Quality, Safety & Experience Committee

Tue 18 November 2025, 09:00 - 12:00

Virtually via Teams

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Committee Chair*

09:05 - 09:05
0 min

2. CONSENT AGENDA BUSINESS

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

09:05 - 09:10
5 min

3. COMMITTEE GOVERNANCE ARRANGEMENTS

3.1. Action Log

Discussion *Carolyn Donoghue, Committee Chair*

3.1 QSEC Action Log QSEC 18 November 2025.pdf (2 pages)

3.2. Matters Arising not Contained within the Action Log

Discussion *Carolyn Donoghue, Committee Chair*

09:10 - 09:40
30 min

4. STAFF AND SERVICE USER EXPERIENCE

4.1. Shared Listening & Learning Story - Mental Health related

Discussion *Lloyd Griffiths, Interim Care Group Nurse Director*

4.2. Executive Director and Independent Member Quality & Safety Walkabouts

Discussion *Richard Hughes, Interim Executive Director of Nursing*

4.2 Walkabouts Report QSEC 18 November 2025.pdf (7 pages)

09:40 - 10:40
60 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Thematic Spotlight Presentation - Preventing Avoidable Pressure Damage in

Unscheduled Care

Discussion *Deborah Matthews, Care Group Nurse Director, Unscheduled Care*

5.1 Spotlight Presentation USC QSEC 18 November 2025.pdf (7 pages)

5.2. Clinical Executives Report

Discussion *Clinical Executives*

5.2 Clinical Exec Directors Update Report QSEC 18 November 2025.odt.pdf (13 pages)

5.3. Care Group Highlight Reports

5.3.1. Unscheduled Care Group Highlight Report

Discussion *Deborah Matthews, Care Group Nurse Director*

5.3.1 USC Highlight Report QSEC 18 November 2025.pdf (20 pages)

5.3.2. Children & Families Care Group Highlight Report

Discussion *Carl Verrecchia, Care Group Service Director*

5.3.2 Highlight Report Children Families Care Group QSEC 181125.pdf (9 pages)

5.3.3. Planned Care Care Group Highlight Report

Discussion *Sophie O'Donovan, Lead Nurse for Anaesthetics, Critical Care and Theatres*

5.3.3 Planned Care Highlight Report QSEC 18 November 2025.pdf (8 pages)

5.3.4. Mental Health & Learning Disabilities Care Group Highlight Report

Discussion *Lloyd Griffiths, Interim Care Group Nurse Director*

5.3.4 MHLD QSE Hightlight Report QSEC 18 November 2025.pdf (8 pages)

5.3.5. Diagnostics, Therapies, Pharmacy & Specialties Care Group Highlight Report

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

5.3.5 DTPS Highlight Report QSEC 18 November 2025.pdf (11 pages)

5.3.6. Primary Care & Communities Care Group Highlight Report

Discussion *Leanne Davies, Head of Nursing Primary Care & Community Services*

5.3.6 PCC Highlight report QSEC 18th November 2025.pdf (9 pages)

10:40 - 11:20
40 min

6. DELIVERING OUR PLAN

6.1. Patient Safety, Quality & Experience Dashboard

Discussion *Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence*

6.1 Patient Safety and Quality Dashboard Report QSEC 18 November 2025.pdf (17 pages)

6.2. People’s Experience Activity Report August – September 2025

Discussion *Becky Gammon, Interim Deputy Director of Nursing & People’s Experience*

6.2 People's Experience Quality Safety Report August - September 25 QSEC 181125.pdf (9 pages)

6.3. Status Report on Commissioned Services (Quality Focussed)

Discussion *Richard Hughes, Interim Executive Director of Nursing*

6.3 Status report on commissioned Servies-Quality focused QSEC181125.pdf (6 pages)

11:20 - 11:50
30 min

7. Governance, Risk & Assurance

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

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

7.1a Org RR Cover Paper - QSEC.pdf (8 pages)
7.1b App 1 - Org RR November 25 - QSEC.pdf (6 pages)

7.2. Mortality Indicators and Mortality Reviews

Discussion *Dom Hurford, Executive Medical Director*

7.2 Mortality Reviews and Mortality Indicators QSEC 18 November 2025.pdf (9 pages)

7.3. Highlight Report from the Harm Free Care Agenda

Discussion *Richard Hughes, Interim Executive Director of Nursing*

7.3 Highlight Report Harm Free Care QSEC 18 November 2025.pdf (8 pages)

7.4. Annual Presentation of Nurse Staffing Levels

Discussion *Becky Gammon, Interim Deputy Director of Nursing & People's Experience*

7.4a NSA Nov 2025 Annual Assurance QSEC 18 November 2025.pdf (7 pages)
7.4b Annual Presentation Board Nov V3 Approved.pdf (3 pages)
7.4c Appendix 1 - Summary of Nurse Staffing Levels Final.pdf (3 pages)

11:50 - 11:55
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the meeting held on 23 September 2025

Decision *Carolyn Donoghue, Committee Chair*

8.1.1 Unconfirmed Minutes QSEC 23rd September 2025 Final QSEC 181125.pdf (17 pages)

8.1.2. Unconfirmed Minutes of the In Committee meeting held on 23 September 2025

Decision *Carolyn Donoghue, Committee Chair*

8.1.2 Unconfirmed Minutes 23rd September In Committee Final QSEC 181125.pdf (3 pages)

8.1.3. Organ Donation Sub Committee Terms of Reference

Decision *Dom Hurford, Executive Medical Director*

8.1.3 ODSC TOR Amendment QSEC 18 November 2025.pdf (3 pages)

8.1.4. Safeguarding Annual Report 2024-2025

Decision *Richard Hughes, Interim Executive Director of Nursing*

8.1.4a Safeguarding Annual Report Cover Paper QSEC 18 November 2025.pdf (5 pages)
8.1.4b App A Safeguarding & Public Protection Annual Report 24-25.pdf (26 pages)
8.1.4c App B CTMSB Annual Report 24-25.pdf (59 pages)

8.2. FOR NOTING

8.2.1. Non-Routine Committee Business (Forward Plan)

Information *Carolyn Donoghue, Committee Chair*

8.2.1 CTMUHB QSEC Non Routine Bus QSEC 18 November 2025.pdf (4 pages)

8.2.2. Annual Cycle of Business

Information *Carolyn Donoghue, Committee Chair*

8.2.2 CTMUHB QSEC Cycle of Business QSEC 18 November 2025.pdf (5 pages)

8.2.3. Clinical Policies Highlight Report

Information *Dom Hurford, Executive Medical Director*

8.2.3 Clinical Policies Highlight Report QSEC 18 November 2025.pdf (5 pages)

8.2.4. CTMUHB National Clinical Audit Programme Quarter 2 Update 2025-2026

Information *Dom Hurford, Executive Medical Director*

8.2.4 Clinical Audit Quarterly Report QSEC 18 November 2025.pdf (8 pages)

8.2.5. CTM Clinical Learning Academy Annual Report 24/25

Information *Richard Hughes, Interim Executive Director of Nursing*

8.2.5a CTM Clinical Learning Academy Annual Report 24-25 QSEC 181125.pdf (4 pages)
8.2.5b Appendix 1 Final Clinical Education annual report 24-25.pdf (83 pages)

8.2.6. Bi-Annual Report CTM Radiation Safety Committee

Information *Lauren Edwards, Executive Director of AHPs and Health Science*

8.2.6 Radiation Safety Committee Report QSEC 18 November 2025.pdf (6 pages)

8.2.7. Antimicrobial Stewardship Report – October 2025

Information *Dom Hurford, Executive Medical Director*

8.2.7 AMR Report QSEC 18 November 2025.pdf (9 pages)

8.2.8. Health Inspectorate Wales Improvement Plan Tracker Report

Information *Richard Hughes, Interim Executive Nurse Director*

8.2.8a HIW Tracker Cover Report QSEC 18 November 2025.pdf (6 pages)
8.2.8b HIW Inspections Recommendations Tracker_QSEC 18.11.2025.pdf (8 pages)

8.2.9. Terms of Reference Annual Review

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

The Terms of Reference are being reviewed as part of the Committee Business Reviews for 2026 and will be presented to a future meeting

11:55 - 12:00
5 min

9. CLOSE OUT BUSINESS

9.1. Committee Highlight Report to the Board

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

9.2. Meeting Feedback

Discussion *Carolyn Donoghue, Committee Chair*

Is there anything we should do more or less of?
Have we managed our time and allowed open and balanced discussion?
Have we considered our values and acted in a way that supports embedding our values across CTM?

Have we maintained a Strategic Focus?
Have we received sufficient assurance from a range of sources?
Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

9.3. Any Other Business

Discussion *Carolyn Donoghue, Committee Chair*

12:00 - 12:00
0 min

10. Private/Closed Session Business

Information *Carolyn Donoghue, Committee Chair*

The following items will be received In Committee:

- Organisational Risk Register - Closed Risks
- Adult Mental Health Cultural Challenges

12:00 - 12:00
0 min

11. Date & Time of Next Meeting

Information *Carolyn Donoghue, Committee Chair*

The next meeting will be held on 20 January 2026 at 9:00am

Committee Action Log

Name
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Date
actio

			/ Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	WAST produced Quality Report to be shared with Members at future meetings of the Committee to help Independent Members to triangulate data between WAST and the Health Board.	Executive Director of Nursing/Deputy CEO	Interim Executive Director of Nursing	20/05/2025 Now 22/07/2025 **Now November 2025**	Open	**In progress** Interim Executive Director of Nursing for CTMUHB to meet with Director of Nursing at WAST to discuss what quality data sets were now available within WAST that could be shared with Committee members.
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	Consideration to be given outside the meeting on the frequency of reporting on this matter to future Committee meetings. Deputy Director of Nursing to discuss further with Committee Chair to determine the level of information required moving forwards.	Committee Chair	Interim Executive Director of Nursing	25/03/2025 Now 22/07/2025 Now November 2025 **Now January 2026**	Open	**In progress** Interim Executive Director of Nursing has suggested that given improved position a closure report could be presented to the Committee on this matter in early 2026
20.05.2025	4,1	3	Listening & Learning Story - Maternity Services	Update to be provided at a future meeting on the work being undertaken by the Team on how it was reaching the wider population via digital platforms.	Care Group Nurse Director, Children & Families	Care Group Nurse Director, Children & Families	TBC	Open	**In progress** Date to be agreed with Team
20.05.2025	4,2	4	Executive and Independent Member Walkaround Framework Cover Paper	Review of proposed frequency of walk rounds to be undertaken alongside a wider review of the new process once one round of walk rounds had been completed	Interim Executive Director of Nursing	Interim Executive Director of Nursing	18.11.2025	Open	**Propose to Close** Review has been undertaken and a report containing details of feedback received from the latest round of walkrounds is on the agenda for the November meeting. The Interim Executive Director of Nursing will also be having a discussion with Independent Members on the future process at the Board Development session on 18 December 2025.
22.07.2025	4,1	4	Listening & Learning Story - Carers	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed, with further discussion required as to what could be done to address the issues.	Head of Corporate Governance & Board Business	Interim Executive Director of Nursing	20.01.2026	Open	**Propose to Close** This item has been added to the forward work programme
22.07.2025	5.2.3	8	Planned Care - Care Group Highlight Report	Update to be provided by G Hughes on what the impacts and expected outcomes were likely to be in relation to the developments within Gastroenterology and General Surgery, for example, reduction in waiting lists, patients having to spend less time in hospital.	Chief Operating Officer	Chief Operating Officer	23.09.2025	Open	**In progress** Awaiting further update from Chief Operating Officer
22.07.2025	5,3	12	Stroke Services Report	Future reports to include focus on AHP and Therapies workforce availability to deliver a 7 day service, along with rehab goals and outcomes.	USC Care Group Service Director	Chief Operating Officer	20.01.2026	Open	**In progress** This will be included in the next scheduled substantive report which is due to be presented to Committee in January 2026
22.07.2025	6,1	13	Patient Safety, Quality & Experience Dashboard	Response to be provided outside the meeting regarding inconsistencies reported in figure contained in paragraph 2.2 regarding number of incidents reported compared to bar chart graph contained later in the report.	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	23.09.2025	Open	**In Progress** Interim Executive Director of Nursing plans to discuss the context of this action with Committee Chair
22.07.2025	6.1.1	14	Committee Referral - Details of the medical negligence claims from the losses and special payments report - Verbal Update	Detailed written update to be presented to the September 2025 meeting of the Quality, Safety & Experience Committee	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	23.09.2025	Open	**Proposed for Closure** Report and explanation presented to the meeting held on 23 September. Audit, Risk & Assurance Committee Chair content that this referral has now been addressed.
22.07.2025	6,4	14	People Experience Forum Update	Review the statement made within the report in relation to underfunding to better reflect the intended message, focusing on concerns rather than asserting underfunding as fact.	Deputy Director of Nursing	Interim Executive Director of Nursing	23.09.2025	Open	**Proposed for Closure** Response shared with Members by email on 5 November 2025
23.09.2025	4,1	3	Listening & Learning Story - Domestic Violence	Link up Head of Safeguarding with the Chair of the Women's Network in order to promote the work being undertaken by the Team to keep people safe	Executive Director of Allied Health Professionals & Health Sciences	Executive Director of Allied Health Professionals & Health Sciences	23.09.2025	Open	**Proposed for Closure - Complete** Executive Director of Allied Health Professionals & Healthcare Sciences has confirmed this has been actioned.
23.09.2025	4,1	5	Listening & Learning Story - Domestic Violence	Head of Safeguarding to return to the Committee in one year to provide more evidence in relation to learning points	Head of Corporate Governance & Board Business	Head of Safeguarding	sep-26	Open	**Proposed for Closure** This item has been added to the forward plan for September 2026
23.09.2025	5,1	6	Report of the Clinical Executives	Report on the current position regarding the proposed changes to the roles and remits for Physicians Associates to be developed and presented to a future meeting	Executive Medical Director	Executive Medical Director	jan-26	Open	**Proposed for Closure** This item has been added to the forward work programme
23.09.2025	5,1	6	Report of the Clinical Executives	The position in relation to the risk of sustainable funding routes for key projects/services which were subject to short term funding to be included in the alert/escalate section of the Committee Highlight report to Board. Positive items for escalation to also be included in relation to the positive inspection carried out by the Human Tissue Act Authority and the recent HIW visits to the Emergency Department at Royal Glamorgan Hospital (RGH) and to Maternity services at Princess of Wales Hospital (POWH).	Assistant Director of Governance & Risk	Assistant Director of Governance & Risk	nov-25	Open	**Propose to Close - Complete** The Highlight Report for the Committee which met on the 23rd September 2025 captured the agreed items and will be received at the November 2025 meeting of the Public Board.
23.09.2025	5.2.2	8	Diagnostics, Therapies, Pharmacy & Specialities Highlight Report	Update to be provided to the next meeting regarding the reasons behind the increased blood transfusion incidents	Executive Medical Director	Executive Medical Director	nov-25	Open	**Proposed for Closure** Update has been included in the Highlight Report as to the reasons behind the increase
23.09.2025	5.2.4	9	Planned Care - Care Group Highlight Report	Outcome and impact of the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate to be presented to the Committee after the trial period of 12 Months	Head of Corporate Governance & Board Business	Care Group Nurse Director, Planned Care	sep-26	Open	**Proposed for Closure** This item has been added to the forward work programme
23.09.2025	5.2.5	10	Unscheduled Care - Care Group Highlight Report	Discussion to be held with DTPS Care Group to clarify any discrepancies and ensure understanding of the patient support model at YGT	Care Group Nurse Director, Unscheduled Care	Care Group Nurse Director, Unscheduled Care	18-nov-25	Open	**In progress**
23.09.2025	6,2	12	Committee Referral - Details of the medical negligence claims from the losses and special payments report	Summary report to be submitted back to the Audit, Risk & Assurance Committee confirming the review outcome discussed at the Quality, Safety & Experience Committee	Head of Concerns & Business Intelligence	Head of Concerns & Business Intelligence	13-nov-25	Open	**Proposed for Closure** This report is on the agenda for information at the November Audit, Risk & Assurance Committee
23.09.2025	7,1	13	Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Stroke risk narrative risk description to be reframed from a sustainability to a performance perspective.	Chief Operating Officer	Chief Operating Officer	18-nov-25	Open	**Propose to Close** In relation to Datix Risk ID 4632 regarding stroke services, the risk has been reframed to take into account feedback received from the September 2025 Quality, Safety & Experience Committee to capture the performance element of the risk and this can be seen in the Organisational Risk Register update on the agenda. The Unscheduled Care Group are currently reviewing the risk score as a result of these changes.
23.09.2025	7,5	15	Health, Safety & Fire Sub Committee Highlight Report 4 September 2025	Further clarity on reporting routes to be obtained for nutrition and catering activity.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	18-nov-25	Open	**In Progress** This action is being taken forward by the Corporate Governance team in their review of the Committee and Sub Committee annual Cycles of Business (timeframe to be complete by end of December 2025) Once a reporting route for nutrition and catering has been identified this will be fed back to the Committee.
23.09.2025	2.3 (CLOSED SESSION)	3	Organisational Risk Register – Closed Risks	Review to be undertaken outside the meeting as to whether the Special School Nursing position should be included as a risk.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	18-nov-25	Open	**Proposed for Closure - Complete** The Special School Nursing Risk is escalated to the Organisational Risk Register and was considered in the Public Committee session. The risk ID for reference is 5753 "Inadequate Special School Nurse Provision".

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Committee Action Log

Nam Com Date actio from			e / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
19.11.2024	5.2d	9	Mental Health & Learning Disabilities Care Group Highlight Report	Consideration to be given to the most appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	21.01.2025	Closed	**Completed** In year delivery plans on estates performance will be presented to the Operational Delivery Committee along with any Estates Risks escalated to the Organisational Risk Register. Activity in relation to the development of an Estates Plan aligned to CTM2030 will be received at the Strategic Development Committee. It is recognised that there will be occasions depending on the nature of the topic being reported that there could be involvement from the Quality, Safety & Experience Committee and Health, Safety & Fire Sub Committee.
25.03.2025	5,1	4	Spotlight Presentation - Stroke Unit Temporary Centralisation	Concerns raised in regard to service inequity and the potential risk to patients to be fed into the Allied Health Professionals Group	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20/05/2025 Now 22 July 2025	Closed	**Completed** Update included in the stroke service report presented to the meeting held on 22 July 2025**.** Future updates on Stroke services will be included in the Unscheduled Care Group Highlight reports
25.03.2025	5,1	5	Spotlight Presentation - Stroke Unit Temporary Centralisation	Report to be presented to a future meeting to outline progress made in this area	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20/05/2025 Now 22 July 2025	Closed	**Completed** Update included in the stroke service report presented to the meeting held on 22 July 2025**.** Future updates on Stroke services will be included in the Unscheduled Care Group Highlight reports
25.03.2025	5.3b	7	Unscheduled Care Group Highlight Report	Spotlight presentation to be presented to a future meeting in relation to the positive experiences that had been achieved in regard to the opening of two wards at Ysbyty George Thomas during the critical incident at the Princess of Wales Hospital	Unscheduled Care Group Nurse Director	Unscheduled Care Group Nurse Director	30/07/2025 **Now 23 September 2025**	Closed	**Completed** An update has been included in the Care Group Highlight report being presented to the September 2025 meeting
25.03.2025	5.3f	9	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report	Further clarity to be provided in regard to the discrepancies highlighted in relation to the higher than average number of clinical incidents being reported within stroke services which did not correlate with the update provided on stroke services earlier in the meeting	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20.05.2025	Closed	**Completed** Update included in the stroke service report presented to the meeting held on 22 July 2025. Future updates on Stroke services will be included in the Unscheduled Care Group Highlight reports
25.03.2025	6,1	10	Patient Safety, Quality & Experience Dashboard	Update to be provided at the next meeting which identifies whether the locally reportable incidents were now being picked up via the Duty of Candour. Ombudsman report to be shared with Committee Members for information and awareness	Assistant Director of Quality & Safety	Assistant Director of Quality & Safety	20/05/2025 22/07/2025 **Now 23 September 2025**	Closed	**Proposed for Closure** This detail will be included in the Duty of Candour section of the dashboard, which will be undertaken once the 2024/2025 annual report has been produced.
22.07.2025	2,1	2	Consent Agenda Business	Internal Audit Review on the Duty of Candour to be deferred to the September 2025 meeting and placed on the main agenda for discussion	Executive Director of Nursing/Deputy CEO	Head of Corporate Governance & Board Business	23.09.2025	Closed	**Proposed for Closure** Item placed on the main agenda for discussion at the September 2025 meeting
22.07.2025	5,1	4	Clinical Executives Report	Future reports to include more detail on the causes behind the increase in pressure ulcer incidents and the lessons that had been learnt	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	23.09.2025	Closed	**Proposed for Closure - Ongoing** Regular updates will be provided to the Committee through the Harm Free Care Update reports being presented to the Committee in sequence, Falls, Nutrition & Hydration and Pressure Ulcer. Next report due in November 2025.
22.07.2025	5,1	5	Clinical Executives Report	Information to be shared with Members outside the meeting in relation to the consequences of the non agreement between Primary and Secondary Care in relation to preconception care and diabetes in pregnancy	Executive Director of Public Health	Executive Director of Public Health	23.09.2025	Closed	**Proposed for Closure** **I**nformation shared by email with Members on 22 July 2025 by the Executive Director of Public Health
22.07.2025	5.2.1	6	Children & Families Care Group Highlight Report	Update to be included in September iteration of the report on the work being undertaken to address Special School Nursing issues	Director of Midwifery	Executive Director of Nursing/Deputy CEO	23.09.2025	Closed	**Proposed for Closure** Brief update included in Care Group Highlight report for the September meeting. Detailed report to be received via September 2025 In Committee session
22.07.2025	5.2.4	9	Mental Health & Learning Disabilities Care Group Highlight Report	Update to be presented to a future meeting on assurances being provided in relation to Learning Disability Services.	Care Group Nurse Director Mental Health & Learning Disabilities	Chief Operating Officer	23.09.2025	Closed	**Proposed for Closure** Update included in Care Group Highlight report for the September 2025 meeting
22.07.2025	5.2.6	9	Primary Care & Community Care Group Highlight Report	Chief Operating Officer to provide an update on the plans in place to address the Paediatric General Anaesthetic Waiting list position given that this was largely dependent on Theatre List availability	Chief Operating Officer	Chief Operating Officer	23.09.2025	Closed	**Proposed for Closure** Update provided to Board members at Board Briefing session held on 21 August 2025. Associated email shared with Board members by email on 16 September containing a further update on the mitigating actions being taken to reduce the Paediatric Dentistry GA Theatre List
22.07/2025	6,1	13	Patient Safety, Quality & Experience Dashboard	Review to be undertaken of any themes and trends that needed to be highlighted to the Committee in relation to patient absconsions. Update to be included in Care Group Highlight report for the September 2025 meeting.	Head of Nursing, Mental Health & Learning Disabilities Care Group	Chief Operating Officer	23.09.2025	Closed	**Proposed for Closure** An analysis of the review undertaken has been included in the September iteration of the Care Group Highlight report.
22.07.2025	6,2	14	Overview of the Development & Delivery of the Research & Development Strategy	Strategy on a page to be shared with Committee members following the meeting.	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	23.09.2025	Closed	**Proposed for Closure** Strategy on a page was included with the Board papers published ahead of the July 2025 meeting
22.07.2025	6,4	14	People Experience Forum Update	For future meetings, there should be one agenda item on People's Experience, particularly when the update from the People's Experience Forum was due to be received.	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	20.06.2026	Closed	**Proposed for Closure** Head of Corporate Governance will ensure this is actioned for the next report which is due to be presented to Committee in January 2026
22.07.2025	7,2	16	Health Inspectorate Wales (HIW) Audit Tracker Report	Healthcare Inspectorate Wales Audit Tracker Report to be presented back to the September meeting on the main agenda for further discussion.	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	23.09.2025	Closed	**Proposed for Closure** Item added to the agenda for the September 2025 meeting
22.07.2025	9,1	18	Committee Highlight Report to Board	Concerns raised in relation to Paediatric General Anaesthetic Waiting Lists to be highlighted as an area for escalation within the Committee Highlight report to Board.	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	25.09.2025	Closed	**Proposed for Closure** This item has been included in the alert/escalate section of the Committee Highlight report being presented to the September 2025 Board

Agenda Item
4.2

Quality, Safety & Experience Committee

Executive Director and Independent Member Quality & Safety Walkabouts

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Richard Hughes, Executive Director Nursing, Midwifery & Patient Care
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Richard Hughes, Executive Director Nursing, Midwifery & Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director Nursing, Midwifery & Patient Care

Pwrpas yr Adroddiad / Report Purpose	For Noting and to Approve

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

Acronyms / Glossary of Terms	
IM/Exec	Independent Member and Executive Director
CVC	Community Vaccination Centre
ELG	Executive Leadership Group
Band 5/7	NHS Nursing grades
IPC	Infection Prevention & Control
H&S	Health & Safety
YGT	Ysbyty George Thomas

1. Situation /Background

1.1 The Executive Director and Independent Member walkabouts have become an established and valued part of our assurance and improvement framework within the Health Board. These visits offer a unique opportunity for senior leaders to engage directly with clinical environments, observe practices, and interact with staff, patients, and their relatives. The walkabouts have consistently highlighted both areas of excellence and aspects needing further attention, offering a balanced and pragmatic view of the realities of care delivery.

Recent walkabouts have highlighted the unwavering commitment of staff, the effectiveness of leadership, and the positive impact of targeted improvement initiatives. At the same time, they have exposed persistent operational challenges, such as limitations in physical infrastructure, staffing pressures, and delays in patient discharge. The walkabouts have also acted as a catalyst for immediate action and escalation, ensuring that risks are addressed promptly and that good practices are recognised and shared.

This paper offers an analysis of recent walkabout findings, based on direct observations, feedback from staff and patients, and documented actions.

It also outlines the proposed future direction for walkabouts, including the development of a themed programme for 2026 and the establishment of a robust reporting framework to support committee oversight.

2. Specific Matters for Consideration

2.1 Walkabouts conducted by Executive Directors and Independent Members aim to offer immediate, first-hand insights into the operation of clinical areas. Unlike formal audits or scheduled inspections, these visits are characterised by their immediacy and authenticity, enabling leaders to experience the environment as staff and patients do.

The scope of the walkabouts covers a wide range of areas, including the physical environment, staff experience, patient and relative viewpoints, and the efficiency of operational processes. The visits are designed to promote open dialogue, encourage sharing concerns and successes, and highlight opportunities for improvement.

Recent walkabouts have included visits to the YGT Community Vaccination Centre, the Princess of Wales Hospital's new theatres and Ward 6 (Acute Frailty), as well as the Stroke Wards (19 & 20) at the Royal Glamorgan Hospital. Each visit has generated detailed feedback, which has been systematically reviewed and used to inform both immediate actions and longer-term planning.

At the YGT Community Vaccination Centre, the team successfully delivered over 2,500 vaccines during a three-week catch-up campaign for children who had missed their school immunisations. Plans are underway for an

expanded staff flu campaign, which will provide vaccination at more sites than ever before.

However, a combined Health & Safety and Infection Prevention & Control report has identified significant shortcomings in the current vaccination centre facilities, prompting escalation to the Executive Leadership Group and the Board.

The introduction of a Mobile Vaccination Unit is expected as a positive development, reflecting the team's commitment to innovation despite resource limitations.

The visit to the Princess of Wales Hospital's new theatres and Ward 6 revealed a well-organised and welcoming environment, with notable improvements in cleanliness and a reduction in clutter. The theatres are spacious and have benefited from efforts to standardise operating kits, which improve safety and simplify training.

Ward 6 has been refurbished to create a positive atmosphere for both staff and patients, with a new day room supported by community partnerships. However, challenges remain regarding storage space, stock availability, and discharge delays, which vary by local authority. The horseshoe corridor area, in particular, was found to be less well organised due to the volume of equipment needed for elderly care. Immediate actions were agreed, including a review of stock ordering processes and reminders to staff to seek support when facing difficulties with patient care.

The follow-up visit to the Stroke Wards at the Royal Glamorgan Hospital offered a valuable chance to evaluate progress since the previous visit. The wards appeared calmer and better organised, with staff showing a positive and resilient approach despite ongoing pressures. Staffing shortages persist, with a reliance on agency staff and block booking used to ensure continuity.

Senior nurses had not previously been involved in student streamlining opportunities, but this is now being addressed.

The daily huddles, although well-meaning, lacked focus and clear ownership of actions.

The use of the therapies space as an office was noted, and relatives raised concerns about falls, indicating potential gaps in the reporting culture.

Immediate actions included increased participation in student streamlining, recruitment for Band 5 and Band 7 roles, refinement of daily huddles, and weekly reviews of the improvement plan with the Service Director.

Across all sites, walkabouts consistently reveal examples of compassionate care, strong leadership, and staff pride. Structured improvement initiatives, such as standardising operating kits and creating dementia-friendly environments, are recognised as models for wider adoption.

Meanwhile, recurring issues related to infrastructure, staffing, and operational discipline have been highlighted as priorities for ongoing focus.

3 Assessment

3.1 The value of the IM/Exec walkabouts is evident in several key areas. Firstly, they provide direct reassurance on-site, enabling leaders to observe practices and the environment in real time.

This approach offers a more detailed and comprehensive perspective than dashboard metrics alone can provide.

For example, the readiness and cleanliness of the new theatres at the Prince of Wales Hospital, along with the positive atmosphere in Ward 6, were readily apparent during the visits.

a. Secondly, the walkabouts facilitate quicker escalation and decision-making. Risks identified during these visits, such as the adequacy of the vaccination centre facilities, are promptly raised to the appropriate forums, ensuring that mitigation plans are developed and implemented without unnecessary delays. Specific operational actions, such as reviewing stock processes and enhancing support mechanisms for staff, have been initiated in response to particular findings.
b. Lastly, the walkabouts yield valuable insights into the workforce experience and practical solutions. Conversations with staff have uncovered missed opportunities for recruitment and development, prompting corrective actions such as advertising vacancies and reinforcing leadership structures. The resilience and commitment of the staff, even under significant pressure, have been consistently acknowledged.
c. The voices of patients and their relatives are also highlighted through walkabouts. Concerns about falls and staffing levels, raised by relatives during visits to the Stroke Wards, have prompted a review of the incident reporting culture and the triangulation of feedback with formal metrics. This level of engagement is difficult to achieve through written reports alone and emphasises the importance of maintaining visible and accessible leadership.
d. Good practices identified during the walkabouts, such as standardising operating kits, refurbishing ward environments, and developing community partnerships, have been highlighted for broader dissemination. These examples demonstrate the potential for horizontal learning across sites and the importance of recognising and celebrating achievements.
e. Balanced against these strengths were several ongoing risks and gaps. Limitations in physical infrastructure, particularly in terms of storage and layout, could compromise safety and operational efficiency. Staffing shortages and reliance on agency staff, particularly in high-acuity areas such as the Stroke Wards, risked disrupting continuity of care and eroding staff morale. Operational discipline, including the effectiveness of daily huddles and the clarity of action tracking, needed further

reinforcement. Delays in discharge, which differ by location, impacted patient experience and increased the potential for deconditioning.
Lastly, discrepancies between lived experiences and formal metrics, such as those related to falls, required targeted review to maintain data integrity and promote a culture of transparency.

f. Looking ahead, the Executive Director of Nursing is developing a themed agenda for walkabouts in 2026, aligned with national and local events of significance.
g. A Board development session in December will be used to agree on the scope, aims, and reporting foundations for the next phase of the programme. The aim is to ensure that walkabouts remain relevant, focused, and capable of driving meaningful improvement.

4 Assessment

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

Impact Assessment		
Ansawdd	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: No changes to service provision proposed
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☐
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
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 In light of the findings presented above, the Committee is asked to **Note** the findings and to **Approve** the development of a standardised reporting framework for walkabouts, to be rolled out from January 2026 and to consider for approval the following next steps:

6 Next Steps

6.1 It is recommended that the IM/Exec walkabout programme continue as a key tool for assurance and improvement. Approval at the December Board development session is proposed to lay the foundation for a themed annual plan for 2026, along with a clear definition of roles and site selection criteria to ensure fairness and alignment with organisational priorities.

6.2 The Committee is requested to approve the development of a standardised reporting framework for walkabouts, to be rolled out from January 2026. This framework should include sections for executive and independent member colleagues, covering context, observations, patient and relative feedback, recognition of good practice, risks and issues, immediate actions,

escalations, dependencies, and follow-up from previous visits. Pre-defined escalation thresholds should be established for key risks such as environmental non-compliance, continued reliance on agency staff, and patient safety signals. When walkabout feedback differs from routine metrics, a brief review should be conducted and reported through the executive function to evaluate data completeness, coding, culture, and feedback mechanisms.

The Committee is further asked to note the targeted follow-ups requested in relation to recent visits. These include receiving the formal outcome of the escalation regarding vaccination centre facilities, confirmation of stock-process reviews and storage solutions at the Princess of Wales Hospital, and assurance updates on recruitment, agency reliance, huddle quality, falls reporting, and therapies space utilisation at the Stroke Wards.

Finally, the Committee is invited to endorse the approach for a proposed template for future walkabout reports, which will promote transparency, consistency, and the sharing of best practices.

(Agenda Item 5.1)	18/11/25	Quality, Safety and Experience Committee	Preventing Avoidable Pressure Damage in Unscheduled Care November 2025

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	
Prepared By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Deborah Matthews, Care Group Nurse Director, Unscheduled Care
Presented By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Deborah Matthews, Care Group Nurse Director, Unscheduled Care
Approving Executive Sponsor:	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Care
Report Purpose	For Discussion For Noting
Engagement undertaken to date:	Prepared for QSEC

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Details implications for quality, safety and experience
Related Health and Care Standard	
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No, this report is a factual account and analysis on issues surrounding pressure damage. There has been no current indication of language being a contributory factor. This will be an ongoing consideration.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Improving Care Creating Health

Introduction & Purpose

This spotlight provides a clear update on avoidable pressure damage across Unscheduled Care.

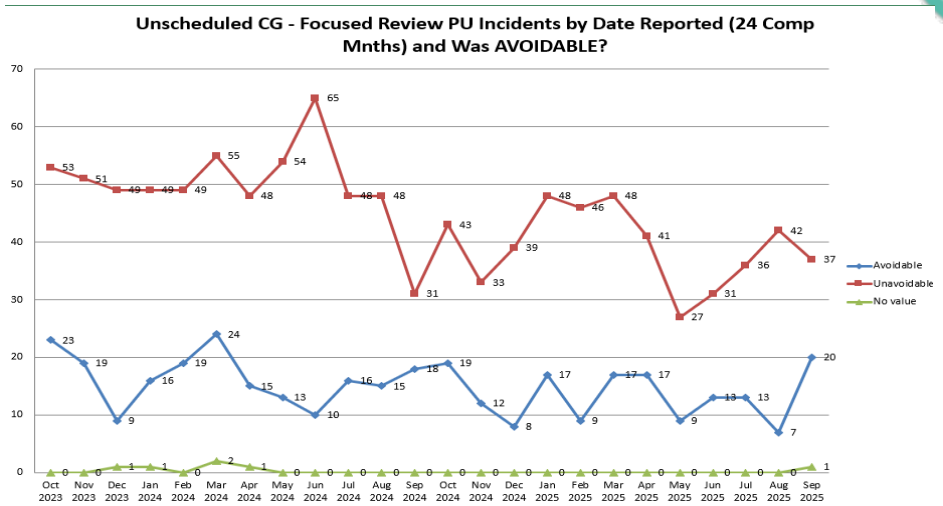
Overall performance has improved, and harm reduction continues, but variation has emerged particularly at RGH and within our Emergency Departments which will require focused senior oversight.

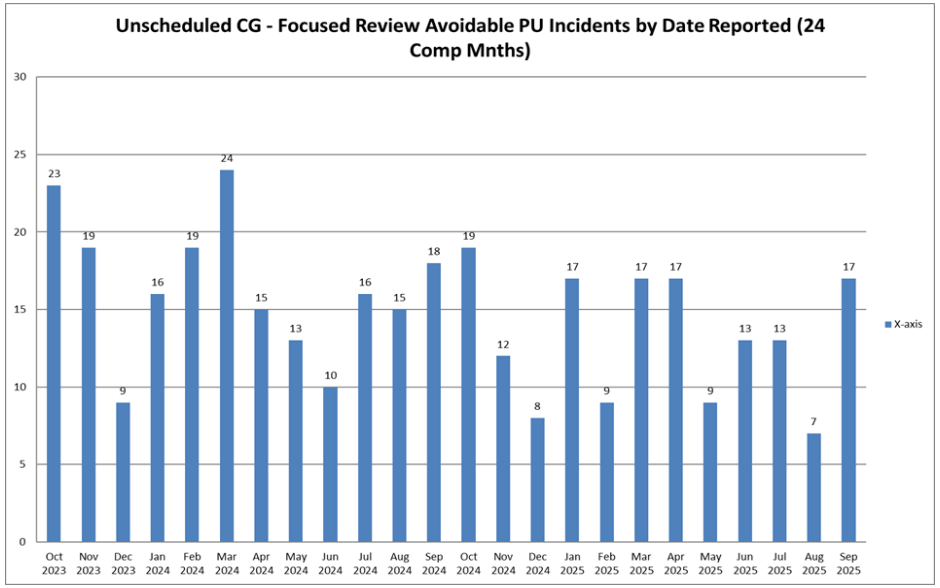
Purpose

- Provide executive-level assurance on pressure damage performance
- Highlight variation and priority focus areas
- Outline actions to maintain patient safety and quality

Key Data & Trends

- 19% reduction in avoidable pressure damage incidents (YoY)
- RGH increase aligned with bed base expansion + strengthened scrutiny
- ED risk emerging (prevalence audit, assessment delays)
- No correlation between staffing levels and avoidable pressure damage





***NB**: It is important to note that the bed base increased in RGH in October 2024 and significantly reduced in POWH due to the Critical Incident. Therefore, there are variables in the data when comparing with the previous 12-month prevalence in both RGH and POWH sites.*

Audit Findings

ED Clinical Prevalence Audit (June 2025)

- 4.35% prevalence; 0% facility-acquired
- 42% unmet clinical need in patients with pressure damage
- 52% risk assessment and 42% skin assessment within 6 hours
- Equipment: mattress + seating met 96%, slide sheet gaps
- Average ED stay 8h 17m → prolonged seated time

Priority Focus:

- Improve timeliness of risk + skin assessments
- Ensure consistent slide-sheet availability
- Reduce prolonged seated time during ED waits

Assurance Actions & Forward Priorities

Actions Taken

- Strengthened MDT panel scrutiny
- Targeted RGH audit cycle underway
- ED improvement actions live
- Bespoke training in low-compliance areas
- Datix dashboards live & monitored monthly
- Slide sheet procurement standardised

Next Steps & Priorities

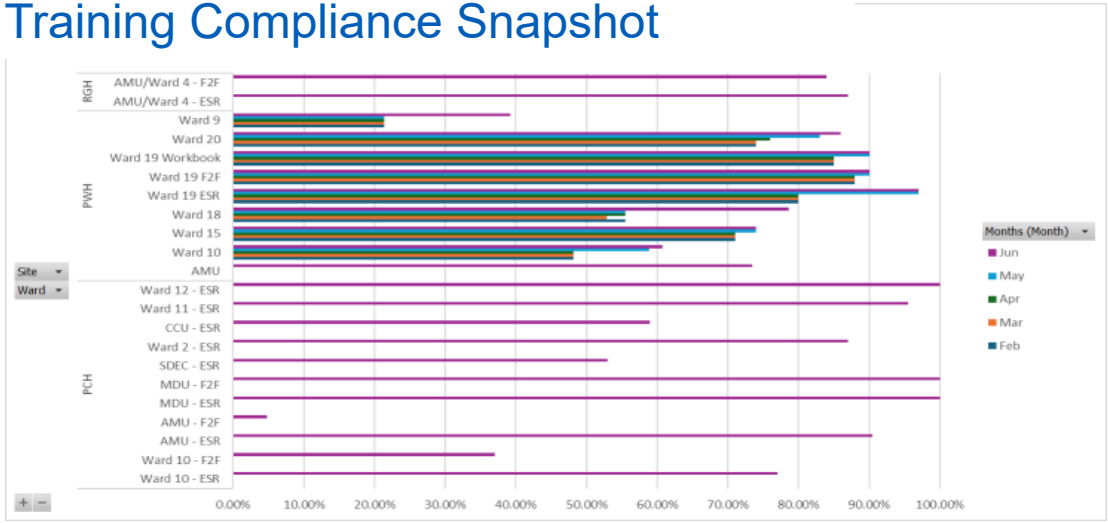
- 90% ED assessment compliance within six hours
- Consistent senior nurse presence and oversight
- Routine ward audits sustained
- Equipment reliability embedded
- Variation reduced at RGH
- Continued reduction in DOC pressure-damage cases

Assurance Position

Improvement is sustained. Variation has been identified early and targeted action is in place.

