby abduction drill on each site.
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		Fully complete (Awaiting approval)	April 2024 Update - Tirion and RGH have completed both a table-top baby abduction drill/discussions with Tirion staff (14.12.23), and the RGH site have supported a full multi-disciplinary baby abduction drill (22.01.24). This action can now be closed. February 2024 Update - Complete - 14.12.23.
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		Fully complete (Awaiting approval)	April 2024 Update - Tirion and RGH have completed both a table-top baby abduction drill/discussions with Tirion staff (14.12.23), and the RGH site have supported a full multi-disciplinary baby abduction drill (22.01.24). This action can now be closed. February 2024 Update - Complete - 23.01.24.
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		Fully complete (Awaiting approval)	April 2024 Update - The annual Tirion report for 22/23 has been shared at a service-wide governance meeting. The next annual Tirion report is currently being compiled, and will be shared at a service-wide audit/governance day upon completion. Previous Update - Complete
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		Fully complete (Awaiting approval)	April 2024 Update - The service share families' stories at all key departmental meetings, and these have included stories from families who have used services at Tirion FMU. There are no current examples of negative feedback from staff. Previous Update - Complete
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		Fully complete (Awaiting approval)	April 2024 Update - The service share families' stories at all key departmental meetings, and these have included stories from families who have used services at Tirion FMU. This action is complete. Previous Update - Complete
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		Fully complete (Awaiting approval)	Complete
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		Fully complete (Awaiting approval)	April 2024 Update - Ongoing review and updating of guidelines continuing. Previous Update - Complete
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		Fully complete (Awaiting approval)	June 2024 Update - This can be closed. There is a comprehensive governance and assurance process including a Guideline Group and Clinical Forums, which includes the monitoring of both new guidelines, and those requiring updating/ratifying. April 2024 Update - ongoing January 2023[4]
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 Communications to ensure awareness of extension of these guidelines.	Children & Families	01.01.2024		Fully complete (Awaiting approval)	June 2024 Update - This can be closed. All current clinical guidance is available via Wisdom intranet/internet. There is oversight of those guidelines coming out of date/requiring updating. April 2024 Update - Communications to staff via email, monthly newsletters and governance meetings. January 2023[4]
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		Fully complete (Awaiting approval)	April 2024 Update - guideline group in progress monthly. Action can be closed. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	**Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)**	The health board must ensure that the young people receive treatment specific to their individual diagnosis and that this is documented clearly within their patient records.	Each young person has an individualised care plan in line with their recovery care outcomes and inclusive of their holistic care needs. Care-plans are audited on a monthly basis. Outcome measurements support tracking quality-of-care against individual patient care needs. The audit asks he following questions; •Is the new care plan being used? •Is it in the YP's voice/words? •Is it outcome focused? •Has it been reviewed? •Is there evidence of an MDT approach? Learning areas are discussed in team meetings and disseminated electronically to the multi-disciplinary team.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1
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 department 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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 2
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. The Part A contains all patient demographics and is filed at the front of the medical record by the ward clerk.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 3
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		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE. In Progress Estimated to be completed by May 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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
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		Fully complete (Awaiting approval)	Completed 13/11/2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 5 + 6
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 7
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 8 + 9
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		Partially complete (Overdue)	June 2024 - Policy to be shared at QSRE in August 2024. June 2024 - The health board has updated the policy which was published 15/11/2023. In Progress Estimated to be completed by May 2024
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 10
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 11 + 12
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 13
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. The registered nurses are trained in paediatric immediate life support that covers management of adverse drug reactions.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 14
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 15
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1
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		Fully complete (Awaiting approval)	June 2024 Update - Completed 04/01/2024 (see Appendix 21) In Progress Estimated to be completed by May 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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023
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		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 16, 17 + 18
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	**Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)**	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Cwm Taf University Health Board acknowledges the findings and we recognise improved and robust assurances are required to improve the quality of patient experience and deliver Safe and Effective Care; Plans are in progress to implement Same Day Emergency Care (SDEC) services with part of this being a front door Frailty Model (Acute Care of the Elderly-ACE) as part of the EU reconfiguration work. This will facilitate early identification of our frailty patients and avoid unnecessary long waits in the EU. The implementation of the above units will reduce the potential overcrowding in the Ambulatory Area where patients are waiting for inpatient beds. There has already been significant progress in the last 9 months with the implementation of the gynaecology, surgical and trauma assessment units aligned to inpatient areas that has diverted patient flow from the EU. Further work is going to develop processes and pathways whereby all GP expected patients will transfer directly to the assessment units and avoid the EU footprint. There is an options appraisal being considered to relocate the GPAU, whereby the GP expected patients will not attend the EU. As part of the work described there are Standard Operating Procedures (SOP) in place where patients requiring immediate resuscitation will transfer immediately to ED in order that patient care and safety is maintained.	Unscheduled Care	01.01.2024	Revised Due Date April 2024	Overdue	Extended to April 2024 due to construction delays and development of SDEC Pathway, where all GP referred patients will be directed and streamed. Frailty Model implemented December 2023, with the successful appointment of 1 Consultant, 2 Advanced Nurse Practitioners, further medical recruitment is ongoing. Following this there is early identification of Frailty Patients within the ED Department with streaming to the inpatient Frailty Ward as required.
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		Overdue	SOP for Ambulatory care remains in place and Huddles continue across the department with a clear focus on patient safety.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	**Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)**	The health board is required to provide HIW with an update on the 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		Overdue	Safe to start meetings continue on site twice daily with regular review of any patient safety concerns and safe staffing is maintained.
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	Revised Due Date December 2024	Overdue	Delayed due to major capital works on site to December 2024.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	**Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)**	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024		Overdue	Awaiting date from Welsh Government following a successful bid for Funding. This will supply an extra toilet and showering facilities.
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		Overdue	
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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 when there are barriers or concerns.	Unscheduled Care	01.12.2023		Fully complete (Awaiting approval)	4 new recliner chairs have been received in March 2024 in Ambulatory Area.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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. The Head of Nursing and Senior Nursing Team are continually present operationally working proactively with the nursing teams to facilitate identification and prioritisation of these patients.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 April 2024 – as above delayed as awaiting date from Welsh Government. Funding approved for extra toilet and showering facilities-specifically Ambulatory Area of ED
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		Fully complete (Awaiting approval)	Achieved 29.09.2023 2 Frailty ANPs appointed-October 2023 Review patients at the front door and streamline access to frailty ward Optimise rolling out formally across the HB-this is the CTMUHB project that encompasses Red2Green and Discharge to Recovery Then Assess Pathways. Daily sitreps available electronically-for audit purposes and action.
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		Partially complete (Overdue)	Temporary signage has been created to support patients as they move throughout the EU footprint, as there is work ongoing across Cwm Taf University Health Board to have consistent signage for the public served by the whole HB.
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 deployed to support. The ED Clinician Team will adopt a Rapid Assessment and Triage (RAT's) model to support any delays in triage, hence there will be senior assessment and streaming at the front door of patients. EU has recently recruited 2.8 wte Patient Flow Coordinators to support timely patient flow and escalation of patient flow delays. The USC group have developed updated Escalation Cards to support actions and provide assurances that ambulance delays are avoided. There are rigorous escalations in place, and when any patient is delayed over 4 hours an internal investigation is undertaken to provide assurances that no harm has occurred.	Unscheduled Care	01.03.2024		Overdue	This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues.
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this we have extended our Patient Advocate Liaison Service (PALS) team offering to support patient with regular updates at front door as also ED volunteers support this. We have also implemented Civica to capture Patient Reported Experience Measures (PREM's) within the ED and we are developing this into themes and trends to inform action plans for improvement.
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 Offer" checklist has been re circulated to the team in EU and the site as a whole.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Completed EU Senior Nurse has met with the HB's Welsh translator to ensure Welsh service users are identified and their needs met. Providing the Welsh language to service users without our Welsh speakers needing to ask. The EU are awaiting the bi-lingual version of an EU leaflet to ensure patient care trajectories are understood by those accessing EU services. The team have also published bi-lingual uniform posters, to highlight staff members to service users.
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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 access to PALs service and putting things right to escalate any concerns. As well as access to clinical team members. In recognition of patient needs champion nurses are in place for pregnancy loss, learning disabilities, dementia, Welsh language and further emerging roles. The opportunity for staff to attend training days to improve knowledge and experience to progress this agenda.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this as part of the Civica PREM's inclusion and discrimination feedback is captured and if this is a theme will inform any ongoing actions for improvement.
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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 internal data has demonstrated continuous improvement in pressure area assessment and care in ED with significant reduction in avoidable pressure damage as well as identifying pressure damage present on arrival to ED. Pressure area audits are undertaken via AMaT and monitored hourly using the "Patient Safety Checklist". Any trends identified are discussed in the ED monthly meeting and the PCH monthly Focus Group meeting to ensure lessons are learned widely. Two Formal Study Days have been undertaken in the last 18 months and the Fundamentals of Care has been key to the agenda. There are 2 further Study Days arranged (by the Senior Nurse for Professional Education) for October and December - these will incorporate Work Stations and Pressure Area Management is included.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this the Welsh Government funding achieved will support integrated nurse call bells in Ambulatory Care.
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 monitored and actions for improvement. The nurse director commissioned an IPC audit with significant improvement demonstrated, compliance has increased to 90%.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Overdue	April 2023 New catering model implemented with a wider range of food offered to patients across the ED. Ceramic and metal crockery now offered along side access to fresh water in the waiting room and across the Ambulatory Care Unit.
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		Fully complete (Awaiting approval)	Achieved 29.09.2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Fully complete (Awaiting approval)	Achieved 29.09.2023
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		Overdue	Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. ED MCA compliance is 56% and Fire is 76% (MCA overall compliance is reduced as a result of a number of newly recruited Registered Nurses and Health Care Support Workers, yet to complete training). There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.
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		Overdue	Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.
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-regularly cascaded to the teams as well as bespoke access to the Clinical Psychologist who is currently in touch with the MDT.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.
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		Fully complete (Awaiting approval)	Achieved 29.09.2023 and 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 details of the action taken to increase staff confidence that when they raise concerns, these will be addressed.	EU staff notice board and EU newsletter under development. Departmental meeting planned for 4th October 2023. Band 7 meetings monthly. This also forms part of speaking up safely and the ongoing work around civility saves lives and psychological safety which is being championed by the senior nurse for EU. We also have a well-being champion who is available to support staff to raise concerns.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.
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 experience, comment report, 2)Monthly heat map, 3)Survey analysis, 4)Have your Say-as part of CIVICA.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved - as part of the Civica roll out in ED Patient Reported Experience Measures' are captured themes and trends are shared. This form part of an action plan for improvement if there is a key area overserved where improvement is required. This is shared in the Head of Nursing monthly focus group. It also forms part of the QSRE meetings and a 'you said, we did' board is being developed.
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 discuss the improvement plans in place-"the so what". The EU team discusses the audit results and improvement plans as part of the monthly governance meetings.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	**Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)**	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	a) Review of Day assessment activity has been undertaken identifying areas where midwifery hours could be re-allocated to cover the night roster (48 hours a month).	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 16/01/2024
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		Fully complete (Awaiting approval)	Completed 15/01/2024
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.	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		Partially complete (Overdue)	Meeting arranged with Assistant director of nursing and peoples experience, All Wales International recruitment manager and Workforce development and efficiency manager for the 21st of may 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.	d) Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate.	Children & Families	31.03.2024		Partially complete (Overdue)	Started November 2023, expected completion end of March 2024 This work is ongoing, in view of the volume of work, the completion date has been extended, all staff with flexible working arrangements have been notified, submissions of new flexible working requests and partnership working with Unions people services. Meetings are taking place on a monthly basis.
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		Fully complete (Awaiting approval)	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)**	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		Partially complete (Overdue)	This work is under continuous evaluation, during the transition from birth-rate plus to safe care and utilising the reflags to evaluate acuity. Progress meeting arranged for 22nd May
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	Revised Due Date February 2024	Partially complete (Overdue)	Commenced September 2023. Due for completion February 2024. A meeting took place with the lead nurse for Perioperative services and Finance to explore the feasibility for perioperative services to cover emergency and elective theatres 24/7. costings did not align with funding. The financing is now being revised to cover 3 elective theatres in the first instance, with meetings being arranged for May 2024
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 Birth-rate + acuity app to the Health Board's 'Safe Care' acuity system which links with Allocate Health Rosters and ensures wider Organisational scrutiny.	Children & Families	01.03.2024		Fully complete (Awaiting approval)	This as been implemented since February, and this is a work in progress and continuously evaluated .
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		Partially complete (Overdue)	Review of safe care tool has been undertaken to ensure that red flags according to NICE safe staffing 2015 are included in the tool
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	**Appendix 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 Communications Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024		Partially complete (Overdue)	
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		Fully complete (Awaiting approval)	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)**	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		Fully complete (Awaiting approval)	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)**	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		Fully complete (Awaiting approval)	In place from 22/01/2024
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.	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		Fully complete (Awaiting approval)	In Place since January 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.	o) Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	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)**	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		Partially complete (Overdue)	In Progress, meeting's have taken please to collate maternity data for the dashboard
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		Fully complete (Awaiting approval)	In place 16/01/2024
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.	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		Fully complete (Awaiting approval)	In place, this is ongoing on a shift-by-shift basis and also. Also longer term, staff that are in well established areas are rotated for longer placements to areas where staffing is more challenging to ensure that the service is being reviewed as a whole.
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		Fully complete (Awaiting approval)	Rotation into community on hold
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		Fully complete (Awaiting approval)	Timescale 31.1.24 & Monitoring in Place. 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		Fully complete (Awaiting approval)	Timescale 11.1.24 & ongoing national meeting attendance. This in ongoing, CTM are represented on this national work and will continue to do so for the duration of the programme.
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		Partially complete (Overdue)	Discussions have been had with the e-roster department to evaluate how we can extract this data, however this seems challenging. A positive effect of limiting access to the roster has the limited ability for staff to manipulate the roster to work with specific groups and avoid Cliques from forming. Staff are being encouraged and supported to raise concerns they have regarding incivility and poor workplace culture.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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		Fully complete (Awaiting approval)	Bank and overtime hours have continued to be offered to staff, PCH has also signed up to use Agency 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		Fully complete (Awaiting approval)	Completed 15.1.24
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		Fully complete (Awaiting approval)	Completed
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		Fully complete (Awaiting approval)	Completed 12.01.24
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		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	**Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)**	Visiting times The health board should review visiting arrangements and communicate timings with families ahead of admission.	Visiting hours within Cwm Taf Morgannwg are in line with other Health Boards in Wales. In response to the service user feedback, an extraordinary My Maternity My Way meeting was held on 22nd January 2024 to discuss visiting and birth partner arrangements. In response to suggestions from service users, visiting hours will be extended for birth partners from 4th March 2024. Visiting hours for the nominated birth partner is being extended until 10pm at night. The service will also facilitate a 30 minute settling in period for partners on transfer to the postnatal ward. Changes to visiting arrangements are advertised via social media, website, communication via all midwifery teams and posters within antenatal clinics (community and hospital).	Children & Families	04.03.2024		Overdue	
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. Myth busting – NMC facilitated session on the approach taken when investigating concerns 14th November 2023. Further NMC session planned 29th April for newly qualified midwives.	Children & Families	01.03.2024		Overdue	Due date 1st March 2024 and under continual review
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		Overdue	
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		Overdue	
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		Fully complete (Awaiting approval)	In place and reviewed daily
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. Consent audit added to the forward audit plan for June 2024.	Children & Families	01.07.2024		Partially complete (Overdue)	In place and monitored via PREM. Audit July 2024
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		Overdue	
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		Fully complete (Awaiting approval)	Completed January 2024
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		Overdue	
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	12.01.2024		Fully complete (Awaiting approval)	Completed 16/01/2024
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	12.01.2024		Fully complete (Awaiting approval)	Completed 15/01/2024
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		Overdue	Started November 2023, expected completion end of March 2024.
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		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	**Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)**	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Work is in progress analysing the staff establishment alongside the birth-rate plus report to ensure appropriate allocation of staff	Children & Families	12.01.2024		Overdue	In progress February 2024
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		Overdue	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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 Birth-rate + acuity app to the Health Board's 'Safe Care' acuity system which links with Allocate Health Rosters and ensures wider Organisational scrutiny.	Children & Families	01.03.2024		**Overdue**	
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		**Overdue**	
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 Communications Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024		**Overdue**	
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		**Fully complete (Awaiting approval)**	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	**Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)**	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review of specialist and operational roles and required commitment for clinical aspects of role to enhance short fall in acute areas as well as staff currently released on secondment.	Children & Families	12.01.2024		**Fully complete (Awaiting approval)**	In place
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	12.01.2024		**Fully complete (Awaiting approval)**	In place from 22.01.24
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		**Overdue**	
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		**Fully complete (Awaiting approval)**	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	**Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)**	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	A corporate nursing and midwifery dashboard is being developed to consistently capture vacancies, sickness, annual leave = to be shared in Care Group Nursing & Midwifery Workforce Productivity Meetings.	Children & Families	30.01.2024		**Overdue**	
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		**Fully complete (Awaiting approval)**	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	**Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)**	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Rotation of Staff from well-established areas to ensure consistent safe staffing across the service and weekly review, meetings in place.	Children & Families	12.01.2024		**Fully complete (Awaiting approval)**	In place
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		**Overdue**	
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		**Overdue**	Due date 31.1.24 & Monitoring in place
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		**Overdue**	Due date 11.1.24 & ongoing national meeting attendance
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		**Overdue**	Due date 31.1.24, continues under review
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		**Overdue**	
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		**Overdue**	
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		**Overdue**	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
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 2024, the outcome of this work and any recommendations will be presented at the Maternity and Neonatal Safety Board in April 2024.	Children & Families	01.04.2024		**Overdue**	
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		**Fully complete (Awaiting approval)**	In place and reviewed monthly
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		**Fully complete (Awaiting approval)**	Completed and monitored daily.
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		**Overdue**	
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		**Partially complete (Overdue)**	Completed and ongoing monitoring 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		**Overdue**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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 be consolidated into one set of procedures. The nuclear medicine procedures will be incorporated into these.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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 are being completely overhauled with the introduction of an Entitlement Certificate for each individual which will detail entitlement for individual IR(ME)R tasks.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)**	The employer needs to ensure that: •Entitlement documentation is completed in full, with appropriate information on entitlement •Training records of the staff should be updated to ensure that staff competences were assessed by an appropriate individual who has been delegated the task by the employer.	Entitlement records are being completely overhauled with the introduction of an Entitlement Certificate for each individual which will detail entitlement for individual IR(ME)R tasks. This will remove the additional 'date of entitlement'. Training records are being updated to ensure correct authorisation of training.	Diagnostics, Therapies, Pharmacies and Specialities	30.09.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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.	This item is under review by Clinical Director and other parties to define how this requirement will be addressed.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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) are being phased out and encompassed within the individual entitlement certificates. Any terminology changes will be made during this process.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)**	The employer needs to ensure that the: •Employer's procedure includes instructions on how to evidence patient identification checks have been made where there are multiple exposures or operators involved. •Completion of referral forms are clear where there are multiple operators and contact points.	Employers procedure will be updated to cover this situation.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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.	Employers procedure will be updated to cover this situation.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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 will be updated with any duplication addressed. A single document will capture all procedures.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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 will be updated to address this.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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: •Delete references which were not relevant to the procedure. •Update the definition of a significant accidental or unintended exposure to reference the guidance supported by HIW. •Refer to the notification criteria required by HIW.	Employers procedure will be updated to address this issue.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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 will be updated to reflect that the use of the Medical Appraisal Revalidation System (MARS) is used for the training records of practitioners.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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 procedures	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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. We will combine the Quality Assurance (QA) handbooks and work with the Medical Physics Expert (MPE) to achieve this.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	**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.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		**In progress**	

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

Agenda Item
9.2.5

Quality & Safety Committee

RADAR COMMITTEE MID YEAR UPDATE

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Dr Richard Jones, Clinical Lead for Resuscitation and Acute Deterioration • Vanessa Jones, Acute Deterioration Lead • Bethan Harding, Resuscitation Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford, Exec Medical Director 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**
RADAR committee	13/05/2024	NOTED

Acronyms / Glossary of Terms	
RADAR	Recognition of Acute Deterioration and Resuscitation
NEWS	National Early Warning Score

Situation /Background

1.1 The purpose of this report is to provide the Quality and Safety Committee with an overview of governance and activity across CTMUHB (Cwm Taf Morgannwg University Health Board) of the Recognition of Acute Deterioration and Resuscitation Committee (RADAR) over 2023 -24.

1.2 The attached annual RADAR report (appendix 1) describes the CTMUHB approach to Acute Deterioration and Resuscitation with reference to:

- The governance infrastructure in place.
- The processes around Resuscitation and Acute Deterioration in terms of Education and Quality Improvement
- The assurance data gathered on these processes
- A description of the quality issues arising from the lack of advance and future care planning.

1. Specific Matters for Consideration

To note the Governance and quality response:

2.1 Structures

2.1.1 The improvement in CTMUHB governance arrangements since 2019 with the formation of the Recognition of Acute Deterioration and Resuscitation Committee (RADAR) and local (previously ILG) RADAR subgroups.

2.1.2 Recognition of the impact and progress made with the Acute Deterioration (AD) programme through the appointment of a Clinical Lead (medical) and an AD Lead (nursing).

2.1.3 The essential role of the outreach team and the progress made towards establishing 24/7 service on all the acute sites across CTMUHB.

2.2 Acute Deterioration Processes

2.2.1 Updating and embedding NEWS Cymru to have a structured and unified approach across CTMUHB in all clinical areas to allow rapid objective detection of deterioration.

2.2.2 Awareness of our NEWS and Escalation Procedure that provides best practice guidance to health care professionals in determining and identifying patients within our care who are at risk of becoming unwell or presenting with abnormal physiological status.

2.2.3 The continuing work with the Sepsis Screening tool via the Sepsis improvement work plan and the Sepsis Working group

2.2.4 Adoption of the All-Wales Treatment Escalation Plan (TEP) as a response to linked work with mortality reviews, where appropriate escalation and de-escalation have been issues in the identified themes.

2.3 Outcomes and assurances

2.3.1 The establishment of audit and feedback processes to monitor and improve performance e.g., NEWS Cymru compliance audit, analysis of Rapid Response and Cardiac Arrest calls to assess the effectiveness of identification, escalation, and response to acute deterioration within CTMUHB

2.3.2 Standardisation of Rapid Response emergency calls throughout CTMUHB.

2.3.3 Progress with the establishment of 24/7 Outreach services on each acute site: - Services are now 24/7 at Royal Glamorgan Hospital (RGH) and Princess of Wales (POW), plan for Prince Charles Hospital (PCH) by November 24

2.3.4 Establishment of standard operating procedures for Outreach teams.

2.3.5 Compliance with Welsh Government Sepsis Guidelines 2017.

2.3.6 RADAR care group data reporting established via the care group Quality Safety and Patient Experience/Risk meetings following the organisational restructure.

3 Key Risks / Matters for Escalation

3.1 Structural

3.1.1 Lack of resilience and robustness within the outreach teams resulting in gaps in service provision, impacting on rapid response to the acutely deteriorating patient and severe sepsis, education and training for Sepsis and NEWS Cymru and measurement/audit of sepsis compliance.

3.1.2.1 Challenges in accessing sufficient dedicated accommodation for training in NEWS, Acute Deterioration, Sepsis, Rapid Response and Resuscitation

3.1.2.2 Need for Performance and Informatics support to provide meaningful timely data sets to assure Care Groups/Health Board and inform improvement

3.1.2.3 Need for Communications support to promote implementation, engage all staff groups and to advertise good practice.