Focus remains on prevention reliability, senior oversight, and consistent delivery at pace.

Training Compliance Snapshot



Training compliance data highlights targeted areas; bespoke education in progress to lift compliance above 85%.

Highlight Report
DM

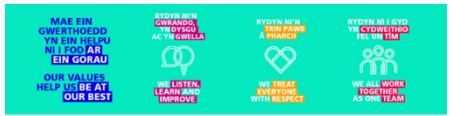
Recommendation

The Committee are asked to:

- *Note this spotlight presentation*

Next Steps

- *As outlined in slide 5*



Agenda Item
5.2

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes-Executive Director Nursing, Midwifery and Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes-Executive Director Nursing, Midwifery & Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	1. Richard Hughes-Executive Director Nursing, Midwifery & Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health

Pwrpas yr Adroddiad /	For Noting

Report Purpose	

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
CTM	Cwm Taf Morgannwg
RNID	Royal National Institute Deaf
OT	Occupational Therapist
YCR	Ysbyty Cwm Rhondda
Physio	Physiotherapy
ESD	Early Supported discharge
HCPC	Health and Care Professionals Council
SLTs	Speech and Language Therapists
ROAG	Responsible Officer Advisory Group
PAG	Performance Advisory Group
HEIW	Health Education and Improvement Wales

1. Situation /Background

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

- Richard Hughes-Executive Director Nursing, Midwifery & Patient Care
- Dom Hurford-Executive Medical Director
- Lauren Edwards-Executive Director of Allied Health Professionals (AHPs) and Health Science
- Philip Daniels-Executive Director of Public Health

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

2. Specific Matters for Consideration - Clinical Executive Director specific Updates:

2.1 Nursing & Midwifery-Richard Hughes

This section of the paper provides an overarching update on the achievements and current challenges within the remit of Nursing & Midwifery.

Successes

Nursing Leadership

We are pleased to announce the successful appointments to the newly established Acute Site Heads of Nursing posts at Prince Charles Hospital (PCH) and Princess of Wales Hospital (POW), strengthening leadership across our acute sites.

We also warmly welcome Lloyd Griffiths as Interim Care Group Nurse Director for Mental Health and Learning Disabilities, bringing valuable expertise to this critical area. Interviews are underway this month for the interim Nurse Director role within the Primary Care and Community Care Group to provide maternity cover, ensuring continuity of leadership and support for our teams.

In addition, we are delighted to confirm the appointment of Becky Gammon as our Deputy Executive Director of Nursing, further enhancing our senior nursing leadership capacity.

We are equally pleased to announce Deborah Matthews as the substantive Nurse Director for the Unscheduled Care Group, reinforcing our commitment to delivering safe and effective care across urgent and emergency pathways.

Celebrating Leadership Development

The Executive Director of Nursing, Midwifery and Patient Care had the privilege of attending an event to celebrate Cheri Lewis, our Senior Midwifery Information Officer, and Sophie Bassett, Lead Nurse for Older Adults in Mental Health, as they successfully completed the Florence Nightingale Foundation Scholarship.

Both have delivered innovative and impactful projects that contribute to service improvement while advancing their leadership journeys. Their achievements exemplify our commitment to fostering professional development and driving positive change across nursing and midwifery services.

Challenges

Emergency Care Flow

While we acknowledge the significant progress made in reducing ambulance handover delays across CTM, which has strengthened our ability to protect communities and support the timely provision of emergency care, we remain concerned about increasing waiting times in Emergency Departments and delays for patients awaiting admission. These pressures impact patient experience and flow through our hospitals.

The Executive Director of Nursing and the Chief Operating Officer are working closely with Care Groups to mitigate the frequency and impact of these delays. This includes ensuring that patients who require admission are prioritised appropriately and exploring new pathways to prevent unnecessary admissions, supporting safe and effective care delivery.

Assurance and update reporting is planned for the January 2026 Committee, which will include a detailed report on the recent escalation protocol changes and their impact across both planned and unscheduled care areas.

Perinatal Assessment

We wish to acknowledge the ongoing All-Wales Perinatal Assessment, which forms part of a national quality assurance process. CTM has completed and submitted its self-assessment and will now participate in hosting colleagues for site visits as part of the review methodology. This collaborative approach provides an opportunity to benchmark our services and identify areas for improvement.

An update will be provided to the Committee in January 2026, subject to the availability of the final report, which is scheduled to conclude during that month.

2.2 Medical Directorate-Dom Hurford

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

Achievements

This section covers the following achievements:

1. Medical Education Governance Meeting
2. Human Tissue Authority (HTA) Inspection Report
3. New Professional Standards PAG/ROAG Process

Medical Education Governance Meeting

There are a number of HEIW reviews into resident doctor training and experience ongoing within CTM. This is not unusual; however, we are constantly striving for better Resident training and education as well as patient experiences and quality of care.

Until now these HEIW reviews have been managed within the Medical Education team with input from the Care Groups and Executive teams. We have now established an oversight group that can hold the teams to account on delivery of improvements and any assurance issues.

The Medical Education Governance Meeting holds this role and we had our first meeting in October. It was a thorough meeting detailing all areas needing attention and sought detailed plans and assurance of progress. All involved felt it was a useful session and we intend to conduct these twice yearly going forwards.

HTA Inspection Report

In September 2025 we received correspondence from the Human Tissue Authority (HTA) regarding the HTA inspection, which took place at Royal Glamorgan Hospital on the third and fourth of September 2025.

We are very pleased to say there were no shortcomings reported, some suggestions were given, and only a few minor recommendations that are in hand already.

The HTA is an important process and we recognise the significant amount of time, planning, and attention to detail that was required to ensure we met the highest standards. Thank you to Martin Ludlam and Paul Davies for the hard work here.

New Professional Standards PAG/ROAG Process

CTMUHB has established a Responsible Officer Advisory Group (ROAG) to support decisions regarding Professional Standards as well as an initial group at Care Group level, to be known as Performance Advisory Group (PAG).

This process will look to:

- Manage cases as early as possible
- Standardise a process that is fair and transparent for all
- All decisions to be made by a group adding a layer of scrutiny, consistency and an opportunity to share knowledge and identify any trends/patterns

- Improve learning between Care Groups to provide a consistent approach for all

The first meeting of this new and improved format will take place in early November 2025.

Areas of Focus

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

1. Clinical Policies and Procedures
2. Mental Health Culture

Clinical Policies and Procedures

We are currently awaiting the finalised Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents following its Consultation which concluded on 24 October. Alongside this, we have drafted a comprehensive guideline that outlines the key differences between Policies, Protocols, Procedures, Guidelines, and Standard Operating Procedures (SOPs) in clinical and healthcare settings. This guideline will accompany the updated Policy when it is issued to the Care Group Clinical Teams.

In the interim, the Medical Directorate team has requested that all Care Groups review their Out-of-Review Date Policies.

Once this review is complete, any obsolete policies will be logged, saved and deleted from SharePoint. This will then initiate the migration of the old SharePoint Clinical Policies page to the new SharePoint platform.

Our goal is that, once the new Policy for the Development of Clinical Policies is circulated and the migration to the new SharePoint page is complete, the new process will enable teams to better manage their Clinical Policy review dates and approval processes.

Mental Health Culture

Issues have arisen over the culture within aspects of the MH team (Mental Health), which stems from the behaviours of a few senior clinicians.

HEIW are involved in supporting trainees and helping us ensure a safe productive environment.

The Care Group are dealing with this, providing a robust plan for challenging and working with the whole team to improve the culture, and allow openness to change and challenge behaviours.

Our overriding aim is to ensure the quality of patient care is preserved and colleagues are able to carry out their roles in a safe environment.

Due to confidential reasons, we will provide a fuller briefing in the In-Committee meeting and with the IMs (Independent Members) involved in Professional Standards.

2.3 Allied Health Professions and Healthcare Science-Lauren Edwards

This section of the paper provides an overarching update on the achievements and current challenges within the remit of Allied Health Professionals and Healthcare Science.

Successes

Audiology Adult Quality Standard Visit
In a recent Adult Quality Standard Visit, the overall compliance score for CTMUHB Health Board was 91.8%.

Lower Scoring Areas for improvement within the Audit were:

- Wait times were compared to national targets and monthly data showed they exceeded this national target, but the team were already aware of this and had actions in place**.**
- The ambient noise measures yielded poor results in some of rooms. The Service has placed mitigations on the use of these rooms to ensure appropriate usage and to reduce the risk.
- Some of the outcomes at the follow up had not been completed. There is a plan in place to address this.

Examples of good practice in the audit were:

- Excellent detailed pathways/Standard Operating Procedures were seen throughout the audit. These are included in the induction for new staff and are ideal for existing staff to refer to.
- CMTUHB excelled in collaborative working with internal and external agencies, including the RNID and Hard of Hearing clubs.
- It was evident throughout the audit process that the team offer good support to their colleagues and they themselves receive good support and encouragement from higher management.

OT and Physio: improving patient flow in YCR stroke pathways by increasing discharges with the Stroke Early Supported Discharge Team

A relaunch of Stroke ESD took place in October 2024. This involved outlining the service model and how it can increase the discharge profile from the YCR stroke pathway. Following feedback from the YCR AHPs, it was identified that not all staff were confident identifying suitable patients for ESD and half reported experiencing barriers referring to the service.

A comparison of data from October 2023-May 2024 and October 2024-May 2025 found a **262.5% increase** in the number of referrals to ESD. Length of stay on the stroke ward is now half that of the other rehab wards in YCR.

What our patients say:

"I feel as if friends are calling when one of the stroke team calls, I am grateful for having them."

"First class service from team, friendly, professional and caring, top marks to them all."

"Our experience of the ESD has been admirable. There is no way we would have coped without their valuable input! Sincere and uttermost thanks! Without the intervention of the ESD team, I would not have recovered the way that I have."

Recognition

The **Cardiac Physiology** department at PoW was successful in winning Swansea University Practitioner Training Programme (PTP) Cardiac Physiology department of the year.

The **Speech and Language Therapy** service was shortlisted for the Mental Health & Wellbeing Wales Awards 2025 for a Mental Health & Wellbeing Wales Awards 2025, in the category of Workplace Wellbeing Award. The awards recognise individuals and organisations who go above and beyond to support the wellbeing of others.

CTM's **Clinical Education** team hosted a Student and Educator celebration event on Wednesday 22 October at Princess of Wales Hospital, opened by the Executive Director of AHPs and Health Science. The event was a celebration for nursing, midwifery, Allied Health Profession, and Health Care Science third year students, and educators across CTMUHB.

Awards included the AHP/Healthcare Science Student of the Year.

The Most Inspiring Student 2025 was awarded to a Speech and Language Therapy student who is now qualified and employed in CTM.

The Most Inspiring Educator 2025 was awarded to David Williams, Cardiac Physiologist.

Awareness

Health and Care Professions Council: Speech and Language Therapists and Occupational Therapists across the UK recently undertook their 2 yearly HCPC registration renewal. Within CTM, all SLTs and OTs successfully renewed their registration without exception.

The Forensic Adolescent Consultation Service held an online national Forensic Interest Group on 18th Sept with a focus on 'the vulnerable child' in relation to online exploitation and radicalisation.

Podiatry have developed a *Nail Care on the Ward* poster to support nursing colleagues in delivering nail care, with use of a QR code for all patients. In 2012, Welsh Government set a directive that routine nail care was not to be provided by Podiatry as it was deemed a social need rather than a medical need. Over the years there has been a reduction in the number of referrals received from the wards, however on average 13 referrals are still received every month requesting nail care. The poster will help in preventing inappropriate referrals to Podiatry reducing the demand by 65%, enabling timelier review of patients who require specialist treatment and improve efficiencies with the administration of referrals.

2.4 Public Health Update-Philip Daniels

This section of the paper provides an overarching update on the achievements and current challenges within the remit of Public Health

Blood Bourne Virus (BBV) Elimination Programmes across CTMUHB: progress and concerns:

Hepatitis B and C Elimination

- Welsh Government is committed to eliminating hepatitis B and C as a public health threat by 2030. Health Boards were requested to lead the development of elimination plans for their respective areas, working with the Area Planning Boards (APB) and Public Health Wales (PHW). There are 13 actions outlined by the Welsh Government roadmap to achieving elimination all of which were addressed within the Cwm Taf Morgannwg Elimination Plan.

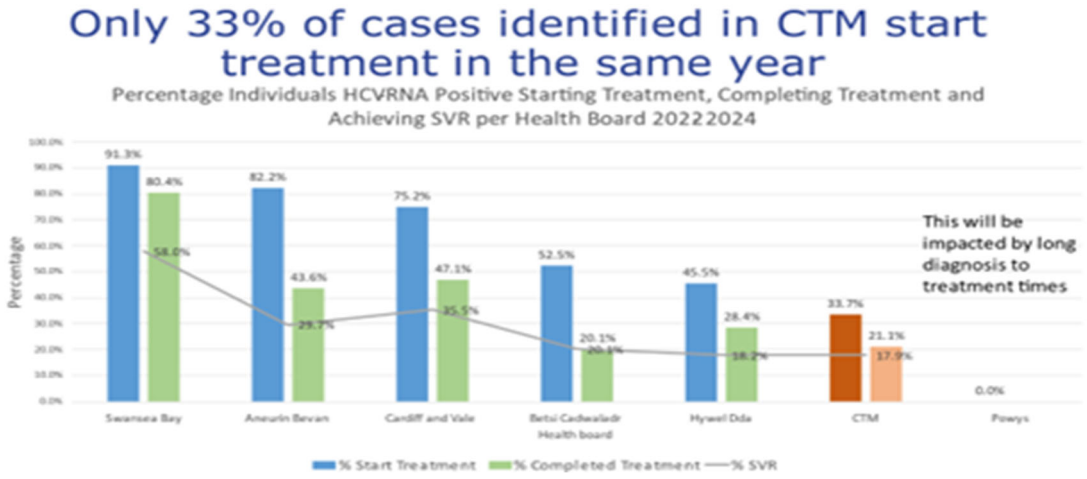
Cwm Taf Morgannwg has made considerable progress against some aspects of the action plan:

- HMP Parc shows a massive improvement in level of testing for Hepatitis C, data from September shows 99% of men were offered a test in the previous 12 months (target for elimination 100%) and 94% of men had taken up that offer and been screened in the previous 12 months (target 90%). The baseline pre improvement work for testing was 37% in March 2024. In August 2025 CTM was the highest level recorded across Wales.

- Hepatitis B vaccination rates in infants (April to June 2025) is at 96.2% coverage, the highest in Wales.

However, there are areas of quality concern, with the offer and uptake of testing in probation and substance misuse remaining relatively low and a considerable delay between diagnosis and treatment with in-year treatment uptake being the lowest in Wales at 33%.

There is ongoing work to improve the diagnosis to treatment pathway in CTM settings.



HIV Elimination: Fast Track Cymru

The HIV Action Plan for Wales 2023–2026 aims to eliminate new HIV transmissions by 2030 and reduce stigma faced by individuals living with HIV.
Despite advances in prevention and treatment, and improved access to testing, HIV (Human Immunodeficiency Virus) remains a public health challenge in CTM. There are 203 people living with HIV, and a recent spike in new diagnoses with 9 new diagnoses so far this year compared with 5 in 2024 and 2 in 2023.

A significant number of local cases are diagnosed late, and opportunities for earlier diagnosis often missed.

Late diagnosis is strongly associated with poorer outcomes, increase healthcare expenditure, and onward transmission.
On the 13th February 2025, the CTM Regional Partnership signed the Paris Declaration officially joining Fast Track Cymru committing to eliminate new HIV transmissions. and achieve the UNAIDS 95/95/95 targets:

- 95% of people living with HIV diagnosed.
- 95% of diagnosed individuals receiving treatment.
- 95% of individuals on treatment achieving an undetectable viral load (U=U: Undetectable = Untransmittable)

There are three regional priority areas of testing, education and tackling HIV related stigma**.**

For CTM to meet the 2030 elimination targets for HIV and Hepatitis B and C, additional focus and resource is required.

The WHC/2023/001 highlighted that *"while there will always be a role for specialised services, to eliminate hepatitis B and C we must simplify service delivery, including testing and treating at the most appropriate setting for the individual, whether that be in primary care, harm reduction services or settings such as prisons. Identifying individuals for testing and supporting linkage to treatment is crucial and will require investment in peer workers and patient navigators".*

CTM is an outlier in Wales as the only Health Board that doesn't provide an outreach service to support BBV testing and treatment adherence.

This also applies to the approach needed for HIV, with considerable overlap across both programmes. There is ongoing work to identify synergies and work across the two elimination programmes.

CTMUHB remains underfunded for health protection areas compared to other Health Boards, and a request for additional funding to support these elimination programmes will be made to Welsh Government in November 2025.

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
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))*	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**	Effective
	If more than one applies please list below: Efficient

(Duty of Quality Statutory Guidance (gov.wales))	Equitable Person Centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Quality of patient care is at the forefront of improvements and decisions made and individual quality impact assessments are completed at the right time by the right team. This paper is presented for information and noting purposes.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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 paper is presented for information and noting purposes.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Providing high quality, safe care is vital to the reputation of the health board. This paper covers items as a broad update for assurance to the members of the Quality, Safety & Experience Committee however, under the directorship and	

	leadership of the four Clinical Executive Directors who hold joint responsibility for this paper, there is a collective strive and dedicated commitment to protect the health board's reputation.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

4 Recommendation

4.1 Quality, Safety and Experience Committee members are asked to **NOTE** the contents of this paper.

5 Next Steps

5.1 Members of the Quality, Safety & Experience Committee will continue to receive regular updates for assurance and awareness of successes, challenges and highlighting Patient Safety and Quality risks through regular update reports.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
5.3.1

Quality, Safety & Experience Committee

Unscheduled Care Group Highlight Report from the Quality & Safety Committee.

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows, Operational Director for Unscheduled care. Deborah Matthews, Unscheduled Care Nurse Director Owen Weeks, Unscheduled Care Medical Director Robin Martin, Unscheduled Care Deputy Medical Director Victoria Healey, Head of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Deborah Matthews, Unscheduled Care Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, 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	18/11/2025	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
YGT	Ysbyty George Thomas Hospital
MDU	Medical Day Unit
Q&S	Quality & Safety
HIW	Health Inspectorate Wales
USC	Unscheduled Care Group
ED	Emergency Department
AMaT	Audit Management and Tracking System
IPC	Infection prevention control
UHW	University of Wales Hospital
ANTT	Aseptic Non Touch Technique
AMU	Acute Medical Unit
ANP	Advanced Nursing Practitioner
COTE	Care of the Elderly
ACE	Acute Care of the Elderly Unit
MRI	Magnetic resonance imaging
OCP	Operational Change Policy
TIA	Transient Ischaemic Attack
PALS	Patient Advice and Liaison Service
SSNAP	The Sentinel Stroke National Audit Programme
STAR	Surgical Trauma and Orthopaedic Rehabilitation
SBAR	Situation Background Assessment Recommendations.
QIM	Quality Management System
PACE	Patient Clinical Engagement
IA	Initial Assessment
PALS	Patient Advice and Liaison Service
PPE	Personal Protective Equipment.
HCSW	Health Care Support Worker
SSNAP KPIs	The Sentinel Stroke National Audit Programme - Key Performance Indicators

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 18th November 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the Quality, Safety, Risk and Experience meeting is to provide assurance to the Care Group and the Health Board's Quality, Safety & Experience 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

Highlight Report

Alert / Escalate	**<u>Stroke Performance</u>** The Health Board's Stroke Performance is below the expected standard. Key Activities in progress: ○ Key stakeholder meeting with weekly huddles ○ Weekly Action log review with clinical engagement ○ Transformation Action Plan monitoring ○ Data and patient tracking review ○ Pathway mapping to identify digital touch points

Stroke Quality Improvement Measures Current Month stats July 2025		
% of patients who are diagnosed with a stroke who have direct admission to an acute stroke unit (<4 hours)		
Admissions	No within 4 hrs	% compliance
53	1	1.88%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 45mins		
Eligible patients thrombolysed	Thrombolysed <= 30 mins	% compliance
3	0	0%
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Patients diagnosed as stroke	Scanned <= 20 mins	% compliance
53	1	1.88%
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour		
Patients diagnosed as stroke	Scanned <= 1 hr	% compliance
53	19	35.84%
% of patients who are assessed by SNS within 4 hours		
Assessments	Assessed <= 4 hours	% compliance
53	22	41.50%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Asssessments	Assessed <= 14 hours	% compliance
53	34	64.15%
% of patients who are assessed by OT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
53	20	37.73%
% of patients who are assessed by PT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
53	19	35.84%

Stroke Quality Improvement Measures Current Month stats August 2025		
% of patients who are diagnosed with a stroke who have direct admission to an acute stroke unit (<4 hours)		
Admissions	No within 4 hrs	% compliance
67	5	7.50%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 45mins		
Eligible patients thrombolysed	Thrombolysed <= 30 mins	% compliance
4	0	0%
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Patients diagnosed as stroke	Scanned <= 20 mins	% compliance
68	10	14.70%
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour		
Patients diagnosed as stroke	Scanned <= 1 hr	% compliance
68	41	60.29%
% of patients who are assessed by SNS within 4 hours		
Assessments	Assessed <= 4 hours	% compliance
68	25	36.76%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Asssessments	Assessed <= 14 hours	% compliance
68	39	57.35%
% of patients who are assessed by OT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
57	20	35.08%
% of patients who are assessed by PT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
57	22	38.59%

Data Interpretation (July – August 2025):

- **Overall Improvement** is seen in several key measures, though compliance remains below target in many areas
- **Direct admissions within 4 hours** improved from **1.88%** (July) to **7.5%** (August) showing early signs of recovery
- **Door-to-needle times** for thrombolysis at CT scan within 20 minutes **remains low**, indicating delays in acute stroke pathway response.
- **SNS assessments within 4 hours and Stroke Consultant reviews within 14 hours**, show modest improvement, though **still below compliance target**
- **Therapy assessments** (Occupational Therapy (OT) and Physio within 24 hours) **remain variable,** reflecting workforce and flow pressures.

Summary

The above data indicates performance in Stroke Pathway timeliness is improving but inconsistent, with continued challenges in rapid diagnostics and senior assessments. Focused action is required to enhance stroke response, access to imaging, and early Multi-Disciplinary Team (MDT) review.

September - October 2025 Performance Overview (21/09 – 05/10)

SSTP Performance Summary

Data shows gradual improvement in **time to CT scan** over the three-week period. The proportion of patients scanned within 20 minutes increased modestly, while those scanned within **1 hour rose significantly**, reaching around **65–70%** by early October.

Performance for admission to the **Acute Stroke Unit (ASU) within 4 hours fluctuated** — declining at the end of September but improving again in early October to near **30–35%,** suggesting some recovery in flow and access to stroke beds.

Improvement Trajectory - SSNAP performance Target:

- 40% of all patients having CT within 20 mins
- 100% of all patients transferring to Acute Stroke Unit (ASU) within 4 hours

Summary:

While progress is evident in timely CT access, further consistency is needed in both scanning and ASU admission times to meet national stroke pathway standards.

<u>Training Provision and ESR Compliance</u>
Limited availability of ILS, Violence & Aggression, and Manual Handling training has led to low compliance across the Health Board.

This poses significant risks to patient and staff safety, increases potential for injury, and may lead to regulatory non-compliance.

Service delivery is also affected, with reduced staff readiness for emergencies and safe patient handling. A review of training capacity and recovery plan is required to address the gaps and improve compliance.

USC mandatory compliance average is currently **65.44%.** The Nurse Director will work in conjunction with Senior Nurse leadership teams to support an upward trajectory to achieve the 85% compliance target and will monitor in monthly HB workforce meetings. However, as stated above the current lack of training provision is a risk to achieving this.

POW Clinical Site Team

Significant investment has strengthened Clinical Site teams at both RGH and PCH. However, POW team remains extremely fragile with high sickness levels and limited site manager cover. A Head of Patient Flow has been appointed at POW to support the team, lead workforce remodelling, and drive further investment to stabilise site operations and improve patient flow. This appointment commences on 3rd November 2025.

Ysbyty George Thomas

Concerns have been raised by Therapy team regarding care and deconditioning at YGT. In addition, concerns have been raised following an incident out of hours on the unit in relation to leadership and behaviours.

Senior Leadership team aware and have instigated several meetings with key stakeholders and establishment of a robust action plan to ensure improvement on the unit. Safeguarding colleagues have been engaged to establish whether any trigger for safeguarding following patient review.

An update was provided to Executive Leadership Group (ELG) on the 10th November 2025.

	The formal YGT OCP concluded on 20th October 2025 to progress the transfer of service from Unscheduled Care to Primary and Community Care, date to be confirmed.
Advise	**Optimise Launch POW** On 6th October the launch of the POW phase of the Optimise programme took place as part of a rapid improvement plan being rolled out across the site over the next couple of months. This programme requires a whole system approach to ensure optimal outcomes for population and to build strong foundations that will support the wider transformation programme for Unscheduled Care services on the Princess of Wales site. The programmes key deliverables focus on achieving SAFER board round compliance and embedding the Optimal Hospital Flow Framework. These elements are designed to support improved multi-disciplinary communication, enhance discharge planning, and ensure timely decision-making to promote safe, effective patient flow and improving patient experience and outcomes. Initial feedback from clinical teams has generally been positive, with increased clarity around daily priorities and awareness of 'home first' concept. Ongoing monitoring will focus on measuring compliance against key indicators, evaluating impact on length of stay, and identifying opportunities for further improvement. **Winter Planning** Winter Plans and surge areas temporarily opened on the 3 Acute Sites (non-commissioned areas) early October 2025.

USC Winter Planning Overview
PCH
Extend UTC Hours
Re-set Acute Medicine
Risk assessed surge space x1 ED
Optimise Launch – following POW (date TBC)
RGH
Review further opportunities to divert GP intake pack to POW – Phase 1 complete
Risk assessed surge space x1 ED
Optimise Launch-following POWH implementation (date TBC)
POW
Re-set Acute Medicine AMU/SDEC – realignment of pathway and workforce
Expansion/realignment of ACE

Ambulatory footprint ED
Optimise Launch – 6th October
Discharge Pathways – support from Julia Wilkinson as part of the reset programme
Risk assessed surge space x1 ED
Additional Plans
Review data and bed modelling
Review additional capacity Requirements
Review additional decisions makers
Risks
Clinical Pathways – remaining at RGH due to critical incident Stoke/Medicine
Confirmation of additional funding required
Workforce/Recruitment

Implementation of UNITE (Unscheduled Care Improvement, Transformation and Efficiency)

The UNITE programme provides overall direction and governance for transforming unscheduled care services across Cwm Taf Morgannwg University Health Board (CTM UHB). The programme led by the Care Group will align with the organisations strategic goals and will deliver intended outcomes. It brings together multiple workstreams, under a single, coordinated structure to improve patient flow, reduce variation, and embed sustainable change in acute settings. UNITE builds on the momentum of previous initiatives such as STAMP, TRUE, and Optimise, serving as framework for all Unscheduled Care, Care Groups transformation projects

UNITE is structured around key domains of unscheduled care, each with its own dedicated delivery group. These include:

- STAMP - Responsible for delivering improvements across Acute Medicine and Medical Same Day Emergency Care (SDEC) pathways.
- ACE Programme - Developing a sustainable Acute Frailty provision across the health board.
- ED - Evaluating clinical spaces to optimise patient placement and experience, alongside embedding digital enablers that support modern, efficient care pathways.
- Discharge & Flow - Working with the Optimise programme to improve performance and capability in line with Optimal Hospital Flow Framework
- Enabling Projects - Development of the Urgent Treatment Centre (UTC), Doccla, and other supporting initiatives that contribute to the transformation of front door services.

Each domain will have a weekly meeting to drive delivery, track progress, and escalate issues.

Emergency Departments: Major Trauma Education

ED nurses are required to maintain critical life-saving skills such as Advanced Life Support (or the paediatric equivalent) and achieving Level 1 and 2 competencies as defined by the National Major Trauma Nursing Group (NMTNG) as part of the Trauma Quality Indicators when the South Wales Trauma network was established.

The NMTNG states that Level 1 competencies should be completed within the first 12 months of the Registrant's start in an Emergency Department (in the 12 months after their initial preceptorship for newly registered nurses). Level 2 competencies should be completed within three years of the Registrant's start in the ED.

Current compliance for these levels is as follows (16-10-2025):

	Adult Competencies	Child Competencies
POW – Level 1	48.65%	7%
POW – Level 2	25.00%	0%
PCH – Level 1	65.00%	18.75%
PCH – Level 2	33.33%	50.00%
RGH – Level 1	79.41%	10%
RGH – Level 2	41.18%	0%

Risks of poor compliance:

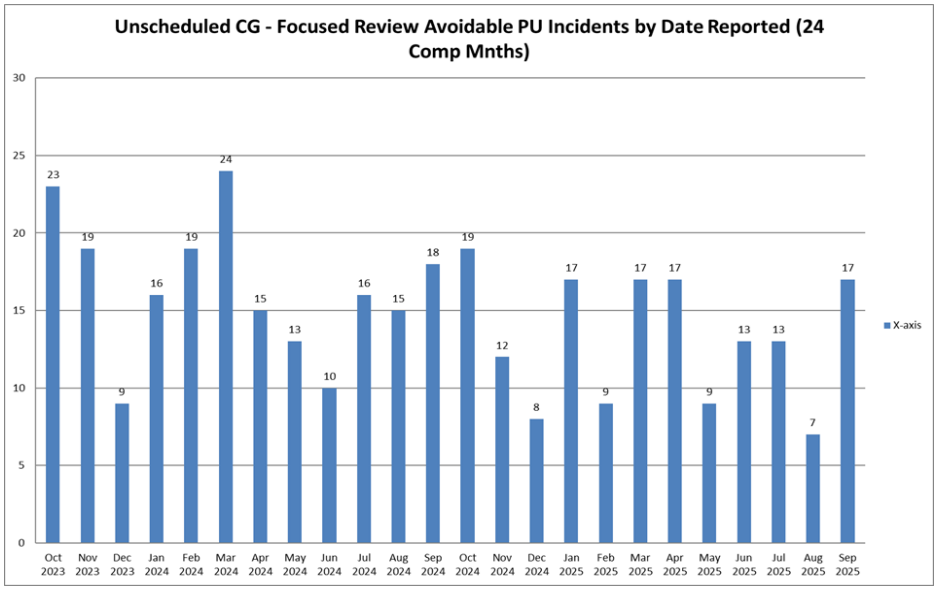
- Non-compliance with Trauma Quality Indicators
- Higher risk of adverse incidents, complaints, and liability
- Reduced staff morale and retention due to lack of advanced training
- Increased risk of clinical errors due to lack of advanced training

Senior Nurse for Professional Development has devised a paper on Major Trauma Level 2 Training as required by NICE and National Major Trauma Nursing Group. These need progressing as an MDT to secure financial investment; to equip our workforce with the required skill set which would develop a gold standard service that supports the needs of our population whilst upholding a positive reputation for the organisation.

Assure

USC Avoidable Pressure Damage Prevalence

Overview of USC reported Hospital Acquired Avoidable Pressure Damage (October 2023 to September 2025) CTMHB wide

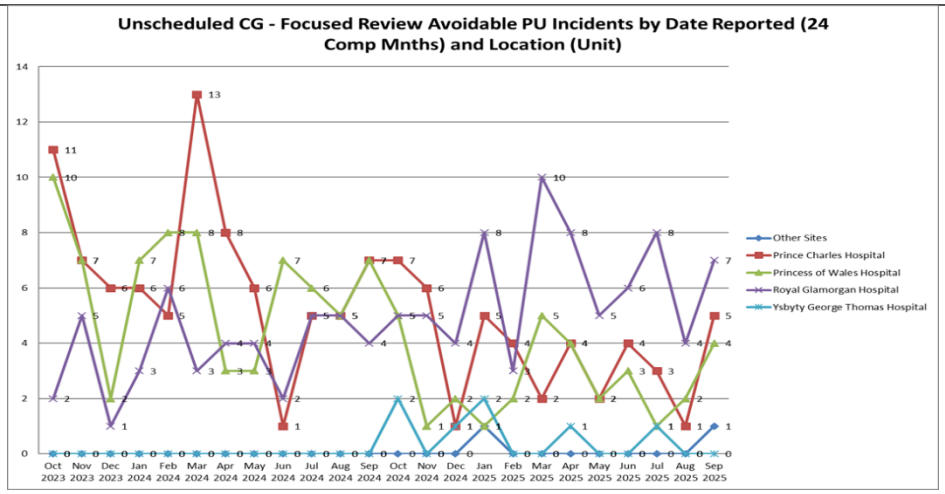


The above graph demonstrates the following key findings:

- During the period of October 2023 – September 2024 a total of 198 avoidable pressure damage incidents were reported
- During the period of October 2024 - September 2025 a total of 161 avoidable pressure damage incidents were reported
- The data illustrates that there were **37 fewer incidents reported in the most recent 12 months** compared to the previous year
- Demonstrating a 19% decrease overall
- The last 12 months show a more stable trend but still fluctuating pattern. However, **September 2025 showed a resurgence (17) which has returned to the higher reporting range.**

Overview of USC reported Hospital Acquired Avoidable Pressure Damage (October 2023 to September 2025) per DGH site

The below graph demonstrates the number of avoidable pressure damage incidents per month for each hospital site over the past 24 months.



During the period October 2024 to September 2025 in comparison to the previous 12 months the data illustrates the following trends for each respective site:

Site	Incident Trend
Royal Glamorgan Hospital	Increase
Prince Charles Hospital	Reduction
Princess of Wales Hospital	Noticeable Reduction

NB: It is important to note that the bed base increased in RGH in October 2024 and significantly reduced in POW due to the Critical Incident. Therefore, there are variables in the data when comparing with the previous 12-month prevalence in both RGH and POW sites.

This increase in avoidable harm has implications for patient outcomes, staff morale, and organisational reputation, and may lead to regulatory scrutiny if not addressed promptly.

HIW Improvement Plan - RGH Emergency Department

Following the unannounced HIW Inspection at RGH Emergency Department on 5-7th August 2025 several areas of improvement were identified during the inspection. In response the service has completed an improvement plan to support the required actions. HIW has commended the comprehensive and robust action plan and will require an update in 3 months (mid-January 2026).

The key areas of improvement have been highlighted by HIW, however, there were no immediate improvements identified. The action plan has been finalised and accepted, and HIW have commended the quality of the report.

In the meantime, progress will be monitored and updated monthly by the CSG and presented at Performance and Assurance meetings.

RGH Ward 3 Respiratory Update

Ward 3 continues to have an improving trajectory in both performance and staff engagement. The recently appointed Band 7, supported by two Band 6 nurses, is providing strong and visible leadership, contributing to the achievement of trajectory targets and the facilitation of ongoing Respiratory training and education for staff.

Infection Prevention and Control (IPC) standards have shown measurable improvement, with enhanced compliance observed during recent audits. Estates colleagues are currently undertaking ward flooring replacement work, which will further support IPC standards and overall ward environment quality.

The Ward Manager is also targeting improved pressure damage training compliance to support a reduction in avoidable pressure damage and harm to patients within this clinical area.

There has been an increase in positive feedback from both patients and staff, reflecting notably improved team cohesion, morale and communication. This progress highlights the effectiveness of targeted support measures provided to the ward.

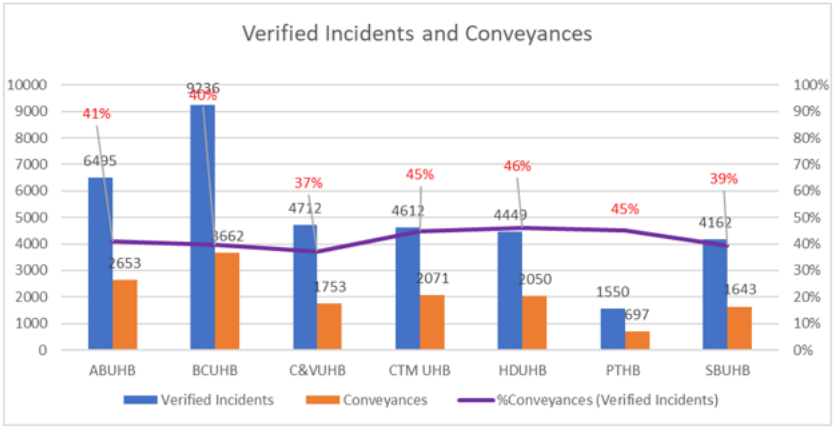
USC Performance and 30-Day Action Plan Update

The **USC Performance and 30-Day Action Plan Update (for September)** CTMUHB outlines significant progress and strategic planning in urgent and emergency care. Key actions include the development and implementation of rapid improvement plans, internal professional standards, and pilot programs such as UTC and UCC. Performance metrics show CTMUHB achieving the fastest ambulance handover times in Wales (average 24 minutes in July), with PCH and RGH leading nationally. Despite challenges like reduced inpatient capacity and a critical incident at POW, CTMUHB maintained low lost hours and improved conveyance rates.

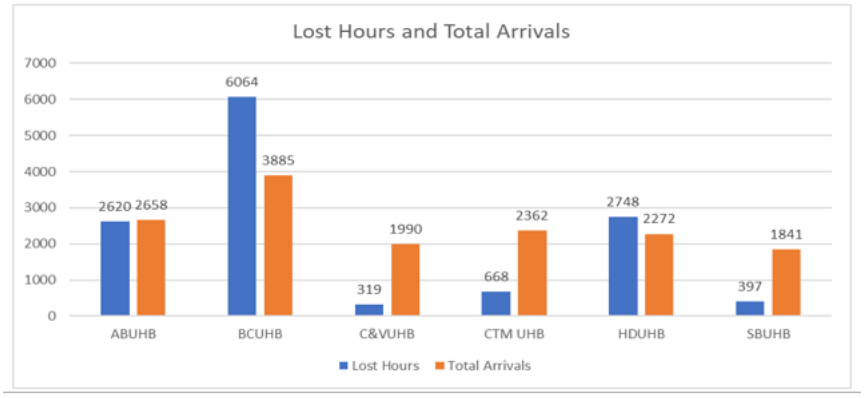
The 30-day deliverables focus on operational enhancements such as defining roles, improving diagnostics access, and refining discharge processes. Transformational goals include discharge protocols and care home admission avoidance. Outcome targets aim for zero tolerance to extended ED waits and improved discharge timings. The 60-day and 90-day plans build on these

foundations, targeting further reductions in wait times, enhanced patient flow, and expanded community care capacity. The overarching goal is to achieve zero tolerance for 12-hour ED waits and 45-minute ambulance handovers by October 2025, supported by trajectory-based planning and system-wide coordination.