3.1.2.4 Clinical pressures continue to impact on attendance at training. The Did not Attend (DNA) rate of all resuscitation training currently is 26%

3.1.2.5 Barriers within the electronic staff record (ESR) system exists when aligning the updated matrix with staff resuscitation competencies, particularly in matching compliance to their job role rather than just a job number

3.1.2.6 Future work: administrative support required to be able to enrol CTMUHB in the National Cardiac Arrest Audit which would give us comparable data to benchmark our systems and training with national data.

3.1.2.7 The need to establish a separate workstream and governance group to improve advance care planning, DNACPR decisions and Treatment Escalation Planning.

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))*	Timely If more than one applies, please list below: SAFE, EQUITABLE, 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: Not required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

4 **Recommendation**

That Quality & Safety Committee

4.1 NOTE the content of this report.

4.2 RECOGNISE the role of a RADAR Clinical Lead and an Acute Deterioration Lead to drive improvement in this area.

4.3 RECOGNISE the essential role that the Outreach teams have in both the response to Acute Deterioration and in delivering education to reduce the impact of Acute Deterioration on the patient and on the Health Board.

4.4 RECOGNISE the importance of good quality training in Resuscitation to ensure as good an outcome as is possible following Cardiac Arrest

4.5 RECOGNISE the need to address the quality issues around DNACPR, Treatment Escalation and Advance Care Planning.

RADAR COMMITTEE

Cwm Taf Morgannwg

University Health Board

Annual Report 2023-2024

What will this Annual Report tell you?

Our Annual Report provides you with information about the Recognition of Acute Deterioration and Resuscitation (RADAR) Committee within Cwm Taf Morgannwg University Health Board (CTMUHB), what we do and how we work across the organisation to ensure quality and governance in patient care and safety, and what we plan to do to deliver and continually improve healthcare education, in order to meet changing demands and future challenges.

It provides information about our performance, achievements to date and what we intend to do to build on these.

Contents

Page

1. Introduction and Current Health context in Wales and CTMUHB..... 6-7

2. RADAR Committee Activity..... 7- 21

2.1. Policy and Governance

2.1.1.1 Supporting services

2.2 Quality Improvement

2.2.1 NEWS guidance
2.2.2 NEWS and Escalation Process
2.2.3 sepsis
2.2.4 Acute Kidney Injury
2.2.5 Fluid Balance
2.2.6 Burden of Acute Illness
2.2.7 Resuscitation and Clinical skills
2.2.8 Rapid Response systems
2.2.9 ACP, DNACPR and Treatment escalation Plans

2.3 Education and Training

2.3.1 Resuscitation training
2.3.2 Outreach

2.4 National Work

Introduction and Background

RADAR Context in Wales.

Health Services in Wales continue to deliver the vision, ambition and approaches that are needed to deliver *'A Healthier Wales'* (1). The demand for services, increasing health and wellbeing inequalities, higher public expectations, the additional challenges due to the impact of COVID-19 on health and social care services, as well as the possibilities that new and emerging medical and digital technologies offer, are set against a backdrop of changing demography, recruitment and resource challenges as healthcare services reset and recover.

Context in CTMUHB

Background

In 2019 CTMUHB received a (Ref 1) Peer Review of Acute Deterioration Services report with a set of recommendations regarding areas for improvement.

The Peer review of Acute Deterioration Services is both a quality assurance and quality improvement programme that assesses the quality of the service being delivered by multi-disciplinary teams and local health boards in Wales. This assessment is set against a framework of local and national guidelines, Patient Safety Alerts and the overall Health and Care Standards for Wales and is underpinned by the principles of Prudent Healthcare.

Sepsis is a specific area of focus of the Acute Deterioration programme.

Also in 2019, the former CTUHB commissioned an external review of Resuscitation Services (Ref 2), where it was noted that governance arrangements regarding the Resuscitation Committee needed to be more robust.

The review team felt that the service should focus more on identifying the organisation's training requirements in relation to the deteriorating patient.

In response to recommendations from both reviews, and practice in other health boards, a new CTMUHB governance infra-structure was created in bringing together resuscitation and acute deterioration (including sepsis) under the consideration of one committee – Recognition of Acute Deterioration and Resuscitation (RADAR) (Ref 3). RADAR reports directly to the Executive Leadership Group, via the Medical Director with links to the Quality & Safety Committee

Two key clinical appointments were made to lead, direct and co-ordinate RADAR activity:

- Medical Clinical Lead x 2 sessions/ week.
- Acute Deterioration Lead Nurse WTE Band 8A. (*key recommendation from Peer Review)

These posts are currently hosted by Clinical Education.

From February 2024 these 2 posts have been made substantive.

2 RADAR Committee

2.1 Policy and Governance

2.2 Quality Improvement – Acute Deterioration Processes including Sepsis

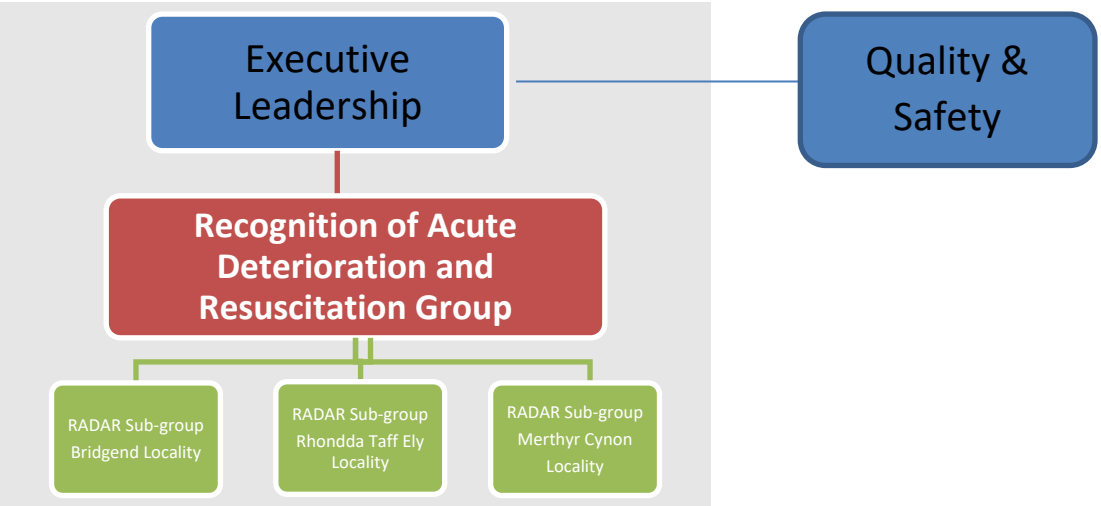
2.3 Education and Training

2.1 Policy and Governance

Organisational governance around resuscitation and acute deterioration has been further developed and aligned. The overarching CTMUHB RADAR Committee (Recognition of Acute Deterioration and Resuscitation) is responsible for the strategic management of all Recognition of Acute Deterioration and Resuscitation related issues within the organisation, supporting the provision of appropriate and effective patient care through implementing operational policies governing the prevention of cardiac arrest and those governing cardiopulmonary resuscitation, practice and training. This approach brought together a number of work streams in order to reduce avoidable mortality and morbidity by improving the function of health board systems that enable early recognition and treatment of deteriorating patients, and cardiopulmonary resuscitation.

It is chaired by the AMD for Quality and Effectiveness on behalf of the Medical Director with a Medical Consultant appointed as the Clinical Lead. There is a Lead post for Acute Deterioration which commenced in January 2021 to develop and embed a structured and unified approach across Cwm Taf Morgannwg University Health board (CTMUHB) in the identification, escalation and response to the acutely unwell patient. There is a Resuscitation Lead Nurse who is responsible for providing professional and clinical leadership in all aspects of resuscitation in the health board.

The internal structure of the subgroups of RADAR have been further re-aligned over 2023 with the establishment of the new CTMUHB organisational structure.



2.1.1 **Supporting services**

Resuscitation service

The Resuscitation Service for CTMUHB has a significant focus on providing training to ensure health care professionals are competent and up to date with the relevant life support skills for their roles. A training and resuscitation equipment service is also provided to Powys Training Health Board, General Practices and Dentists among other SLAs. This service is also a Resuscitation Council Accredited Training Centre for Level 4 Life support training.

The Outreach Service

To provide a 24-hr response to acute deterioration the Outreach teams have been expanded.

Current Outreach establishment

- Princess of Wales Hospital 6.43 WTE (3 x band 7,4 x band 6)24/7
- Royal Glamorgan Hospital 7WTE (7 x band 7)24/7 1 on fixed term
- Prince Charles Hospital 7WTE (2x band 7, 5 x band 6) 24/7 Friday-Monday

The expansion of the teams allows an Outreach presence at all rapid response calls. The establishment of 7 WTE per site allows for a vital teaching role to be included, which supports the provision of training on acute deterioration, NEWS, sepsis and acute kidney injury (AKI). Due to increased demand for both clinical workload and education, bids have been submitted to expand the teams to 8WTE on each site.
The service continues to face challenges where outreach staff are called back to cover gaps in ITU, emergency departments and areas of high acuity. Strategic direction and leadership are required for this team and service and moving forward could be provided by the acute deterioration lead post.

2.4 **Quality Improvement – Acute Deterioration Processes**

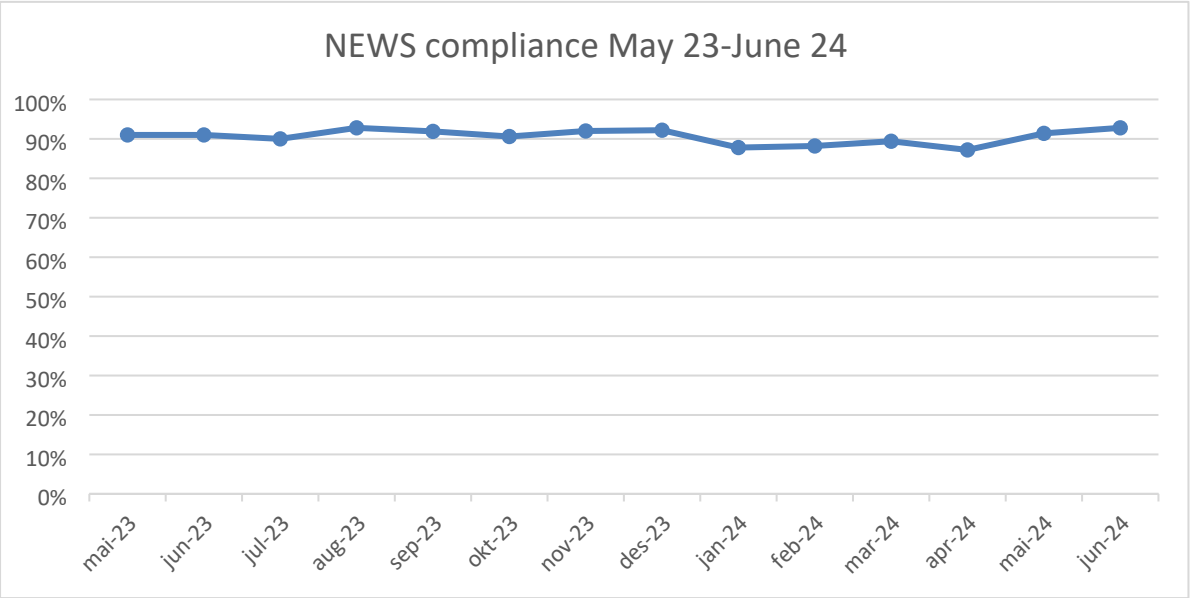
2.2.1 NEWS Guidance

The focus of work is to have a structured and unified approach across Cwm Taf Morgannwg University Health board (CTMUHB) in the areas set out in the Welsh Government (WG) Task and Finish group report on provision of Outreach services in Wales Ref and compliance with Welsh Government Sepsis (2017) guidelines (ref 5) including the use of the National Early Warning Score (*NEWS*) in all clinical areas to allow rapid objective detection of deterioration.