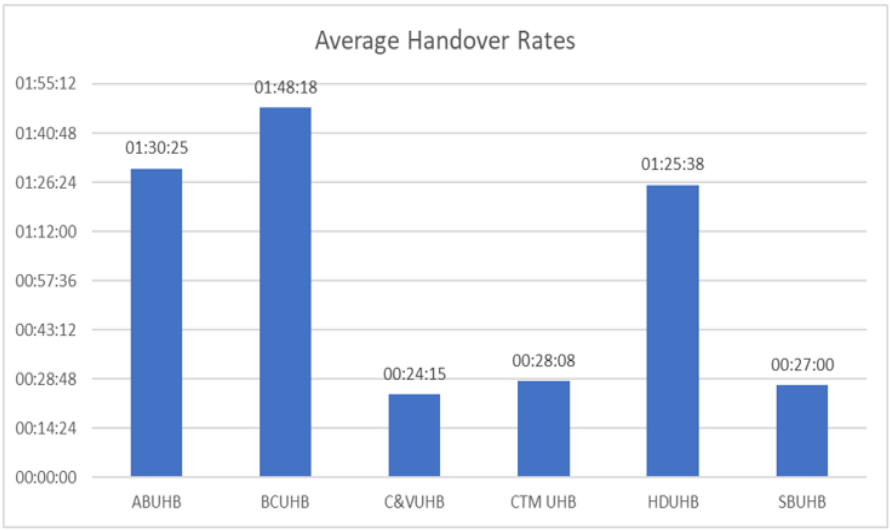
Please see below graphs relating to September's Ambulance performance.



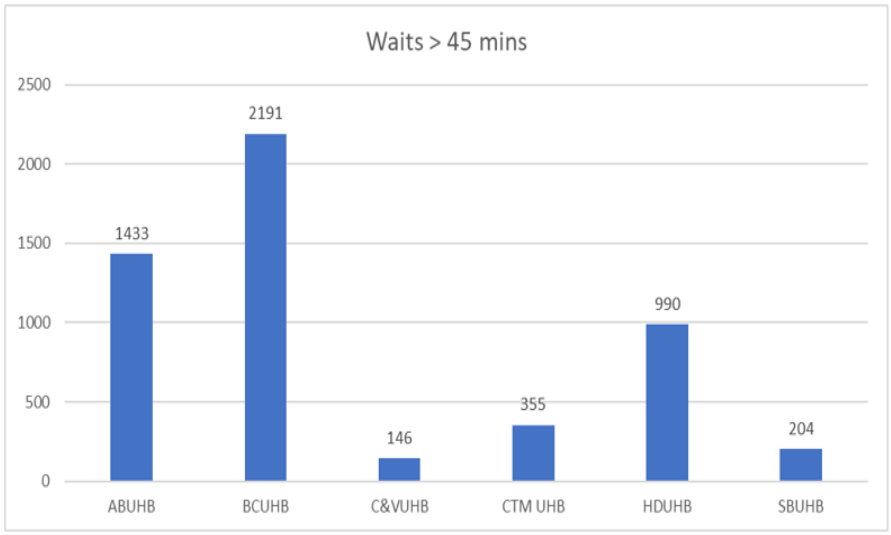
The above graph demonstrates that CTMHB's conveyance rate (46%) is above the midpoint compared to other Health Boards. Overall CTMUHB is showing slightly above average performance in terms on incident verification and conveyance in September.



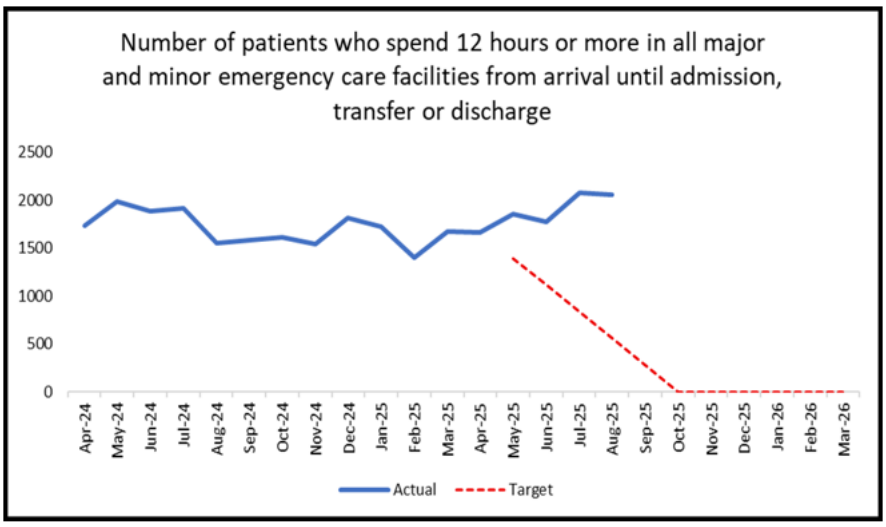
The chart above demonstrates that CTMUHB lost 668 hours with a total of 2,362 arrivals. CTMUHB has relatively low lost hours compared to most other Health Boards in September.



The above graph illustrates CTMUHB had strong performance in handover efficiency in the month of September, with an average handover rate of 28 minutes, it performed significantly better than several other Health Boards.



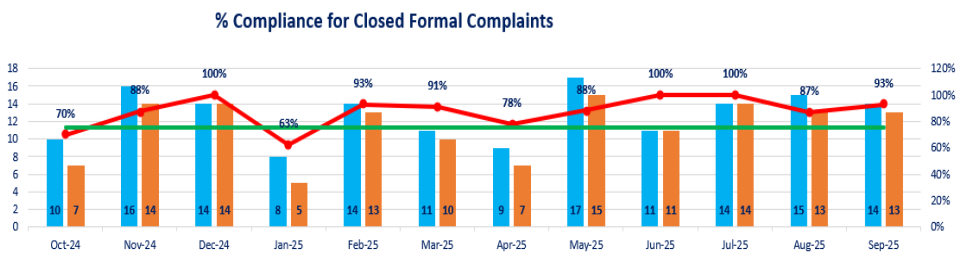
CTMHB records a relatively low number of ambulance waits > 45 mins compared to most other Health Boards in September, indicating strong performance in reducing patient delays.



While earlier data indicates a reduction in ambulance handover delays – meaning ambulances are transferring patients into Emergency Departments more efficiently. This chart reveals a contrasting upward trend in the number of patients waiting over 12 hours inside Emergency Departments.

This pattern suggests that bottlenecks have shifted downstream, likely within the hospital system itself. While ambulance offloads are now quicker, patient flow beyond ED (into wards, diagnostics, discharge pathways) has become constrained, leading to crowding and extended stays in departments. The increase in 12-hour waits highlights internal capacity pressures, suggesting the need for improved inpatient flow and discharge processes to sustain overall system efficiency.

Concerns ED & Medicine



Overall compliance has shown a positive upward trend, increasing from 87% in August to **93%** in September 2025. Ongoing

monitoring will continue to ensure this progress is maintained and embedded across clinical teams.

Since the reintroduction of the Patient Advice and Liaison Service (PALS) presence within the Emergency Department, there has been a notable rise in the number of enquiries received. This increase is being closely monitored to determine underlying themes, particularly around patient experience, communication and waiting time. Early indications suggest that accessibility to PALS within the department has improved visibility and encouraged more real-time feedback from patients and relatives.

There are currently **25 open complaints**. There has been an increase in the number of complaints received compared to previous months. Despite this rise, it is important to note that **all complaints remain within the 30-day response compliance** timeframe, with zero breaches reported. The complaints predominantly relate to diagnosis/treatment, communication, waiting times, unsafe discharges, long ED waits and other aspects of patient experience. These are being monitored through governance processes to identify learning to support the required service improvements.

Professional Standards & Behaviours

There have been several recent incidents where staff behaviours have not aligned with the organisation's expected standards of professionalism, values and behaviours. Such incidents have the potential to impact team culture, patent experience and the overall reputation of the Health Board. These incidents are being addressed through appropriate management processes.

As an immediate response, the Corporate Nursing Team has implemented targeted Professionalism Training sessions for Band 6 & 7 staff groups. These sessions aim to reinforce the Health Board' core values, strengthen leadership accountability and promote consistent professional conduct. This proactive approach supports our ongoing commitment to maintain high standard of care and upholding the reputation of the Health Board.

Designated Nursing Officer (DNO) Training for Medical Gases

Compliance relating to Designated Nursing Officer (DNO) training for medical gases governance remains low across the Health Board. An analysis and co-ordinated response, supported by the Assistant Director of Nursing, to determine the designated

	persons per area, and develop a targeted improvement plan to address gaps and strengthen compliance in underway. **Nutrition and Hydration: Catering Model Pan CTMHB** The digital catering model now needs to be implemented at RGH and POW to align with the successful approach already embedded at PCH that support our populations nutrition and hydration needs safely. Standardising this model across all sites will strengthen governance, improve the consistency and quality of patient care, and reduce variation in practice. Implementation will focus on facilitating patients' dietary requirements safety, thus supporting recovery and improved patient outcomes. **AMaT** AMaT actions for USC as reviewed weekly by the USC Directors. There is a rigorous approach to daily assurance checks by either the HON or Lead Nurse. For all sites, as part of their ward assurance the Lead and Senior Nurses are reviewing AMaT at a minimum of once a week to ensure compliance with the audits and action plans. With support from the outreach team Fluid balance compliance has improved, weekly audits continue and bespoke training by the outreach team has continued. **Risk Register** No new risks greater than 15 have been added to the Risk Register
Inform	**Head of Nursing Vacancies PCH and POWH** Interviews undertaken 27th October 2025 and 2 new Heads of Nursing recruited for PCH and POWH. **Senior Nurse Appointment RGH** A Senior Nurse has been appointed for Integrated Medicine and has now commenced in post. This role will provide enhanced nurse leadership and strengthen governance, support the required service improvement work and quality oversight. **Recruitment & Workforce Stability** Targeted recruitment efforts continue across unscheduled care and medical wards, with several key posts successfully filled. Ongoing campaigns aim to reduce reliance on temporary staffing and improve workforce stability, supporting safer staffing levels and service continuity.

An opportunity has been supported for a Lead Nurse secondment to cover the 3 Emergency Departments pan CTMUHB as a proof of concept for 6 months. The role will provide strategic and operational oversight, promote standardisation of care, and strengthen nursing leadership that has proven effective and efficient in Planned Care. This restructuring will form part of a wider strategic initiative for the senior nursing leadership across Unscheduled Care on the acute sites.

Equality, Diversity and Inclusion

Our newly appointed Senior Nurse in Medicine RGH has been approached by the RCN and has agreed to participate in a photo shoot in University of Cardiff to celebrate diversity within senior positions in the NHS in Wales.

POW Ward Moves

All required ward moves to date have been undertaken on the POW site successfully.

Patient Experience & Well-being

Collaboration with the Daring to Dream charity continues, with several music events scheduled over the coming months across POW COTE wards. These sessions aim to enhance the well-being and engagement of patients within our dementia and elderly population, supporting a more therapeutic and person-centred environment.

MyPorter Task Request Management System

A new digital portering task management system is being launched 1st November pan CTMHB to enhance operational efficiency and patient experience.

MyPorter has been adopted by over 70 NHS Trusts across the UK and has demonstrated measurable improvements in patient flow, especially in Emergency and Radiology departments

The system enables real-time task allocation and tracking, supporting timely patient transfers, reducing delays, and promoting a smoother healthcare journey across hospital sites.

	Recognition and Achievement: CTM Cardiology The CTMHB Cardiology team received national recognition at the **Welsh Health Care Awards 2025**, achieving success in the **Improvement in Cardiology Care** category. This award highlights the teams outstanding commitment to innovation, collaboration, and delivering high quality, patient centred cardiac services across the Health Board.
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:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Choose an item.
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:
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/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.	
	People	

4. Recommendation

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

Agenda Item
5.3.2

Quality, Safety & Experience Committee

Highlight Report from the Highlight Report from the Children & Families Care Group Quality, Safety and Experience Meeting

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Suzanne Hardacre, Director of Midwifery & Nursing, Carl Verrecchia, Service Director Mohamed Elnasharty, Medical Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Carl Verrecchia, Care Group Service Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, 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	
Badgernet	Digital Maternity Information System
BR+	Birthrate Plus – nationally recognised midwifery workforce acuity tool
CTM	Cwm Taf Morgannwg
CYP	Children & Young People
HIW	Health Inspectorate Wales

PCH	Prince Charles Hospital
IQPD	Integrated Quality, Performance & Delivery
MatNeo SSP	Maternity and Neonatal Safety Support Programme
NHS	National Health Service
PACE	Playfulness, Acceptance, Curiosity and Empathy
PoW	Princess of Wales Hospital
QSE	Quality, Safety and Experience
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment
WG	Welsh Government
Wte	Whole Time Equivalent

1. Introduction

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

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

2. Specific Matters for Consideration

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

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Children and Families Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Duty of Quality and 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	• Welsh Government national maternity and neonatal assurance assessment underway. Self-assessment tool submitted 31/10/25. Site visits will be based on the 15 steps approach, Staff and services user voices workstream also planned for November. P&I have indicated that they require to meet with Board leaders as part of the assurance process, communication to be received via CEO office imminently.

- Special School Nursing (Risk ID 5753) remains the highest Care Group risk within Children & Families (Risk score 20). Sickness absence position improving in Bridgend. One registrant recruited to Heronsbridge, recruitment to Ysgol Ty Coch unsuccessful, back out to advert. Risk score reviewed but remains at 20 due to fragility of services.

- Unite are currently balloting their members in the Health Visiting Service, on decision to vote to strike, Unite issued the Health Board with a letter of intention to ballot if the Band 7 uplift of posts was not agreed.

- Badger net implementation - The current status, risks, and resource requirements for the implementation: critical gaps in technical delivery, training, infrastructure, and governance, potential to cause delay in the safe and successful go-live in March 2026. Escalated to Director of Digital for point of contact to try to progress mitigating actions.

- Maternity Priority Unit. - The Maternity Priority Unit is an assessment unit for women in pregnancy requiring Urgent attention and care. The Birmingham Symptom specific Obstetric Triage System (BSOTS) model is used to standardise the assessment and prioritisation process, it aims to improve the overall efficiency of the maternity unit and enhance patient safety. Using the BSOTS model is also a directive from Welsh Government.

  Recent serious incidents and scrutiny on the delivery of high-risk care women with complex needs received, necessitated the establishment of a high care area for women requiring additional clinical care in the labour ward area. This occurred during the PoW closure and resulted in the Maternity Priority Unit (MPU) being displaced to accommodate this. During the closure MPU was located on ward 32 (Paeds outpatients) which was an ideal area to fully implement the BSTOS model. Since the PoW reopening, MPU is now run from 2 single rooms (previously 4 beds) on the labour ward corridor the following challenges are faced which impact on patient safety and experience:
  - Insufficient rooms to assess women on arrival in line with BSOTS causing delays in care
  - No oversight of the waiting room area if women become unwell
  - challenges with confidentiality as this is located on a main corridor to labour ward -

	○ No sluice facilities for urine testing causing Infection, Prevention & Control (IP&C) challenges - ○ Environmental challenges have resulted in the BSOTS model not being followed correctly causing delays in care, and negative experiences for women and staff. Data collection shows around 20% of women are not being seen in the 15 min timeframe standard, from the 1st to the 4th of November, this increased to 40%, contour to monitor. <u>Mitigations</u> • A handover room has been established in a storage area to allow an area to take triage calls and be within a close distance to the assessment rooms. • Two midwives allocated to MPU when possible to assess women and utilise rooms on Labour ward and tair afon when available, however this creates logistical challenges as this involves the women being cared for in different areas. This risk is on the risk register (6249). Conversation taken place with the senior clinicians and management to evaluate options which are limited due to the footprint of maternity. Ideal location for MPOU is on ward 32. However, this is a separate department and are not in a position to support.
Advise	• Birth rate + report is in draft and under review, suggestive of requirement of significant additional funding in clinical and specialist/management workforce to align with the standard. Care Group is reviewing the draft with a view to draft a paper for executive team. • Waiting time performance for Neurodevelopment children (RISK ID 2808) currently remains at a risk score of 12. This is being reviewed to see how the National Neurodivergence Improvement Programme (NDIP) funding received is likely to affect the trajectory. NDIP 25/26 – total budget for region and for ND team now confirmed by WG and is reduced from what was expected. This will limit our improvement opportunities and our aim to get below 78 weeks at March 2026. Raised at Welsh Government IQPD in July and again in November. Monthly trajectory meetings with Performance and Escalation team. Current wait at 102weeks. • Menopause service review delayed due to absences, the review will ensure provision within CTM is in accordance with national standards and guidance awaiting further date.

	• Welsh Government report on Allergy Services across Wales published, joint working group for paediatrics & adult services being led by Head of Commissioning. • Multi-professional baby abduction drills carried out across all maternity units in August. The exercise has highlighted the need for standardised security systems across all sites (weighted mattresses at RGH and PoW vs fully secure XTAG system in PCH). (Statement of Need (SON) submitted awaiting capital approval) • External review of previous four nationally reportable incidents – midwifery review completed, awaiting outcome of obstetric and anaesthetic review. Early learning highlighted from internal governance and assurance process and external recommendations completed (Improvement plan available for review on request). Internal investigations on schedule. • Healthcare support workers at PoW Maternity and Paediatrics continue to be responsible for hostess trolley / mealtimes. Concerns raised by the team as this task continues to detract from providing clinical care to women.
Assure	• Risk ID 6199 reduced as PROMPT training compliance has significantly improved over the recent months due to additional sessions. • 20 newly qualified midwives recruited, unfilled vacancies newly appointed into and will be in post by January. Streamlining events attended by Heads of Midwifery at University of South Wales (USW) in readiness for March cohort of graduates. 7.96 wte streamlining nurses recruited across children and young people services (CYP). • Resolution to school hearing screening service progressing. School entry hearing screening service will move to audiology. Posts have been recruited to awaiting start dates. School Nursing Service commencing transition year pupils following Fluenz Program in December. • Plans to fully return wards 18 at Royal Glamorgan Hospital underway, due to be handed back to paediatrics week commencing 10th November, deep cleaning and repatriation of all equipment required, target date for active use of ward week commencing 24th November. • Gynaecology Cancer action plan underway to deliver significant improvement in cancer treatment for our population. July Performance dipped to around 31%.

(unvalidated but August trajectory heading over 40% and should continue to improve as we work on both the triage at single point of access and the treatment stages. Risks to this are for the patients who require tertiary level treatment

- Gynaecology RTT target of no patients over 104 weeks at end of October 2025 met. SIG meetings have been established to have oversight and progression of improvements.

- Some outstanding estates issues remain following the re-opening at PoW. There is a schedule of maintenance work for Estates team to rectify which is still outstanding, this has Been escalated through IP&C committee and Children & Families Operational Management Board (C&F OMB).

- Midwifery and Health Visitor skills sessions introduced across all areas to share learning and build relationships, all three sessions have been delivered and are currently being evaluated.

- Health Inspectorate Wales (HIW) Unannounced visit to maternity unit at Princess of Wales Hospital Bridgend. No immediate assurances given. Action plan accepted and final report published.

- School Fluenz Campaign progressing, as of Friday 7th November 2025, end of week 7 16,662 children and young people have received their vaccination in school. Uptake rate of 54.7%. The team are currently working on two service improvement projects around e-consent and digital.
    - Invested in digital and data support for the school nursing team.
    - Development of individual links for schools containing universal nasal flu information, so we can measure uptake against parents/carers engagement, and also evidence if schools send out information we send to them.
    - Development of a bespoke vaccination data capture tool, support by power Business Intelligence (Bi), to give live updates on vaccine uptake, etc.
    - Rolling out of phase two of the e-consent system for all schools in Merthyr and Bridgend.

- Recruited Lead Nurse for women's health (18.75hrs) recruited to lead on the Womens Health Plan

	Risk Register There is currently one risk scoring high with 16 or more. Discussed with executive colleagues **Risk ID** | **Description** | **Score** **5753** | **Inadequate Special School Nurse provision** | **20**
Inform	• Research, Development and Service Improvement update received at Care Group Quality and Safety Committee in August. Several clinical research portfolio, non-portfolio, commercial, non-commercial and service evaluation projects underway across the Care Group. • Health & Safety have recently supported the review of Entonox exposure levels across maternity services. This involved environmental and personal monitoring. The Care Group team is working through actions to reduce risks in the areas with higher readings. • Consent training within maternity has commenced across sites for obstetricians. • Sickness absence among nursing workforce within special care baby units at PCH and PoW improving. • Labour ward beds at PCH have been replaced, bed borrowed from PoW returned. • Maternity & Neonatal National Assurance Assessment (NMNAA) self-assessment tool has been completed and submitted on 31/10/25. • Informatics Midwife has been shortlisted for NHS Wales award 18th November; Consultant midwife shortlisted for Royal College of Midwifery (RCM) leadership award. Bereavement Midwives and Infant feeding team have been shortlisted RCM Awards London (2026). International Confederation of Midwives (ICM) Lisbon (2026) conference - four midwifery leaders form CTM have had their posters/abstract accepted. • World Prematurity day 17th of November, engagement events occurring across CTM
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 • Inspiring People • Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well If more than one applies please list below: • Growing Well • Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below: • A Globally Responsible Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	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)	Yes - Reduce If more than one applies please list below: • Repurpose • Reuse • Refine • Recycle

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

5. Recommendation

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

Agenda Item
5.3.3

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Care

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	
POWH	Princess of Wales Hospital
DTPS	Diagnostics, Therapies, Pharmacy Services

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience meeting on 20th October 2025.

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

2.1 Purpose of this Meeting

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

2.2 The Planned Care/Surgery QSRE Group will:

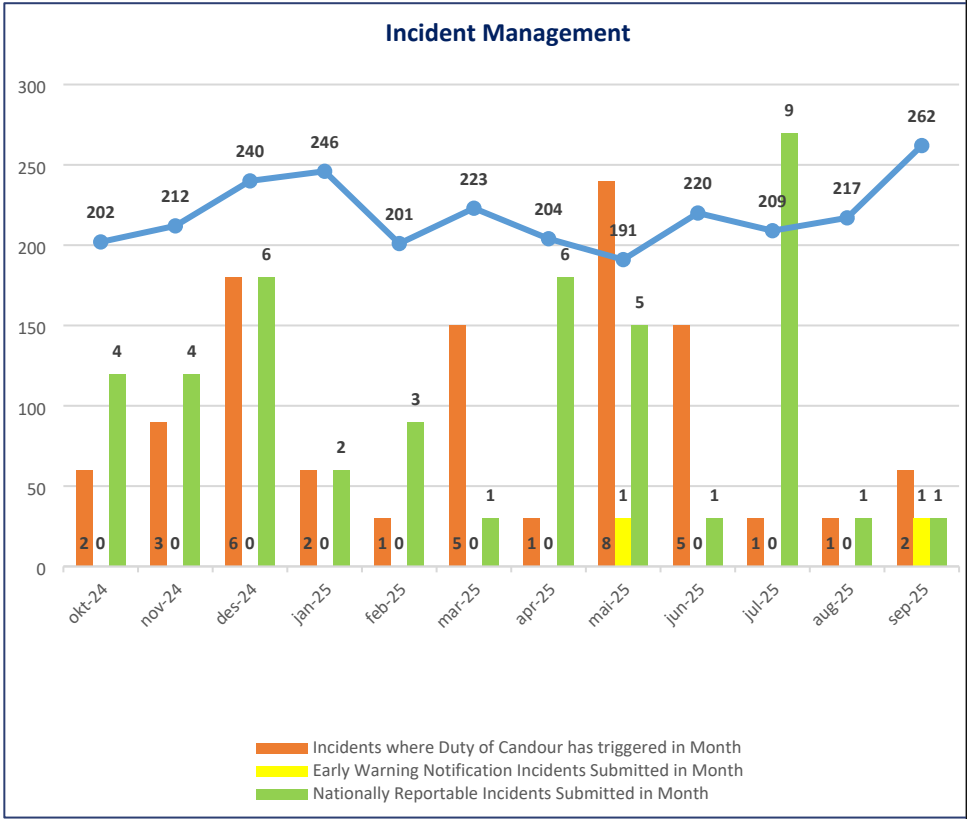
- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the Planned Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Planned Care Group in relation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

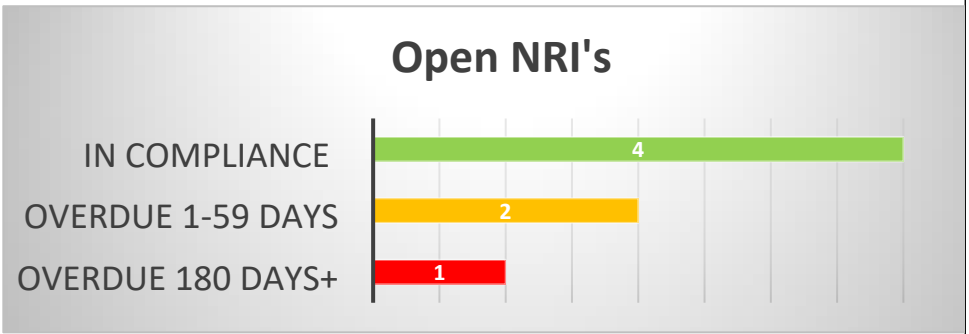
3.0 Highlight Report

Alert / Escalate	Endoscopy Unit in POWH • Infection, Prevention & Control (IP&C) concerns raised in September 2025 via the Endoscopy Verification Report. Recent audit demonstrates decontamination is not compliant with required standards, in relation to the ventilation systems. IP&C leads have confirmed that the risk was not low, but the risk of cancelling patients outweighs the risk associated with continuing to utilise the unit. • Action plan being devised by Estates Department and Contractors being sourced to work alongside the Estates leads with weekly meetings scheduled. Laser Protection Officer (LPO) for POWH. • Planned Care Group are working with DTPS Care Group to ensure allocated LPO cover at POWH.

Advise

Incidents overview



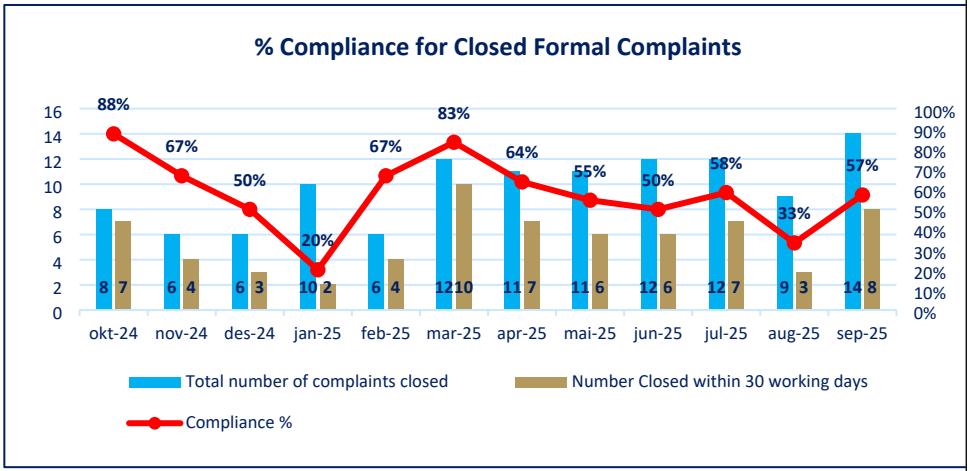


4 in compliance are historic ophthalmology and will be approved within timeframe

The 2 overdue are being finalised for Care Group Director approval

Longest overdue was due to complexities of standardisation of prescribing pre-operative anticoagulation but is now finalised and being prepared for approval.

Concerns overview



Large number of Early Resolution calls from patients relating to orthopaedics and waiting times.

Directorate have produced standardised response templates for Concerns and Patient Advice & Liaison Services (PALS) teams

Meeting in place with Lead for Concerns Team and Care Group Directors regarding how teams can support and improve response at time of the call to alleviate patient anxiety.

Call For Concern

Soft launch of the Call for Concern initiative was launched on 2nd October 2025 at POWH, specifically for critical care discharges only.

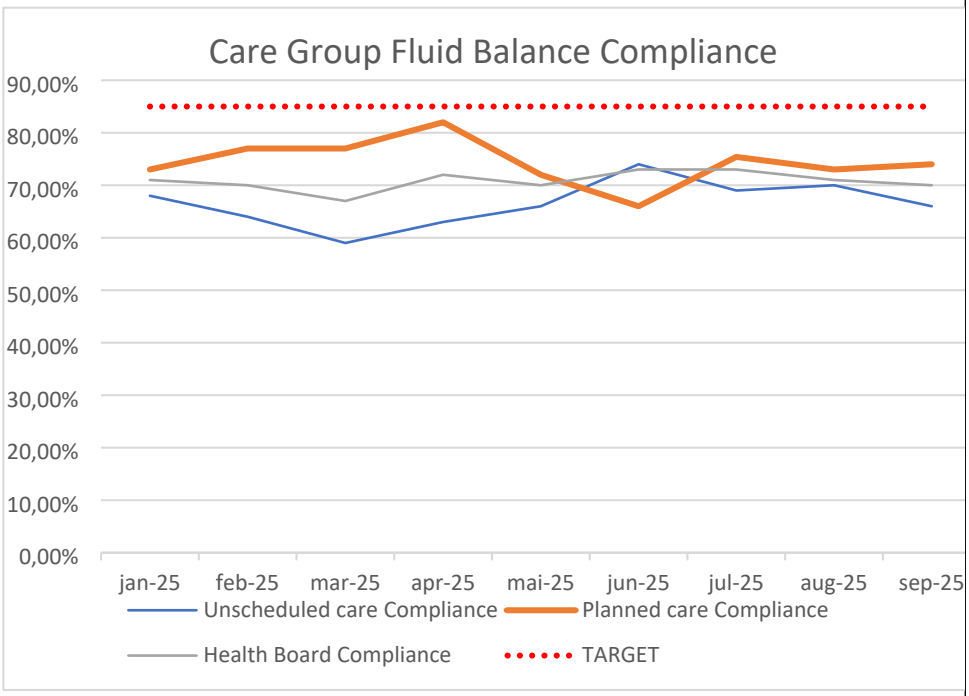
This is part of the National Programme of work and is Phase 1 – Design and Consultation (Sept 25-Feb 2026).

Theatre refurbishment in RGH

Work will commence in November 2025 on 4 theatres in RGH.

	Relocation of theatre activity will be moved to the 4 theatres in the Vanguard Unit. Ward 11 in RGH will move to the Vanguard unit to support Day Surgical capacity from 10th November. Ward 18 in RGH will move into ward 11 over the weekend of 8th/9th November. **Pressure ulcers** A spike in avoidable pressure damage recorded on Ward 11 in POW in August/September led to a targeted piece of work being undertaken, including; • Introduction of the Pink Pressure Ulcer (PU) Proforma for medical device checklist. • Implementation of the Pressure Ulcer Check list that is already in use in RGH and PCH. • Bespoke teaching on grading pressure ulcers. • An easy access PU ward information resource folder has been created. Following introduction of the above, there has been a significant reduction with only 1 PU in October, which at panel was deemed unavoidable. Significant improvement in Pressure Ulcer damage in Critical Care in RGH and POWH with no reportable PU damage in September onwards.
Assure	**COVID national review panels** Final COVID deaths panel completed – no harm identified for any patients who were being cared for within Planned Care. **Audit & Assurance** No outstanding AMAT actions across Planned Care. Ward 18 in RGH has achieved the Bronze award in the Ward Accreditation programme. Following ward audits, there has been a focus on accuracy of fluid balance recording which has seen an improvement in compliance. Education continues across Planned Care via Professional Nurse Focus Groups on the 3 acute sites and ward-based training.

Ward 10 in RGH winners of September's fluid balance audit.



Centralisation of Cataract Services

Following centralisation of cataract service from RGH to POWH staff and patient feedback has been positive.

Elective Orthopaedic in POWH

- Dedicated Arthroplasty unit at the POW from 1st September 2025
- Three dedicated laminar flow theatres running concurrently
- Dedicated 28-bedded Orthopaedic ward.
- Therapies 7 days a week
- Pharmacy standardisation and dedicated support

Between the 1st Sept – 22nd October 239 elective arthroplasty cases have been performed in POWH.

Average LOS is 1.9 days compared to 5 days this time last year.

Inform	**Good News** The Alcohol Care Team won the 'Management of Substance Dependency' category at the Welsh Healthcare Awards 2025. The team have also been shortlisted for the 'NHS Wales person centred award'. Nursing and Operational Teams in POWH were recognised at this year's CTM Seren Award for their commitment and dedication to patient safety and wellbeing during the Critical Incident. **CTM Research & Development Conference** 3 posters from Critical Care have been accepted at the CTM R&D conference. "Intensively Caring for each other: A Service Evaluation of the ICU Coffee Morning Peer Support Groups "An exploration of critical care survivors' experience of self-compassion during recovery from critical illness, using Interpretative Phenomenological Analysis." "Virtual Reality to Improve Sleep in Healthcare Staff. A randomised controlled trial."
Appendices	N/A

2. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	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:
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: Not applicable as CTM board papers are prepared in English
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	

3. Recommendation

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

Agenda Item
5.3.4

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths Interim Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths Interim Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AMAT	Audit Management and Tracking system
CTM	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
CAVUHB	Cardiff and Vale University Health Board
ICB	Improving Care Board
IMTP	Integrated Medium Term Plan

IT	Information Technology
LPMHSS	Local Primary Mental Health Support Service
MHA	Mental Health Act
MH	Mental Health
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
POW	Princess of Wales Hospital, Bridgend
QSE	Quality Safety Experience
RN	Registered Nurse
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
RGH	Royal Glamorgan Hospital
SHED	Service for High Risk Eating Disorders
SLT	Senior Leadership Team

1. Situation /Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the MHLD Care Group at its QSE meeting on 08/10/2025.

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

2. Specific Matters for Consideration

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

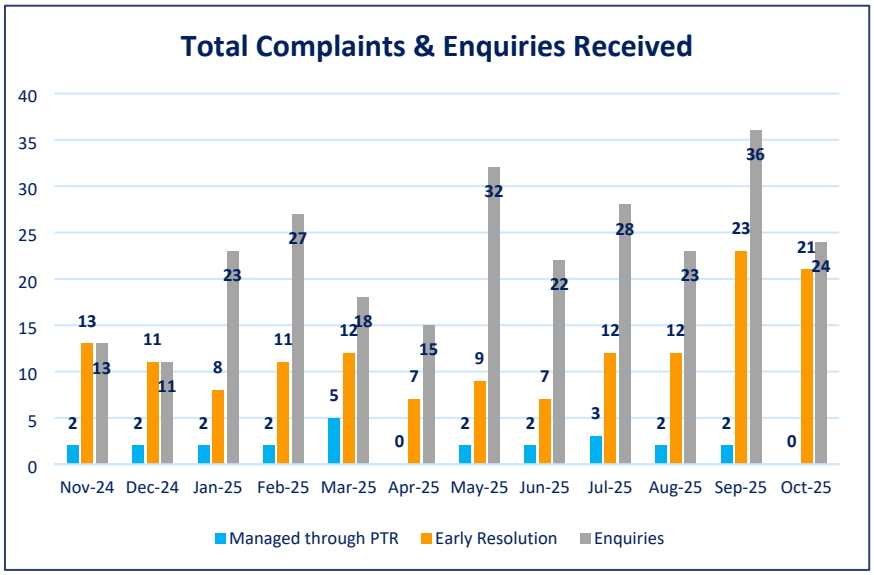
2.2 The MHLD Care Group QSE Board will:

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

3. Key Risks / Matters for Escalation

Alert / Escalate	• The Local Primary Mental Health Support Service (LPMHSS) provides assessment, brief psychological interventions, advice, and signposting for individuals presenting with mild to moderate mental health difficulties. The service delivery requires a consistent team of administrative and business support staff; however, current staffing shortages have resulted in a marked operational deficit. The Adult Mental Health Directorate has implemented a number of temporary mitigations to ensure the service remains safe, prioritised, and clinically effective until full staffing establishment is restored. In the short term the Care Group are monitoring the effectiveness of these mitigations in weekly meetings between the Directorate and Care Groups SLTs.

	• CTM commissions the Tier 3 Eating Disorder Service (SHED) from Cardiff and Vale University Health Board (CAVUHB). The CAVUHB service is currently experiencing significant and sustained operational pressures, characterised by high levels of staff sickness and multiple vacancies. As a result, the service is unable to deliver the full scope of specialist provision within its existing resource envelope. This presents clear clinical risks for the small cohort of CTM patients who require access to this service (currently totalling 10 individuals). CTM does not presently possess the capability or capacity to repatriate this specialist function. Furthermore, the Care Group has been unable to identify any available internal capacity or Tier 3 expertise to provide interim cover. Consequently, this issue has been escalated and recorded on the organisational risk register. There is an urgent requirement for CAVUHB to develop and implement mitigating actions to stabilise and sustain the SHED service. In response, the Care Group Service Director has formally requested a meeting with senior representatives from CAVUHB's Mental Health leadership team to explore potential solutions and agree a way forward. • During September and October 2025, concerns were raised verbally by resident doctors in the Care Group via educational and Care Group routes. A thematic review of the verbal concerns identified five main themes that have been shared with a range of leaders in the care group with a message that all concerns will be treated fairly and confidentially and that directorate leaders are key in driving changes to behaviours that are not in keeping with professional and CTMUHB values. The care group SLT are continuing to work with executive directors to address professional practice concerns. Immediate actions to address patient care have been taken which include ensuring regular medical review of patients on acute mental health wards in RGH. A detailed plan to address medium term culture and behaviour changes is being developed.

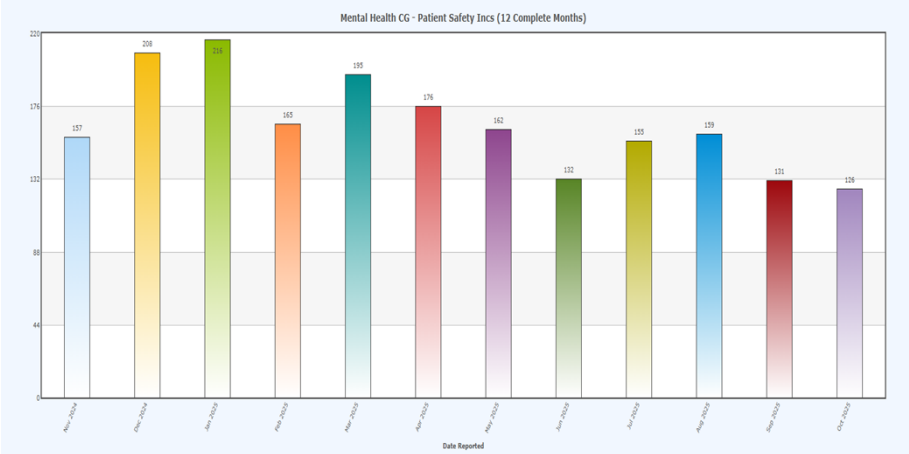
Advise	• Changes to the adult inpatient model at RGH were implemented in October. The changes are designed to improve continuity, reduce unnecessary transfers, and enhance patient flow in alignment with the current Bridgend model and national good practice and strategic objectives by moving from a single admissions ward to 2 admissions wards and 1 pre discharge ward without effecting bed capacity. Initial feedback has been positive, the Care Group will continue to monitor the changes through the Adult directorate QSE and ICB. • Medical staffing remains fragile across the Care Group. Medical staffing in Adult MH services has been added to the organisational risk register with a score of 16. The Care Group continues to manage medical staffing with daily scrutiny to identify and communicate pressures, prioritise work and release Consultant time.
Assure	• The number of complaints received by the Care Group during this reporting period (14 in August, 25 in September and 21 in October) was higher than the 2 year monthly mean of 18. The increase in complaints was spread across all services with no discernible reason or theme for the increase. The vast majority of complaints were managed through the Early Resolution process with the number of formal complaints received during this period (4 in total) being lower than the monthly mean of 5.  The top 3 subject areas for complaints and enquiries has remained consistent over the past 12 months; 1. Appointments

2. Communication Issues
3. Clinical Treatment/Assessment

The themes of complaints and enquiries are monitored in the individual directorate QSE meetings using the datix dashboards.