As a direct result of the work led by the Clinical Lead and the Acute deterioration lead posts, NEWS charts have been updated in alignment with NEWS2 principles and rolled out as 'NEWS Cymru' charts (ref 7) standardised across all acute and community hospitals in CTMUHB. Specific education and training to support the standardisation has been provided to all staff and incorporated into existing training programmes e.g., Health care support worker induction training and our resuscitation training programmes.

To provide assurance within the health board that the NEWS charts are completed accurately and appropriately escalated an audit pro forma has been developed based upon NICE CG50. Data is entered monthly onto the Audit Management and Tracking (AMaT) system. Results are disseminated to all ward managers, senior and head of nursing for review. Any compliance issues are also discussed within the ILG Recognition of Acute Deterioration and Resuscitation RADAR meetings. NEWS audits are used to provide evidence of learning in Learning from events reports (LFER).

Fig 1. CTMUHB Secondary Site NEWS audits up to June 24



- Current NEWS compliance **94.8% across** CTMUHB acute sites

Focussed improvement on lowest scoring areas.

2.2.2 NEWS and Escalation Procedure

This clinical procedure has been produced to provide Cwm Taf Morgannwg University Health Board (CTMUHB) best practice guidance to health care professionals in determining and identifying patients within our care who are at risk of becoming unwell or presenting with abnormal physiological status.

The procedure specifically provides a framework through which doctors, registered nurses, healthcare assistants and allied healthcare professionals are informed of their responsibilities in relation to: -

- the minimum standards for monitoring patients' physiological observations
- recording and communicating the results of the monitoring of such physiological observations
- the minimum actions and referral route that must be taken in accordance with the NEWS scoring system

2.2.3 Sepsis Screening Tool

Sepsis
Sepsis is a complication of infection in which a *dysregulated host response is associated with organ dysfunction and increased risk of death.* It is estimated that there are in the region of 500 'suspected sepsis' admissions per year in CTMUHB, with a mortality of about 7%.

Early recognition and response to Sepsis improves outcome.

Sepsis is one of the leading causes of Acute Deterioration and therefore our response to the Acutely Deteriorating patient has Sepsis at its core. Our response to Sepsis is built upon the response to all forms of Acute deterioration i.e., recognition, escalation and timely response by appropriately trained clinicians.

The entry criteria for recognising "Sepsis" are the Suspicion of infection PLUS a NEWS score of 3 or more. This should lead to a patient being screened for sepsis using a *sepsis-screening tool.*

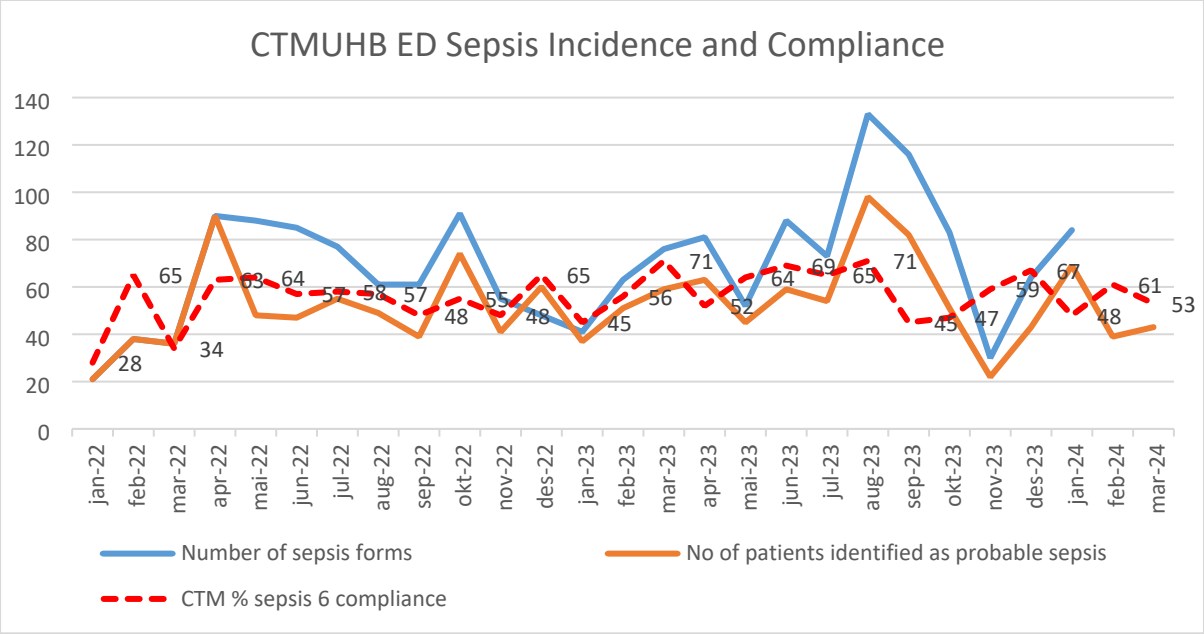
**A note on tools*
Screening tools are used to help clinicians make a judgement on a likely diagnosis at the bedside in a timely manner. Waiting many hours for microbiological confirmation is obviously not an option. There are several tools used for screening a patient for Sepsis. They have varied sensitivities and specificities, and no individual tool is ideal. Tools that are too sensitive overestimate the likelihood of sepsis and lead to many people being over-treated with antibiotics and fluids. This in itself is harmful but added to this is the risk that treating a non-septic patient as septic leads to the true diagnosis being missed e.g.: heart failure, pancreatitis etc. Tools that are too specific under-estimate the likelihood of sepsis leading to patients not receiving essential, early antibiotics. Tools that are overly complicated are difficult for staff to follow and are not practical in most clinical situations as presenting cases seldom conform to rigid protocols.

Sepsis is one of the main causes of acute deterioration and if not identified and treated in a timely manner can lead to multi-organ failure, admission to Intensive Care and death.

In CTMUHB historically there were several sepsis screening tools in use. To ensure consistency in the identification of sepsis within the hospital setting a new sepsis tool was developed using a collaborative approach between pharmacy, medical and nursing leads and using the NICE guidelines and the new guidance from the Academy of Medical Royal Colleges. We introduced it into our Emergency Departments (where we see 75% of Sepsis presentations.) Over the year, through a significant effort in education, we have rolled it out to the rest of our hospitals. The new sepsis tool focuses on risk stratifying patients into categories to ensure those at most risk receive timely care. (Ref 4)

To support the timely administration of antibiotics, the first line antibiotics for use within Emergency departments was standardised and a QR code attached to the tool which links to the Antibiotic guidance. This has helped to reduce the time to prescription and administration of antibiotics in the patient with probable sepsis.

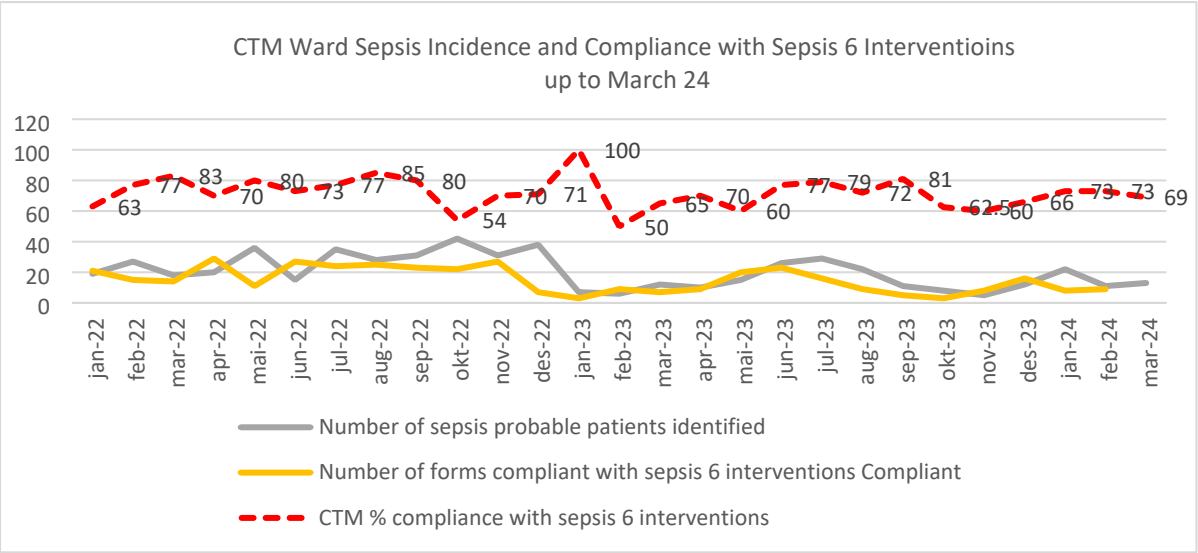
Fig 2 CTM Emergency Department Sepsis Incidence and Compliance



- Overall compliance in our Emergency departments is **53%,** however, recording the median 'time to antibiotics' is a more useful measure within the EDs

Following on from the initial trial in ED the sepsis screening tool has been introduced into *all wards* within RGH/PCH/PoWH. Ongoing work continues on providing meaningful data from all sites.

Fig 3 CTM Ward Sepsis Incidence and Compliance



- Current ward sepsis compliance is **69%,** data dependant on outreach teams and the amount of data entered on the Sepsis screening tool.

2.2.4 Acute Kidney Injury (AKI)

The National Confidential Enquiry into Patient Outcomes and Death report (NCPOD) in 2009 demonstrated poor management of acute kidney injury (AKI) throughout the UK. In the UK up to 100,000 deaths each year in hospital is associated with acute kidney injury. Up to 30% could be prevented with the right care and treatment. NICE recognises this and identifies only 50% of cases with AKI documented as cause of death received satisfactory or good care (NCEPOD 2009).

In order to improve the management of AKI within CTMUHB an AKI steering group was developed, and an AKI sticker bundle was drafted which prompts actions for Medical/nursing staff when patient has an AKI. The AKI steering group reports into RADAR.

The AKI sticker bundle has been introduced into the acute medical wards within RGH, and the care of the elderly wards (COTE) wards in POWH. To measure sticker compliance an audit has been developed on AMaT to ensure that AKI alerts are being managed appropriately and in a timely manner and to identify areas of low compliance to make improvements. Ongoing roll out will take place within all sites in 2024.

Fig. 4 AKI Sticker Bundle compliance Audit RGH up to April 24

Audit	Frequency	Compliance over last 6 periods						Current
Acute Kidney Injury (AKI) audit	M	65.9%	62.2%	70.3%	68.0%	67.5%	59.7%	67.7%

2.2.5 Fluid Balance

Fluid balance is an essential tool in determining hydration status. Accuracy in recording fluid intake and output is vital to the overall management of certain patient groups and facilitates the assessment and evaluation of the patient's condition. In addition, accurate fluid balance is an essential component in the prevention and management of an AKI.

To improve compliance with recording of a patient's fluid balance status a whole site audit within Royal Glamorgan Hospital and within the Care of the elderly (COTE) wards at POWH were conducted. The results of the audit identified areas for improvement. Ongoing work is being done with the Health Care Support Worker (HCSW) team to develop a fluid balance training session. Registered nursing staff are educated via the Outreach team within the acutely unwell study days and on the ward teaching. To underpin fluid balance training a procedural document has been written.

The procedure raises staff awareness by providing a clear set of standards in managing optimal hydration and effective fluid balance. The aim is to guarantee that health care staff apply a consistent and safe approach to maintaining, assessing and recording of individual patient's fluid balance. The intention is to create a set method for recording a detailed and accurate fluid balance by establishing effective standards and management for optimal hydration while supporting staff to determine an appropriate and timely rationale for starting and stopping a fluid balance.

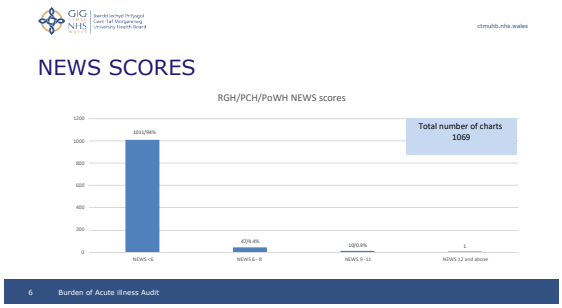
To provide assurance on compliance a monthly fluid balance audit is conducted within RGH site which will was introduced to all sites in June 24. Some focused work within surgery PCH has seen improvement in compliance. There will be an action plan formulated to improve education and subsequent compliance in fluid balance completion.

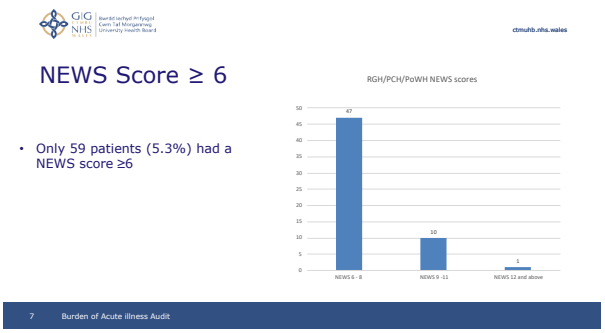
Fig .5 CTM Fluid Balance up to June 24

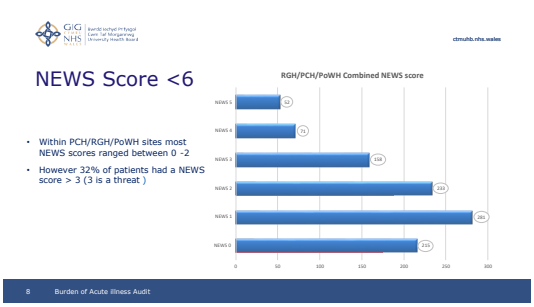
Audit	Compliance over last 6 periods						Current
Fluid Balance Audit (V.3)	64.8%	62.2%	66.0%	66.5%	67.6%	71.8%	61.4%

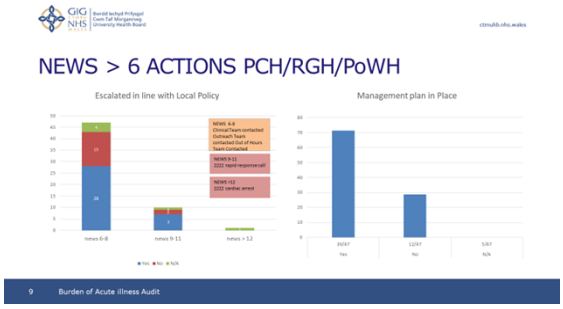
2.2.6 Burden of Acute Illness

Knowledge of how many acutely unwell patients we have in our acute hospitals in any one period of time is vital to plan provision of services for Acute Deterioration. We conducted an audit to assess the burden of acute illness within each secondary care hospital over a 24-hour period and to review the escalation process in order to provide assurance around the management of acute deterioration on each site. (Ref 4)









We looked at these parameters:
The number of NEWS charts in each clinical area
The number of patients scoring NEWS ≥6 in each area
The number of patients who scored ≥6 – 8 who were escalated in line with policy
The number of patients scoring ≥9 in each area who were escalated as per clinical policy

We undertook a separate review into:
The number of rapid responses calls in previous 24 hours
The number of admissions to Critical Care in previous 24 hours
The number and location of cardiac arrest calls in previous 24 hours

Audit to be repeated in April 24

2.2.7. Resuscitation and Clinical Skills

The resuscitation service for CTMUHB currently has 12 members. This consists of 1 resuscitation manager, 3 resuscitation practitioners, 3 resuscitation training officers, 3 Clinical skills officers and 2 administrators. Due to maternity leave and the position not being backfilled there are currently 5 members of the team actively training, however, 2 of these have additional managerial responsibilities within the UHB (University Health Board). In addition to this they provide a service to Powys Health Board, GPs, Dentals and other SLAs.

Throughout 2021-22, there was a focus on standardisation of Resuscitation Standards in CTMUHB. This included a complete review of the CTMUHB resuscitation policy, and a renewed resuscitation training compliance matrix for the organisation.

Additionally, the resuscitation equipment was standardised across the health board, with a major change to equipment taking place in Princess of Wales Hospital with the rollout of new resuscitation trolleys across what was then the Bridgend locality group.

The standardisation of equipment, along with the rollout of the Rapid Response Calls, has not only improved patient safety, but has also rationalised equipment with a significant reduction in equipment utilised.

During 2021-22 the Royal Glamorgan Hospital and Prince Charles Hospital received 40 new defibrillators along with the relevant training of staff to ensure competence and safe use.

The service also provided support and training for staff to roll out a new standard operating procedure in Ty Llidiard, as part of the response to a Welsh Government investigation into a recent incident. This included working closely with Welsh Health Specialised Services (WHSSC) Committee and Welsh Ambulance Service NHS Trust (WAST) to create a hybrid 2222/999 response to emergency calls.

2.2.8 Rapid Response Systems

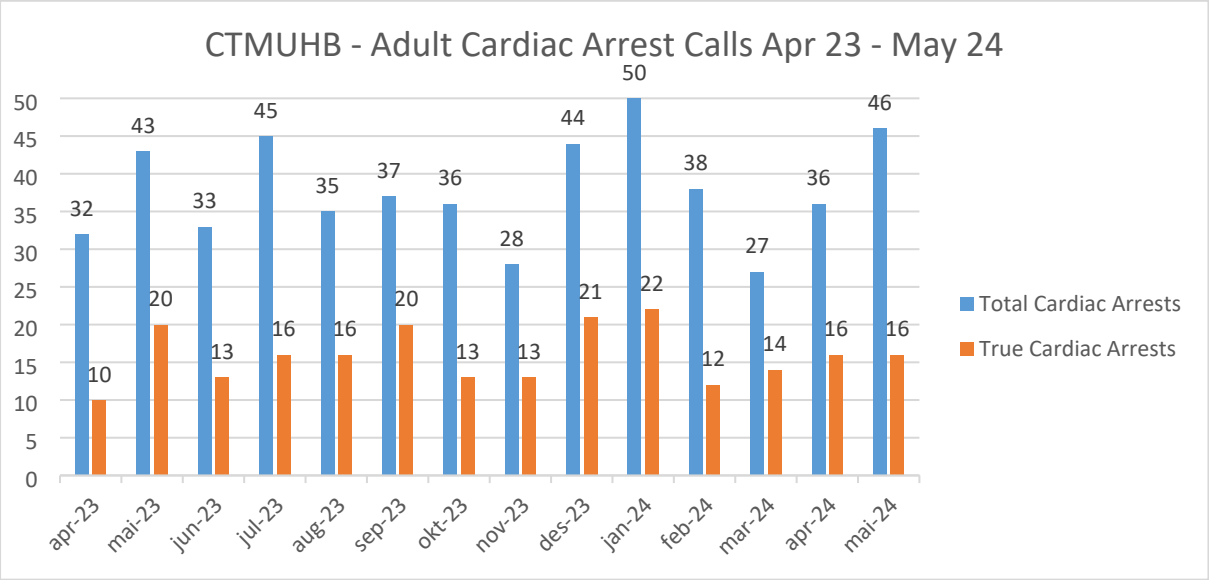
Clinically significant deterioration of patients admitted to general wards is a recognized complication of hospital care. Rapid Response Systems aim to reduce the number of avoidable adverse events. Over the last 3 years in CTMUHB we have standardised our Rapid Response Call to a NEWS of 9 or over. Rapid arrival at the bedside of the appropriate team has led to patients being seen earlier in their deterioration. Access to Critical Care is enhanced, ward-based treatments are maximised and decisions on further management e.g.: end of life decisions are clarified.

Quality metrics for the evaluation of Rapid Response Systems recommended by the International Society of Rapid Response systems (ref 5)

Metrics	Method of data collection	Rationale	How we will do this
Hospitals should measure and track cardiac arrests in regular ward patients	Measure all cardiac arrests occurring within the ward environment	Rates of cardiac arrests on general wards can be seen as an indicator of an organisations ability to appropriately identify and manage patients who deteriorate	We compile a monthly list from switchboard of 2222 calls and input onto AMAT (Audit Management and Tracking), differentiating which are for Cardiac Arrest and which are for Rapid response
Hospitals should measure predictable cardiac arrests in general ward patients	Cardiac arrest occurring in hospitalised ward patients who met the hospital's escalation threshold at least 30mins prior to and within 24 hr of the cardiac arrest.	IHCA associated with a mortality risk of 80% historic data show that there are preceding derangements in patient observations for up to 8 hours prior to the CA. This forms the basis for escalation criteria for the RRS.	From the RR/CA audit form we have a record of monthly Cardiac arrests that had a NEWS> 6 in the 24hrs prior to arrest. Cardiac arrest review meetings are conducted monthly to review all cardiac arrests within the secondary sites
Hospitals should measure timeliness of their response to ward patient deterioration	measure hospitalised patients who received evaluation by staff with critical care skills or advanced skills within the pre specified time	To assess whether the response of the RRS is timely	There is a box on the audit form that is Y/N for a timely response. Rather than having specific response times in there it may be a judgement call of the auditor whether there was a timely response or not

Hospitals should evaluate timeliness of critical care interventions	Proportion of hospitalised ward patients who receive critical care within 6 hrs of an escalation criteria breach	To measure the facilitation or provision of critical care within 6 hrs. Respiratory support invasive/non invasive Vasopressors/ inotropes Invasive monitoring	In the rapid response box, we record Critical Care intervention and a Time (which could mean transfer to ITU or intervention on the ward or t/f to theatre etc) There is also an updated data system MedICUs in use within PCH/PoWH that the Outreach teams use to enter data on reviews
Patients that exhibit warning signs should receive a timely documentation of goals of care	Proportion of hospitalised ward patients who had goals of care discussions either in place or newly documented by a clinical provider within 24hrs of first breaching the escalation criteria	Delays of care at either end of palliation-invasive spectrum are associated with avoidable morbidity. The deteriorating patient's best interest can only be served if a treatment plan communicating the goals of care is developed and implemented at this time.	This is recorded in the DNACPR/Not for escalation box.
Hospitals should provide means by which patients and family members can activate the rapid response team			This is under discussion.
Hospital should consider measuring the frequency of RRT activations by patients and family members			This would be easy to measure when we proceed with family member activation.
Hospitals should evaluate safety culture in relation to deteriorating patients and their care	The hospital uses a survey tool regularly to evaluate hospital staff perceptions of safety culture in relation to the Rapid response systems Adapt existing tool.	RRS organisation wide patient focused systems to be developed to prevent potentially avoidable deaths and serious adverse events as cardiac arrests. Culture and attitudes of an organisation affect patient outcomes	The regular Staff feedback form on Outreach records this.
Hospitals should measure the length of stay on general wards of all patients with breach of escalation criteria	Measure total length of stay for ward patients who breach escalation criteria differentiated from those patients with timely documented goals of care. Should include ITU LOS	RRS operates under the premise that early identification of patients experiencing clinical deterioration leads to early intervention and better clinical outcomes.	A NEWS of 9 is a rapid response call. Further administrative support is needed to ascertain this data.
Hospitals should measure ICU (Intensive Care Unit) length of stay of patients transferred to ITU following breach of local escalation criteria.	Measure the length of stay for patients admitted to ITU from the ward within 24hrs of triggering deterioration. Patients admitted with delayed initiation of critical care should be differentiated from those with prompt escalation of care.	Value in healthcare is defined as the health outcomes achieved relative to their financial cost. The cost of emergency ITU admissions from general wards unknown	This is deliverable if and when as above, administrative support is forthcoming.