At the time of compiling this report there are no open formal complaints in the MHLD Care Group.

- The Datix incidents reported this period, 159 in August, 131 in September and 126 in October are lower than the 2-year mean of 198 per month and lower than the last reporting period.



- There are 4 open NRIs which is consistent with the 2-year mean. 2 of these are overdue both are in the final stages of approval.

  There were 2 new NRIs reported during this period (1 in August and 1 in September).

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

Project	Number of audits	Current compliance	Improvement	Overdue actions
Health & Safety	1		➤	0
Health and Care Standards	2	G 100.0%	▲	0
Infection Control	16	G 95.0%	▲	11
Medicines Management	2	G 96.1%	➤	0
Patient Safety	26	A 91.9%	▼	34

	Patient safety compliance has gone up from 91% to 92%. Of the overdue actions has gone up from 28 to 34 as more audits have been added, 31 of the 34 are RAG rated green with 2 RAG rated as amber and 1 as red, all 3 relate to CTP compliance. Performance against these audits is monitored in the individual directorate's QSE meetings.
Inform	• Sophie Bassett, Lead Nurse in OPMHS completed the Florence Nightingale Foundation scholarship presenting on her project about improving Memory Assessment Services. • Ward 14, POW are part of a national pilot to implement the Safe Wards Programme. The first 2 interventions have been introduced to the ward which have been positively received by staff and patients. The NHS Wales Improvement Team visited the Ward in September with positive feedback given in terms of both the progress being made and the motivation of the team to adopt the safe wards model. Ward Leads attended a National Team Support Meeting in September. • The Psychology team in OPMHS Memory Assessment Service were runners up in the annual Seren Awards Innovation, Research and Improvement category.
Appendices	None

4. Assessment

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

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below: Culture and valuing people 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 Committee is asked to NOTE the highlights outlined in section 3 of this report.

Agenda Item
5.3.5

Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	18.11.25
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Hannah Wilton, Director of Pharmacy and Medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

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

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 27th October 2025.

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

2. Purpose of this Meeting

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

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

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

1. **Highlight Report**

Alert / Escalate	**<u>Pathology</u>** **LIMS 2.0:** The LIMS Programme remains in RAG status RED. The Deployment Plan, agreed to at the 12th August Programme Board, has changed twice since acceptance. This is primarily due to: the incomplete configuration of the LIMS system, the number of Severity 1 & 2 defects outstanding, delivery of National Interfaces, completion of Data Migration and Legacy Data. This has been escalated via operational routes. Cellular Pathology initial go live was planned for Swansea Bay Health Board (SBU) on 10th November with other Health boards to follow, this has now been delayed as user acceptance testing is yet to be approved and signed off. **<u>Healthcare Science</u>** **Neurophysiology** Deficit continues between demand and capacity with backlogs continuing to rise for both testing and reporting, which has been further exacerbated by Healthcare Science (HSC) onboarding work. Plans to increase neurology consultant capacity within the CTMUHB is also expected to increase activity and consequently waiting times. Planned Care Recovery funding is currently being utilised to hold additional weekday clinical sessions to increase activity. Further mitigations in the form of outsourcing activity could rapidly reduce current waiting lists. Further information around potential outsourcing opportunities is currently being gathered. **<u>Radiology</u>** There is a significant backlog of reporting radiology examinations, with just over 10,000 X-rays pending. Current mitigation measures include rostering SPRs for extra reporting, outsourcing Musculoskeletal (MSK) cases, utilizing training posts and the returning from parental leave. We are aiming to address the backlog in the more likely clinical urgent cases (chest x rays) by December as a priority. Staffing challenges, particularly in relation to out of hours cover, continue to impact service resilience and staff wellbeing. These concerns were identified during the PCH IR(ME)R inspection as an area requiring improvement. Monitoring and workforce planning are ongoing to mitigate risks to safe and effective service delivery. There is currently an insufficient number of support staff at Healthcare Support Worker (HCSW) Band 2/3 level, and a staffing review is underway to mitigate this risk. This shortage has a significant impact on the ability to provide ultrasound

services, particularly due to the requirement for chaperones during intimate examinations.

A number of sonographers across the health board have been affected by work-related musculoskeletal disorders (WRMSKD), resulting in a critical workforce issue that is directly impacting the department's ability to deliver NOUS services. Risk assessments have been completed in collaboration with the Manual Handling Advisor and the Health and Safety Radiographer and a report drafted. Mitigations include the use of locum sonographers.

Radiology-supported endoscopy services at RGH have been temporarily suspended following the identification of critical faults in the endoscopic equipment. As a result, the service has undergone reconfiguration, with procedures being redirected to other sites. This has led to a decrease in overall service capacity, which may affect access to the service and contribute towards longer waiting times. A capital bid to replace all faulty equipment and return the service to PCH has been submitted to Welsh Government and we are expecting to hear by the end of November 2026.

A recent power outage and manual generator/UPS switch-over at RGH damaged CT scanners, exposing a critical risk. If the manual switch-over process is not corrected, further damage could occur, potentially resulting in complete loss of CT service and significant delays in patient care, with repair costs of approximately £350,000 per tube. Estates have committed to prioritising CT during generator activation, and weekly meetings with the scanner manufacturer and estates are ongoing to monitor progress and mitigate this risk.

Medicines Management

- Primary Care
  - Potential risk to patients with the change in strengths of Rybelsus® (due to change in formulation and bioavailability). Ready to go with information to practices and ScriptSwitch messages in anticipation of these products being available to prescribe in primary care.
  - Ongoing issues with Antiviral availability – now adding Paxlovid and Molnupirivir to NHS Urgent Medicines Supply Advanced Service (NUMSAS) in Community Pharmacy– aiming for end of week of 27/10/25.

AHP

Dietetics - No sustainable funding identified for PIPYN beyond March 26. Ongoing conversations with operational colleagues.

	AWDPP (All-Wales Diabetes Prevention Programme) – risk that no delivery from April 26 onwards is a missed opportunity to reduce the prevalence of Type 2 Diabetes given national evaluation demonstrated 25% reduction in development of Type 2 Diabetes. Ongoing conversations with operational colleagues.
Advise	**Radiology** Plans for MRI at RGH are progressing to reduce entry points to the MR Controlled Access Area, as outlined in the physics risk assessment. Statement of Need (SON) and Fire Build applications have been approved, and architects and contractors appointed. Nuclear Medicine, a revised permit for POW is being prepared to accommodate increased waste in readiness for service centralisation. There is a new national taxonomy policy for radiation incidents within Datix. This will enable thematic analysis at both a national and local level. **Pathology** **Cellular Pathology – Transfer of reports from outsourcing**: currently all reports received from the outsourcing company are manually transferred from the results portal to the Pathology system. This has resulted in incidents where reports have been incorrectly transcribed, and the risk has been increased to reflect this. Cellular Pathology is currently working with the outsourcing company to implement an automated solution which will enable results to be electronically transmitted directly to the pathology system. A statement of need has been submitted to progress this; now on the Capital priorities list awaiting consideration. **Health Science** **Audiology** Rise in equipment failure in adult services (pan-CTM). Statements of need have been submitted which will enable the procurement of replacement equipment. Insourcing in Ear, Nose & Throat (ENT) has started with an impact of 50 new referrals per week into audiology with an understanding that this could further increase. A demand and capacity exercise has been undertaken to understand if there is any underutilised capacity within the system and how this could be better utilised to reduce audiology waits.

	Plans to mitigate an evacuation risk at Keir Hardie Health Park (KHHP) for patients with decreased mobility are being developed through the proposed use of downstairs room when available. Further discussions are currently being undertaken to ensure the suitability of the room and to understand any limitations. **Clinical Engineering** The service is currently unable to progress Quality Management System implementation to regain ISO 9001:2015 and technologist training plans due to service pressures and continual demand on time to beds service. Consideration is being given to how these areas can be progressed to avoid any impacts in the future. **Increased Blood Transfusion Risk:** As reported to the previous meeting, 9 clinical incidents were reported in relation to Blood Transfusion 07/07/2025 – 20/08/2025. Six of these resulted from errors that originated in Blood Bank. The increased incidents in the Blood Transfusion Service was previously escalated via the Clinical Director of Health Science, with a recent assurance paper being presented to the Executive Leadership Group. A follow-up brief has been written to provide further assurance in relation to the current status of the Blood Transfusion service and the outcome of incident review meetings and actions taken. This will be discussed within ELG and through operational governance routes. Although the staffing risk remains, the depleted senior team is now back to full capacity and no further moderate (or above) harm incidents have been reported throughout September/October.
Assure	**Medicines Management** **CD audits:** Target= 100% Current figures for completion of CD audits are: • **RGH**: 97% [Previous Quarter 81%] • **PCH**: 100% [Previous Quarter 100%] • **POW**: 82% [Previous Quarter 84%] • **YCR:** 100% [Previous Quarter 100%] • **YCC:** 85% [Previous Quarter 100%] AMaT team building dashboard to assist with planning and reporting on compliance • HMP Parc ○ Controlled drugs training has commenced with all staff – multiple sessions scheduled, good attendance and response to date. Working with Principal Pharmacist Antimicrobials on introduction of AMS Huddle at Parc, aimed at supporting pharmacists in enhancing antimicrobial prescribing.

Pharmacy team is also working with Public Health Wales (PHW) to support data collation for the review of antimicrobial prescribing practices in Welsh prisons.

Pathology

Biochemistry analyser upgrade: The Biochemistry Department at Royal Glamorgan Hospital has now completed the implementation of new analysers, involving a detailed process of quality testing. The project was delivered on time (target date end of October) and the service is now back to full capacity.

Unannounced HTA /Inspection:
The unannounced HTA inspection took place on the 3rd and 4th September across the three CTM Mortuaries and associative support services (including Porters, Estates, Midwifery). This was followed by an extensive documentation assessment of Standard Operating Procedures (SOPs), Policies, Risk Assessments, Maintenance and training / competency records. All required documentation was submitted on time, and no shortfalls were found. This outstanding outcome represents a significant achievement for the CTM Mortuary and associated support services; staff have been commended for their dedication and commitment to maintaining such a high standard of service delivery.

RGH Postmortem Suite Ventilation:

Concerns have been raised regarding a recent ventilation report for the RGH postmortem suite. There are specific HTA standards in relation to ventilation of postmortem suites, and with the negative pressure being low, advice was sought from HTA. The ventilation remains compliant as the room pressure is still negative (negative pressure prevents cross-contamination into surrounding areas), and the necessary 10 air changes are being recorded. Any further decline in the ventilation will be reported to HTA. In the interim, a statement of need has been submitted to replace/repair the postmortem suite door, any high-risk postmortems will be transferred to PCH (where ventilation is better), and staff and visitors will continue to apply universal precautions in relation to Personal Protective Equipment (PPE). Longer term plans are to move the Postmortem (PM) suite to PCH.

Community Body Stores
On 3rd November, a pilot will be undertaken where Pathology will take over the management of Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon body stores, supported by facilities and nursing colleagues. This is in line with Welsh Government recommendations following the publication of the Fuller Report.

Infected Blood Inquiry: implementation of recommendation 7e – implementing Serious Hazards of Transfusion (SHOT) reports:

Following the publication of the Infected Blood Inquiry (IBI) Report and its recommendations on 20th May 2024, an oversight group has been tasked with monitoring their implementation and reporting progress into Welsh Government.

Health Science

Audiology

In a recent Adult Quality Standard visit the service obtained an overall compliance score of 91.8%, exceeding the required target score of 85% and a clear demonstration of the continuous quality improvements made by the profession.

Cardiac Physiology

The previously reported demand–capacity gap within the Echocardiography service continues to decrease through the provision of funded additional weekend appointments. Even with this targeted approach further work is required to achieve the 8-week target. Absence in PCH and RGH Echo staff is exacerbating the situation.

A longer-term workforce plan is being developed to support sustainable service delivery. Initial engagement has commenced for a demand and capacity review of Echo resources across CTM, with the objective of ensuring equitable access, consistent service provision, and improved operational efficiency.
Utilising bank staff to maintain ECG service to wards in PCH

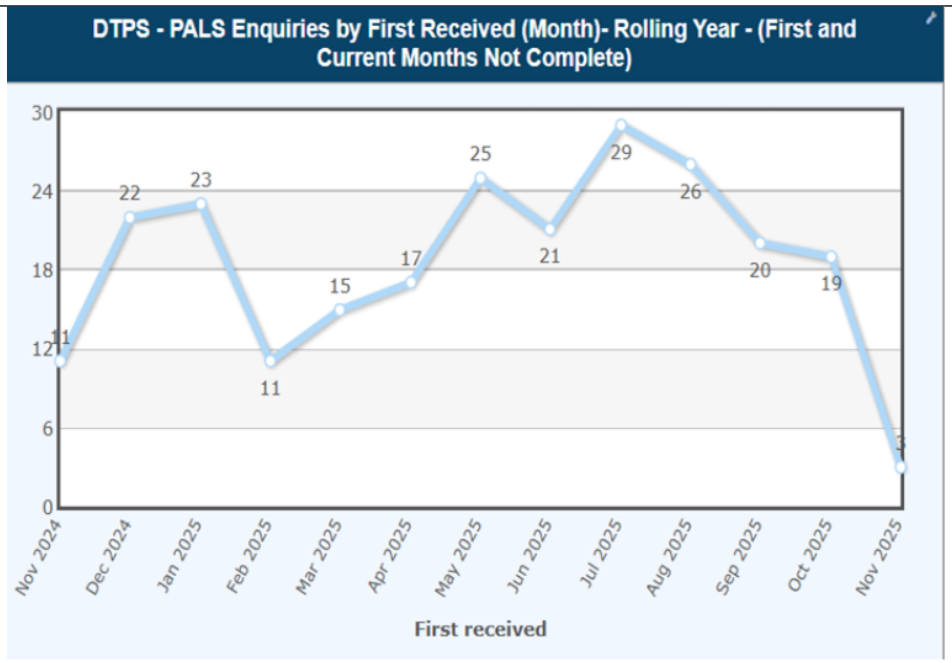
Radiology

A regular Emergency Department Radiology meeting is being established to strengthen communication and governance across services. In addition, Lunch and Learn sessions will be launched across all acute sites to promote Continuing Professional Development (CPD) among Radiology staff. A Basic Life Support training drive is underway to ensure all Radiology team members maintain good compliance.

AHP

Occupational Therapy (OT) Principal Team attending 'Safe to start' meetings daily in RGH, POW and PCH. Very positive feedback received regarding value and impact of this by site/patient flow leads.

	OT – very much involved in Optimise plan for POW. Senior OT leads 'ward sponsor', championing MDT upskill and education. This supports the wider OT and CTM winter plan. **SLT / OT** – all registered SLTs / OTs re-registered successfully with HCPC by the deadline with no issues.
Inform	**Radiology** External referrers have been entitled to refer into CTMUHB. All other health boards in Wales are looking to adopt the same approach so we may receive a similar letter. **Medicines Management** • YCC/YCR-High Risk drugs Whiteboard now implemented across YCR and YCC which includes Clozapine. **Pathology:** **UKAS (United Kingdom Accreditation Service) Inspection:** UKAS inspection took place during the first week of July. Minor findings were received for each department; all findings have now been cleared. The team are currently arranging the next surveillance visit which is planned for June 2026. **AHP** The AHP Rapid Community Access Model has been shortlisted for AHA Cymru Awards 2025. Final award ceremony on 14/11/25 OT – continuing demand for OT at YGT, as discussed in previous meeting. AHP leads are working with colleagues in USC with a plan in place to support improvements. SLT – CTM's Speech and Language Therapy service shortlisted for the Mental Health & Wellbeing Wales Awards 2025 for a Mental Health & Wellbeing Wales Awards 2025, in the category of Workplace Wellbeing Award. The awards aim to recognise individuals and organisations who go above and beyond to support the wellbeing of others. **DTPS Complaints Received and Compliance**



Appendices	N/A

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Effective

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

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

4. Recommendation

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

Agenda Item
5.3.6

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Nurse Director, Primary Care & Communities
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Nurse Director, Primary Care & Communities
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
C&V	Cardiff and Vale Health Board
CTM	Cwm Taf Morgannwg
D2RA	Discharge to Assess
DAP	Dental Access Portal
DHCW	Digital Health Care Wales
DN	District Nursing

GA	General anaesthetic
GAA	General Anaesthetic Assessment
GMS	General Medical Services
GP	General Practitioner
HMPPS	His Majesty's Prison and Probation Service
IPC	Infection Prevention Control
LES	Locally Enhanced Service
NHS	National Health Service
OCP	Organisational Change process
OOH GP	Out of Hours General Practitioner
PBMA	Prevention and Behavioural Management Assessment
PCH	Prince Charles Hospital
POWH	Princess of Wales Hospital
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
SBUHB	Swansea Bay University Health Board
SCD	Special Care Dentistry
SPOA	Single Point of Access
UCAF	Unified Contract Assurance Framework
WIS	Welsh Immunisation System
WG	Welsh Government
WL	Waiting List

1. Situation /Background

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 13th October 2025.

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

2. Specific Matters for Consideration

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

2.2 The Primary Care and 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 Care and Community Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.

- Provide assurance to the Primary Care and 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	**Paediatric GA List** There are approximately 508 children on the waiting list for a GAA and a further 622 children on the waiting list for PBMA which could lead to treatment under GA. There has been a significant increase over the last month (+134 patients) due to a recent validation of Bridgend legacy waiting lists. There have been some positive developments in relation to the number of lists proposed for the service with 1.5 lists per week being allocated in PCH and 2 lists per week in RGH, with potential for a further 2 lists per week in RGH. The lists in PCH are now operational but the lists in RGH have still not commenced due to a delay in theatre/ward movements to accommodate refurbishments.
Advise	**Comprehensive Dental Care for Paediatrics** work to repatriate this service from Cardiff & Vale (C&V) is currently being undertaken and representation from both Health Boards including Primary Care, Planned Care and the Paediatric Wards are being engaged. It is anticipated that the service will be transferred back to CTM in January 2026 and one of the existing lists within PCH (1 per month) will be used to accommodate this cohort of patients. Therefore, the trajectory for 'routine' GA patients may be slightly delayed as a result of a decrease in capacity to accommodate the comprehensive care. It is expected that C&V will treat any children that have already been referred into their services and therefore, the current backlog will not transfer to CTM, however Cardiff are yet to confirm this agreement on the waiting list transfer. Once the secondary care dental service repatriation has occurred with SBUHB, it is planned that dental SCD is more appropriate for delivery on the POWH site, this is the longer-term option. **Parc Prison Optometry Service:** the opticians service is running well within the prison the provider has introduced a new

	triaging process. The change has reduced the waiting list by 19 patients between June & July (in addition to 115 patients being added to the WL between June & July). Additional sessions commenced in August which are expected to have a positive impact on the waiting list. **Dental Access:** there have been 8789 patients allocated via the DAP since 12th February 2025. Out of this number 3835 patients currently registered on DAP are waiting for an NHS Dentist in CTMUHB (313 of which have been made an offer but have declined it and re-entered WL). Consultation for **New National Dental Contracts** across Wales. A new dental contract will be implemented and will go live on the 1st April 2026. There remains the risk that some existing NHS contract holders may choose not to engage with the new contract and hand back contracts, this could pose a significant risk to access should this happen. It is essential that WG develops a communication plan for both patients and the profession and a Multi-Disciplinary Team (MDT) implementation group established to work through the detail of the contract which is needed by HBs to be able to monitor the contract effectively **Lymphoedema service:** Improvement work continues and have completed check phase, Plan phase commencing 1/10/25. Recent Llais enquiry completed showing long waiting lists and increase in referrals to the service that is under resourced and lack of investment and reoccurring funding over many years. Additional investment proposal to be drafted, to reduce the risk of further impact to waiting list times, which will continue to increase and will have continued delays to patient treatment. **Wound Clinics:** meetings held with GP leads to look at a more collaborative approach. Further work required with the LES agreement with GP practices. **Community Vaccination Centres (CVCs):** Following a recent IPC and Health and Safety assessment across the 6 vaccination centres in June, the overall conclusion is the centres are not fit for purpose. Recommendations have been made under each of the key findings. In response to this a full review of the delivery model will be undertaken and proposals will take into consideration the recommendations. This work remains ongoing. **Vaccinations:** the updated WIS 2.0, was launched on the 1st September 2025. The new platform has had a number of issues which have been reported back to DHCW for an urgent resolution.

Mobile Vaccination Unit: The team are progressing with the procurement of a three-year lease bespoke vaccination vehicle to address vaccine equity and access issues across CTM. Final sign off has been given to the layout and interior fitments and a delivery date scheduled for 22nd October 2025.

The **Autumn COVID Vaccination Programme** began on 1st October for eligible individuals. Staff are no longer universally included. The eligibility criteria for this campaign is:

- Adults aged 75 years and over on 31st January 2026;
- Residents in a Care Home for older adults;
- Individuals aged 6 months and over who are immunosuppressed.

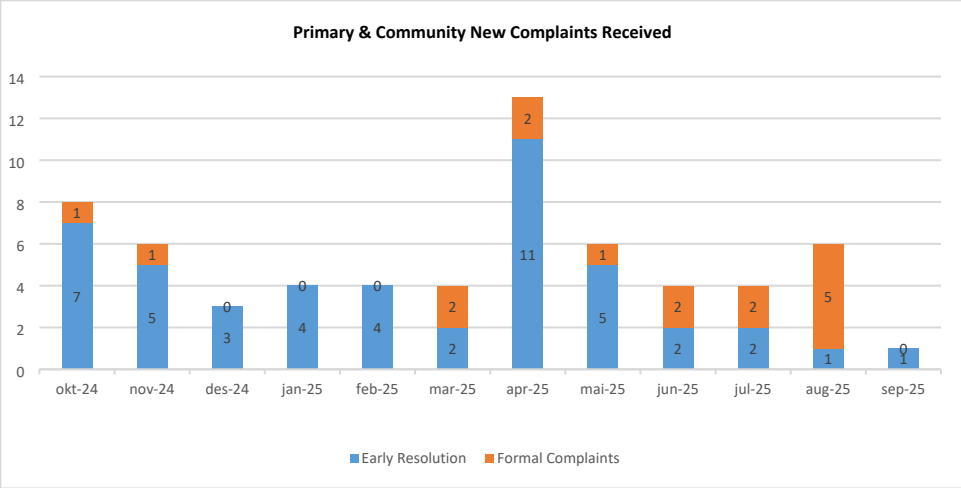
GP Practices: The team have now completed the annual GMS UCAF desktop reviews for the second consecutive year. **Six** practices have been identified for visits this year, including one that will receive a full-day review. All practices have been informed, and those not scheduled for a visit have been issued with action logs to complete and return. The multi-disciplinary visits are undertaken by a Clinical Director and Medicines Management representatives. They commenced from September and will assess performance against Quality Standards. Following the visits, reports will be shared with each practice to support action planning and provide further assurance.

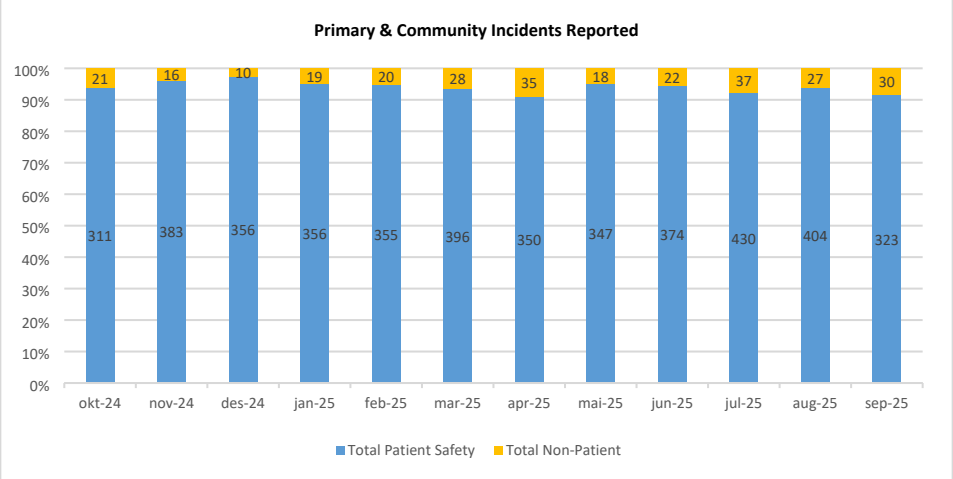
Navigation Hub: there will soon be a name change, the Clinical Navigation Hub will be known as CTM SPOA in line with WG direction.

Parc Prison: Operational Staffing and Estate Challenges which are due to fluctuations in staffing and regime changes continue to impact healthcare resource allocation and service delivery. To mitigate this, the Directorate is working with G4S to explore wing-based medicine administration, reducing reliance on healthcare runners.

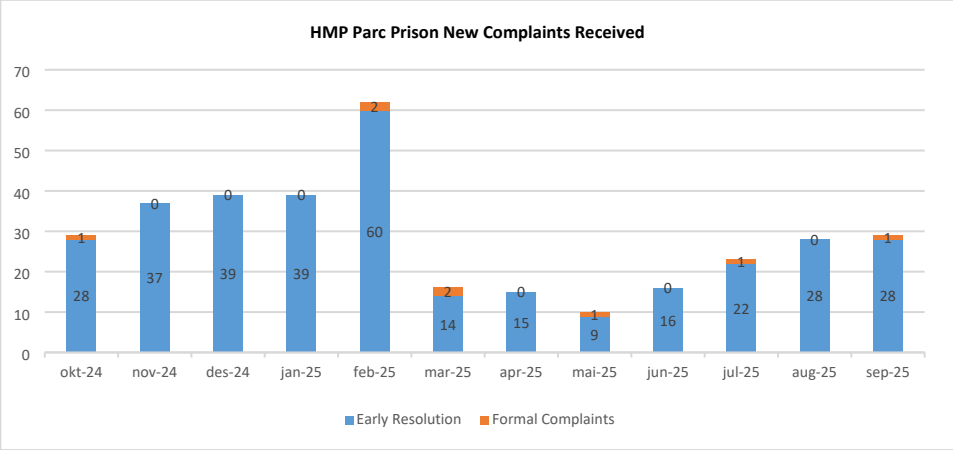
Specialist Palliative Care Ward 6: Challenges to the medical workforce on ward 6 Specialist Palliative Care in YCC remain. An initial discussion with Llais has taken place and we are now finalising the consultation process and a further meeting is taking place with LLais on Monday 10th November. The consultation document has been drafted and it will consider a range of options to support a sustainable service going forward. The Care Group has been advised to follow a 6-week engagement/consultation

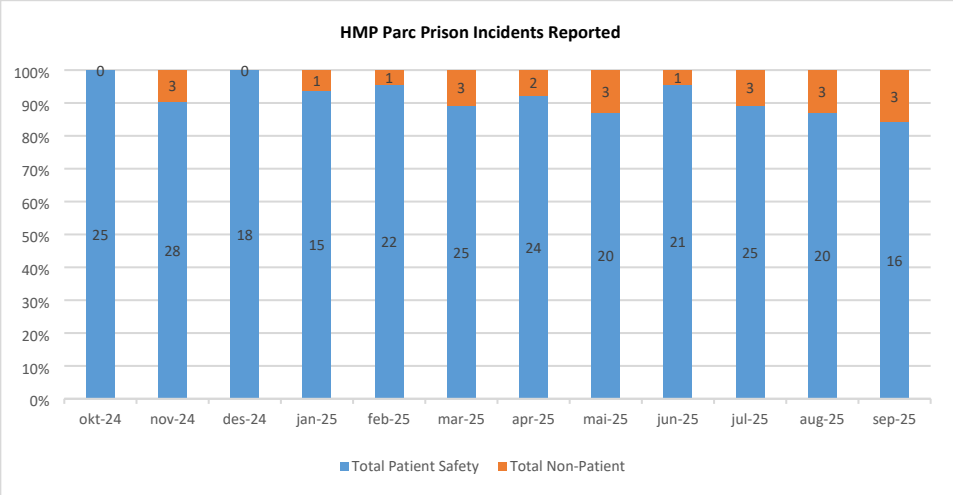
	with our public in the first instance and feedback from this will help inform the final outcome.
Assure	**Concerns and incidents (excluding Parc Prison)**





HMP Parc Prison concerns and incidents





Inform

Bladder and Bowel service: plans for a new Continence Pilot in Bridgend Locality as an Integrated approach with the aim to have a holistic assessment with support of therapists prior to prescribing products.

Community Hospitals: D2RA audit to be undertaken across community hospitals within the next few months. This audit will identify any delays with discharging patients.

YCC Ward 5: awaiting a confirmation date of handover of the area from Capital. No funding agreed as yet to allow recruitment of nursing staff.

Clinical Navigation Hub: the Respiratory Virtual Ward currently has 35 patients across RCT and Merthyr. Meetings are scheduled with a respiratory physician and Doccla (monitoring equipment) to this patient cohort. Also, options are being explored for a pharmacist to support the team. This will enable the team to accept and review more patients.

	Clinical Navigation Hub: The team are in the process of developing a new Head injury pathway for patients over 65 with a frailty score of 7. This pathway is being developed in consultation with neurology and radiology colleagues in order to prevent unnecessary hospital admissions for those patients who would not be eligible to undergo any surgical intervention following a head injury. In the initial phase this pathway will be rolled out across care homes within RCT. **Clinical Navigation Hub:** District Nurse (DN) Escalation pathway, if a patient has been identified as having an urgent healthcare need but the patient's own GP does not have availability to review the patient and the advice provided is to contact 999, the DN will contact the Hub to request a medical review from an OOH GP. The Navigation Hub clinician will respond to the DN via telephone initially within 20 minutes to triage the patient then provide a plan of care. **Parc Prison:** expansion Plan HMPPS and G4S have secured planning permission to expand the prison's capacity by an additional 345 individuals by October 2028. The approved development includes a new kitchen and dining block, gym, multi-faith facility, education building, and a redesigned visitor/staff entrance with increased car parking and supporting infrastructure. Initial discussions between the Directorate and G4S have focused on healthcare space allocation within the expansion plans. To ensure continued oversight and coordination, the Prison Expansion Plans will remain a standing agenda item on both the Prison Assurance Board and the Healthcare Partnership Board.
Appendices	N/A

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: Ageing well Dying Well Growing Well

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): 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 and Experience Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
6.1

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Services

Pwrpas yr Adroddiad / Report Purpose	For Review

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

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

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.09.25 and 31.10.25 taken from systems on 03.11.25, unless otherwise specified.

Key areas to note in this reporting period are:

- Reduction in the number of formal complaints open over 30 working days
- One PSOW final report received – not upheld
- Decrease in number of National Reportable Incidents
- Increase in number of incidents where duty of candour was triggered
- No regulation 28 report received
- Increase in medication incidents reported
- Decrease in patient fall incidents reported

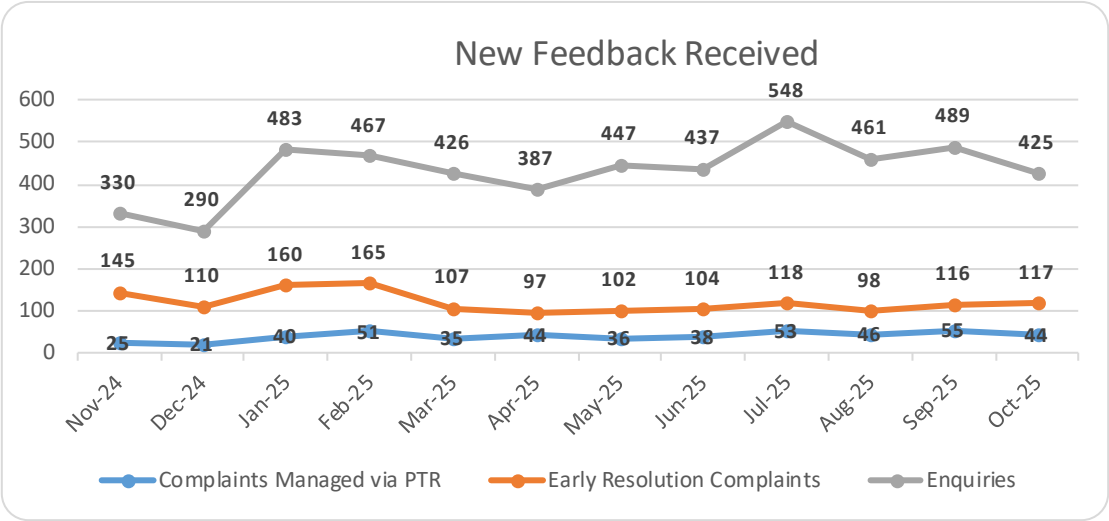
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

Complaints & Enquiries

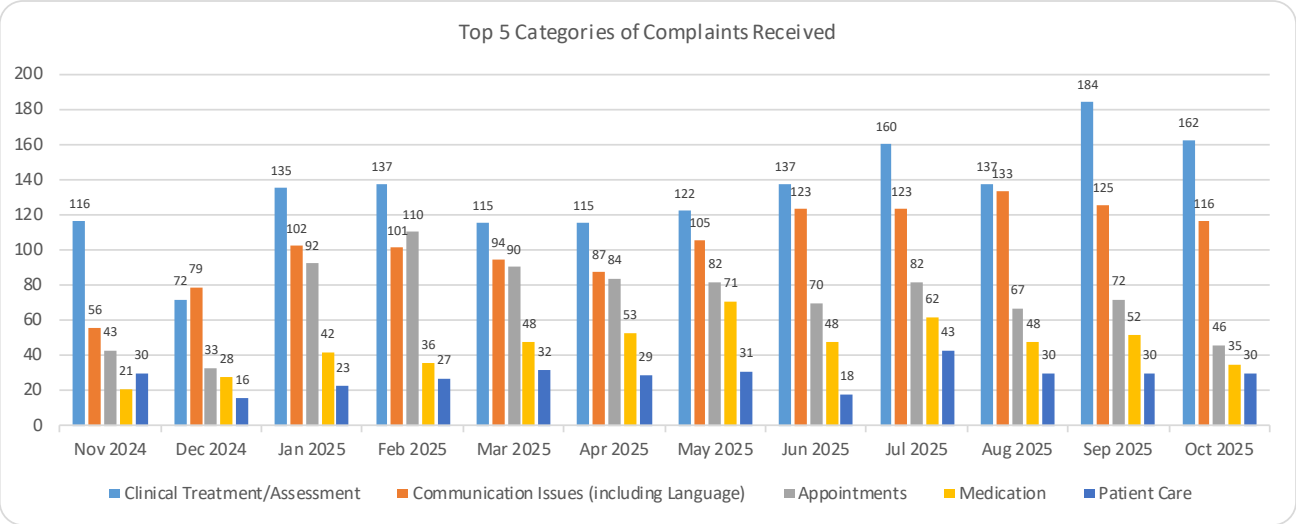
New Complaints Received

Between the 01.09.25 and 31.10.25 the Health Board received a total of 332 complaints and 914 enquiries. Of 332 complaints received, 99 were categorised as formal and managed under the Putting Things Right Regulations (PTR). The number of Early Resolution complaints has increased slightly over the last two months since August 2025 figure, PTR complaints and enquiries increased during September 2025 compared to August 2025 however the number dropped back down for October 2025.



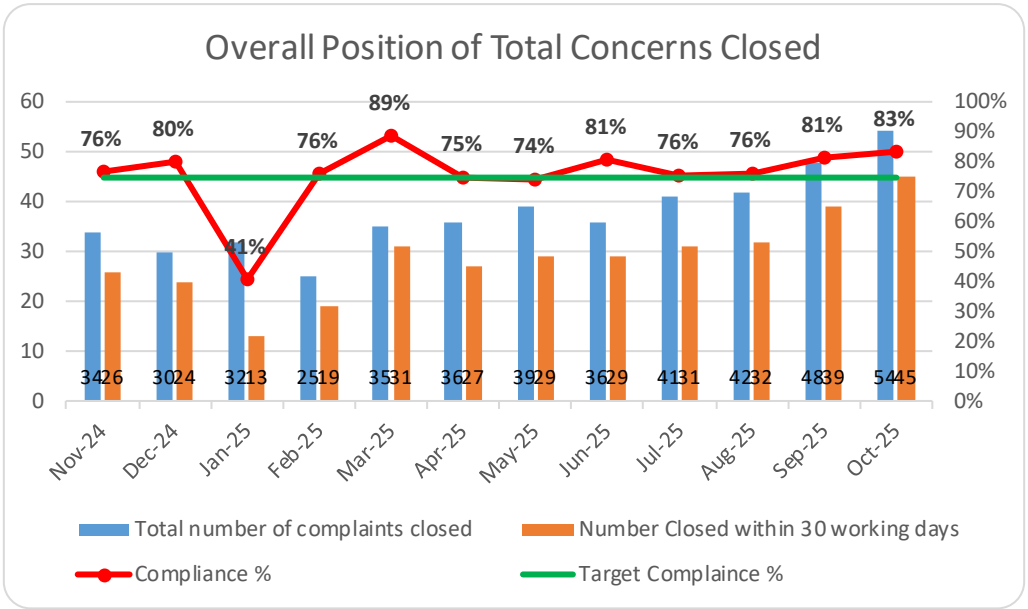
For all feedback (Complaints and Enquiries) received in September and October 2025, accounting for 62% of the feedback received, the top 3 types remain consistent with

previous months. These relate to Clinical Treatment / Assessment (346), Communication Issues (including Language) (241) and Appointments (118).



Closed Complaints

Within the period of 01.09.25 to 31.10.25, the Health Board closed a total of 102 formal complaints (managed through PTR). During the 2-month period, the national target of 75% compliance for responding to complaints within 30 working days was achieved (82%). As at 03.11.25, the Health Board had 67 open formal complaints. Of these, 14 complaints were open over 30 working days which is one more open complaint compared to the position at the beginning of September. Focused work continues to be undertaken to improve the efficiency of the Health Board's concerns triage process to ensure a timely response.



Public Services Ombudsman for Wales

Open cases

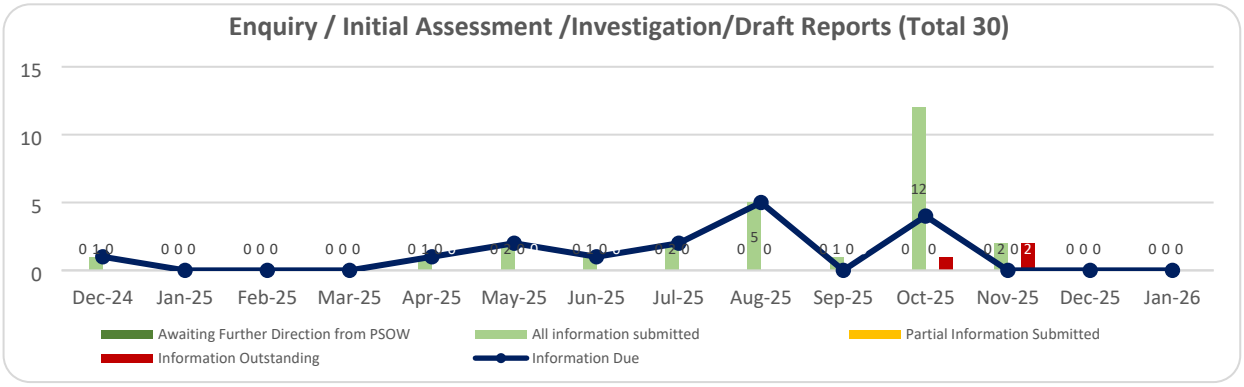
As at the 05.11.25 the Health Board has 41 open Public Services Ombudsman for Wales (PSOW) Cases. Of these, 32 are awaiting a response from the PSOW.

Current Status	Enquiry / Initial Assessment/ Investigation	Early Settlement	Draft Report Comments	Final Report Compliance	Information Only	Total
All evidence submitted and awaiting closure by PSOW	0	0	0	0	0	0
Awaiting further direction from PSOW	0	0	0	0	2	2
Information Received	0	0	0	0	0	0
Information Submitted	24	3	3	0	0	30
Information Outstanding	2	3	1	0	0	6
Information Partially Submitted	0	1	0	2	0	3
Total	**26**	**7**	**4**	**2**	**2**	**41**

New PSOW Cases Received

The Health Board received notification of 26 new referrals to the Public Services Ombudsman for Wales (PSOW) between the 01.09.25 and 31.10.25. Of the 26, 17 were received as enquiries, 8 as decision not to investigate and 1 as full investigation.

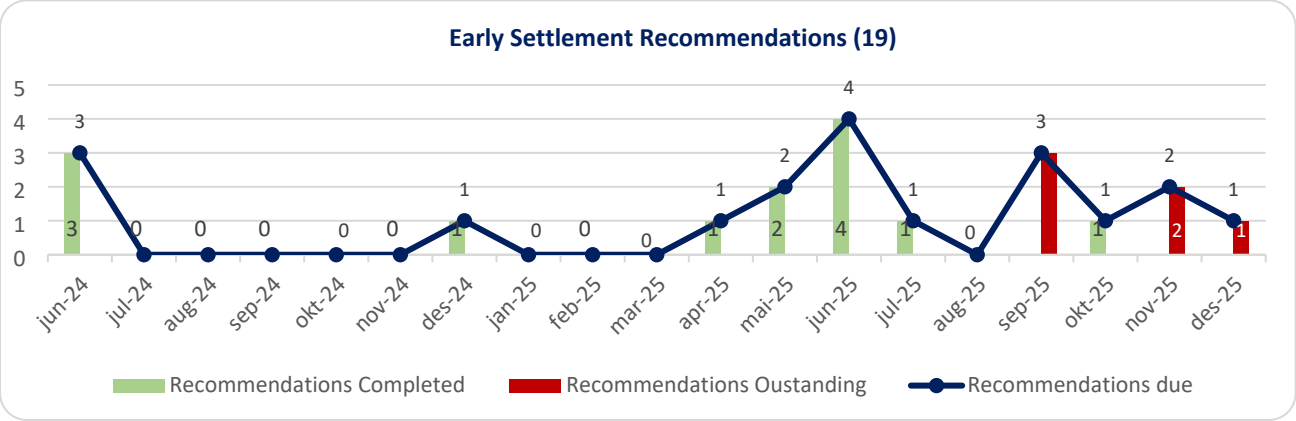
Of the 30 cases, the Health Board currently has at 05.11.25 in the enquiry / initial assessment/investigation stage, 3 cases have outstanding actions. One action is currently overdue. This is reflected in the chart below:



Early Settlement Proposal

During the same period the Health Board agreed 3 early settlement proposals. It should be noted that more than one action can be attributed to a case. As at the 05.11.25, the

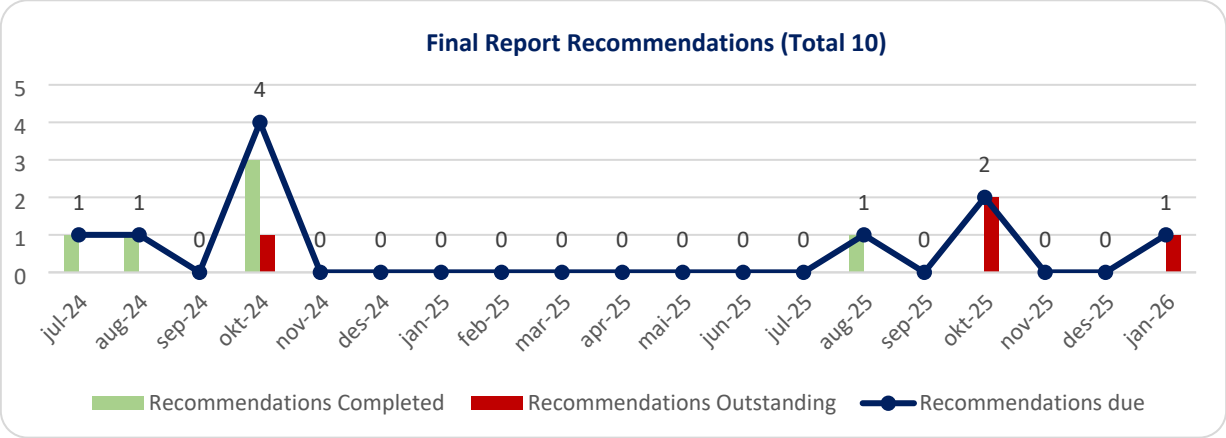
Health Board has 7 open early settlement cases, with 19 associated case actions. Of the 19 actions, three are currently overdue the deadline agreed with the PSOW.



Final Reports

During September and October 2025, the PSOW issued 1 final report to the Health Board which was not upheld.

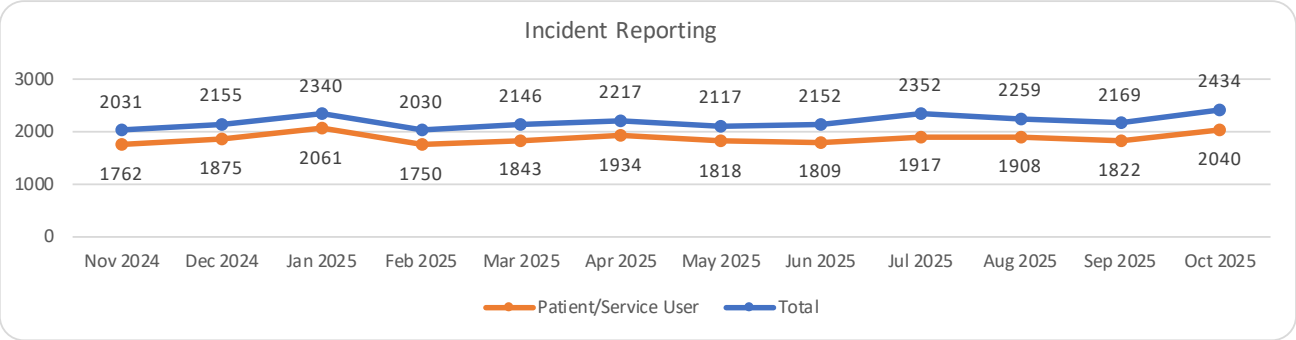
As at 02.05.25, the Health Board has 2 cases which are currently in the final report stage of the PSOW process. These cases have 10 associated recommendations. Of these recommendations, 4 are currently outstanding, with 1 currently overdue the timescale for completion.



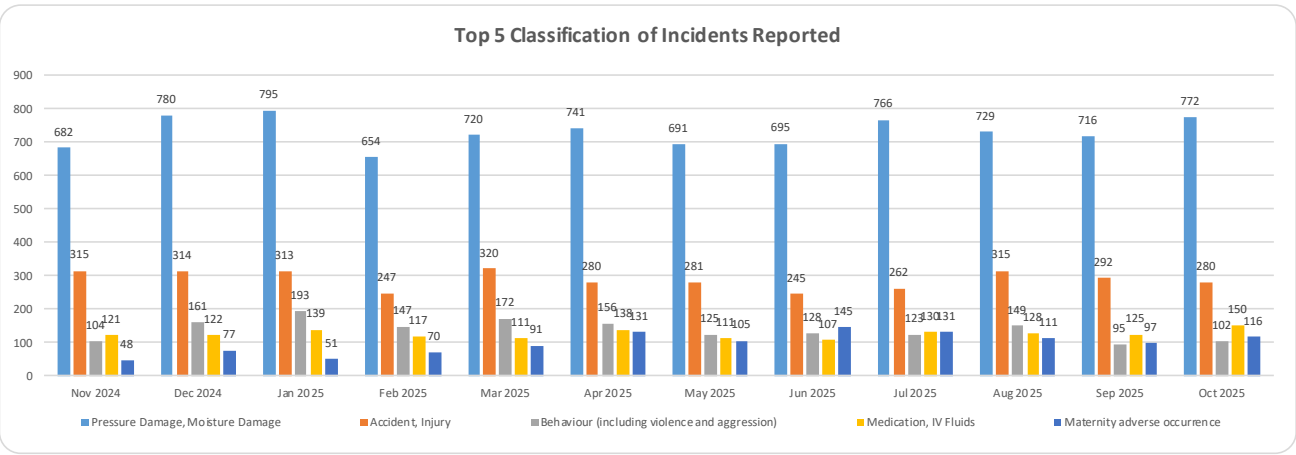
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,603 incidents were reported as occurring between 01.09.25 to 31.10.25, this represents a decrease of 8 when compared with the previous 2 months (4,611). The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,603 incidents reported, 84% (3,862) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

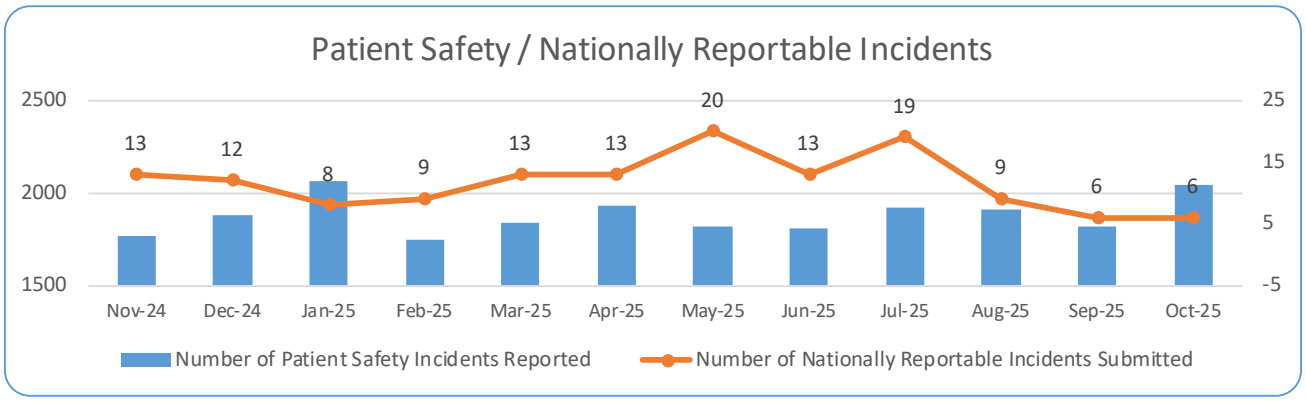


The top 5 classification of incidents reported as occurring in September and October 2025, linked to a patient affected incident are: Pressure Damage /Moisture Damage (1,488), Accident, Injury (572), Medication, IV fluids (275), Maternity adverse occurrence (213) and Behaviour (including violence and aggression) (197). This is consistent with the previous two-month period, apart from Behaviour (including violence and aggression) which has moved to fifth place with a significant drop in incidents from 272 to 197. The trend for the top 5 classification of incidents is highlighted in the chart below:



<u>Nationally Reportable Incidents</u>

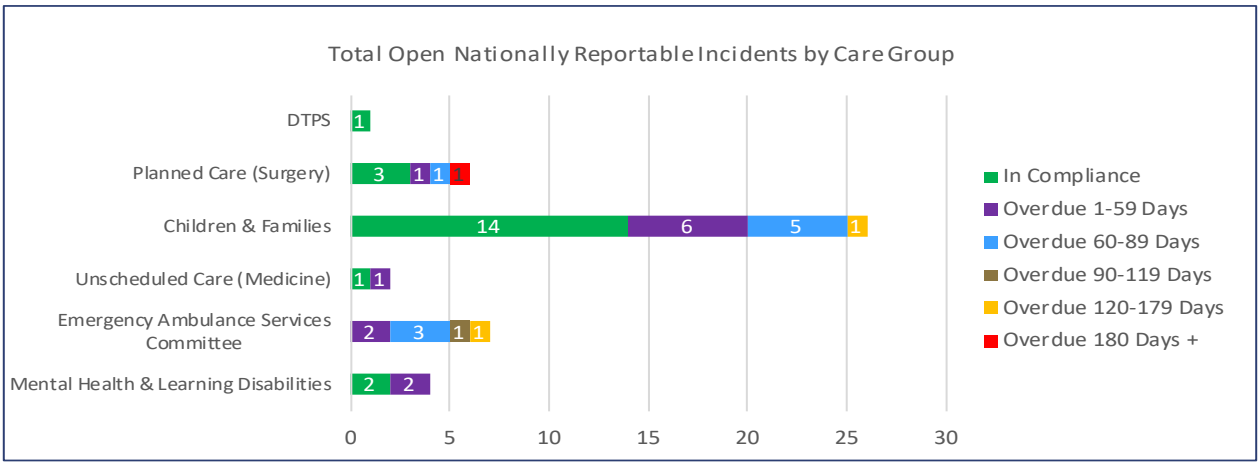
Between 01.09.25 and 31.10.25, 28 Nationally Reportable Incidents were submitted to the NHS Performance & Improvement Team. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



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 Performance & Improvement Team. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

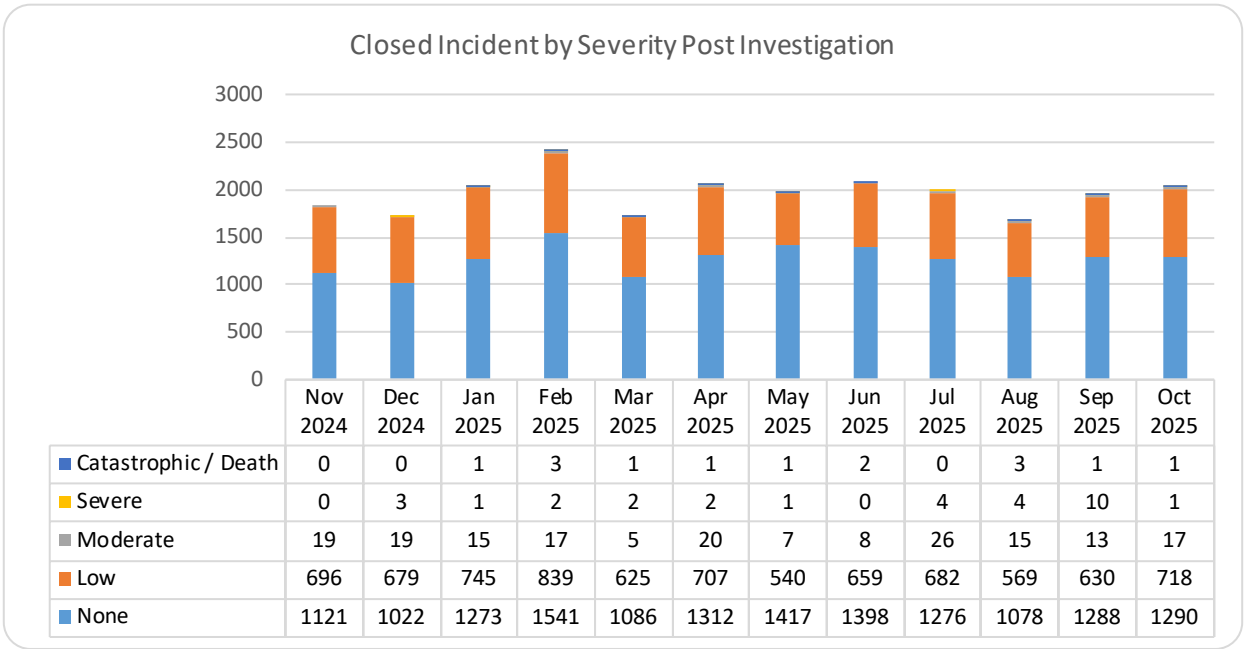
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Total
Access, Admission	0	0	0	0	1	1	3	1	0	0	0	0	6
Assessment, Investigation, Diagnosis	0	0	0	0	1	0	2	0	2	0	0	0	5
Behaviour (including violence and aggression)	1	0	0	0	0	0	0	0	0	0	0	0	1
Equipment, Devices	0	0	0	0	0	1	0	0	0	0	0	0	1
Infection Prevention and Control	0	2	0	0	4	3	2	0	0	0	1	0	12
Maternity adverse occurrence	2	2	4	1	3	0	5	2	0	5	1	5	30
Nutrition, Hydration	0	0	0	1	0	0	0	0	0	0	0	0	1
Patient/service user death	2	0	1	1	0	1	1	1	1	1	1	0	10
Pressure Damage, Moisture Damage	6	7	2	4	4	3	7	6	15	3	3	1	61
Transfer, Discharge	0	0	1	1	0	4	0	2	0	0	0	0	8
Treatment, Procedure	2	1	0	1	0	0	0	1	1	0	0	0	6
Total	13	12	8	9	13	13	20	13	19	9	6	6	141

As at the 03.11.25, the Health Board currently has 46 open Nationally Reportable Incidents, of which 25 are overdue the timescale for completion. Focused work continues to be undertaken to ensure investigations are concluded and ensure a timely outcome is provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

Between the 01.09.25 and 31.10.25 a total of 3,969 patient safety incidents were closed. The 12 month trend is reflected in the table below.

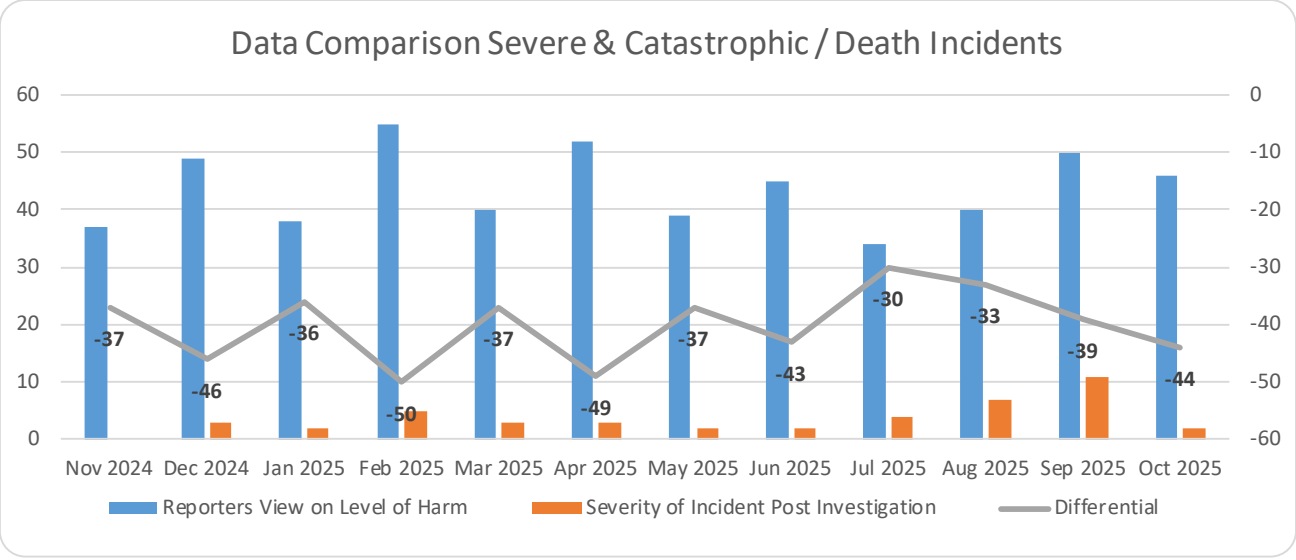


	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025
Catastrophic / Death	0	0	1	3	1	1	1	2	0	3	1	1
Severe	0	3	1	2	2	2	1	0	4	4	10	1
Moderate	19	19	15	17	5	20	7	8	26	15	13	17
Low	696	679	745	839	625	707	540	659	682	569	630	718
None	1121	1022	1273	1541	1086	1312	1417	1398	1276	1078	1288	1290

Of the 3,969 patient safety incidents closed, 13 were closed with severity post investigation of severe harm (11) or catastrophic/ death (2). A breakdown of incidents is provided in the table below:

	Planned Care	Mental Health and Learning Disabilities	Total
Access, Admission	4	0	4
Assessment, Investigation, Diagnosis	3	0	3
Behaviour (including violence and aggression)	0	1	1
Infection Prevention and Control	1	0	1
Monitoring, Observations	1	0	1
Treatment, Procedure	3	0	3
Total	12	1	13

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



Duty of Candour

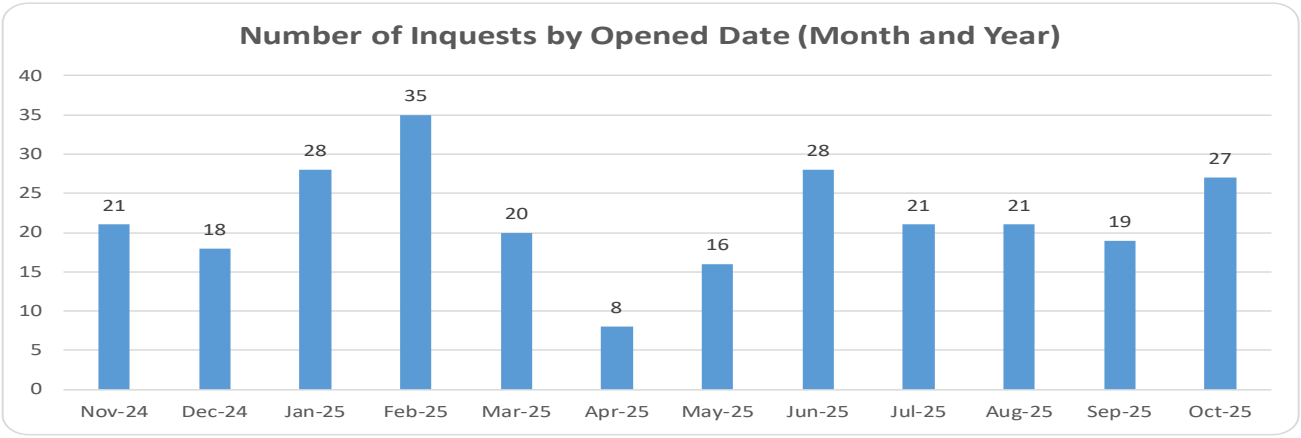
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

Number of Incidents	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025
Where Duty of Candour Triggered	15	13	9	8	13	15	21	17	8	11	12	23
Where In-person notification completed	15	13	8	6	12	15	19	17	8	8	11	17
Where letter of notification sent	15	13	7	6	11	13	18	17	7	7	9	15

2.3 Inquests Case Activity

New Inquests Received

In the time period 01.09.25 to 31.10.25, the Health Board received notification of 46 inquests. This is a slight increase when compared with the previous 2-month period (42). A trend graph of the inquests opened during period is provided below.

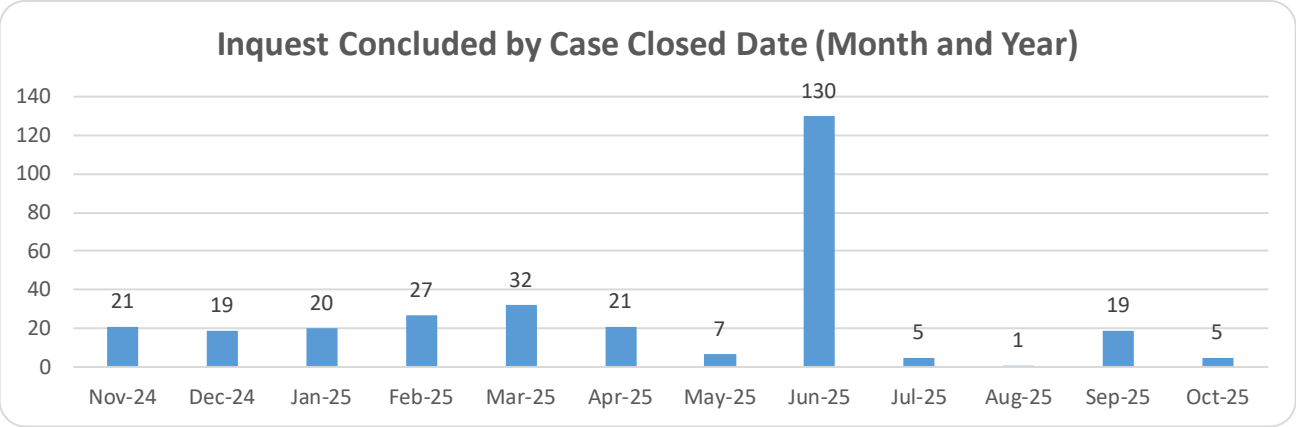


Of the 46, the highest number of inquests were received for the Mental Health and Learning Disabilities Care Group (16). A breakdown of inquests received by Care Group is provided below.

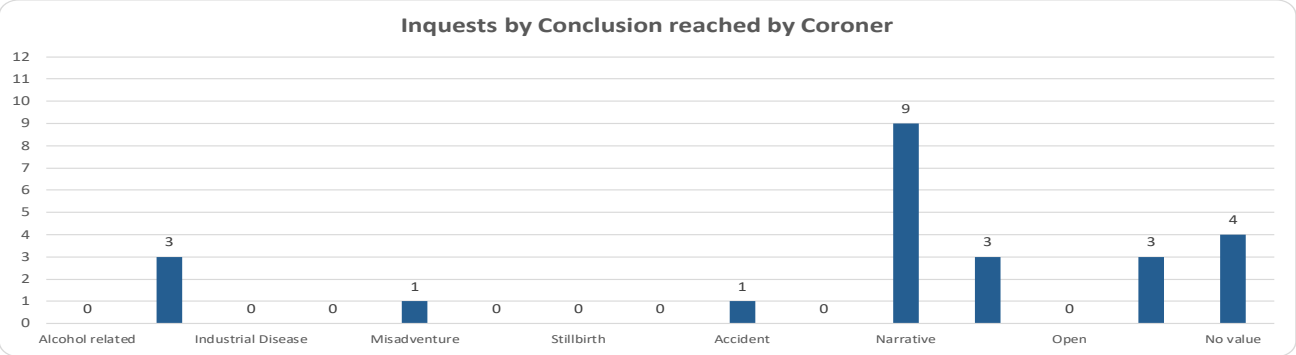
Care Group	Number Received
Children and Families	0
Primary Care and Community	6
Mental Health and Learning Disabilities	16
Planned Care	12
Unscheduled Care	11
DTPS	1
Not Specified	0
Total	46

Inquests Concluded

During the same 2-month period, 24 inquest cases were closed on the Health Board's Datix system. A trend graph of inquests concluded during the period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 24 inquests cases closed on Datix, 3 were discontinued by the Coroner prior to hearing. Of the remaining cases (21) a breakdown of the outcome of inquests closed between the 01.09.25 and 31.10.25 is provided in the chart below.



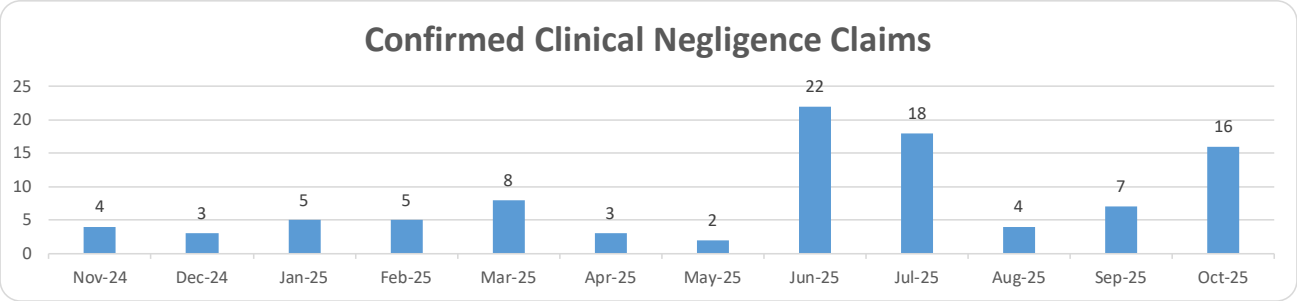
Regulation 28 Reports / HMC Letter Received

On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. Between the 01.09.25 and 31.10.25 the Coroner did not issue any regulation 28 reports to the Health Board.

2.4 Clinical Negligence Claims

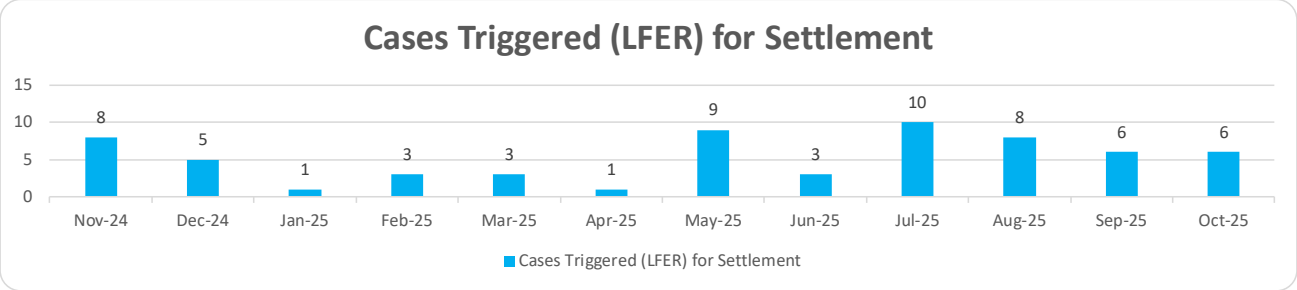
New Confirmed Clinical Negligence Claims

Between the 01.09.25 and 31.10.25 the Health Board received confirmation of a total of 23 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



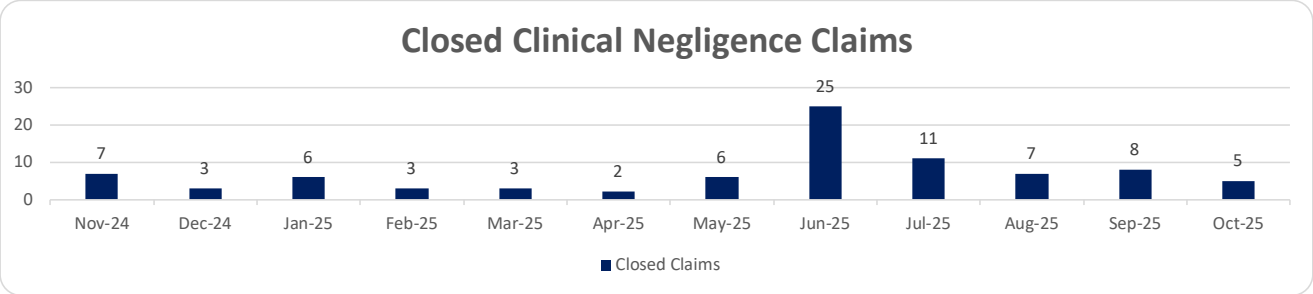
Clinical Negligence Claims triggered for settlement

Between the 01.09.25 and 31.10.25 in the Health Board, 12 Clinical Negligence Claims triggered for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



Closed Clinical Negligence Claims

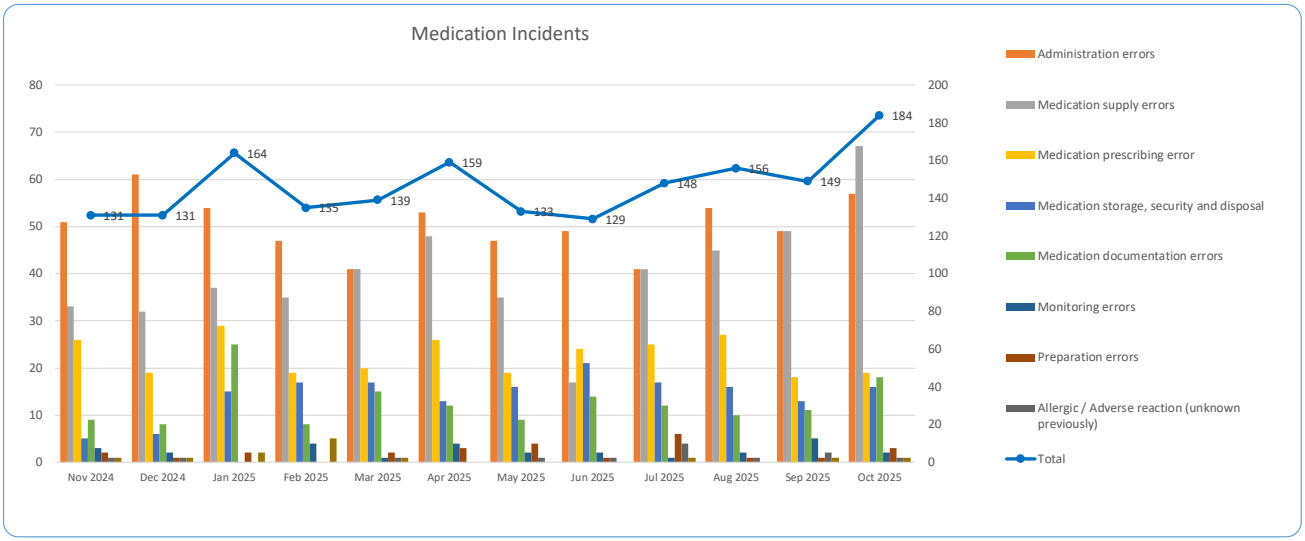
Between the 01.09.25 and 31.10.25 in the Health Board, 13 Clinical Negligence Claims were closed. The trend for clinical negligence claims closed in the last 12 months is highlighted in the chart below:



2.5 Specific Quality & Safety Metrics

2.5.1 Medication Safety

A total of 333 medication incidents were reported as occurring between 01.09.25 and 31.10.25. This is an increase of 29 when compared with the previous 2-month period (304). Of the total number of medication incidents reported, the top 3 types of medication incidents relate to medication supply errors (116), administration errors (106) and medication prescribing errors (37).



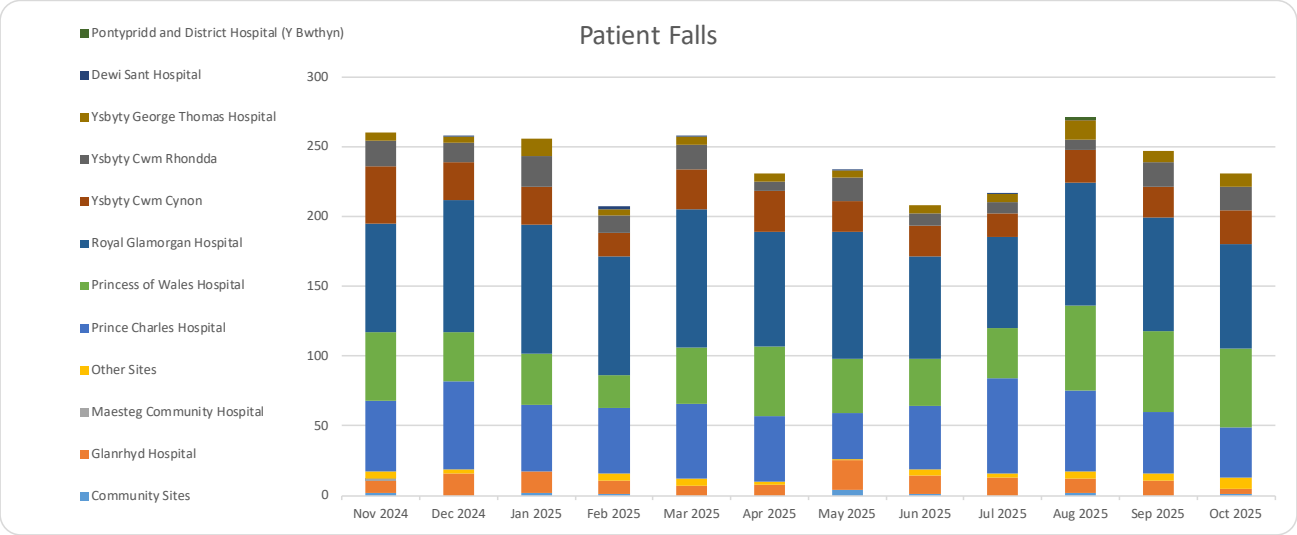
89% of the medication incidents were reported as resulting in no (147) or low (148) harm, with the remaining reported as resulting in moderate harm (36), severe harm (2). While no medication incidents were reported as resulting in catastrophic harm / death. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.5.2 Patient Falls Incidents

A total number of 478 falls, where the person affected was a patient, were reported during September and October 2025. This represents a decrease of 10 compared with the previous two months (488).

Of the falls incidents within the time period, 95% were reported as no (140) or low (316) harm. The remaining incidents were reported as resulting in moderate (22) and severe

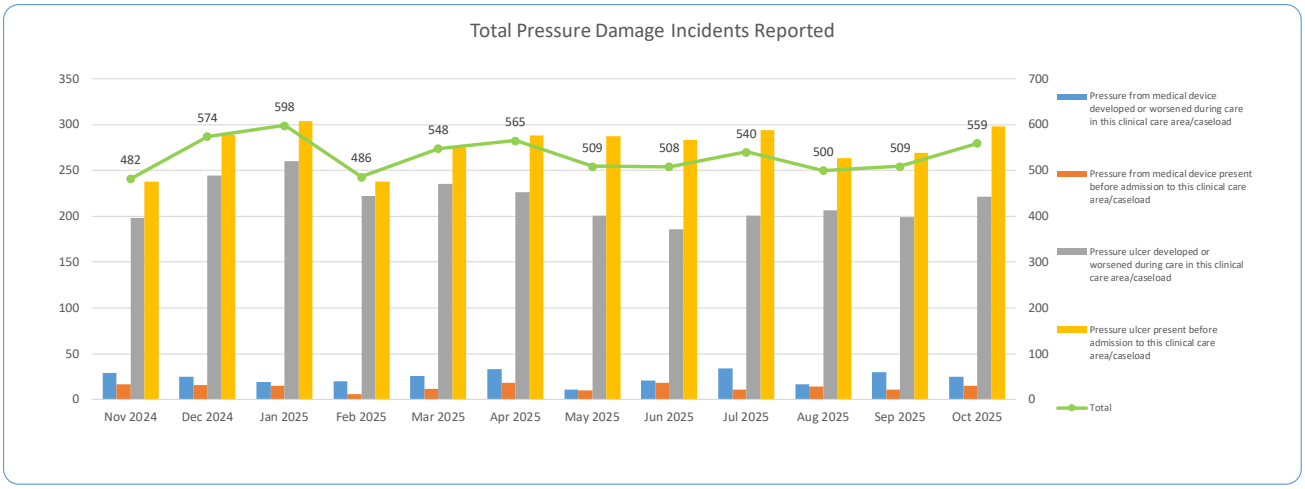
(1) harm. No incidents relating to patient falls were reported as resulting in severe harm or catastrophic harm / death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



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

2.5.3 Pressure Damage

Between the 01.09.25 and 31.10.25, a total of 1068 pressure damage incidents were reported, of which 475 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (593) were reported as being present before admission to this clinical care area/caseload.



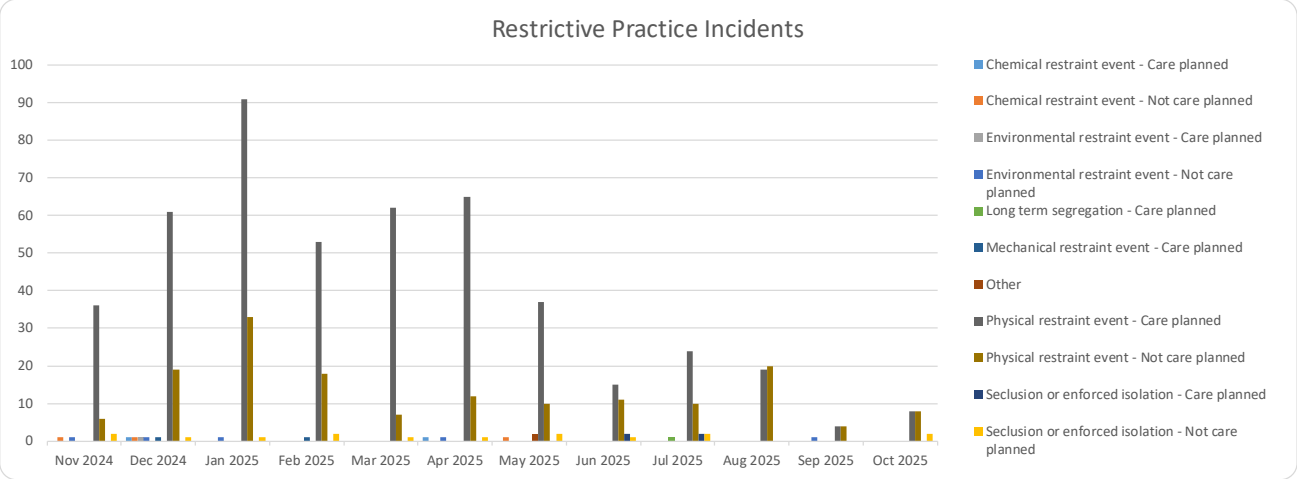
Of the 475, identified as developing or worsening during current caseload, 212 were identified as occurring within the community, which represents a decrease of 20 compared with the previous two-month period (232).