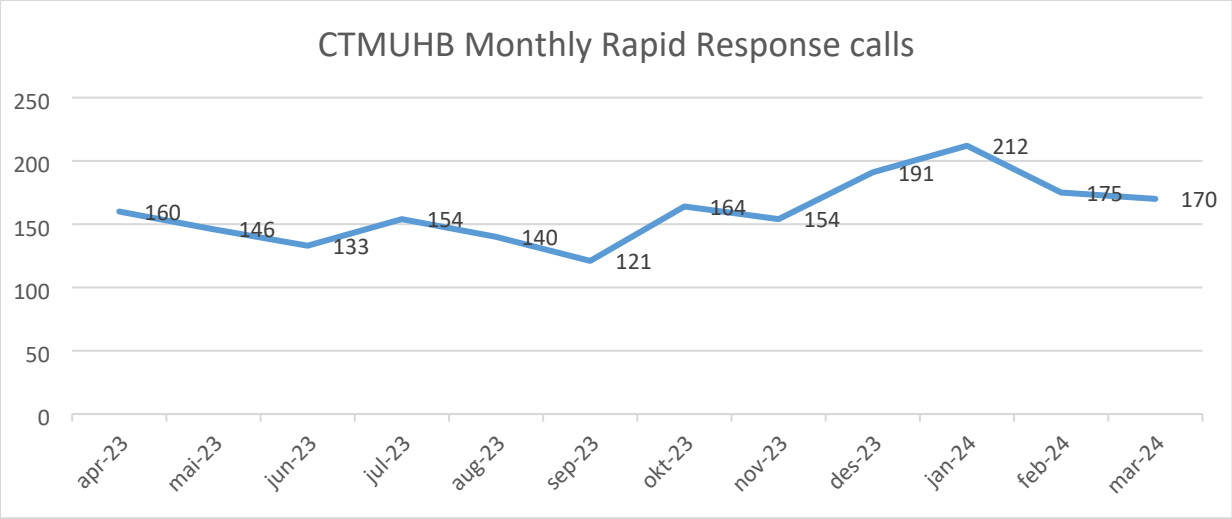
Fig 6. Graph illustrates the total number of monthly Cardiac Arrest calls and true Cardiac Arrest calls within PCH/RGH/POWH Apr 23 – Mar 24



*Not all Cardiac arrests within EDs Recorded

FIG 7. Graph Illustrates Rapid Response calls for RGH/POW/PCH sites via AMaT *not all recorded dependent on Outreach service)

April 23-March 24



2.2.9 **Advanced Care Planning Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Treatment Escalation Plans (TEPS)**

Advanced and Future Care Planning:

In many clinical interactions, the response to Acute Deterioration is good.
Often, where the response is less good, the problem lies in issues around appropriateness of escalation. Too often, patients in the last few hours of a natural and anticipated death are subjected to investigations and interventions that are futile and distressing for them and their families.

Advance care planning has been on the agenda of our local RADAR groups for a year. While it is not technically a part of the RADAR brief, the lack of advance planning i.e.: the lack of treatment escalation plans and DNACPR decisions leads to over-intervention with associated quality, experience, and resource implications. Several sources of assurance are informing us that we need to act in this area, and we describe them below.

The repeat of the CTM documentation Audit this year where a sample of DNACPR forms were taken from all three localities in CTMUHB and across a range of sites, including primary, community and secondary care.
This documentation audit has found poor recording of the assessment of mental capacity, poor documentation that the patient was informed of the DNACPR decision, poor documentation that the next of kin was informed of the decision and a very poor lack of section 6 countersignature by a Senior Clinical Decision maker.
The Audit showed no improvement since the last audit and no follow through of the recommendation to identify an individual or team to plan and deliver education on DNACPR.

A similar focused audit into DNACPR decisions and documentation in patients who had a fractured neck of femur (FNOF) across the three sites was undertaken in late 2023.
Research has shown that the chances of a successful outcome following Cardiac Arrest in patients that suffer a fractured neck of femur (FNOF) approaches 0%.
DNACPR decisions should never be initiated in a blanket fashion, however, the associated co-morbidities and frailty with FNOF patients should prompt all patients to be potentially considered for a DNACPR decision. The audit showed forms for only 28% of these patients. This has profound quality, experience and resource implications for those patients who unfortunately arrest without a DNACPR in place.

Mortality reviews conducted by the Medical Examiner frequently show that DNACPR decisions are being initiated by junior medical and nursing staff without any validation and agreement being documented by a consultant or a GP as evidenced by a countersignature.

This raises questions around competency and validity and exposes the organisation, the patient and the junior staff member to risk.

DNACPR forms are being initiated by non-medical healthcare practitioners.
While this is to be encouraged within the spirit of the All-Wales DNACPR policy, there is no governance structure in our health board that provides assurance that these nurses have the necessary training or assessment of competencies to fulfil this role. This exposes the patient, the staff member and the organisation to risk.

There has been a recent All-Wales thematic review of DNACPR by the NHS Executive which has shown poor understanding and knowledge of the process, poor record keeping, poor processes around the DNACPR form e.g.: communication and handover of decisions between professionals and wider organisational end of life issues.

A recently published HIW report, likewise, shows issues with documentation, communication, patient/family understanding, timing of decisions, overall decision-making issues with disability and inclusivity, mental capacity issues and senior clinical decision-maker oversight.
Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions for Adults in Wales

Our rolling RADAR audit of all 'true' cardiac arrests in CTM, undertaken every month, is suggesting that 80% of those that died should have had a DNACPR in place before they had an arrest.
This represents 80% of patients who have futile, invasive, undignified and resource-heavy intervention when advanced decisions/DNACPR could have spared them this.

Pulling all these assurance sources together we can see that DNACPR decisions are not made often enough due to lack of communication, education and awareness of the futility of CPR in certain patients. When they are made, there are failings in assessment of Mental Capacity, communication with the patient and family is poor and documentation is poor.

While this is not in the remit of the RADAR group per se, we have identified a real quality shortfall and believe it needs escalating and addressing.

We would propose that a governance group needs to adopt this. The group would assess the assurance measures, put in place an action plan and define a resource to educate, train and communicate on DNACPR and other advance care planning issues

Treatment Escalation Plans (TEPs)

A TEP form is a way of the healthcare team recording a patient's individual care plan should they deteriorate in an emergency, focusing on which treatments may or may not be most helpful to them. The information recorded on the TEP form

helps to guide healthcare professionals in an emergency, as to which treatments would or would not help an individual patient.

A TEP encourages a patient and their team to discuss certain aspects of treatment in advance, promoting careful planning. A TEP ensures that a patient does not receive treatments that they wouldn't want.

In CTMUHB we have adapted and adopted the All-Wales TEP template and are currently progressing with rollout on each secondary site
(Ref 6)

DNACPR

Sharing and Involving- A Clinical Policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales.

This policy was updated in April 2022 and recommends a biennial audit into documentation of the DNACPR discussion using the DNACPR forms.

This re-audit of documentation (available on request) looked at patients from all clinical areas of Cwm Taf Morgannwg including those from primary care, community hospitals and acute hospitals.

Where compliance in documentation fields was over 90% it was reassuring.

Areas notably less compliant than this were:

- Assessment of Mental Capacity 84%. This average was brought down by the Rhondda locality being at 50%.
- Recording of discussion with patients was significantly poor in Rhondda locality. (46%)
- Recording of discussion with a proxy e.g.: a family member was poor across the health board.
- Documentation around the involvement of a senior clinical decision maker was around 62%. Again, this is poor.
- Since the last audit there has been no improvement in the 3 key areas of documentation. Namely: 1, assessment of Mental Capacity, 2 Discussion with patient and/or proxy and 3, involvement of a Senior Clinical Decision maker

This, arguably, is due to the LHB not following through the action of the earlier Audit which was:

"To improve DNACPR form completion a structured approach should exist involving identifying an individual/team to deliver education across the health board on a regular basis. "

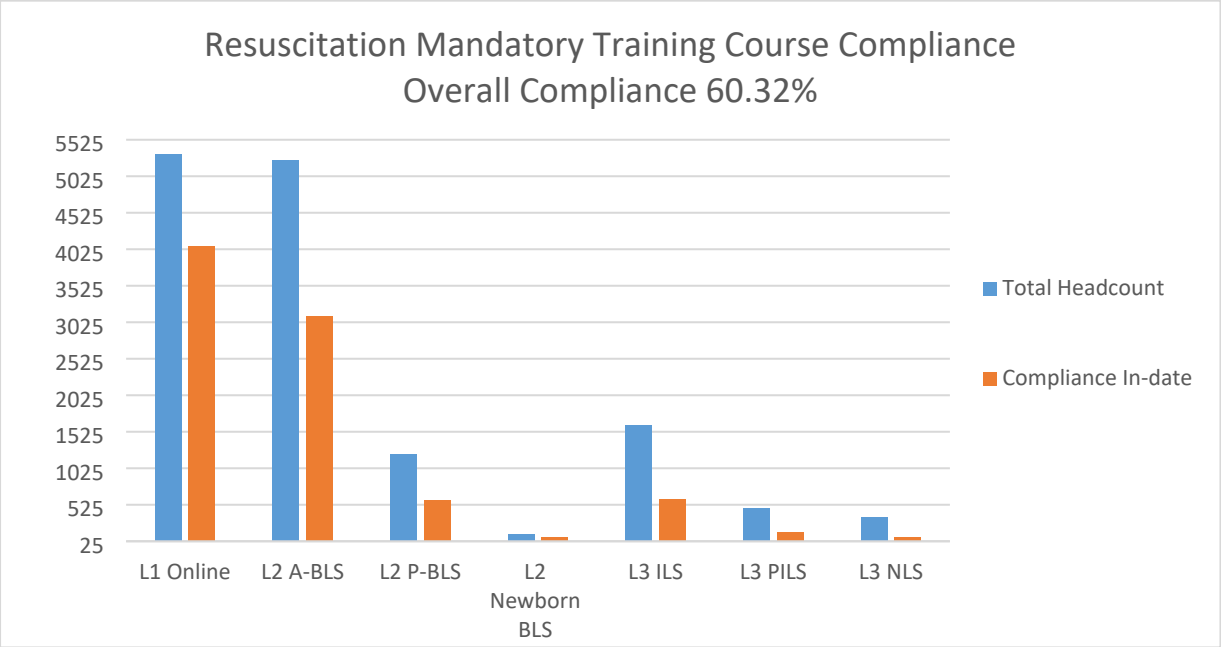
We have identified this need to establish a separate workstream and governance group to improve advance care planning, DNACPR decisions and Treatment Escalation Planning as a key risk and matter for escalation to the Q+S Committee, RADAR group and Nurse and Medical Directors.