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

2.5.4 Mental Health Metrics

Restrictive Practices

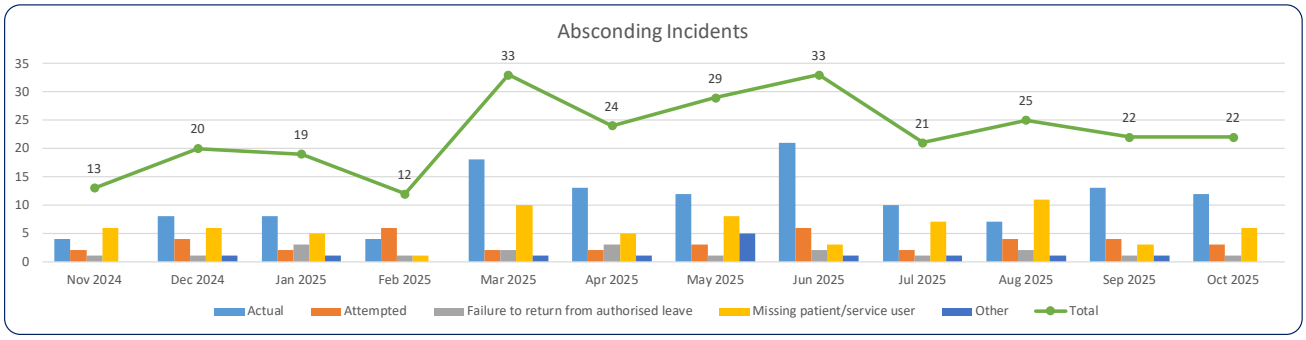
Between 01.09.25 and 31.10.25, a total of 27 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 51 incidents when compared to the previous two months (78).



Of the 27 incidents, 15 were reported as not care planned (not included in the care and treatment plan for the patient) and 12 were reported as care planned (included in the care and treatment plan for the patient), 0 were recorded as Other. The highest number of incidents were reported as occurring on the Coity Clinic (PICU), Princess of Wales Hospital (12).

Absconding incidents

During September and October 2025, a total of 44 incidents were reported under the category of absconding, which represents a decrease of 2 when compared with the previous two-month period (46). 25 were recorded as actual absconding, with the remaining recorded as missing patient/service user (9), attempted absconding (7), failure to return from authorised leave (2), and other (1). The highest number of incidents were reported as occurring in the Supported Recovery Unit (Mental Health) at the Ysbyty George Thomas Hospital (7).



3. Key Risks / Matters for Escalation

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

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

4. Assessment

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

Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Timely Effective Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate):	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

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

6. Next Steps

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

Agenda Item
6.2

Quality, Safety & Experience Committee

People's Experience Activity Report August – September 2025

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Becky Gammon, Deputy Director of Nursing & People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMU HB	Cwm Taf Morgannwg Health Board
PALS	Patient Advisory Liaison Service
BSL	British Sign Language

1. Situation /Background

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

2. Specific Matters for Consideration

Engagement Opportunities

As the demands of our communities change and develop, the People's Experience Team continue to engage and explore opportunities to develop relationships within the community across CTM and third sector stakeholders. This enables a more person centred, cohesive approach to be adopted and the voice of the community fed back into the Health Board.

The table below gives an insight to the recent engagement activities attended by the PE Team.

Date	Event	Attendance
2nd September 2025	Learning from Post Death Care Event	Clinical Bereavement Lead, Lead Chaplain
16th September 2025	Falls prevention and Education workshop	PALS Team, Princess of Wales
17th September 2025	Value Base Healthcare Showcase Event	Head of People's Experience

Llais Cymru Partnership

Ongoing collaboration with Llais continues to ensure any feedback they gain through their engagement events is fed back to CTM and appropriate actions undertaken. Monthly meetings with Regional Director for Llais Cymru, Head of People's Experience, Deputy Executive Director of Nursing support open and timely conversations.

Following a recent engagement event held in the community of Hirwaun a number of key themes were raised and shared with CTMUHB.

The key themes and actions being undertaken are below:

Event	Themes	Response and Actions
Community event held in Hirwaun – June 2025	Concerns raised surrounding patients experience of aftercare following surgery, especially when they have had surgery outside the HB.	Concern raised with the care group to ensure patients are aware of the surgical pathway and who to contact for support and advice post-surgery.
	Nutrition & Hydration:	Assessments undertaken on admission and recorded in Welsh Nursing Clinical

	• Concern around communication and recording of food allergies and availability of food for diverse cultures and faiths • Catering	record. Where indicated a red wrist band is placed on patients to highlight allergies. Specific allergies or dietary requirements are requested with the catering department to meet the needs of the patients. Allergens are recorded electronically onto a Catering Bed Plan by the Registered Nurse daily and as necessary throughout the day New catering model has been piloted through Health Board's Harm Free Agenda across Prince Charles and partly across Royal Glamorgan sites. Plans are in place to expand across further areas in Royal Glamorgan.
	Guidance on Breastfeeding	Health Board has developed an infant feeding strategy and links shared with General Practitioners.
	Late cancellation of surgery	Process in place to monitor this, theatre and day surgery units correspond regarding activity. Any complications that arise that may impact surgeries are communicated to patients as much as possible without breaching confidentiality. Patients due to be admitted for afternoon surgery may also be contacted to attend later to prevent unnecessary waiting.

	Car parking at Prince Charles Hospital	Work has been undertaken and the site has increased spaces from 1178 to 1352. On completion of Phase 3 work this will increase to 1415 spaces.

NHS Wales People's Experience Framework and Toolkit

Work continues to promote the PE toolkit, and champions from each care group have been instrumental in populating an overview of the self-assessment tool with a robust action plan to follow evaluation

Ongoing Projects

Falls/Pressure Area review

Through collaboration with all care groups, a patient information leaflet has been created to support patients and carers with information on the prevention of deconditioning, falls and pressure damage. This is being taken through the relevant steering groups for approval and sign-off.

Toiletry/clothing for inpatients

People's Experience Team have coordinated the procurement and distribution of essential toiletries and clothing for inpatient sites to be distributed to patients who have attended as an emergency admission or who do not have personal toiletries. Feedback on the impact this has on patient experience will be collated to understand the impact and sustainability.

Support for patients, families and carers

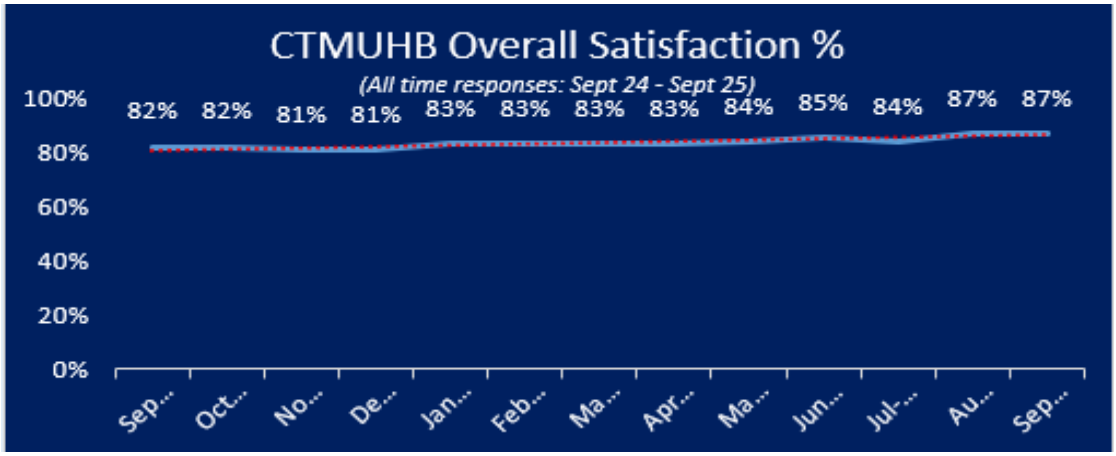
The People's Experience are exploring several areas to extend their support to improve the experience of people accessing services in CTM, with a number of PALS and the Clinical Bereavement Lead having joined the course, as well as the Volunteer Manager completing the Level 2, BSL.

Patient Satisfaction Feedback

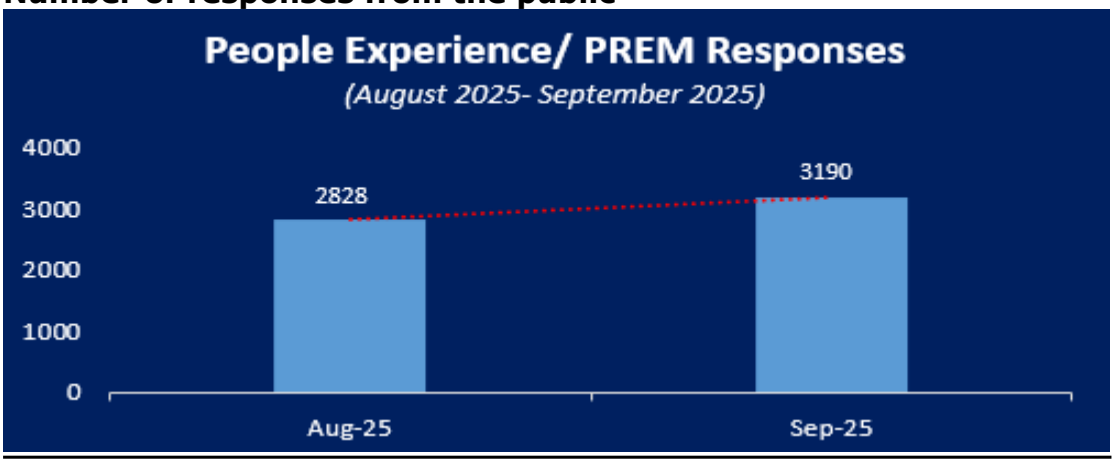
The Health Board is working towards changing the software platforms to facilitate the collection of service user feedback, moving from Civica to Promptly. A working group has been established to support this change, led by the Senior Project Manager, Value-Based Healthcare and representation across the Care Groups.

It is anticipated that the Promptly system will go live on 18th (for SMS)

Overview of feedback satisfaction score for CTMU HB



Number of responses from the public



Chaplaincy

The visibility and support the team provides is continuing to increase as evidenced by the figures provided in the table below.

Number of people supported with significant spiritual and pastoral care.	
Patients	724
Relative's/carers	224
Staff	242

The team are working proactively to explore how they can increase awareness of the service to support spirituality rather than solely through multifaith perspectives. Below is an extract from the lead chaplain, where this has proved to have a positive impact

"*I met a patient who was in distress on a ward in RGH, and in chatting with her and one of the doctors, I discovered that her husband was also in hospital but on a ward in POW. She was anxious to know how he was. Initially, I referred the patient to my colleague in POW in order to establish some more details. My colleague followed this up and then had the brilliant idea that we might be able to facilitate a video call between them. Working with the Lead Chaplain, a standard operating procedure was put in place, including permission from the ward managers on each site and then another colleague and I followed the procedure and arrived at the beautiful moment when we could coordinate and establish the video connection between the husband and wife across sites. It was so joyful to witness the love and care between them and to see how important this act was for them both*."

Bereavement
There are several key areas of work being led by the Clinical Bereavement Lead to support bereaved relatives, such as:

- Facilitated memory-making activities (e.g., fingerprints, dressing) for grieving families.
- Developed documentation for the Miscarriage Association to support pathway publication.
- Collaborated with chaplaincy and crematorium teams on memorial garden planning.
- Attended and facilitated Continuing Professional Development events for Health Care Support Workers focused on post-death care

Volunteers
There has been an increased focus on increasing the number of volunteers across CTM:

- Volunteer orientations held across multiple sites (Maternity, Chaplaincy PCH, Seren & St David's Wards, Royal Glamorgan Hospital, Wards B2/D2 Ysbyty Cwm Rhondda), supporting local engagement and integration.
- Volunteer inductions delivered at Royal Glamorgan and Glanrhyd Hospital, enhancing the onboarding experience.
- Ongoing dementia awareness training offered to volunteers:

55 volunteers completed Level 1, with some advancing to Levels 2 and 3
- Updated volunteer induction training to include Level 1 safeguarding, improving volunteer preparedness and safety awareness.

Armed Forces/Veterans
Following the Health and Wellbeing Event held in June 2025 a highlight report is currently being produced that captures feedback from all the stakeholders involved. A partnership has been established that meets on a regular basis to take forward actions that have been formulated from the feedback received.

- Lead Chaplain is exploring support for Valley Veterans for a volunteer Padre to provide holistic support for those who access this Hub.
- Working partnership with a representative from Primary Care who has already undertaken teaching sessions with GP trainees to provide support and insight in this area.
- People's Experience Team have linked with the Information team to agree the creation and usage of a poppy symbol across the Health Board's Electronic whiteboards. The team will now work with veterans/armed forces family to create an information package around this to inform discussions with inpatients and their families when they come across this symbol.
- An information leaflet has been created following the health/wellbeing event that is now available to the public containing details of all the stakeholders that attended the event.

PALS (Patient Advice Liaison Service)
The PALS team continue to raise the profile of their service internally and externally with staff, public and third sector stakeholders.

Number of PALS contacts across CTM	
August	311
September	332

Top Three Themes
Communication Issues
Clinical treatment/Assessment
Patient Care

- The team will be presenting to the University of South Wales Students to provide an insight into their role and the types of situations they deal with regarding the above subjects.

Unpaid Carers
Corporate Unpaid Carers Lead continues to foster relationships with various stakeholders internal/external to the Health Board to ensure the voice of the unpaid carers is central to changes and demands in services.

- Supported the development of Falls and Pressure Ulcer leaflets to improve patient awareness and self-management.
- Represented patient and carer voice at the Carers Trust Wales Round Table and Carers in Primary Care Meeting, ensuring carers' needs are embedded in service planning.
- Contributed to workforce development via the Band 7 Development Day, enhancing leadership capacity in community services.
- Coordinated a Champions Meeting to empower staff as advocates for safer care and better patient outcomes

3. Key Risks / Matters for Escalation

The Volunteer Team continue to carry a vacancy and is waiting for the outcome of a review being undertaken by the Health Board. This will impact the ability to support areas across the Health Board, but work is continuing in this area.

During transition from Civica to Promptly, this will result in the two systems running side by side until 30th November to help services transition. Once the Promptly system goes live on the 18th (for SMS) the Value Based Healthcare (VBHC) team will manually push the SMS out to patients through Promptly. This is a massive pull on VBHC resources, but it reduces the risk of disturbing the pathway timeline within the system and doesn't increase digital resources.

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:
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): Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Development of services aligned to communities is crucial ensuring their contribution to ensure their needs are met.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Committee are being asked to **NOTE** this report.

6. Next Steps

6.1 **Patient Stories** - work to promote patient stories as a feedback mechanism from a community aspect continues. Head of People's Experience is working with the communications team to look at the engagement aspect and event calendar to explore further opportunities in this area.

6.2 **Armed Forces/Veterans –** a working group has been established and there is discussion around the areas the group are looking to work towards to improve veteran/armed forces identification in primary care settings.

Agenda Item
6.3

Quality, Safety & Experience Committee

Status Report on Commissioned Services (Quality Focussed)

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care

Pwrpas yr Adroddiad / Report Purpose	For Noting And for Approval of a revised approach to quality assurance for commissioned services

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

Acronyms / Glossary of Terms	
LTAs,	Long-Term Agreement – covers ongoing service provision over multiple years.
SLAs	Service Level Agreement – defines specific service standards and monitoring arrangements.

1. Situation /Background

1.1 Cwm Taf Morgannwg University Health Board (CTM UHB) commissions over 100 clinical and third sector services through formal agreements (LTAs, SLAs, contracts, and grants) with NHS partners and external providers. The Quality, Safety & Experience Committee has requested a review of these arrangements from a quality perspective, with a focus on assurance, monitoring, and future developments in line with Welsh legislation and the Health Board's duty of quality.

Commissioning Relationships:

CTMUHB holds numerous agreements with NHS bodies:

Organisation Name	Service/Role
CTM UHB (Cwm Taf Morgannwg University Health Board)	Commissioning Body
ABUHB (Aneurin Bevan University Health Board)	NHS Partner
C&VUHB (Cardiff & Vale University Health Board)	NHS Partner
HDUHB (Hywel Dda University Health Board)	NHS Partner
SBUHB (Swansea Bay University Health Board)	NHS Partner
PTHB (Powys Teaching Health Board)	NHS Partner
Velindre University NHS Trust	NHS Partner
University Hospitals Bristol & Weston NHS Trust (UHBW)	NHS Partner (England)
WAST (Welsh Ambulance Services NHS Trust)	NHS Partner
PHW (Public Health Wales)	NHS Partner

As well as third sector organisations:

Organisation Name	Service/Role
Age Connect Morgannwg	Older people support
BAVO	Bridgend Association of Voluntary Organisations
Care & Repair	Independent living support for older people
Cancer Aid	Cancer support services
CRUSE	Bereavement support
RNIB	Support for blind and partially sighted people
Halcyon	Mental health support
INTERLINK	Voluntary action organisation
Marie Curie	Hospice and palliative care
MIND	Mental health advocacy and counselling
New Horizons	Mental health day services
Rowan Tree Cancer Care	Cancer support
Stroke Association	Stroke recovery and communication support
Terence Higgins Trust	Sexual health and HIV support
Ty Hafan	Children's hospice
Valley Steps	Self-management support
VAMT	Voluntary Action Merthyr Tydfil
Mental Health Matters Wales	Mental health support and wellbeing hubs
Adferiad	Mental health and substance misuse support
Platfform	Mental health and housing support
Hepatitis C Trust	Support for people affected by Hepatitis C
Cerebral Palsy Cymru	Support for children with cerebral palsy
Bridgend Care and Repair	Local Care & Repair branch
Bridgend Carers	Carer support
Homestart	Family support
Snap Cymru	Support for children with additional needs
New Pathways	Sexual abuse counselling
RCT Citizens Advice Bureau	Welfare rights and debt advice
Care Collective	Community support

Agreements:
All agreements reference statutory requirements, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Welsh Language Standards, Safeguarding, Data Protection, and Quality Assurance. Providers are required to maintain robust policies and procedures, submit regular monitoring information, and participate in performance reviews focused on quality and safety.

Review and Monitoring:
Regular commissioning meetings and contract reviews are held, with frequency determined by service type and value. Quality and safety are embedded in contract terms, with expert input during tendering and ongoing monitoring.

Engagement and consultation with staff and the public are mandated for service changes, supported by Equality Impact Assessments (EIA).

2. Specific Matters for Consideration

Duty of Quality:

The Health Board and providers are legally required to deliver high-quality, safe, effective, efficient, equitable, and person-centred care. The Health & Care Quality Standards (April 2023) provide the framework for assurance and improvement, covering safety, timeliness, effectiveness, efficiency, equity, and person-centredness.

Quality Assurance Mechanisms:

- **Performance Monitoring**: Providers must submit reports, with progress reviewed against agreed indicators. Failure to provide timely monitoring information may constitute a breach of contract.
- **Review Meetings**: Issues discussed include quality and safety, achievement of objectives, service improvement, user involvement, satisfaction, compliments, complaints, and concerns.
- **Policies and Procedures**: Providers must have comprehensive policies for safeguarding, health and safety, confidentiality, risk management, incident reporting, equality, and information governance.
- **Welsh Language**: Providers must embed bilingual services, reflecting the legal requirement and the importance of accessible, high-quality care for Welsh-speaking communities.
- **Duty of Candour**: Introduced in April 2023, this ensures openness and honesty in care delivery, with both parties cooperating in responding to concerns within agreed timescale

3. Key Risks/Matters for Escalation

Future Developments:

Current quality review arrangements for commissioned services are considered satisfactory; however, there is recognition that these processes should and can be further strengthened.

Opportunities exist to enhance the robustness of quality monitoring, assurance, and integration across all commissioned services, ensuring that approaches remain responsive to evolving standards, best practice, and the needs of the population.

The Executive Director of Nursing is working with the Executive Director for Strategy and Transformation to enhance quality monitoring and assurance for commissioned services. This includes developing more robust frameworks, strengthening links with partner organisations, and ensuring expert quality and safety input in all commissioning activities.

4. Assessment

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

Environmental /Sustainability Impact (5Rs)	

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: 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 person/team. This paper is presented for information and noting purposes.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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 person/team. This paper is presented for information and noting purposes.
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 It is proposed that the Committee **NOTES** and **APPROVES** a revised approach to quality assurance for commissioned services. This will include strengthened monitoring, reporting, and partnership working, with assurances integrated into the Committee's annual cycle of business.

5.2 Future papers will set out the revised framework and seek formal Committee endorsement, ensuring ongoing oversight and continuous improvement.

6. Next Steps

1. **Strengthen Quality Monitoring**: Continue to develop and implement enhanced quality assurance frameworks for all commissioned services, ensuring alignment with the Health & Care Quality Standards and the duty of quality in Wales.
2. **Improve Data Collection and Reporting**: Ensure all providers submit timely, comprehensive monitoring information, with clear escalation processes for non-compliance.
3. **Enhance Engagement**: Maintain robust engagement processes for service changes, including EIAs and public/staff involvement.
4. **Embed Welsh Language and Duty of Candour**: Ensure all providers meet Welsh Language Standards and operate in accordance with the duty of candour.
5. **Collaborative Working**: Strengthen collaboration between the Executive Director of Nursing, Strategy and Transformation, and commissioning teams to drive continuous improvement in quality assurance and monitoring.
6. **Regular Review and Audit**: Schedule regular audits and reviews of commissioning arrangements, focusing on quality, safety, and outcomes for service users.

Agenda Item
7.1

Quality, Safety & Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	18 November 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	October / November 2025	RISKS REVIEWED
Executive Leadership Group	10 November 2025	MANAGEMENT REVIEW & SIGN OFF RECEIVED
Audit, Risk & Assurance Committee	13 November 2025	RISKS REVIEWED

Acronyms / Glossary of Terms	

1. Situation /Background

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

2. Specific Matters for Consideration

Risk Review

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

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

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

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

2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 5 November 2025.

Training

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

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

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

2.8 To date **804** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2. A dedicated risk session was also delivered to the Local Public Health Team Away Day on the 4 November 2025 and numbers are being confirmed.

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

2.10 120 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.81 out of a maximum score of 5.

2.11 100% of the 120 attendees providing formal feedback found that:
- The session provided the right amount of information.
- They gained more confidence and knowledge in risk management having attended.
- They would recommend this training to a colleague.

2.12 98% of the 120 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

2.13 Some of the recent comments from the session, received through evaluation, have been included below:
- *Personalised, well placed, easy to understand, time and opportunities to ask now, or at a later date*
- *Informative and succinct training, really well delivered, opportunities to ask questions and talk openly.*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Planned Care – Care Group
- Datix Risk ID 6294 - Insufficient Consultant Workforce - Endoscopy / Gastroenterology. New risk escalated in October 2025 with a risk score of 16.
- Datix Risk ID 6280 - Suspension of the Regional Hepato-Pancreato-Biliary service model. New risk escalated in October 2025 with a risk score of 16.

Diagnostics, Therapies, Pharmacy & Sciences
- Datix Risk ID 2713 - Backlog of Reporting Radiology Examinations. New risk escalated in October 2025 with a risk score of 16.
- Datix Risk ID 6379 - CT Scanners at RGH damaged by power outage and manual generator/UPS switch over. New risk escalated in October 2025 with a risk score of 16.

Mental Health & Learning Disabilities Care Group
- Datix Risk ID 6318 - Tier 3 SHED Team Service Delivery. New risk escalated in October 2025 with a risk score of 16.

Primary Care & Community Care Group
- Datix Risk ID 5877 – New Worker Contract for Out of Hour GPs. New risk escalated in November 2025 with a risk score of 16.

3.2 CHANGES TO RISKS

Risk Score Increased

Nil this period.

Risk Score Decreased

Facilities Directorate

- Datix Risk ID 5691 - CCTV System Failure in Prince Charles Hospital and Princess of Wales Hospital. Risk score decreased from a 16 to a 12. Rationale for de-escalation captured within the report and within closed session due to business sensitivities.

Medical Director Directorate

- Datix Risk ID 6111 – Medical Examiners Delay. Risk score reduced from a 20 to a 12. QR Code solution now live and active. Process should now be sped up and performance will be monitored closely. The Team will remain a watching brief on submissions in order to identify any issues. The likelihood has been reduced to a 3 rather than the target level of 2 in the interim whilst the new process is monitored closely.

Digital & Data Directorate

Diagnostics, Therapies, Pharmacy & Sciences

- Datix Risk ID 5304 - The Air Handling Unit (AHU) for the pharmacy aseptic production suite. This risk has been reduced from a 16 to a 12. The rationale for de-escalation is that the NHS Wales Shared Services Partnership verification is complete, and the Air Handling Unit is functioning as expected.

- Datix Risk ID 3567 - Capacity of Cellular Pathology Service – Space. This risk has been reduced from a 16 to a 12. The rationale for de-escalation is that current controls are expected to mitigate this risk at a level of 12 unless there is a new trigger. Department changes are being considered with Infection Prevention Control team relocation. Further detail is captured in Appendix 1.

Mental Health & Learning Disabilities Care Group

- Datix Risk ID 5646 - The impact of "Right Care Right Person" (RCRP) approach. Proposed for de-escalation. At the MHLD Care Group Operational Management Board in October 25 it was agreed that it was unlikely the policy is not going to adversely affect the frequency of RCRP related incidents and therefore the likelihood scoring was reduced. The risk score is therefore recommended for reduction from a 16 to a 12.

Infection Prevention & Control

- Datix Risk ID 4218 - Reduced on site Consultant Microbiologist/ IPC Doctor cover for Bridgend. This risk has been reduced from a 16 to a 12 as temporary microbiology cover arrangements have been established.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Digital & Data Directorate

- Datix Risk ID 6102 - Patient Pathways - Working in WPAS Instances, is proposed for closure in November 2025 as the target score has been met. Rationale for closure is that Patients are no longer being moved across two separate instances of WPAS in CTM.

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

3.5 EMERGING RISKS

Identified as part of the risks considered and reviewed for escalation in the October 2025 iteration of the Organisational Risk Register:

- The Planned Care - Care Group are reviewing a risk regarding Laser Safety at Princess of Wales Hospital as there is no designated laser safety advisor on site. As part of the risk review the Operational Management Board has directed the Care Group to engage with the Diagnostics, Therapies, Pharmacy and Sciences Care Group to consider workforce cover across CTM. Once the review is complete further consideration will be given to escalation to the Organisational Risk Register. (Datix Risk ID 6124).
- The Planned Care and Unscheduled Care Care Group are jointly considering a risk in relation to 'Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology'. Once the co-ordinated review between both Care Groups has been undertaken the risk will be considered for escalation to the Organisational Risk Register as one risk with shared actions across both Care Groups as appropriate. (Current Datix Risk IDs are 5797 and 3596).
- Primary Care & Community are considering the escalation of the following risks:

- a risk relating to pathway of care delays following a notable increase. This has been highlighted with Welsh Government and Local Authorities and this will be further explored at the Discharge Board, which has representation from Local Authorities.
- Social Care Capacity within Care Homes / Community is also being reviewed due to increasing concerns.

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

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score
1.	Improving Care, Sustaining our Future Click Here for Risk 1a Click Here for Risk 1b	**a) Enough capacity to meet elective demand** **b) Enough capacity to meet emergency demand**	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4) 20 (C4xL5)
2.	Improving Care, Sustaining our Future Click Here for Risk 2	**Ability to deliver improvements which transform care and enhance outcomes**	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4)
3.	Sustaining our Future, Improving Care and Inspiring People Click Here for Risk 3	**Enough workforce to deliver the activity and quality ambitions of the organisation** *(Including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4)

4. Assessment

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

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

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	6052	Chief Operating Officer	Facilities Directorate	Facilities Director	Sustaining Our Future	Statutory Duty, Regulation, Mandatory Requirements	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrakarts)	**If:** The patient beverage trolley fleet is not maintained/replaced **Then:** Patients are unable be fed breakfast and beverages. This is an essential part of the patient care. **Resulting in:** Patient hydration and nutrition non-compliance. Existing fleet of beverage trolleys in CTM UHB require a replacement programme (as per regen trolleys). The current fleet (apart from the Seren assets) are 10 plus years old and maximum life is 10 years old if maintained. The Ultrakarts are used for patient breakfast and beverages and then on used on average 5 times a day for beverages so are heavy use. The current models at all district general and community sites are not able to be put on maintenance contracts due to age, hence non-compliant. Several sites are now running with one per two/three wards and the service level is one per ward. YCC have 1 beverage trolley that is non-repairable.	There is a repair programme in place at each site when equipment is broken. However the beverage trolleys are too old to put on maintenance contracts. Replacement is the only alternative.	There is not enough budget in revenue to purchase singularly and the beverage trolleys are manufactured to order (cost decreases with volume). An investment bid has been included in the Facilities IMTP (submitted March 2025) An agreed replacement process has been approved, the risk will remain high until such time we have sufficient spares from replaced carts to maintain the existing equipment. Update October 2025 - This risk was reviewed on the 24th September and is scheduled for review again at the end of December. At present there is no change to the risk score.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	8 (C4xL2)	↔	15.01.2025	24.09.2025	31.12.2025
3	5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning DTPS Care Group	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	If: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update October 2025 - An executive discussion is to be held on this subject with the paper currently being drafted. An internal working group is to be established which will oversee the approach to managing this service risk. Conversations ongoing with Welsh Government and North Bristol Trust.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	4 (C4xL1)	↑	08.07.2024	20.10.2025	31.12.2025
6	6179	Executive Director of Public Health	Public Health - Health Protection	Executive Director of Public Health	Creating Health & Improving Care	Quality / Complaints / Assurance / Patient Outcomes Impact on the safety – Physical and/or Psychological harm	High and increasing prevalence of overweight and obesity in children and adults.	**If** there is insufficient preventative activity to reduce rates of overweight and obesity **Then** rates of obesity will remain high in CTM . **Resulting in** increased activity/acuity/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents.	A range of work is currently under way in response to high levels of obesity in CTM including: 1)Grant funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment 2)Adult Weight Management Service – the scale of this is vastly insufficient to make a difference to population level rates of obesity 3)Children and Young People's weight management service – current time-limited funding for Pipyn, preventative family based intervention, ongoing development work to maximise population impact, scale remains small. Proposed future development of a service in line with level 3 of the All-Wales Weight Management Pathway. 4)Healthy pre- and health schools programmes – working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: -healthy environments -healthy settings, -healthy people, -leadership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	Update September 2025 The Healthy Weight Steering Group is currently developing a healthy weight road map for CTMUHB, outlining actions and strategic direction over the short, medium and long term. This will be in line with Healthy Weight: Healthy Wales, and take into consideration health board actions under the new national action plan. The Healthy Weight roadmap is under development and due at Board for approval in November 2025. There is a business case in place for sustainability and increased capacity for Pipyn (level1+), and a CYP level 3 weight management service. A level 3 weight management service will help improve outcomes for some our most disadvantaged children. Update 08.08.25 funding has not yet been released for this business case as it is dependent on savings as part of the IMTP. A further panel for scrutiny was held for all IMTP business cases on 19th August before resubmission back to ELG for consideration. Update November 2025 The mitigation remains unchanged from that reported in September 2025. The risk will be reviewed further at the end of November 2025.	Quality, Safety & Experience Committee. Strategic Development Committee.	20	C4xL5	9 C3xL3	↔	06.05.2025	17.10.2025	30.11.2025
7	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	October 2025 - Unscheduled Care A number of actions are being taken by the care group to address the demand and improve patient experiences/outcomes. Launch UNITE (Unscheduled care Improvement, Transformation and Efficiency programme) POW ED Ambulatory Footprint opened Re-set RGH – short term de-escalation and re-alignment of Acute Medicine complete Medical workforce review and Job Planning Significant invest to save in Medical workforce UTC Pilot extended in PCH March 2026 45 min Escalation Action Cards and escalation policy implemented Weekly performance meetings established support by Unscheduled Care Dashboard Phase one GP intake back to POW Additional Ambulatory area in POW identified by the team to support the STAMP reset Targeted recruitment currently underway for additional consultant posts Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established Successful recruitment of medical staff to uplift rotas and reduce reliance on agency completed CTM UHB Winter Planning progressed October 2025 - Planned Care The below is a summary of initiatives reflecting the ongoing efforts by the care group to improve capacity and meet the elective demand. Centralisation of Cataract Service: All cataract treatments have been consolidated to the POW Eye unit from 1st September 2025.Two main theatres plus sessions in the surgicube are dedicated to the service. Direct listing of cataracts has commenced. Paediatric Dental Surgery: A recovery plan has been agreed upon between the Community Dental and RGH Theatre Service to increase theatre capacity. 6Cancer Services: Performance for August was 63.4%, and September 2025 is currently unvalidated but aiming at over 63%. Key actions are required for tertiary referrals, pathology, and optimisation pathways. The backlog has started to reduce against the trajectory, with a focus on Urology, Gastrointestinal, and Gynaecology. Centralisation of Trauma & Orthopaedics: The POW theatres opened on 1st September 2025 with three dedicated arthroplasty theatres. Ward 7 is now a protected elective Orthopaedic Ward with 28 beds. Between 1st September and 22nd October, 239 elective arthroplasty cases were performed at POWH. The average length of stay has reduced to 1.9 days compared to 5 days this time last year. Theatres: Utilisation and late starts are improving, especially in the Princess of Wales Hospital (POWH), although they are still below target. Speciality deep dives are being introduced, starting with Urology, to address persistent issues. Theatres are recovering from previous disruptions, such as roof issues, but upcoming work at the Royal Glamorgan Hospital (RGH) may impact progress. The care group will monitor all impact and escalate /mitigate accordingly. Regional Outpatient Insourcing commenced at CTMUHB is ongoing. Aiming to reduce Outpatient waiting times across all specialities Progress made on >104 week. All specialities aim to maintain <104 weeks with the exception of Orthopaedics.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 C4 x L3	↔	13.7.2023	06.11.2025	06.12.2025
8	5276	Director of Digital	Central Corporate - Digital & Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update October 2025 Cell Path deployment pushed back to October 2025 and is now very close to Micro deployment - concerns around short time frames planned for User Acceptance Testing sign off and Cutover Qualification (CQ). Blood Sciences deployment is now delayed until 2026 due to significant issues in the aliquoting process in Biochemistry. It has been agreed to roll out on a per discipline basis instead of per Health Board. The predicted time lines are: Pre production environment – July 2025 (completed). Production Environment – Beginning of October 2025. Cell Path and Andrology – End of October 2025. Microbiology – Beginning November 2025. Blood Transfusion and Blood Sciences – No dates yet agreed, likely in the new year.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	27.10.2025	30.11.2025
10	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.	The emergency departments across CTM remain overcrowded. There are many internal actions being undertaken within Care Group to reduce attendances, improve flow and reduce overcrowding: • CTM UHB Development of Urgent & Emergency Care Rapid Improvement Plan (45 minute ambulance handover and 90-day ED performance) • TRUE Rapid Improvement Plan through 6 Goals Programme – SRO - Deputy Exec Med Director and Deputy COO • USC CG Formalise and sign off 30/60/90-day improvement plan • Acute Medicine Transformation Programme (STAMP) – POW – 2 workshops complete – 3 further planned June/early July • New investment agreed for x3 Consultant Acute Physician posts. Targeted recruitment drive currently underway. • Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established. • Targeted recruitment of Acute Medicine Consultants following new investment to provide 7/7 October 2025 TRUE rapid improvement actions being worked through. Action cards signed off and live. Acute med reset in Prince Charles Hospital and Royal Glamorgan Hospital complete. Princess of Wales Hospital STAMP programme on going and optimise ongoing. Improvement plans to create and ambulatory area in Emergency Department in Princess of Wales Hospital Escalation policy has been enacted following OMB sign off. This policy will assist in standardising and consistencies in approach across all sites. The escalation triggers and actions will assist with gridlock situations, particularly during peak winter pressures or critical incidents.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	06.11.2025	06.12.2025
11	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 October 2025 On review of the plans there has been a delay in the September implementation date and it is now anticipated that from the end of November / December a sufficient number of lists will be allocated to the service to enable the backlog to be reduced and manage ongoing demand. Lists will operate from 2 acute hospital sites initially with ambition that the lists will be provided from the 3 sites, which requires further planning as we progress with these plans. Additional assessments sessions will be put in place with community dental to ensure full utilisation of the lists. The care groups will continue to monitor the position and review the risk following assurance all lists have commenced in November as planned. Available is the latest trajectory from the Care Group reflecting the trajectory and target date. It is considered that the risk score could be reduced and this will be reviewed by the Primary Care and Community Care Group ahead of the next iteration of the report.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	9 C3xL3	↔	20.04.2023	06.11.2025	06.12.2025

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
12	5753	Executive Nurse Director / Deputy Chief Executive	Children & Family Care Group	Care Group Service Director	Improving Care	Workforce / Organisational Development / Staffing / Competence	Inadequate Special School Nurse Provision	**If** the Health offer towards the current Special Schools Nursing Model is not increased and Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools **Then t**he Community Children's Nursing (CCN) Service are unable to meet their obligations across the five special schools in CTM and be unable to fulfil their obligation to Rhondda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA **Resulting in**, Dissatisfaction and fractured relationships within RCT and Merthyr LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), impact on Consultant Led clinics, inability of special school nurse to deliver on School Nursing Framework in Wales part 2 - Nursing in Special Schools and Healthy Child Wales (HCW) part 2, lack of access to continual professional development and peer support for the nurses based in Special Schools, continued issues with recruitment and retention of nursing staff into Special Schools	Mitigation – reviewing SLA at pace with LA, high level meetings with EDON, Nursing Director and Directors of education. Supporting staff, sharing risk across SSN schools. During periods of absence or vacancies; access to a school nurse will not be available in person 5 days per week. However, telephone advice and support will be available. These control measures do not meet expectations of Local Authority. Meetings have been held between Directors of education and Director and Executive Nurse. SBAR has been escalated to Care Group OMB but needs to be escalated to HB OMB (19/02/2025) Engagement between senior nurse and head teachers and support for special school nurses has been given.	Update October 2025 There has been a slight improvement since the schools have restarted, but remains a high risk for the care group, due to workforce vacancies, despite attempts to fill. This has been raised at the Quality , Safety and Experience Committee, and clarity from Welsh Government has been requested on their position specifically around the adherence to the framework. It has been raised to consider as an item for discussion at the Integrated Quality, Planning and Delivery (IQPD) meeting with Welsh Government.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	8 (C4xL2)	↔	16.04.2024	06.11.2025	06.12.2025
14	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) while ensuring optimal performance and quality standards are consistently met	**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. Additionally, the performance targets to monitor improvement of the stroke prevention and care service will be adversely affected, leading to significant challenges for the health board to include noncompliance with Quality Improvement Measures (QIMs).	• 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 October 2025 Risk reframed to take into account feedback received from the September 2025 Quality, Safety & Experience Committee to capture the performance element of the risk. Medical Workforce Update 1.0 wte consultant returning from maternity leave October 25 1.0 wte consultant appointed, starting January 26 1.0 wte consultant returned from LTS - phased return Specialty Medicine Directorate aiming to appoint 2.0 wte consultant neurologists. Job plan will support 1 clinical session allocated to stroke on call rota. In terms of the risk score remaining at 16 the USC Care Group considers that the following mitigations support this rating. - there has been and will be a senior decision maker for stroke i.e. a consultant who will immediately attend all stroke calls - Monday – Friday with Thrombolysis prioritised. - CNS 6/7, based in ED, covering core hours 9-5 (some days till 1800). - Enhanced monitoring with senior leadership oversight in place, through daily breach huddles with a live improvement plan. This is undertaken using an MDT approach, we have already seen improvement in CT and admission to ASU. - Daily breach and weekly reports of top breach reasons and associated actions captured and tracked. - A robust improvement action plan is in place for the unit which focusses on leadership, workforce, IP&C, and fundamentals of care – the actions are 89% complete. -Nursing workforce and leadership now significantly improved; we have 2 x Band 7 ward manager which enables 7/7 cover for the unit. -Medical workforce stabilised with a return from mat leave and start date for new consultant end of November -Internal Audit report recently received indicates a positive outcome with an overall reasonable assurance rating. Whilst the USC Care Group acknowledge there has been limited improvement in the QIMs to date there has been clear improvement in overall quality of care which was the basis of reducing this score from a 20 to a 16.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4 x L3)	↓	11.05.2021	06.11.2025	31.12.2025
16	6228	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Effective and efficient management of requests from the HM Coroner	**If:** the Health Board fails to effectively respond and manage requests from the HM Coroners Office in a timely manner. **Then:** there is a risk that the Health Board will breach 'The Coroners (Investigations) Regulations 2013' in failing to provide documentation on time and take required action in a timely manner to ensure lessons have been learned. **Resulting in:** poor experience and the wellbeing impact for the families and staff members involved in inquests, reputational impact of the Health Board in terms of trust and confidence in the service, an increase in the number of Regulation 28 / 29 reports on actions to prevent future deaths, an increase in potential enactment of the Coroners powers, including under Schedule 5 - "Power to require evidence to be given or produced".	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Review and remap internal processes in the management of inquest cases within the organisation. Weekly coronial meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage inquests effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 - Weekly escalation meeting established with Senior Coroner's Officer to highlight cases requiring urgent action. Weekly meetings with Legal & Risk to track action and progress with high-risk/high-profile inquests. Works continues to be undertaken to improve the accuracy and robustness of information contained within the Datix Cymru system. Enhanced reports and trackers being developed to support the operational management of inquests. Mechanisms for providing reporting and providing assurance to be embedded. Documentation for supporting staff with the inquest process to be finalised. Update October 2025 - on an interim basis a designated lead has aligned to the legal services function to provide greater oversight as to the Coroners Inquests activity. Whilst this is a relatively new step the risk remains as current it will be reviewed as part of the legal services recovery programme and implementation of the Organisational Change Process within the Patient Care and Safety Directorate.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	06.11.2025	31.12.2025
17	6229	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Timely development of, management and response to Learning From Event Reports (LFERs)	**If:** the Health Board fails to achieve timely completion of LFERs, respond promptly to the questions from the Welsh Risk Pool Learning Advisory Panel and provide assurance that learning has been implemented and shared. **Then:** there is a risk that improvement to quality and safety in healthcare aligned to learning which flows from case investigations, and the LFER (Learning From Event Report)s is not acted upon. **Resulting in:** reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned. Missed opportunities to improve patient care and safety following identification of areas for improvement. Financial penalties if the Welsh Risk Pool consider withholding reimbursements due to being dissatisfied with the learning and actions taken in a case.	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Incident Management Framework and Toolkit. Incident Investigation Training Visibility of data using the Datix System. Listening and Learning Framework	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 - LFER workshop held 04/09/25 with the health board internal Legal Services team and Heads of Quality & Safety to review the recently revised LFER process and to look at implementing a revised and smarter way of working. Revised process to be further updated and to include timeframes for actions ensuring deadlines are adhered to. Final documentation to be shared at the Executive Director led Quality & Safety weekly meeting on Monday 29th September 2025 for Exec' review and approval with an action for immediate implementation. Further work will be progressed to undertake a wider review of how learning is further embedded across CTM, and will take place with support of the QI team in reviewing the Listening & Learning Framework and the Learning Repository. Collaborative work continues between the Assistant Director of Nursing and the health board assigned WRP Principal Safety & Learning Advisor, with a meeting scheduled to discuss the format and set up of an internal CTMUHB Learning From Event Report Panel, with engagement from the WRP Principal Safety & Learning Advisor. Terms of Reference for the LFER panel will be developed including membership & frequency and presented to the Executive Director led Quality & Safety weekly meeting for approval. Update October 2025 LFER pannels currently in the process of being setup with support from Welsh Risk Pool. Awaiting a number of submissions end of October for status to be determined.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	08.10.2025	31.12.2025
18	6231	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future	Standard Duty, regulation, mandatory requirements.	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	**If:** the Health Board fails to comply and proactively manage cases that qualify for consideration under NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. **Then:** there will be a missed opportunity to deal with concerns under a single and consistent method for grading, investigating and to actively involve the person raising the concern in an open and engaged manner to put things right. **Resulting in:** Delays in improving patient safety and experience as a result of identifying how services may have improved as a result of concerns notified and dealt with under these arrangements, Early resolution of cases which provide an opportunity for closure for families and staff as well as effective and efficient learning to be implemented. Avoidable costs should a case proceed to litigation due to failure to comply proactively with the arrangements. Reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Putting Things Right - Handling Concerns Procedures Engagement with Legal & Risk Services. Experienced Concerns Handlers in post.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025: The organisation is maintaining performance in the management of concern responses within 30 days. The acknowledgement within 2 working days has been improved, however, will need additional time and support to embed, thus providing confidence to lessen the risk. Work continues to attend to the responses in early resolution and tailor the outcome of the Organisational Change Process changes to reflect the resource needs in attending to focus on localised early resolution. Update October 2025 - Focussed activity is underway in terms of reviewing systems and processes. CTM has also benchmarked with other Health Boards to learn and share best practice. As part of the recovery plan detailed scrutiny on early resolutions has been undertaken which has identified areas of improvement that need to be rectified at pace in order to improve the rate of compliance. This programme of work will entail communicating with service users to ensure to inform as to the status of their concerns.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	06.11.2025	31.12.2025
21	5045	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Access to Neurology Inpatient and Outpatient Services for CTM Residents	**If:** there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of RTE; **Then:** existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue; **RESULTING IN**: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients.	An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint x3 consultant neurologists within CTM as part of the Neurology Liaison Plan.	Update September: Ongoing capacity challenges are faced in Royal Glamorgan Hospital and Prince Charles Hospital with long waiting times, lack of epilepsy nurse service and a lack of inpatient provision. Agreement has been given to appoint 2x Consultant Neurology Liaison posts within CTM in line with the plan for developing a neurology liaison model across CTM; the care group have been working with the CTM recruitment & retention lead to pull together a recruitment pack that will maximise the chances of successfully recruiting to the posts. The care group have also been working with commissioning colleagues to progress development of the neurology LTA with C&V and SBUHB, so that it accurately reflects current service provision and that as a commissioner of neurology services, CTM are receiving the appropriate level of service. Update from C&V received. Summary: • Confirmed that the reporting of the WL would stay with C&V until >52wk backlog is cleared. • Nobody waiting over 104 weeks. • The locum started in Dec 24 and will remain in post until Dec 25 • Performance against 52 weeks continues to improve with a total of 576 patients above that target at end of August. Further assurance requested via Commissioning colleagues of delivery of the remaining 575 patients >52 weeks. The locum consultant in RGH is expected to remain in post until at least the end of December 2025 and there has been some funding allocated for WLI's to support both C&V and CTM. The care group have requested further assurance via CTM commissioning colleagues on the delivery of the remaining >52 weeks patient cohort. Update October 2025 Consultant in Liaison Neurology vacancy live and closes 16 November. The risk continues to be monitored and reviewed by the care group.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	09.3.2022	06.11.2025	31.12.2025
22	5576	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Palliative Medicine Staffing	**If** the Health Board are unable to recruit to the vacant Palliative Medicine Consultant post in Ysbyty Cwm Cynon (YCC) for Merthyr/Cynon. **Then**, there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant compliment. **Resulting In**.. a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status.	Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant. Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards	Update September 2025 The Care Group has had a successful recruitment to all the vacant SPC CNS vacancies restoring 7 day working for the service as a whole across the Health Board footprint. Risk score currently remains unchanged. Update October 2025 With the recent changes to the services at Ysbyty Cwm Cynon there is a reduced impact on the staffing. A comprehensive review of this risk is planned in collaboration with key colleagues. This will ensure that all relevant perspectives are considered ahead of the next articulation. This collaborative approach will allow us to discuss and address any implications arising from the recent changes in the service.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	11.10.2023	06.11.2025	31.12.2025
23	4973	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical Medical Cover within CTM Adult Mental Health Services	**If:** CTM Mental Health Service fails to implement adequate senior medical cover across adult in-patient and CMHT services **Then:** the Health Board's ability to provide quality care, a safe environment for patients and a good standard of training for junior doctors will be reduced and potentially compromise the safety of patients and staff **Resulting in**: sub-optimal care to patients, inability to discharge its legal duties under the Mental Health Act, due to insufficient numbers of suitably skilled and experienced Approved Clinicians. Junior doctor supervision will be reduced which may affect future recruitment, patient safety/experience compromised and staff well being will be poor.	Functional inpatient model in place with 3 consultants to cover. Redeployment out of the service and resignation has led to a further depleted workforce and cover will reduce to two consultants from January 2025 with additional middle grade support. Rehabilitation service is at a critically low level with urgent closure of one service needed. Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients. Difficulty recruiting to locum posts due to introduction of rate card and need to have Welsh AC approval. Permission to go out to non-DE has been provided. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements. Two PAs recruited to Rehab and IP in Jan/March 2025 which will free up senior time The Adult Directorate is managing medical staffing through "escalated action" procedures with daily scrutiny and communication pressures and counter measures to release the Consultant body. Daily reviews with Retinue on the availability of staff	Substantive jobs which are new posts are being developed and advertised. Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025. Update October 2025 Medical staffing remains fragile across the whole of Adult Mental Health Services. There are significant pressures across inpatient services at Consultant level and particularly in relation to availability of Approved Clinicians. Recent recruitment activity has been unsuccessful. Mitigation plans include the use of Health Education Improvement Wales funding to secure a recruitment agency to fill two post and focused work to secure ST6's due to complete training in the next six months. Sufficient Approved Clinician input remains challenging and the recent recruitment processes for a Multi Professional Approved Clinician has not been successful. Care Group continue to monitor service fragility.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4xL3)	↔	06.01.2022	06.11.2025	31.12.2025

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
25	4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care Sustaining our Future	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process	If: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library.	October 2025 Update: The project to review the non-clinical policies is underway in compliance with the objectives set out in the Project Initiation Document with an update being received at the Executive Management Board (EMB) on the 29th September. The revised "Policy on Policies" is currently out for consultation and now provides a more simplified policy and process to follow. The new master library is in development and the new system for monitoring is established as a structure but not yet being populated. The front facing policy page for staff has been designed and ready for population. The downloading of documents from the existing sharepoint site is underway but has required a significant amount of resource time and therefore the impact on the original timeframe of the 31st December has been flagged as a risk to EMB as it is likely that this will not be met.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	⇔	26.10.2021	8.10.2025	31.12.2025
26	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. Update May 2025 - No change to risk score or mitigation this period. Executive Medical Director to raise risk again at next All Wales Medical Director meeting. Update 23 June 2025 -- Still no movement here. Its within the discussion of Digital HealthCare Wales provider status and open sharing of data between Health Boards. The current proposal has not been agreed between ABUHB and DHCW. CTMUHB are asking and raising the concern, however, cannot directly resolve. Update September 2025 - remains as August 2025. It is raised at the relevant forums (All Wales Medical Director Meetings) regularly. No changes to risk score. Update October 2025 - remains as reported previously. The risk continues to be raised at the relevant forums (All Wales Medical Director Meetings) regularly.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	27.10.2025	31.12.2025
27	5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PIPYN continues to be delivered in Merthyr (PHW funding until 26) and Taff Ely and Rhondda (Cluster funding until 26) 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3)Business case developed submitted and submitted for IMTP consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Finance-dependant controls: 1)Set up service if funding identified via IMTP process.	Update September 2025 - Risk reviewed 19 August. No change to the risk score and mitigations remain current as outcome of the Integrated Medium Term Plan discussions is awaited. Update October 2025 No change or movement with further mitigations for this risk. The risk continues to be monitored by the care groups to manage any changes.	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	06.11.2025	31.12.2025
31	6294	Chief Operating Officer	Planned Care - Care Group	Service Director Planned Care	Sustaining our Future	Workforce / Organisational Development / Staffing / Competence	Insufficient Consultant Workforce - Endoscopy / Gastroenterology	**If** the Consultant posts cannot be filled, **then** it will impact on Service Delivery and affect our ability to deliver both diagnostics and clinical services to patients. **If** the Consultants that are currently in post were no longer in post, **then** this would significantly affect our ability to deliver both diagnostics and clinical services to patients. Furthermore it would impact on ability to support inpatient services at POW. Fragility of the Consultant workforce is contributing to potential gaps within the on call bleed rota, with little redundancy. This could **result in** a situation in which the on call bleed rota could not be covered. Unsustainable service provision to safely care for inpatients.	In terms of recruitment posts remain out to advert. Locum in post for one of the vacancies however they are due to leave in the near future due to other obligations. There has been no interest from agencies in supporting the vacancies.	Mitigating actions currently limited. Continuing to advertise for posts.	Quality, Safety & Experience Committee. Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	9 (C3xL3)	New risk escalated to the Organisational Risk Register in November 2025	07.08.2025	06.11.2025	31.12.2025
32	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTPS	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	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** impact on patient outcomes, 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. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service 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.	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.	There is a significant backlog of reporting radiology examinations, with just over 10,000 X-rays pending. Current mitigation measures include rostering SPRs for extra reporting, outsourcing MSK cases, utilising training posts and the returning from parental leave. We are aiming to address the backlog in the more likely clinical urgent cases (chest x rays) by December as a priority.	Quality, Safety & Experience Committee. Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	6 (C2xL3)	New risk escalated to the Organisational Risk Register in November 2025	08.02.2017	6.11.2025	15.12.2025
33	6379	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTPS	Improving Care	Safety & Wellbeing Patients / Staff and Public	CT Scanners at RGH damaged by power outage and manual generator/UPS switch over	**IF** the manual switch over following a power outage is not rectified. **THEN** the CT scanners/tubes may become damaged **RESULTING IN** no CT service on site, causing significant delay in patient outcomes, and significant cost to repair (circa £350k per tube)	Discussion with manufacturer and All Wales procurement Discussion with estates team Estates will ensure CT is switched on first, for generator to kick in Regular weekly meeting with GE and estates to monitor	Action plan required urgently to show regular monitoring. If a separate or modified UPS is required then a statement of need for Capital consideration will be required.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	4 C4xL1	New risk escalated to the Organisational Risk Register in November 2025	20.10.2025	06.11.2025	31.12.2025
34	6318	Chief Operating Officer	Mental Health Care Group	Service Director - MHLD	Improving Care	Safety & Wellbeing Patients / Staff and Public	Tier 3 SHED Team Service Delivery	**If:** The level of vacancies continues in the C+V UHB service for high risk eating disorder patients (SHED) **Then:** The service will be unable to fully deliver assessment and treatment interventions for CTM UHB residents. **Resulting in:** Patient safety concerns for a number of high risk patients	There are regular meetings with the SHED team to discuss the caseload.	Escalated at OMB 29.10.25 risk rating increased following dialogue with CMHTS. escalated to service director and director of nursing. The care group will progress with an action plan to mitigate the risk and the Care Group Service Director has requested a meeting with CAVUHB senior Mental Health leadership team to consider a route forward.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	C3xL2 = 6	New risk escalated to the Organisational Risk Register in November 2025	29.08.2025	6.11.2025	31.12.2025
35	6280	Chief Operating Officer	Planned Care - Care Group	Service Director - Planned Care	Improving Care	Safety & Wellbeing Patients / Staff and Public	Suspension of the Regional Hepato-Pancreato-Biliary service model	**If…** The commissioning of this service is not prioritised as part of the regional commissioning arrangements **Then…** there will be no Regional service for Severe Acute Pancreatitis **Resulting in….** sub optimal care for this group of acutely unwell patients	Each case currently being discussed on a case by case basis between neighbouring Health Board Medical Directors, however, this will add delays to an already complex and time sensitive treatment pathway.	As this is a service that is regionally commissioned the Health Board will need to have ongoing discussion with the Joint Commissioning Committee as to a way forward.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	9 C3xL3	New risk escalated to the Organisational Risk Register in November 2025	06.08.2025	6.11.2025	31.12.2025
36	5877	Chief Operating Officer	Primary Care and Community Care Group	Service Director - Primary Care	Improving Care	Service / Business interruption	New Worker Contract for Out of Hour GPs	**IF** the new worker contract for out of hours GPs is implemented (ambition is for Dec 2025) it will require the application of Working Time Regulations. **THEN** there will be a significant impact on shift fill rates. **RESULTING in** the Health Boards ability to fill shifts across the whole roster having a negative impact on both WAST and ED departments.	Recruitment of more GPs who do not also work day time in other roles. Whilst the weekend service will be affected to some degree, weekday evening service will be most adversely affected as any GP working until midnight will not be able to work in practice the next morning.	Additional recruitment of GPs is critical to establish the service.	Quality, Safety & Experience Committee Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	C3xL2 = 6	New risk escalated to the Organisational Risk Register in November 2025	07.08.2024	7.11.2025	01.12.2025
37	6232	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future	Safety & Wellbeing Patients / Staff and Public	Stability of the Legal Services Function	**If:** the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. **Then**: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. **Resulting in:** an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 -The recovery programme continues to make progress in standardising and stabilising processes and work plans. The Organisational Change Process remains delayed as a result of the prioritisation of work and gaps in senior leadership owing to non-work-related absence. Update October 2025 - position remains as reported in September 2025. A designated lead has been assigned to the Legal Services Function to provide stability and oversight on an interim basis.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C3xL5	C3xL2 = 6	↔	3.7.2025	6.11.2025	31.12.2025

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
38	6217	Executive Medical Director	Children & Family Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity	If: the safeguards and quality systems and processes are not robust Then: - mothers and babies may not receive the best evidence based care Resulting in - Potential for patients to have poor outcomes and experience within the service.	Rapid reviews have been undertaken on all cases with findings and learning from each. Meetings held with Care Group and executive team to decide on way forward. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan).	Update September 2025 External review commissioned on Nationally Reported Incidents. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) - the action plan and risk will be further reviewed once external report received. Response received from obstetrician reviewer with further information requested. Update October 2025 The Health Board is still awaiting obstetric review from the external clinician in order to be able to review the risk and continuation of actions.	Quality, Safety & Experience Committee.	15	C5xL3	10 (C5xL2)	↔	14.05.2025	6.11.2025	31.12.2025
41	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 Corporate - Digital & Data	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of a Single Electronic Patient Record in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update July 2025 -The Care Group are currently in the third week of the procurement process which has allowed suppliers to bid. This is scheduled to finish on 5th July when the Care Group should be in a position to know how many suppliers are in the procurement activity. Update September 2025 - no further update at this point. Risk reviewed and no change to score. Update October 2025 1.Awaiting recommendation/outcome report 2.Report will be taken to Programme Board and Executive Board for approval 3.Supplier to be known 4.Procurement process to conclude	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	06.11.2025	31.12.2025
42	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 September 2025 Risk reviewed 27 August 2025 - no change at present Meeting arranged with Adult Directorate to fully update mitigation to include; Potential ward moves Cessation of PICU SLA with SBUHB Impact of National programmes of work Changes to the RGH inpatient model Single S136 suite Update October 2025 Routine ligature audits have identified key environmental risks on one of our wards at Royal Glamorgan Hospital. Estates work is planned and until this is completed additional staff are being rostered to supervise the particular area.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	06.11.2025	31.12.2025
43	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	**IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. **THEN** there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. **RESULTING in** avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update October 2025 - Reviewed at Strategic Group Meeting and current risk score remains unchanged.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	17.10.2025	31.12.2025

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5691 Closed Session due to business sensitivities	Chief Operating Officer	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	CCTV System Failure in Prince Charles Hospital and Princess of Wales Hospital	Business Sensitive - Detail captured in closed session.						
6111	Executive Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Medical Examiner Delays	**If:** there continues to be delays in length of time for scrutiny of deaths by the Medical Examiner Service **Then:** death certification will not be completed in a timely manner and so increasing the length of stay of the deceased **Resulting in:** complaints from bereaved relatives due to delayed funerals, inability to view loved ones, and deterioration in condition due to delay and inability to comply with WG bereavement framework and mortuary capacity being overwhelmed	Bereavement database updated to track cases and ensure timely attendance by doctors following scrutiny. Bereavement teams to provide estimated timescales for scrutiny based on database. Daily monitoring of daily occupancy. Funeral directors to be contacted by mortuary teams. All contingency capacity HB wide activated in line with mortuary escalation action card. Use of contracted funeral director staircase if required. Use of medilink sessions to manage post mortem demand.	Plan to improve timely death certification by CTMUHB specific QR code to alert wider staff and reduce delays and education videos from MES to improve accuracy. Continue to improve on communication with families around delays and estimated timescales. Update September 2025 The requirement for QR code solution has been escalated to the Director of Digital to help find a solution. Respite awaited. QR code with additional details would improve communication between departments and potentially speed up the process for families. Update November 2025 - QR Code solution now live and active. Process should now be sped up and performance will be monitored closely.	Quality, Safety & Experience Committee. Operational Delivery Committee.	12 (C4xL3) Risk score reduced from a 20 to a 12	8 (C4xL2)	As both OR Code solutions have commenced and are working well this risk is proposed for de-escalation. The Team will remain a watching brief on submissions in order to identify any issues. The likelihood has been reduced to a 3 rather than the target level of 2 in the interim whilst the new process is monitored closely.
5304	Chief Operating Officer	Sustaining Our Future	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU at the Royal Glamorgan hospital (RGH) is 25 years old, therefore is at higher risk of failing to meet the required standards due to its age and design, with four recent incidents occurring. **If** the AHU is not maintained to the required standard this could **then** lead to further closures at short notice or production being halted. **Resulting in**: •Patient Safety and Quality: Delays in supplying treatments, particularly for cancer patients, which could compromise patient outcomes. There is also a risk of severe patient harm if regulatory compliance cannot be maintained. •Complaints and Patient Experience: Increased waits to start treatment or delays in treatment, leading to poor patient satisfaction and an increased number of complaints. •Reputational Risk: Negative publicity due to increased waiting times for cancer treatments or the inability to provide certain treatments, resulting in reduced patient and clinician confidence. •Financial Risk: Increased medicines expenditure and wastage from having to outsource aseptically prepared products from external suppliers. •Research and Innovation: No opportunity to conduct clinical trials involving aseptically prepared products.	The output from the AHU is continuously monitored internally & externally The estates department maintain the AHU regularly here are contingency plans in place to outsource products from elsewhere.	Capital resource approved and the service is working with project manager on timelines which will then initiate a review of the risk to see if mitigations are successful and risk score can be reduced. Update October 2025 Upon reviewing the risk, the risk score has been reduced to 12. NWSSP verification is complete and the AHU is functioning as expected. However, it is considered to be at the end of its shelf life; therefore, appropriate controls are in place for regular monitoring. To ensure prompt action and escalation if the risk fluctuates rapidly or if testing fails, both internal and external monitoring will be conducted.	Quality, Safety & Experience Committee Operational Delivery Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	4 (C4xL1)	Proposed for de-escalation as upon reviewing the risk, the risk score has been reduced to 12. NWSSP verification is complete and the AHU is functioning as expected. However, it is considered to be at the end of its shelf life; therefore, appropriate controls are in place for regular monitoring. To ensure prompt action and escalation if the risk fluctuates rapidly or if testing fails, both internal and external monitoring will be conducted.
3567	Chief Operating Officer	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	Capacity of Cellular Pathology Service - Space	**If**: there is not enough laboratory and office space for Cellular Pathology to operate the core service safely or support increasing demand, service disaggregation and future Health board changes; **Then:** the service will be unable to work effectively and efficiently in line with Duty of Quality guidance and recognised Health board standards for IP&C, H&S etc. **Resulting in:** - Inability to meet increasing demand - increase in staff stress and compromised well being due to working in suboptimal conditions. - Poor cancer performance and inability to meet expected turnaround times, impacting on Health Board cancer performance - poor quality patient care due to delays in diagnosis or misdiagnosis - Increase in clinical incidents, complaints and potential for reputational damage. - Inability to effectively disaggregate the current SLA with Swansea Bay and repatriate services from Bridgend impacting clinical services across CTM. - inability to support full digital rollout and support regional reporting in line with WG strategic direction - delayed development of advanced scientist dissection to support increasing reporting capacity and delivery of workforce modernisation - loss of tissue leading to Serious incidents and Regulatory non-compliance with HTA and potential compromise of HTA license. - financial risk of outsourcing - threat to strategic regionalisation project due to the scale of the lack of capacity in CTM	SOPs are in place to standardise practice and mitigate risk of variation in practice caused by limitations of the laboratory environment. Controls to reduce the use of reception/dissection as a thoroughfare including signage and demarcation belt. Workflows established to maximize efficiency of limited space. Block and slide filing removed from laboratory area where possible. System of work including check established in dissection to minimize risk of error. IPC and H&S environment inspections undertaken to assess impact of laboratory environment on clinical effectiveness and risk to patients and staff.	Mitigating Action Plan includes: Engagement with estates to review small scale projects to increase laboratory space. Engagement and participation in Regional Scoping group to scope options including estates to look at long term solutions. Update September 2025 Risk reviewed on the 20 August 2025 - Procuring workbenches to support initial conversion of office space to support initial Invest to Save paper of increase of one Pathologist and associated workload. Awaiting estates work to convert the office. Statement of Need (SON) for feasibility study of preferred option for medium term option to be prepared. Update October 2025 Reviewed by Care Group Service Director. Risk remains, however, current controls are expected to mitigate this risk at a level of 12 unless there is a new trigger. Department changes are being considered with Infection Prevention Control team relocation. Non-financial appraisal completed for Regional Estates options; top two will proceed to financial assessment. Local feasibility study approved for short-term improvements. Assessing both local options and regional timelines due to urgent need.	Quality, Safety & Experience Committee Operational Delivery Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	6 C3xL2	DTPS Care Group Service Director has reviewed the risk and proposed for de-escalation. The rationale for de-escalation is that current controls are expected to mitigate this risk at a level of 12 unless there is a new trigger. Department changes are being considered with Infection Prevention Control team relocation. Non-financial appraisal completed for Regional Estates options; top two will proceed to financial assessment. Local feasibility study approved for short-term improvements. Assessing both local options and regional timelines due to urgent need.
5646	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The impact of "Right Care Right Person" (RCRP) approach.	**If:** South Wales Police (SWP) implement Right Care Right Person **Then:** In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. **Resulting in**: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register.	Update October 2025 The final Phases of RCRP went live in March 25. There have been no incidents escalated through the health board in relation to RCRP. In the RCRP Health Board wide meeting held on June 25 it was agreed to recommend a reduction in the likelihood score from 4 to 3 which would give an overall score of 12. This position was considered at the MH&LD Care Group OMB in July but with the release of the SWP revised S135/6 policy it was agreed to wait to review. This policy has not been released. At the MH&LD Care Group OMB in October 25 it was agreed that it was unlikely the policy is not going to adversely affect the frequency of RCRP related incidents and therefore the Likelihood scoring. The risk score is therefore recommended for reduction to 12.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	8 C4xL2	Proposed for de-escalation. At the MHLD Care Group Operational Management Board in October 25 it was agreed that it was unlikely the policy is not going to adversely affect the frequency of RCRP related incidents and therefore the likelihood scoring was reduced. The risk score is therefore recommended for reduction to 12.
4218	Executive Director of Nursing / Deputy CEO	Improving Care	Safety&Well-being Patients/Staff/Public	Reduced on site Consultant Microbiologist/ IPC Doctor cover for Bridgend	**If:** there is no dedicated on site Microbiology cover . **Then:** there will be no antimicrobial/ ITU ward rounds, no root cause analysis to learn from incidents. **Resulting in:** mismanagement of patients/ inappropriate treatment and no learning to influence practice. IPC Doctor support is required to help support/deliver the IPC and decontamination agenda Concerns raised regarding SLA and role of microbiologist under it to support IPC.	Service Level Agreement (SLA) for microbiology support under review at present moment. IPC team continues to invite microbiologists on duty at Princess Of Wales (POW) Hospital in all investigations/Root Cause Analysis. Working towards joint meetings between IPC, microbiology for POW and microbiology for the other sites to work towards same processes and support across CTM.	SLA to be reviewed. IPC has sent GAP analysis and SBAR with identified gaps and concerns to inform new SLA. Risk Monitored by the Infection Prevention and Control Committee. Update October 2025 - Temporary arrangements have been put in place to secure access to a Microbiologist on site to provide the cover required whilst the discussions on the SLA continue. In light of the temporary arrangements and the improvement that provides the risk score has been reduced from a 16 to a 12 but will continue to be monitored locally.	Quality, Safety & Experience Committee	12 (C4xL3) Risk score reduced from a 16 to a 12	4 (C4xL1)	Proposed for de-escalation. 6.11.2025 - Temporary arrangements have been put in place to secure access to a Microbiologist on site to provide the cover required whilst the discussions on the SLA continue. In light of the temporary arrangements and the improvement that provides the risk score has been reduced from a 16 to a 12 but will continue to be monitored locally.

	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	6102	Director of Digital	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patient Pathways - Working in WPAS Instances.	**If**: A patient is moved between Swansea Bay University Health Board WPAS and Cwm Taf WPAS and their pathway is closed in one before it is opened in the other. **Then:** The pathway will not be automatically re-opened by the systems (this must be manually transacted) and the pathway will remain closed. **Resulting in:** The incorrect ending of the patient pathway, as they will not be visible on the system, which could lead to possible patient harm/ death.	Monitor records/ processes through agreed Standard Operating Procedure's and ensure corrective actions are taken until mitigation is successful. Flagging to users/ management where examples of this not being followed are identified.	Review current business processes and Standard Operating Procedures to clarify the importance of opening the CTM record before closing the Swansea Bay University Health Board record. This process prevents delays in urgent pathway management, as highlighted by flagged dermatology cancer referrals that were discharged on WPAS but not set up on another system at the time of checking. It is anticipated that the target score will not be achieved until CTMUHB have a fully migrated PAS systems and the whole organisation is using a singular PAS system for patient pathways. Update October 2025 - Patients are no longer being moved across two separate instances of WPAS in CTM. Therefore this risk can be closed form a Digital & Data perspective	Quality, Safety & Experience Committee. Operational Delivery Committee.	nov-25	Risk proposed for closure as target score met. Rationale for closure is that Patients are no longer being moved across two separate instances of WPAS in CTM. Therefore this risk can be closed form a Digital & Data perspective.

Agenda Item
7.2

Quality, Safety & Experience Committee

MORTALITY INDICATORS AND MORTALITY REVIEWS

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
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)		

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
HMR	Hospital Mortality Review
ME	Medical Examiner

1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience 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 24th October 2025), 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	Screened - pending Dashboard update	Under Investigation/ Action Required	Closed
CTMUHB	**4411**	**78 (2%)**	**49 (1%)**	**85 (2%)**	**4199 (95%)**

Learning from Mortality Reviews

1.3 Medical Examiner Service is now reviewing all of CTMUHB, in-hospital deaths and deaths in the community setting since September 2024.

1.4 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.

The table below shows the number of cases identified for HMR since 2022-23 (as of 24th October), 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	619	618* (99%)	11%
2023-24	373	373 (100%)	84%
2024-25	376	358 (95%)	67%
2025-26	113	58 (51%)	16%

***1 case recently added as was missed initially by ME service**

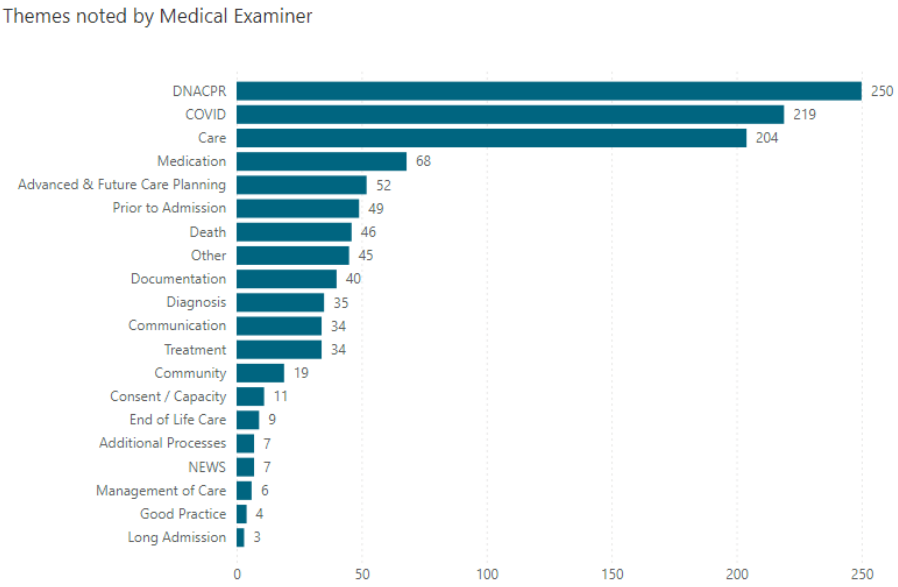
1.5 Completion of HMR <28 days has dropped due to a shortage of HMR reviewers, and historic good will funding for 2 regular reviewers stopping end of March 2025. This has resulted in longer completion times and a backlog of cases accruing. We are now also undertaking an HMR for every in-hospital death where notified that a Coroner's Investigation or Inquest is

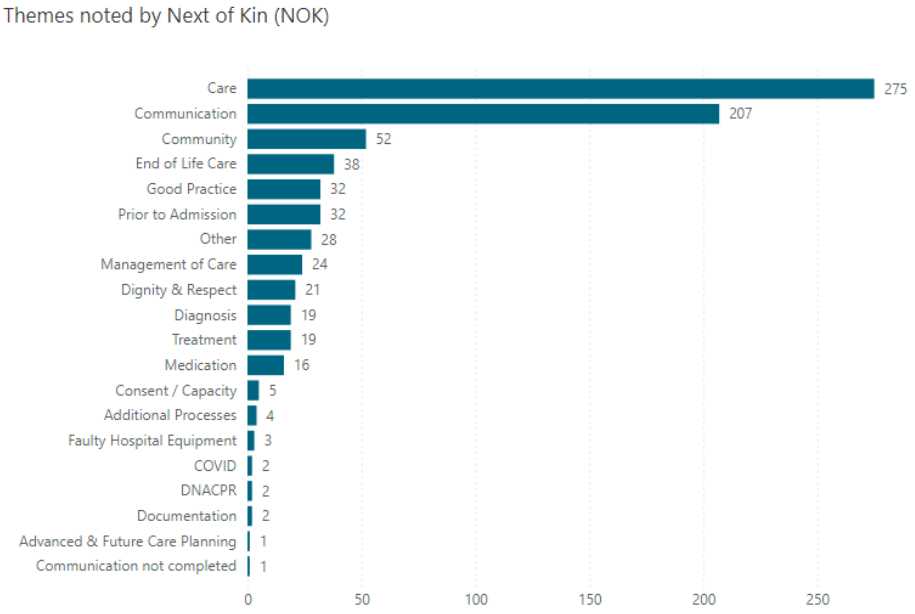
taking place. October 2025 has also seen a significant spike in Hospital Acquired Covid cases, that will further increase the current backlog (currently 74 cases).

1.6 Stage 3 Mortality Review panel continues to be held on a monthly basis via Teams. There are currently 4 cases either waiting to be reviewed or in progress.

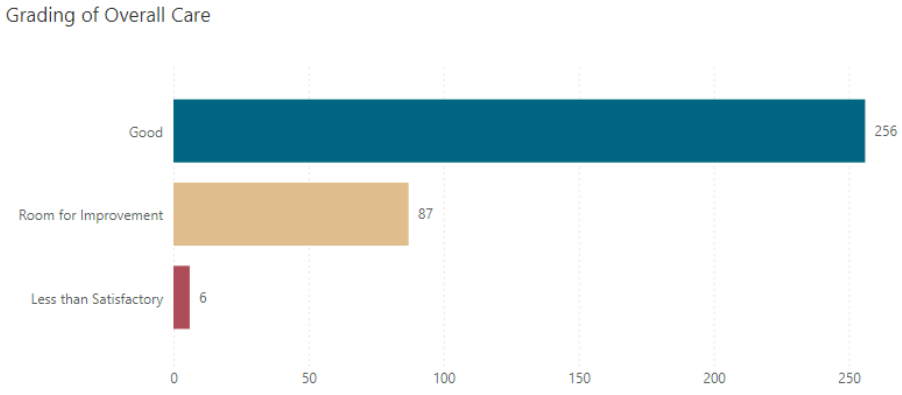
1.7 Each review with the medical examiner or at level 2 or 3 provides an opportunity to gather and share learning. A Themes database separate to the Datix Mortality Review Module has been created to capture this and feed into the Mortality Review (MR) Dashboard that is currently in development stage. This has given us the opportunity to differentiate between themes from issues noted by the Medical Examiner themselves or the family/next of kin during discussions with the Medical Examiners Service.

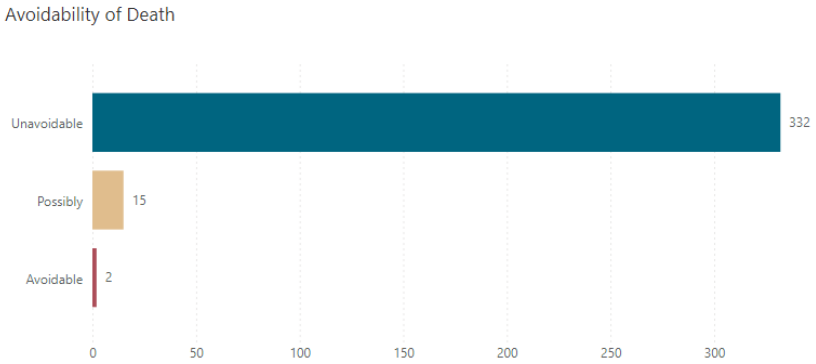
The following charts have been taken from the MR Dashboard. It is important to note the dashboard is still at an early development stage and the data is yet to be fully tested. Due to IT issues we are currently unable to add data for deaths in A&E and Primary care. This is being investigated.



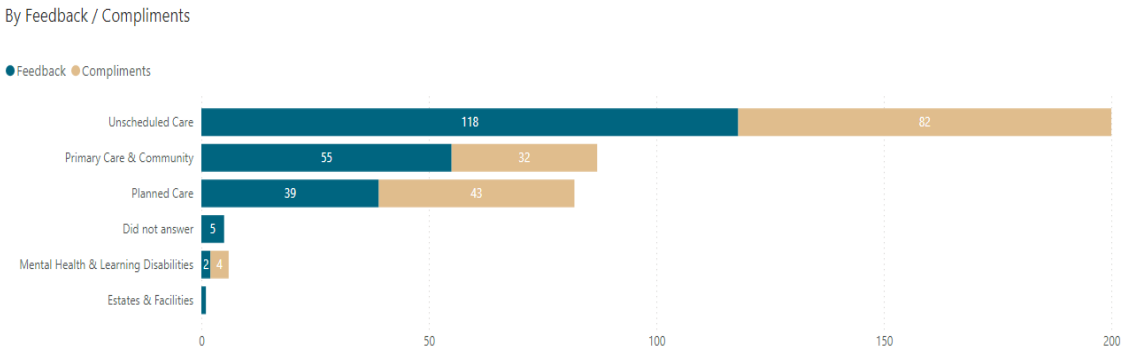


1.8 Current CTMUHB Mortality data shows that there is room for improvement in care in around 26% of deaths.





1.9 CIVICA form has been developed 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 gives 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. Data has been captured in this system since August 2024.