2.3 Education and Training

2.3.1 Resuscitation training

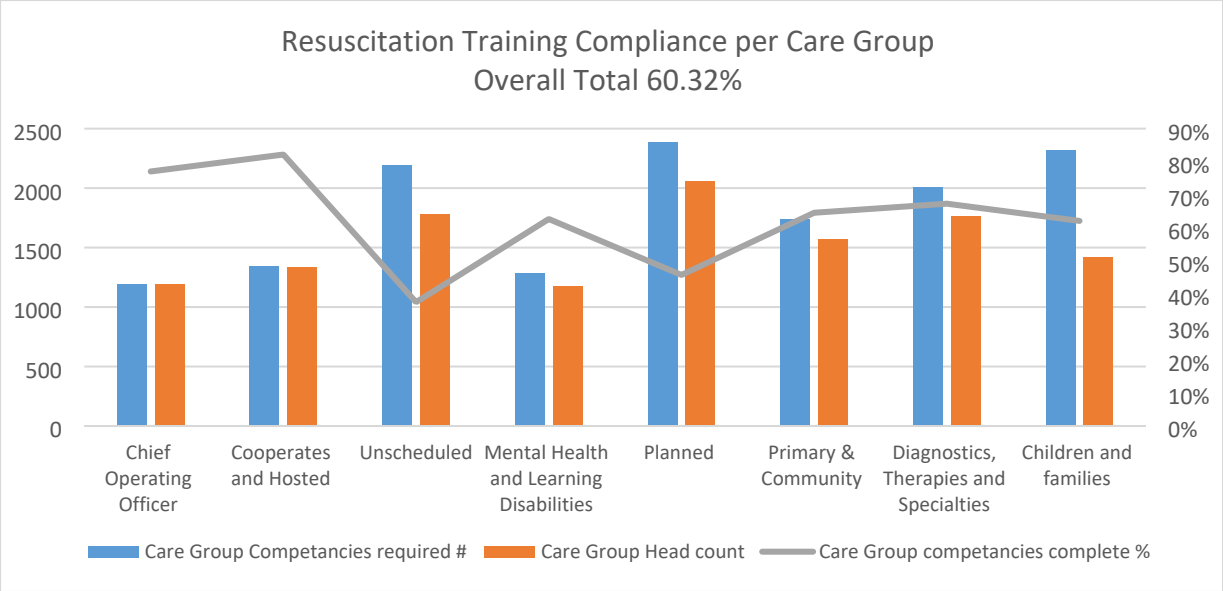
The Resuscitation Service continues to deliver mandatory life support training from Level 1-3 (graph 1 and 2), for CTMUHB, Powys HB and all local GP's and Dentists. The department is also a leading National provider in the delivery of Level 4 Advanced Resuscitation Courses, for Adults, Paediatrics, Newborns and Trauma. These courses are delivered on an income generation basis, with internal and external faculty engagement required to deliver. The number of staff trained is outlined below

Fig. 8 Training Compliance



Staff trained, April 2024 Resuscitation Training Compliance

Fig.9 Care Group Resuscitation Training Compliance



Over the past year, the Resuscitation Team worked collaboratively with the Practice Development Nurses and Midwives (PDN & PDM) to deliver 'Train the Trainer' (TTT) 'in house' training programmes for Level 2 Basic Life Support, increasing flexibility and opportunity to offer further training places and therefore increasing compliance. A concerted effort has been achieved with a particular focus on ensuring staff members are adequately trained to the appropriate compliance level. The Resus department carried out surge training initiatives to provide comprehensive support and implemented targeted training programs tailored to address areas of lower compliance. This proactive approach was aimed to bolster care group compliance across the whole of CTM.

There has still been a shift in focus from for the Resuscitation Practitioners and Training Officers to focus on the delivery of Level 3 training, organising and facilitating debriefing sessions following arrest calls, investigating and preparing evidence for Rapid Reviews and scrutiny panels, attending 2222 calls, cardiac arrest audits, and Datix queries. Through this activity areas for improvement are identified and training needs incorporated into future training programmes. E.g., redesign of the cardiac arrest audit form. The revised audit enables identification of areas needing improvement in training and provides a trail of decision making.

To meet service demand and provide the UHB with the most appropriate training, alternative training packages have been considered beneficial. Following investigation into the prevalence of sick patients and cardiac arrests in our Community Hospitals, it has been agreed to offer qualified nursing staff a bespoke package, which includes Basic Life Support, Sepsis and AKI, among other things. This package is being designed with the UHB's Outreach Teams. This will replace the previous training of ILS, which is more suitable for acute sites. This has enabled the service to increase the number of participants on each course and collaboration between Resus and Outreach has increased the training delivery capacity.

Additionally, training for other allied health professionals has been reviewed, identifying appropriate level of training for the role being undertaken e.g., level 2 rather than level 3, as they are either looking after "well patients" in outpatient departments or in an area covered by Outreach/2222 calls and where the patient should be accompanied by a nurse i.e., Radiology. In response to changes to the Resuscitation Council UK Guidance regarding the suitability of Paediatric ILS up to the age of 18, we have changed training requirements for staff working within Ty Llidiard to reflect this.

The changes to CTMUHB training compliance standards to more appropriate requirements for each health care role and the promotion of Train the Trainer packages are intended to enable increases in compliance for Resuscitation training (for training matrix please see ref 11).

Other training initiatives have included the crucial tasks of updating defibrillators in the community sites with new make and model defibrillators. This required the Resus department to upskill staff in using the new device. Whilst ensuring all areas met the latest standards and technology achievements across community sites.

Additionally, resuscitation services of Cwm TAF Morgannwg University health Board joined the National cardiac arrest audit (NCAA) in April 2024.

2.3.2 HMP Parc Prison

Subsequent to the recent spate of deaths in HM Prison Parc the Resuscitation service in CTM Health Board have reviewed the level of Life Support training that we require from our prison healthcare staff.

Recently CTM Health Board have taken on responsibility for Primary Healthcare in HM Prison Parc.

This included ensuring Basic Life Support (BLS) training has been undertaken by the healthcare professionals that work there.

BLS focuses on good quality chest compressions, early defibrillation using an automatic defibrillator and removal of a foreign body if choking.

We know that Basic Life Support ensures:

- cardiac arrest is recognised early
- help is sought – shout for nearby help and dial 999
- CPR is promptly started according to current guidelines
- an Automatic Defibrillator is located, retrieved and used as early as possible.

This is crucial in the Primary Healthcare setting, however, after review, we feel we can build on this by offering another 'Resuscitation Council UK' course called "Immediate Life Support" (ILS) which also teaches the healthcare professional to:

- recognise and treat the deteriorating patient using the ABCDE approach

- identify the causes and promote the prevention of cardiopulmonary arrest;
- undertake the skills of quality CPR and defibrillation and simple airway manoeuvres;
- utilise non-technical skills to facilitate team leadership and effective team membership.

Our Resuscitation training team have scheduled courses to train all Registered nurses at HMP Parc in ILS by August 13th 2024. This training will also include Mental Health scenarios, Loss of Consciousness and Asphyxiation

2.3.3 Outreach Service

The Outreach Teams deliver acute deterioration training within the secondary sites. NEWS training is also provided by the health care support worker programme and the resuscitation practitioners during Immediate Life Support and Advanced Life Support.

To complement the Immediate Life Support (ILS) course provided by the resuscitation team, the Acute Life-Threatening Events-Recognition and Treatment (ALERT) course has been introduced across CTMUHB for all registered nursing staff. This ensures a unified approach to education to manage an acutely unwell patient within a ward environment. The plan for 23-24 is to extend the provision of the course and develop a multi-professional faculty to facilitate, this would provide best learning environment for the candidates on the course.

Title	Sites	Frequency	Staffing and hours
Acutely unwell study day	All	Monthly	X6 staff total 36hrs
ALERT	All	Monthly	X6 staff total 36hrs
NEWS		Weekly	12 hrs. monthly
Sepsis		weekly	12 hrs. monthly
AKI		Weekly	12 hrs. monthly
Newly Registered Nursing Induction Programme (NRNIP)	All	Biannually	6 hrs. annually
Student Nursing Programme	All	Biannually	18hrs annually
CTM Tracheostomy training	All	Monthly	6hrs monthly

. **National Work**

The focus of RADAR since it commenced in 2021 has been on establishing fit for purpose ways of working across CTMUHB. It has noted activity ongoing at a National Level and has been working to identify what would be appropriate to

engage with further. This is an area of focus and further development over 2023-24.

2.4.1.1 Work within UK

Resuscitation Council UK. (RCUK)
CTMUHB adheres to the RCUK's guidelines for protocols and training of staff. The RCUK are a collaboration of research councils working effectively to enhance the overall impact and effectiveness of resuscitation research, training and innovation activities in the delivery of the government's objectives for science and innovation.

The National Cardiac Arrest Audit (NCAA)
The NCAA monitors and reports on the incidence of, and outcome from, in-hospital cardiac arrest in the UK to inform practice and policy. Many organisations in the UK are enrolled in the audit but no LHB in Wales is. A paper was submitted to the RADAR committee in 2021 which agreed that CTMUHB should participate in the NCAA.

Beginning April 2024, funding has been secured to pay for entry into the audit for this financial year, As of April 2024, we now collect data and submit to the audit. Results/Report will follow in a year's time.

Academy of Medical Royal Colleges (AoMRC)

A recent paper from the AoMRC (Ref 9) led healthcare organisations across the UK to review their approach to Sepsis screening. In summary, the paper acknowledges there is a balance to be found between early antibiotic administration and the danger of over-use of antibiotics and that priority is given to sicker patients based on NEWS scoring. Decision to treat should come from early review by a senior clinical decision maker.
Both at an LHB and a Wales level we are engaged in addressing the paper.

2.4. 2 Work within Wales:

The predecessor to Improvement Cymru, 1000Lives+, had several national workstreams focussed on Acute Deterioration pulled together via the Rapid Response to Acute Illness learning set (RRRAILS).
CTMUHB worked closely with RRAILS and led the way in updating and standardising our approach to NEWS, sepsis and AKI.

After a 4-year hiatus, Improvement Cymru, at the behest of Welsh Government, is attempting to set up a National Acute Deterioration Faculty: an expert panel that will review the current evidence and make recommendations to LHBs in Wales.
The Clinical lead for RADAR and Lead for Acute Deterioration are key members of this expert panel and expect CTMUHB to be at the forefront of any changes.

Up until 2021 Welsh Government required all LHBs to submit monthly data on Sepsis incidence and compliance. It is hoped that Welsh Government will resume a requirement for data when the Acute Deterioration Faculty advises it what data is meaningful to collect.

Our Lead for Acute Deterioration is the Chair of the Welsh Outreach Forum, a co-opted board member of UK National Outreach Forum. Regular meetings occur where peers share service innovations and discuss future collaboration.

The Sepsis in Wales group has recently been set up to bring all LHBs together to update and standardise our approach to Sepsis screening following the publication of the Academy of Medical Royal College's Sepsis paper. The group is chaired by our Clinical lead for RADAR.

Reference for papers All available on request

1 CTUHB Peer review report:	2 Resuscitation Services review
3 RADAR TOR	4 WG critical care report
5. CTM Sepsis Screening Tool	6. Burden of Acute Illness Audit
7. TEP policy/form/patient information leaflet	8. DNACPR audit and Policy
9. AoMRC Statement on Antibiotics In sepsis	10. International Society for rapid response systems Metrics
11. Cardiopulmonary policy and Resuscitation Training matrix	

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

Agenda Item
9.2.6

Quality & Safety Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME QUARTER 1 UPDATE 2024-2025

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit & Quality Informatics, Lauren Dyton – Clinical Audit Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
NMTR	National Major Trauma Registry
CA&QI	Clinical Audit & Quality Informatics Department
NEIAA	National Early Inflammatory Arthritis Audit
NAIF	National Audit of Inpatient Falls

NELA	National Emergency Laparotomy Audit
SWTN	South Wales Trauma Network
PWH	Princess of Wales Hospital
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
AMaT	Audit Management and Tracking
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
MINAP	Myocardial Ischaemia Audit Project
NICE	National Institute for Health and Care Excellence
HQIP	Healthcare Quality Improvement Partnership
WG	Welsh Government
NCA&ORP	National Clinical Audit and Outcome Review Plan
COPD	Chronic Obstructive Pulmonary Disease
DHCW	Digital Heath Care Wales
NHFA	National Heart Failure Audit
NNAP	National Neonatal Audit Programme
ICS	Integrated Care Systems
PROMs	Patient Reported Outcome Measures
GIRFT	Getting It Right First Time
BSR	British Society for Rheumatology
EIA	Early Inflammatory Arthritis
QS	Quality Standard/Quality Statement
NCDA	National Core Diabetes Audit
LFER	Learning From Events Reports

1. Situation /Background

1.1 The purpose of this report is to provide an update for the Quality and Safety Committee on progress against the CTMUHB Clinical Audit Forward Plan 2024-2025. The CTMUHB plan was based on information from the HQIP directory of United Kingdom wide agreed audits and approved in March 2024. However, this has been reviewed against the NCA&ORP for Wales (2024/25) published June 2024 and the following additional audits have now been included, a number of additional national cancer audits for Ovarian Cancer, Pancreatic Cancer, Non-Hodgkin Lymphoma and Kidney Cancer. In addition, the National Gestational Diabetes audit has been included although the data capture methodology for Wales is currently in development.

1.2 **32** out of 45 national audits (tier 1) are green fully compliant and 3 amber (NMTR / TARN, NEIAA (PWH), NJR (PWH) where the audits are delayed, a backlog exists work is ongoing to partially or fully comply with the national audit deadlines. **1** audit is red the NCDA as CTMUHB was not in a position to share the diabetes audit data for 2023 with the NCDA audit group via DHCW this year, owing to the absence of the necessary data disclosure agreements on a pan Wales basis, we will be an 'outlier' for the NCDA. 9 out of the 45 national audits are new and data collection methods yet to be agreed. (5 new cancer audits, Gestational Diabetes, Diabetes Prevention Programme Audit, National Diabetes Inpatient Safety Audit, Wales Primary Care COPD Audit)

1.3 Dr. Richard Jones, Consultant Anaesthetist finalised the DNACPR audit findings and has presented them at clinical audit meetings and to the Clinical Audit, NICE & Effectiveness Group. The audit findings concluded that DNACPR decisions need to be considered more frequently by clinicians, that documentation on DNACPR needs improvement and communication with patients and families must improve.

1.4 The AMaT system continues to develop with work in progress to further develop the use of the inspections module by the CTMUHB corporate governance team.

2. Specific Matters for Consideration

2.1 Clinical Audit Forward Plan 2024-2025 Current Position

A number of audits are amber due to competing demands on clinician time, these include:

NJR activity at the PWH is not covered by the directorate, ongoing discussion taking place to transfer funding for the data capture responsibilities to Clinical Audit team for 2024/25, as per arrangements for RGH.

NEIAA due to clinical pressures and limited administration resources to support the service particularly in the PWH.

TARN interim measures remain in place following the taking down of the system by the University of Manchester (refer to key risk point 3.1) which has impacted on national data capture.

Developments since the last report:

NHFA position is green, additional clinical support identified for PWH to assist in addressing the NHFA backlog, data capture exceeded minimum requirements for all sites.

NAIF clinical input for case note reviews identified across all 3 District General Hospital sites, data capture for 2023 closed at the end of March 2024 with data submitted for all eligible cases identified. NAIF position is now green.

NELA compliance improved at RGH during May and June, data submitted for all eligible cases identified for July deadline. NELA position is now green.

Potential outlier notification received regarding the National Audit of Dementia relating to delirium screening, data validation exercise was undertaken and data resubmitted, Royal College of Psychiatrists confirmed no longer outlier and no further action is required.

2.2 Key clinical audit publications, findings and actions

NCEPOD – Testicular Torsion Report

A review of the pathway and quality of care provided to children and young people aged 2-24 years who presented to hospital with testicular torsion. Testicular torsion is a surgical emergency requiring prompt diagnosis and surgical intervention. Delay in recognising testicular torsion and delay in presenting to hospital is known to lead to poorer outcomes.

NCEPOD recommends increased public awareness of the subject, care pathways minimise the need for transfers. Urgent senior review, with senior involvement in the decision-making and operation. Extended follow-up for patients was another improvement recommendation made by NCEPOD.

At CTMUHB collaborative conversations are taking place across Paediatrics, General Surgery and Radiology. Findings are being shared and recommendations are under review.

2.3 Clinical Audit Training

In collaboration with the University of South Wales the Clinical Audit Department welcomed two second year nursing students as part of a 3 week placement within Patient Care & Safety during April and May.

Providing a wide-ranging introduction to clinical audit, an in-depth insight into key national clinical audits and ward-based auditing. Feedback from the student nurses was very positive.

Senior nursing team training has been provided on action planning at the RGH, lecture theatre. Training well received and sessions planned for PCH and PWH. To date over 577 Health Board staff have received training on the ward and area module.

2.4 AMaT Implementation

The AMaT system continues to develop with work in progress to further develop the use of the inspections module by the corporate governance team. A number of CTMUHB specific enhancements have been specified and submitted approval and development.

Working with the CTMUHB Quality Improvement team on an All Wales agreed Falls audit that is being piloted on AMaT across 7 areas.

Utilising the AMaT system to support evidence for LFERs and Ombudsman cases. The work includes provision of data from existing audits and/or developing new audits based on concerns e.g. Safeguarding audits).

The first Business Intelligent dashboards have been developed utilising data automatically pulled into the organisation data warehouse that will allow triangulation of AMaT data with data from other system for improvement.

2.5 NICE Compliance Programme of work

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB is the responsibility of the care groups. However, in collaboration with the Medical Director's office a process to disseminate new NICE guidance, receive feedback from care groups and annotate compliance statements on the AMaT system has been approved and this activity is planned to commence in quarter 3 / quarter 4.

2.6 Clinical Effectiveness Committee (CEC)

The Assistant Medical Director for Clinical Audit is leading the establishment of a Clinical Effectiveness Committee (CEC) for CTM supported by the Clinical Audit Manager, the Head of Clinical Audit and Quality Informatics, and the Medical Director's Office. The inaugural CEC meeting will be held on Tuesday 16th July 2024, where the agenda will focus on the national mandatory cancer audits. An introduction to the new CEC was hosted by the Executive Medical Director and the Assistant Medical Director for Clinical Audit on Monday 17th June 2024.

3. Key Risks / Matters for Escalation

3.1 On 9 June, the University of Manchester confirmed it had taken down the Trauma Audit Research Network's National Major Trauma Database, resulting in the inability to submit or access data. SWTN liaised with Health Boards and WG to address the issue.

The SWTN in collaboration with DHCW regarding the creation of a long-term data capture solution for use by Health Boards in Wales, solution proposed was incompatible for CTMUHB, therefore basic interim methods remain. It is anticipated that Welsh health boards will participate in the new NMTR from September once to the appropriate data disclosure and governance arrangements are established (NMTR available for England since April).

The consent tier 2 organisation priority audit has been delayed awaiting further communication from audit Lead on the date to commence this audit.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
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: Data to Knowledge
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies please list below: Efficient and Safe Care
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable If more than one applies please list below:

Environmental /Sustainability Impact (5Rs)	

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is not a policy or service review
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB.

6. Next Steps

6.1 To ensure completion of the full CTMUHB Clinical Audit Forward Plan 2024-2025, by the end of March 2025.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
9.2.7

Quality & Safety Committee

Annual Unpaid Carer's Report 2023/24

Dyddiad y Cyfarfod / Date of Meeting	23/07/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jenny Oliver, Head of People's Experience & David Watkins, Carer's Coordinator. Cwm Taf Morgannwg University Health Board.
Cyflwynydd yr Adroddiad / Report Presenter	Becky Gammon, Assistant Director of Nursing and People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director Executive Director of Nursing
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
CTM Carers Steering Group (quarterly basis)	Click or tap to enter a date.	Updates provided to RPB

Acronyms / Glossary of Terms	
BCBC	Bridgend County Borough Council
CBC	County Borough Council
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
RPB	Regional Partnership Board
WG	Welsh Government
RIF	Regional Integrated Fund

1. Situation /Background

1.1 CTM Carers Partnership Group was established in 2019, this group oversees the CTM Carers Statement of Intent and brings together representatives from local councils, the health board, and the third sector to promote carers' wellbeing and develop supportive services.

Funding sits within the RPB to ensure parity of support across the CTM footprint.

1.2 Carers Statement of Intent: Created in 2019/20, this statement outlines five primary aims focused on identifying carers, providing information and support, empowering carers, and maximizing resources for their benefit

Aim 1: Identify carers of all ages and acknowledge their contributions.

Aim 2: Provide up-to-date, relevant, and timely information, advice, and assistance to carers of all ages.

Aim 3: Offer support, services, and training to meet the needs of carers of all ages.

Aim 4: Empower carers of all ages by giving them a voice and more control over their lives.

Aim 5: Collaborate to maximise resources for the benefit of carers of all ages.

These aims are under review, with a planning and consultation exercise led by the CTM RPB involving all the stakeholder groups and alignment with the four national priorities for carers in 2020/21 as designated by WG (appendices available on request). Updates expected at end of 2024. Additionally, WG are leading a Rapid Review Task and Finish Group to review the ongoing work undertaken by Local Authority and Health Boards to ensure it is embedded in the relevant organisations

1.3 CTMUHB has been progressing work on identifying and supporting unpaid staff carers through the Corporate Unpaid Carer's Lead. Working alongside the CTMUHB Retention and Workforce Planning Lead we will support staff carers to balance work and their caring duties in order to remain in employment and maintain their emotional health and wellbeing.

2. Specific Matters for Consideration

2.1 Previously, the CTM Carers Partnership were responsible for commissioning carers' services using the WG Carers Grant, which was allocated to health boards across Wales (CTM Region's value in 2022/23 was £161,000). The

distribution process has changed, with CTM RPB now receiving the funding and disseminating via the RIF.

2.2 The RIF funds the Corporate Unpaid Carers Coordinator position within CTMUHB. The primary focus is to identify carers upon hospital admission, support/involve them during the hospital discharge process, and work with local authorities/voluntary sector to assist and support carers post-discharge to reduce patient re-admission from a holistic aspect.

2.3 The CTM Carers "End of Year progress report" is written by the CTM Regional Partnership Board and is pending authorisation for circulation.

2.4 During the 2023/24 financial year the RIF approved £196,732.00 of short break funding. The Short Breaks Scheme is aimed at providing unpaid carers in the Cwm Taf Morgannwg area with opportunities to take breaks from their caregiving responsibilities, thereby promoting their mental and physical wellbeing.

2.5 To proactively facilitate awareness of unpaid carers within the HB and community setting the Corporate Unpaid Carer's co-ordinator has facilitated a number of actions:

- **Optimise:** Collaborated with the Optimise Development Team to ensure carer referrals are seamlessly passed to local authorities via the Electronic Transfer of Care system. Efforts are underway to develop a dedicated carer icon for the patient electronic whiteboard.
- **Allied Health Professionals (AHPs):** Engaged with the Clinical Director of Therapies to explore collaborations with allied health professionals aimed at upskilling carers to provide additional support and low-level rehabilitation for discharged patients.
- **Carers Week**: Organised a series of activities for Carers Week in July, including recording three patient carer stories, preparing a comprehensive social media campaign, and procuring pamper packs for carers.
- **Staff Carers Café:** Established and agreed upon the Terms of Reference for the group in preparation for its re-launch during Carers Week (June 24).
- **Age Connects Morgannwg:** Coordinated with trusted assessors to identify and support carers on hospital wards effectively.
- **Presentations:** Delivered presentations to senior and paediatric nursing heads, and the strategy and information team, focusing on carer awareness and integration with current workstreams.
- **Collaboration with Carers Trust:** Worked collaboratively with Carers Trust to develop and deliver carer awareness training programs for staff.
- **Third Sector Engagement**: Coordinated with third sector organisations and the three community voluntary councils on social prescribing and carer support initiatives.

- **Innovation Cwm Taf Morgannwg (ICTM) Engagement:** Presented to the ICTM team to raise awareness of the carers agenda and ensure their voices are considered in future workstreams.
- **Patient Experience Collaboration**: Partnered with the People's Experience team to identify and support carers effectively.
- **Community Engagement Events:** Participated in multiple community events to connect with carers in community settings.
- **CTM2030 Engagement:** Coordinated with the Head of Engagement and Involvement to ensure carers are included in future strategic plans.

3. Key Risks / Matters for Escalation

3.1 Funding for the CTMUHB Corporate Unpaid Carers Coordinator position is renewed annually. The RPB, initially set up for five years, distributes funding through the Regional Integrated Fund (RIF). This funding cycle will end in two years, with uncertainty about continuation beyond the initial period.

3.2 CTMUHB remains committed to collaborating with partners to advance national priorities and enhance the support available to carers. Our focus will be on addressing the issues that matter most to carers, including enabling carers to have a fulfilling life beyond their caregiving responsibilities, identifying, recognising, and supporting carers to ensure they can continue their caregiving roles effectively, and providing timely and accurate information and advice to carers as needed.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	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	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:
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 not a policy or service review.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No change to service provision
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 To **NOTE** the report highlighting the work and activity that has been undertaken to support carers across the health board footprint internally and the continued engagement with third sector stakeholders.

6. Next Steps

6.1 To continue the coproduction work with RPB and third sector stakeholders with the opportunity to increase awareness and ensure the carer's voice is heard within care and community settings.