Mortality Board

1.10 An oversight Mortality Board has been established that oversees and receives assurance that processes are in place to learn from all deaths.

Membership includes, Medical Director, Deputy Medical Directors, Primary Care Medical Director, Clinical Lead for Mortality, Assistant Director of Nursing and Peoples Experience, Mortality Review Manager, Senior MR/Quality Informatics Facilitator, Bereavement Clinical Lead, Mortuary/Bereavement Manager, Head of Peoples Experience, Operations Lead, AHP Representative and Medical Examiners Service Representative.

The Board meets quarterly, and oversees;

1) Data & Dashboard
2) Medical Review Process
3) Learning from Mortality
4) Patient / Family Experience
5) Medical Examiner link

Initial actions required with timescales:

- Standard Operating Procedure (SOP) for Screening Process – Awaiting formal approval
- Governance meeting template for Specialties completed
- Approval of Mortality Review Dashboard – awaiting IT sign off

Ongoing Development

1.11 Whole Mortality Data - Work continues to develop a Mortality Database to collate all information related to Mortality across the Health Board. This is currently in development in partnership with colleagues in Cardiff & Vale and developers from AMaT (Audit Management and Tracking). Current plans are for this to function alongside the existing Datix Mortality module

1.12 Use of an external company to provide peer matched data to compare trends and causes of death on different sites and specialties. This will help to identify outliers and target in-depth analysis of cases and themes. The care groups will take ownership of this analysis and will report to the mortality board.

1.13 QR codes for notifying deaths to both the coroner and the medical examiner service have just been introduced. These aim to reduce the time taken to notify and therefore, reduce waiting time for families.

Baseline Population Numbers

1.14 The population CTM health board 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

1.15 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.

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

Deaths per region 2024(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Bridgend	169	142	164	158	147	117	138	143	117	147	132	
RCT	294	257	227	248	240	202	250	216	179	264	210	
MCT	53	65	67	67	65	70	62	67	54	52	59	

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	41	1.3
June	2710	36	1.3
July	2649	78	2.9
August	3043	102	3.4
September	2360	38	1.6
October	2679	56	2.1
November	3292	67	2.0

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

2.2 **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.

3. Key Risks / Matters for Escalation

3.1 Limited clinical reviewers with appropriate MR experience available in each Care Group remains challenging, and the biggest risk to the non-completion of the MR process.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	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 *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: 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.
6.3 Continued development of CTMUHB Mortality Dashboard and use of the data from the external company
6.4 Monitoring of the use of the QR codes for notification to reduce delays for families
6.5 Continued development of Whole Mortality Database

Agenda Item
7.3

Quality, Safety & Experience Committee

Highlight Report from the Harm Free Care Agenda

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Care
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Care

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Improving Care Board (materials have informed the report)	October 2025	Noted

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

1. Introduction

1.1 This report provides an update on the three Harm Free Care workstreams: Inpatient Falls Reduction, Nutrition & Hydration, and Pressure Damage, based solely on the October 2025 steering materials and presentations. It includes Key Performance Indicator (KPI) progress, audit findings, risks, and next steps, following the standard highlight format used in May 2025.

2. Purpose of this Meeting

2.1 To note progress, consider key risks, and endorse next steps for the Harm Free Care programme, ensuring continued focus on prevention, standardisation, and learning.

3. Highlight Report

Alert / Escalate	**Inpatient Falls Reduction Rate:** • Collaborative wards recorded 8.68 falls per 1,000 occupied bed days (reference point: UK median 6.6). A spike in August 2025 is highlighted for targeted review. • **Operational pressures:** Variability in enhanced supervision is contributing to increased use of temporary staff for 1:1. • **Equipment:** A review of lifting equipment is underway, with some incident reviews citing equipment or lack of equipment as a contributing factor. • **Data flow:** Ongoing reliance on manual Datix extraction continues to limit the timeliness of reporting and local learning. **Nutrition & Hydration** • **Fluid balance audit:** 35.7% of wards (15/42) met the 85% 12-month compliance target; 50% (21/42) achieved >71%. Two wards reached 100% in July 2025. • **Data completeness:** Near misses are not consistently reported, constraining trend analysis and learning at scale. **Pressure Damage** • **ED audit (3–5 June 2025):** a) **Risk assessment**: 52% completed within 6 hours of admission. b) **Skin assessment:** 42% documented within 6 hours (58% not completed within the timeframe). c) **Reassessment:** 89% of at-risk patients reassessed within 24 hours.

	d) **Equipment:** 4 patients at elevated risk lacked appropriate mattresses/seating; 85% of seated patients had suitable pressure-redistributing chairs. e) **Planning & categorisation:** 86% of pressure ulcers had no documented care plan at assessment; discrepancies in categorisation noted between ED staff and TVN review, training need identified. • **Slide sheets:** Procurement inconsistency and availability remain issues; a cost-comparative SBAR has been conducted to support standardisation.
Advise	**Inpatient Falls Reduction** • **Education & tools:** a) Falls workshops held September and October (community strategies and data). b) Lying & standing BP audit undertaken; training sessions implemented. c) Delirium checklists piloted across selected wards. d) Patient/carer information leaflet produced (awaiting final approval; digital and print). e) Policy & SOP drafted for Learning & Assurance Panels. • **Governance:** Community falls prevention workstream aligned to the Health Board falls steering group to avoid duplication and maintain oversight. **Nutrition & Hydration** • **Practice support:** a) Standardised 'How to' fluid balance poster distributed to acute wards. b) Patient Deterioration study days include Fluid Balance workshops (188 staff attended up to July 2025). c) All-Wales ESR Fluid Balance modules have been updated and are live since September 2024. • **Forthcoming assurance:** Annual nutritional risk screening audits scheduled for October (Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda). • **Systems:** Catering model bed plan piloted and implemented at PCH to ensure individualised nutrition plans are captured electronically.

	Pressure Damage • **Education & guidance:** a) E-learning (risks with medical beds/transfer trolleys) live on ESR. b) Education package developed for HCSWs and registrants. c) Standard Operating Policy and checklists for PU & Falls Assurance Panels finalised for Health Board implementation. • **Data & audit:** a) Dashboard testing underway to triangulate pressure ulcer data. b) Prevalence audit across Emergency Units (June 2025) completed; feedback and actions disseminated.
Assure	**Inpatient Falls Reduction** • **Strategic oversight:** Established through the Harm Free Board and steering group, with participation of >25 wards in the collaborative. • **Measurement**: DATIX for incident rates; AMaT audits for process adherence; training compliance monitored via ESR. **Nutrition & Hydration** • Policy and SOPs (Mouth Care; Eating & Drinking; Adult Acute Dysphagia Referrals) agreed. • Electronic capture of individualised plans at PCH in place. • Learning & Assurance Panel to give consistent oversight of incidents and themes. **Pressure Damage** • **Panel standardisation**: Development of SOPs and Terms of Reference agreed across primary and secondary care to promote consistent learning and accountability. • **KPI governance:** Task & Finish groups established; dashboard in test; prevalence audit results informing standardisation in ED documentation/practice.

Inform	**Pressure Ulcer Steering Group – KPIs (status from Oct 2025 materials)**

Key Performance Indicator	Update
KPI-1: HAPU rate per 1,000 bed days	HAPU rate per 1,000 bed days – measurement baseline reset; Task & Finish completed to ensure consistency of denominators.
KPI-2: Monthly reporting of all grades to WG	Dashboard testing to triangulate data in progress.
KPI-3: 60-day investigation/review compliance	SOP developed by the Task & Finish group.
KPI-4: Timely access to pressure-reducing equipment	Scoping completed; slide sheet SBAR completed (single-use vs washable).
KPI-5: Enhanced support where rates increase	PU & Falls collaborative in place supporting 16 wards.
KPI-6: Prevalence audits	June 2025 ED audit completed; feedback given; actions initiated to standardise documentation.
KPI-7: Prevention bundle compliance (risk assessment within 6h, skin assessment within 24h, individualised care plan, nutrition assessment)	Scoping of datasets underway; aligns with dashboard development.
KPI-8: Screening tools awareness/compliance (MUST, WAASP, paediatrics tool pending)	ICTM reviewed core audits; frequency moved to bi-monthly to release time to care while retaining assurance.
KPI-9: Staff education	Scoping underway to consolidate training pathways into a single accessible place.

	KPI-10: Patient/carer involvement	RCN Improvement funding secured for information resources (digital/QR/printed). Work is underway to align patient narrative (patient stories, PTR) to the assurance process.

Falls – Monitoring arrangements (per Oct 2025 presentation)

- **Key metrics:**
  a) Falls rate per 1,000 bed days (target: reduce variation; reference UK median 6.6).
  b) Process adherence to prevention (>95% target via AMaT).
  c) Training compliance >95% via ESR.
- **Insights:** Initial harm severity for falls is frequently downgraded after the manager's review; a clear outlier was noted in August 2025, requiring local learning.

Hydration & Nutrition – Audit and implementation

- **Fluid balance performance:** See figures under *Alert/Escalate*.
- **Learning assets:** Posters, training videos (thickened fluids), study days, and updated ESR modules.
- **Governance**: Proposal to introduce Learning & Assurance Panel for N&H incidents to strengthen oversight.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
	Aging Well
	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))*	Leadership
	Data to knowledge Learning, improvement and research Whole-systems perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	Efficient Equitable Person-centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a report on the work being undertaken within the Harm Free Care Agenda. No current recommended service change exists.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a report on the work being undertaken within the Harm Free Care Agenda. No current recommended service change exists.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

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

5. Recommendation

5.1 The Committee is asked to note:

5.1.1 Progress across Falls, Nutrition & Hydration, and Pressure Ulcers, including completed Task & Finish work, SOPs for Panels, and education developments.

5.1.2 Risks and gaps:

5.1.2.1 Falls rate variation (August 2025 outlier); supervision and equipment pressures.

5.1.2.2 N&H data completeness for near misses; variable fluid balance compliance.

5.1.2.3 PU assessment, care planning, and equipment gaps evidenced in the June 2025 ED audit.

5.2 **Standardisation actions underway:** dashboard testing; panel SOPs and ToR across sectors; consolidation of training pathways; adoption of electronic care planning where implemented.

5.3 The Committee is further asked to support:

5.3.1 Continued oversight of Falls, PU and N&H priorities through the Harm Free Board and steering groups, including national and local audit cycles.

5.3.2 The education and training matrix for clinical staff (falls, PU prevention, hydration & nutrition).

5.3.3 Formalising ward champion roles and embedding them in Panels and QI projects.

5.3.4 Operational standardisation for slide sheets and pressure-reducing equipment, guided by the SBAR.

5.3.5 Implementation of ED audit recommendations (accurate weighing on admission; timely risk/skin assessment; individualised repositioning and equipment provision; documentation and categorisation training).

6. Next Steps (from the October materials)

6.1 **Falls:** Continue the improvement collaborative; maintain community–acute alignment; finalise and publish the patient/carer leaflet.

6.2 **Pressure Ulcers**: Progress dashboard to live use; roll out Panel SOPs & checklists; deliver the education package; standardise ED documentation following the June 2025 audit.

6.3 **Nutrition & Hydration:** Deliver scheduled nutritional risk screening audits; embed fluid balance training and poster use; agree Learning & Assurance Panel arrangements to improve incident oversight.

Agenda Item
7.4

Quality, Safety & Experience Committee

Annual presentation of Nurse Staffing Levels

Dyddiad y Cyfarfod / Date of Meeting	18th November 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tanya Tye, Senior Nurse Professional practice & Nurse Staffing lead
Cyflwynydd yr Adroddiad / Report Presenter	Becky Gammon, Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Experience.

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Internal- Planned Care including Executive Nurse Director, Nurse Director and Senior/ Lead Nurses	8/04/2025 & 4/09/2025	Agreed Establishments
Internal- Paediatrics and Neonates- including Executive Nurse Director, Nurse Director and Senior/ Lead Nurses	9/04/2025 & 2/09/2025	Agreed Establishments
Internal- Unscheduled care including Executive Nurse	10/04/2025/ & 2/09/2025	Agreed Establishments

Director, Nurse Director and Senior/ Lead Nurses		
External- All Wales Nurse Staffing Group	07/04/2025 12/05/2025 02/06/2025 07/07/2025 04/08/2025 01/09/2025	All Wales meeting regarding implementation, governance and reporting in relation to the Nurse Staffing Levels (Wales) Act 2016

Acronyms / Glossary of Terms	
25a Wards	All wards providing nursing care including inpatient, community and specialist wards.
25b Wards	Adult acute medical and surgical inpatient wards and paediatric inpatient wards.

1. Situation /Background

The Nurse Staffing Levels (Wales) Act 2016, hereafter referred to as *the Act*, became law on 21 March 2016. The legislation initially applied to all adult acute medical and surgical inpatient wards and came into force in April 2018. An extension of the Act to include paediatric inpatient wards was enacted on 1 October 2021.

Statutory Guidance under the Nurse Staffing Levels (Wales) Act 2016 requires the designated individual—namely, the Executive Director of Nursing—to formally present to the Board the nurse staffing requirements for adult acute medical, surgical, and paediatric inpatient wards.
The Act places a duty on health service bodies to ensure appropriate nurse staffing levels are maintained, enabling nurses to deliver care with sensitivity and compassion.

Under Section 25A, Health Boards are required to have robust workforce plans, recruitment strategies, organisational structures, and operational processes in place to support safe and effective nurse staffing across their services.

Section 25B specifies the inpatient wards where there is a statutory duty to calculate nurse staffing levels using a prescribed methodology. This methodology is well established across the Health Board and is supported by a clear governance framework. Wards falling under Section 25B must conduct a biannual acuity audit, led by ward managers and senior nursing staff. The resulting data is triangulated with professional judgement, patient demographics, staffing levels, and a range of pre-defined patient outcomes considered to be nurse-sensitive indicators—such as incidences of patient falls or hospital-acquired skin damage.

This report provides an overview of compliance with Section 25B of the Nurse Staffing Levels (Wales) Act 2016 and outlines any changes or amendments to ward areas and specialities during the period from 1 October 2023 to 30 September 2024.

2. Specific Matters for Consideration

Statutory Guidance under the Nurse Staffing Levels (Wales) Act 2016 requires the designated individual, the Executive Director of Nursing, to formally present to the Board the nurse staffing requirements for adult acute medical, surgical, and paediatric inpatient wards.
The Act places a duty on health service bodies to ensure appropriate nurse staffing levels are maintained, enabling nurses to deliver care with sensitivity and compassion. Under Section 25A, Health Boards are required

to have robust workforce plans, recruitment strategies, organisational structures, and operational processes in place to support safe and effective nurse staffing across their services.

Section 25B specifies the inpatient wards where there is a statutory duty to calculate nurse staffing levels using a prescribed methodology. This methodology is well established across the Health Board and is supported by a clear governance framework. Wards falling under Section 25B must conduct a biannual acuity audit, led by ward managers and senior nursing staff. The resulting data is triangulated with professional judgement, patient demographics, staffing levels, and a range of pre-defined patient outcomes considered to be nurse-sensitive indicators, such as incidences of patient falls or hospital-acquired skin damage.
This report provides an overview of compliance with Section 25B of the Nurse Staffing Levels (Wales) Act 2016, and outlines any changes or amendments to ward areas and specialities during the period from 1 October 2023 to 30 September 2024.

Adult and Paediatric inpatient wards where Section 25B applies.

The table below illustrates the number of wards at the beginning and end of the reporting period from 1st October 2024 to 30th September 2025. There was a total of 35 Section 25B wards across the Health Board at the time of the June 2025 (illustrated as September 2025 in the table below) bi-annual acuity audit.

	Oct 2024	Sept 2025
Number of Acute Medical inpatient Wards	17	16
Number of Acute Surgical inpatient Wards	16	13
Number of Paediatric inpatient wards	3	3

It is noted that during the reporting period, one ward was repurposed as a surgical ward. The staffing establishments for these wards are detailed in Appendix A.

3. Key Risks / Matters for Escalation

Each of the Care Group Nurse Directors, together with finance and workforce colleagues, participated in discussions regarding the staffing establishment templates and any proposed workforce changes identified following the June 2025 acuity audit.

In addition to informing workforce calculations, the acuity audits supported the Care Group Nurse Directors in their decision-making processes. They reviewed nurse-sensitive quality indicators, such as patient falls, pressure ulcers, medication errors, and nursing-related concerns—and applied professional judgement when considering amendments to the funded establishment.

4. Financial impact

Breakdown of staffing costs (proposed Uplifts/ decreases following June 2024 acuity audit)		
Site and Ward	**Additional requirements**	**Financial cost**
PoWH ward 6	Increase of beds from 22 to 24 Uplift 1 HCSW day and night	£218,095
PoWH ward 7	Increase of beds from 15 to 28 Uplift 1 RN day and night Uplift 1 HCSW day and night	Surgical plan being worked through, no costs provided at present
RGH ward 3	Increase RN day and night	£314,000
RGH ward 10	Decrease 1 RN & HCSW by day and night	Surgical plan being worked through, no costs provided at present
RGH ward 15	Uplift 1 HCSW day and night	£218,095

5.

Following the declaration of a critical incident at Princess of Wales Hospital in October 2024, ten wards were relocated across the Health Board. This necessitated further reviews prior to the next biannual acuity audit.
In accordance with the requirements of the Nurse Staffing Levels (Wales) Act, any changes to ward clinical models, reconfigurations, and staffing requirements were reflected in the designated staffing level templates. These templates were approved by the respective Care Group Nurse Directors and, following their endorsement, formally authorised by the Executive Nurse Director.

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

Link to CTMUHB Strategic Areas	
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))*	Data to Knowledge
	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: No impact on patients as this looks at staffing
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 impact as this looks at staffing levels.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Adherence to the Nurse Staffing Levels Wales Act 2016	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)
	Any increases to current agreed ward establishments will have a financial implication. These will be reported and discussed at the operational board in partnership with Executive Director of Nursing, People and Finance.

7. Recommendations

- Receive the report as **assurance** that the statutory requirements relating to Section 25B wards have been undertaken.
- **Note** the changes to the funded establishments to ensure the Health Board remains fully compliant with the Nurse Staffing Levels (Wales) Act.

8. Next Steps

- To continue to audit compliance with the SafeCare Module across 25B wards in the Health Board.
- To continue to support the clinical teams in using SafeCare to its full potential to capture professional judgement and red flags alongside acuity and dependency.
- Review and analyse data to support reviews and potential changes to the establishment and skills mix.
- Continue to progress the implementation and use of SafeCare across community hospitals, mental health services, and palliative care settings.
- Continue to review and report on compliance status, in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016.

Annual Presentation of Nurse Staffing Levels to the Board

Health Board	Cwm Taf Morgannwg University Health Board (CTMUHB)
Date of annual presentation of Nurse Staffing Levels to Board	November 2025
Period Covered	This report covers the changes that have been made to nurse staffing levels for wards covered by Section 25B of the Nurse Staffing Levels (Wales) Act 2016 between 1st October 2024 to 30th September 2025.
Number and identity of section 25B wards during the reporting period. • **Adult acute <u>medical</u> inpatient wards (inclusive of Oncology & Haematology inpatient wards)** • **Adult acute <u>surgical</u> inpatient wards (inclusive of Womens Gynaecological inpatient wards)** • **<u>Paediatric</u> inpatient wards**	Appendix 1 of this report lists the nurse staffing levels for all wards that have been included under Section 25B of the Nursing Staffing Level (Wales) 2016 Act (hereafter referred to in this document as the 2016 Act), during the period 1st October 2024 to 30th September 2025.

	Adult acute <u>medical</u> inpatient wards	**Adult acute <u>surgical</u> inpatient wards**	**Paediatric inpatient wards**
01/10/24	17	16	3
30/09/25	15	13	3

During the reporting period October 2024- September 2025, a critical incident was declared in Princess of Wales Hospital (PoWH) resulting in the relocation of several wards. A significant number of these were designated under Section 25B of the Nurse staffing Levels (Wales) Act 2016 and were subsequently moved both within PoWH and across Cwm Taf Morgannwg University Health Board (CTMUHB) footprint.

The following is a summary of the affected wards and their movements:

Princess of Wales Hospital (PoWH)

- **Ward 5**: Relocated to Royal Glamorgan Hospital (RGH) Ward 19; (subsequently closed October 2024)
- **Ward 6**: Relocated to Ward 16 (subsequently closed October 2024)
- **Ward 7**: Relocated to RGH Ward 7 (subsequently closed October 2024)
- **Ward 8**: Relocated to Ward 19 (subsequently closed October 2024)
- **Ward 9**: Relocated to RGH Ward 11 (subsequently closed this ward changed speciality to Day surgery in October 2024; now designated as a section 25A ward)
- **Ward 10**: Relocated to Ward 18 (subsequently closed October 2024)
- **Ward 11**: Relocated to RGH Ward 18(subsequently closed October 2024)
- **Ward 16**: Relocated to Ward 21 (October 2024)
- **Ward 18**: Relocated to RGH Ward 2 October 2024
- **Ward 19**: Relocated to Ysbyty George Thomas (YGT) Dinas Ward in October 2024 now designated as a Section 25A ward.

Royal Glamorgan Hospital (RGH)

- **Ward 2**: Relocated to Ward 9 in September 2024 and became a Surgical Assessment Unit (SAU) therefore now a Section 25A area.
- **Ward 9**: Relocated to Ward 7 September 2024- 5 Post Anaesthetic Care unit (PACU) 5 head and neck beds & 9 ward beds.
- **Ward 15**: Relocated to Ward 1 in January 2025
- **Ward 19**: Relocated to Ward 3 December 2024
- **Ward 20**: Relocated to YGT Fernhill Ward in October 2024; now designated as a Section 25A ward.

Prince Charles Hospital (PCH)

- **Ward 10**: Relocated to RGH Ward 19 in January 2025
- **Ward 3**: Relocated to Ward 10 in May 2025; specialty changed to Frailty, now under Section 25A of the Act.

The final ward locations are detailed in Appendix 1 of this report. During the critical incident, staff were temporarily redeployed from wards that had reduced bed numbers and were used to support areas with staff vacancies. As the wards transitioned back to their final locations, staff were moved back to their original clinical areas.

Princess of Wales Hospital (PoWH)

- Ward 18 Closed in August 2025 (22 beds) – ward moved back to ward 8 (28 beds) as a Surgical Trauma and Rehabilitation (STaR) ward therefore section 25A.
- Ward 19 Closed August 2025
- Ward 20 Closed August 2025

Royal Glamorgan Hospital (RGH)

- Ward 1 Closed 31st August 2025 (22 beds)

Prince Charles Hospital (PCH)

- Ward 3 Closed 9th May 2025 (24 beds).

	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**

Required establishment (WTE) calculated (October 2024)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	363.75	289.59	327.97	247.21	97.62	19.1
WTE of required establishment funded (October 2024)	363.75	289.59	327.97	247.21	97.62	19.1
Staffing requirements following Spring Cycle (May 2025)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (May 2025)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	334.86	237.94	198.91	189.29	97.62	19.1
WTE of required establishment funded (May 2025)	334.86	237.94	198.91	189.29	97.62	19.1
Staffing requirements at end of reporting period (September 2025)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (September 2025)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	269.28	218.52	238.16	210.18	97.62	19.1
WTE of required establishment funded (September 2025)	269.28	218.52	238.16	210.18	97.62	19.1
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	15 (NB: decrease in number of wards as they have been realigned to section 25A of the Act due to change of speciality)		13 (NB: decrease in number of wards as they have been realigned to section 25A of the Act due to change of speciality)		3	
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards.	The triangulated methodology outlined in Section 25C of the 2016 Act sets out the principles for calculating nurse staffing levels. It requires that, as a minimum, for each ward within Section 25B of the Act. staffing calculations reviews are undertaken every six months. The Nurse staffing lead for the HB on behalf of the designated person, facilitates the nurse staffing levels process to ensure templates are created, populated and ready for review in the sign off meetings with the designated person. For June 2025 bi-annual acuity audit reporting for each inpatient ward under Section 25B, the data was captured across multiple systems, collated, and analysed to assess compliance with the nurse staffing recommendations. The areas below are discussed in collaboration with the Ward Sister, Senior Nurse, Lead Nurse responsible for the wards along with Heads of Nursing from each acute hospital and approved by the Care Group Nurse Directors. • Current bed numbers and specialities, including any proposed service changes. • Patient acuity data for June 2025, captured using the SafeCare system. • Care quality indicator data from the previous six months (including falls, medication errors, pressure damage, and serious incidents and concerns). • Workforce metrics, including mandatory training compliance, vacancy rates, recruitment activity and sickness absence. • Clinical dashboards from the Datix system capturing care quality metrics and Power BI applications providing patient acuity and flow data. • Assurance that all workforce models are compliant with the required 26.9% uplift and include a supernumerary Band 7 Ward Sister/Charge nurse, as mandated in the Nurse Staffing Levels Act. • Planning templates ratified by the Ward Sister/Charge Nurse, Senior Nurses, Heads of Nursing, and Care Group Directors of Nursing. Final templates are endorsed by the Executive Director of Nursing during a sign-off meeting with the Care Group Nurse Director, Head of nursing and Nurse staffing Lead. The planned rosters in Appendix 1 are those agreed by the designated lead following the June 2025 acuity audit.					
Finance and workforce implications.	Following June 2025 acuity audit, when compared to the planned rosters/required establishments agreed during the January 2025 acuity audit, it was noted that there were no changes to the planned roster or required establishment for 27 adult medical/surgical inpatient wards and three paediatric wards. The remaining 4 wards relocated (table below), audit identified the following financial and workforce uplift requirements. The table below summarises the financial implications based on the proposed staffing changes. This includes the uplift required to deliver the roster, as well non-rostered staff who support the delivery of care (e.g. Supervisory Ward Manager, Frailty/Rehabilitation Support Workers, Ward Clerks).					

Breakdown of staffing costs (Uplifts/ decreases)		
Site and Ward	**Additional requirements**	**Financial cost**
PoWH ward 6	Increase of beds from 22 to 24 Uplift 1 HCSW day and night	£218,095
PoWH ward 7	Increase of beds from 15 to 28 Uplift 1 RN Day and night Uplift 1 HCSW day and night	Surgical plan being worked through, no costs provided at present
RGH ward 3	Increase RN Day and night	£314,000
RGH ward 10	Decrease 1 RN & HCSW by day and night	Surgical plan being worked through, no costs provided at present
RGH ward 15	Uplift 1 HCSW day and night	£218,095

The changes to nursing establishments result from a combination of benchmarking against other wards across CTM UHB and an increase in bed capacity/ changes to the function of the ward within clinical areas. The establishment

	changes were reviewed with finance colleagues which determined that some of the associated funding will present as cost pressures. Ongoing discussions are taking place regarding the transformation and realignment of services to address how budgets can be aligned and maintained. Due to seasonal variations in patient acuity, the paediatric wards adjust their staffing levels to meet changing demands throughout the year. This dynamic approach to staffing management ensures there is no impact on overall staffing requirements or associated cost implications, as all adjustments are planned, calculated, and funded within existing establishment budgets.
Conclusion & Recommendations	

	The Nurse Staffing Levels (Wales) Act 2016 bi-annual acuity audit, conducted in June 2025, has enabled the Planned, Unscheduled, and Children and Young Persons Care Groups to review patient acuity and activity over the preceding six months and plan their workforce accordingly. The Nurse Directors have greater ownership and accountability for the services and provision within their respective delivery areas. Following the June 2025 audit, changes to nursing establishments were identified, implemented, and approved by the Care Group Nurse Directors, and subsequently ratified by the Executive Director of Nursing.
	
	The Board is asked to.
	
	• Receive the report as assurance that the statutory requirements relating to Section 25B wards have been met.
	• Note the changes to the funded establishments, ensuring that the Health Board remains fully compliant with the Nurse Staffing Levels (Wales) Act 2016.
	• The work programme for CTMUHB inpatient wards under section 25B of the 2016 Act for 2025/6 will include:
	  ○ Continuation of audit compliance with the SafeCare Module across 25B wards in the Health Board.
	  ○ Continued support for clinical teams in using SafeCare to its full potential- to capture professional judgement and red flags alongside acuity and dependency.
	  ○ Interrogate and analyse data to support reviews and potential changes to the establishment and skills mix.
	  ○ Sustaining progress in the rollout and use of SafeCare across community hospitals, mental health services, and palliative care settings.
	  ○ Continuing to review and report compliance in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016.

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	CTMUHB
Period of the report	1st October 2024- 30th September 2025
Adult Acute Medical inpatient wards	Start - End

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

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

Adult Acute Medical inpatient wards

		Reported to the Board in November 2023						Calculated during spring 2024 cycle								Calculated during autumn 2024 cycle								Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2024)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2024) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**New location**	**Name of Ward**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2023 cycle**		**Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**New location**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2023 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)					**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)					**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)										
PCH	2	E	4	3						E	4	3						E	4	3									
		L	4	3	19,9	14,21	1	No change	2	L	4	3	19,9	14,21	1	No change		L	4	3	19,9	14,21	1	No change	Y	N					
		N	3	2						N	3	2						N	3	2									
PCH	3	E	4	3						E	4	3						E	4	3									
		L	4	3	19,9	14,21	1	Ward moved to ward 10 then ward closed	10	L	4	3	19,9	14,21	1	No change		L	4	3	19,9	14,21	1		Y	N					
		N	3	2						N	3	2						N	3	2									
PCH	9	E	4	3						E	4	3						E	4	3									
		L	4	3	19,9	14,21	1	No change	9	L	4	3	19,9	14,21	1		No change	L	4	3	19,9	14,21	1	No change	Y	N					
		N	3	2						N	3	2						N	3	2									
PCH	10	E	4	4						E	4	4						E	4	4									
		L	4	4	19,9	19.9*	1	Moved to RGH 19	RGH ward 19	L	4	4	19,9	19.9*	1		No change	L	4	4	19,9	19.9*	1		Y	N	*HCSW includes a 2.84 Band 3 OT tech				Move of services to RGH to centralise
		N	3	3						N	3	3						N	3	3									
PCH	11	E	4	3		14,21	1			E	4	3		14,21	1			E	4	3		14,21	1							
		L	4	3	19,9			No change	11	L	4	3	19,9				No change	L	4	3	19,9				Y	N					
		N	3	2						N	3	2						N	3	2									
PCH	12	E	5	3						E	5	3						E	5	3									
		L	5	3	23,74	17,06	1	No change	12	L	5	3	23,74	17,06	1		No change	L	5	3	23,74	17,06	1		Y	N					
		N	3	3						N	3	3						N	3	3									
RGH	5	E	4	4						E	4	4						E	4	4									
		L	4	4	19,9	19,9	1	No Change	5	L	4	4	19,9	19,9	1		No change	L	4	4	19,9	19,9	1		Y	N					
		N	3	3						N	3	3						N	3	3									
RGH	12	E	4	4						E	4	4						E	4	4									
		L	4	4	19,9	19,9	1	No Change	12	L	4	4	19,9	19,9	1		No change	L	4	4	19,9	19,9	1		Y	N					
		N	3	3						N	3	3						N	3	3									
RGH	14	E	4	4						E	4	4						E	4	4									
		L	4	4	19,9	19,9	1	No Change	14	L	4	4	19,9	19,9	1		No change	L	4	4	19,9	19,9	1		Y	N					
		N	3	3						N	3	3						N	3	3									
RGH	19	E	4	4						E	4	4						E	4	4									
		L	4	4	19,9	19,9	1	Moved to ward 3	3	L	4	4	19,9	19,9	1		No change	L	4	4	19,9	19,9	1		Y	N					Ward location move to accommodate stroke services
		N	3	3						N	3	3						N	3	3									
RGH	20	E	3	4						E								E												
		L	3	4	18,06	19,9	1	Moved to YGT Dinas ward Became section		L								L							Y	Y	War moved to YGT dinas ward now section 25A area				
		N	3	3						N								N												
PoWH	4	E	6	4						E	6	4						E	6	4									
		L	6	4	33,69	13,62	1		4	L	6	4	33,69	13,62	1			L	6	4	33,69	13,62	1		Y	Y	Ward now has an 8 bedded CCU area- staffing not changed at present				
		N	6	1				No change		N	6	1					No change	N	6	1									
PoWH	5	E	4	4						E	4	4						E	4	4									
		L	4	4	19,07	19..07	1	Moved to RGH ward 20 then closed	RGH ward 20	L	4	4	19,07	19..07	1			L	4	4	19,07	19..07	1		Y	N					Move of services to RGH due to critical incident and to centralise
		N	3	3						N	3	3					No change	N	3	3									
PoWH	6	E	4	3						E	4	3						E	4	3									
		L	4	3	19,07	13,62	1	Moved to ward 16 then closed	Ward 16	L	4	3	19,07	13,62	1		Ward 9	L	4	3	19,07	13,62	1		Y	N	Ward location change only				Ward location move only due to critical incident
		N	3	2						N	3	2						N	3	2									
PoWH	10	E	5	5						E	5	5						E	5	5									
		L	4	5	23,79	24,52	1	Moved to ward 18	Ward 18	L	4	5	23,79	24,52	1		Moved to ward 10	L	4	5	23,79	24,52	1		Y	N					Ward location move only due to critical incident
		N	4	4						N	4	4						N	4	4									
PoWH	18	E	3	5						E	3	5						E	3	5									
		L	3	5	13,62	24,52	1	Moved to RGH ward 2	Ward 2 RGH	L	3	5	13,62	24,52	1		PoW ward 5	L	3	5	13,62	24,52	1		Y	N					Ward location move only due to critical incident
		N	2	4						N	2	4						N	2	4									
PoWH	20	E	4	3						E	4	3						E	4	3									
		L	4	3	19,07	16,34	1		Ward 20	L	4	3	19,07	16,34	1		Pow Ward 6	L	4	3	19,07	16,34	1		Y	N					
		N	3	3				No change		N	3	3						N	3	3									

Following wards closed October

Appendix 1: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	CTMUHB
Period of the report	1st October 2024- 30th September 2025
Adult Acute Surgical Inpatient Wards	Start - End

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties

Adult Acute Surgical Inpatient Wards

		Reported to the Board in November 2024							Calculated during spring 2025 cycle								Calculated during autumn 2025 cycle								Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2024)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2024) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**New location**	**Name of Ward**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2025 cycle**		**Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**New location**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2025 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**ChANged**	**Date**	**Rationale**
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)					**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)					**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)									
PCH	5	E	4	4				No Change	5	E	4	4					No Change	E	4	4						N	Ward has a GAU/ Waiting room increase HCSW1x day and night for increased activity	N	N		
		L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1							
		N	3	3						N	3	3						N	3	3										
PCH	6	E	4	4				No Change	6	E	4	4					No Change	E	4	4					Y	N	Ward has SAU/ Waiting room increase HCSW 1 x day and night for increased activity	N	N		
		L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1							
		N	3	3						N	3	3						N	3	3										
PCH	7	E	4	3				No Change	7	E	4	3					No Change	E	4	3					Y	N		N	N		
		L	4	3	19,9	14,21	1			L	4	3	19,9	14,21	1			L	4	3	19,9	14,21	1							
		N	3	2						N	3	2						N	3	2										
PCH	8	E	4	4				No Change	8	E	4	4					No Change	E	4	4					Y	N		N	N		
		L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1							
		N	3	3						N	3	3						N	3	3										
RGH	2	E	4	3				Moved to ward 9 on	RGH 9	E	4	3					No change	E	4	3					Y	Y	Now an SAU ward section 25A	N			Now an SAU ward section 25A
		L	4	3	19,9	14,21	1			L	4	3	19,9	14,21	1			L	4	3	19,9	14,21	1							
		N	3	2						N	3	2						N	3	2										
RGH	3	E	4	4				Moved to ward 16 16/10/2024	RGH 16	E	4	4					No change	E	4	4					Y	Y		Y	n		Ward location move only due to critical incident
		L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	19							
		N	3	3						N	3	3						N	3	3										
RGH	8	E	4	4				No change	RGH 8	E	4	4					No change	E	4	4					Y	N		N	N		
		L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1							
		N	3	3						N	3	3						N	3	3										
RGH	9	E	3	3				Moved to ward 7	RGH 7	E	3	3					No change	E	6	2					Y	Y	Change of speciality and acuity of patients to more RN dependant	Y	N		Ward location move only due to critical incident
		L	3	3	18,06	14,21	1			L	3	3	18,06	14,21	1			L	6	2	31,34	8,53	1							
		N	3	2						N	3	2						N	5	1										
RGH	10 & 11	E	4	4				Ward 11 changed to DSU	RGH 10	E	3	3					No change	E	3	3					Y	N		Y	Y		ard 11 changed to a DSU area following critical incident ward move
		L	4	4	23,74	17,05	1			L	3	3	14,21	14,21	1			L	3	3	14,21	14,21	1							
		N	4	2						N	2	2						N	2	2										
RGH	15	E	3	3				Moved to RGH ward 1	RGH 1	E	3	3					PoW ward 7	E	4	4					Y	Y	Increase of beds from 15 to 28	Y			Ward location move only due to critical incident
		L	3	3	14,21	10,56	1			L	3	3	14,21	10,56	1			L	4	4	19,9	19,9	1							
		N	2	1						N	2	1						N	3	3										
PoWH	7	E	4	4				Moved to RGH ward 15 and ward closed	RGH 15	E	4	4					No change	E	4	4					Y	N		Y	N		Ward location move only due to critical incident
		L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1			L	4	4	19,9	19,9	1							
		N	3	3						N	3	3						N	3	3										
PoWH	8	E	4	4	19,07	20,07	1	Moved to ward 19 and ward closed	PoWH 19	E	4	4	19,07	20,07	1			E	4	4	19,07	20,07	1							
		L	4	4						L	4	4						L	4	4					Y	Y	Change of speciality to a Rehabilitation ward now section 25A	Y	N		Ward location move only due to critical incident
		N	3	3						N	3	3					PoW ward 8	N	3	3										
PoWH	9	E	4	4	19,07	20,07	1	Moved to ward 11 RGH as DSU (Section 25A) and ward closed	DSU ward 11 now section 25A	E	4	4	19,07	20,07	1		DSU ward 11 now Section 25A	E							Y	Y	Change of specilaity to DSU now section 25A	Y	Y		Now an SAU ward section 25A
		L	4	4						L	4	4						L												
		N	3	3						N	3	3						N												
PoWH	11	E	3	4				Moved to RGH ward 18	RGH 18	E	3	4					No change	E	3	4					Y	N					
		L	3	4	14,62	16,34	1			L	3	4	14,62	16,34	1			L	3	4	14,62	16,34	1							
		N	2	2						N	2	2						N	2	2										
PoWH	16	E	2	2				Moved to PoWH ward 21	PoWH 21	E	2	2					Moved to PoWH ward 11	E	4	4					Y	Y	Ward almalgamated with Bridgend clinic				
		L	2	2	10,9	10,9	1 Shared with Bridgend clinic			L	2	2	10,9	10,9	1 Shared with Bridgend clinic			L	4	4	19,07	20,07	1							
		N	2	2						N	2	2						N	3	3										
PoWH	Bridgend Clinic	E	2	2				No change	Bridgend Clinic	E	2	2					Moved to PowH ward 11								Y	Y	Ward almalgamated with ward 21 onto ward 11				
		L	2	2	11,9	10,9	Shared with ward 16			L	2	2	11,9	10,9	Shared with ward 16															
		N	2	2						N	2	2																		

Following wards closed October

Appendix 1 : Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	CTMUHB
Period of the report	1st October 2024- 30th September 2025
Paediatric Inpatient Wards	3

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff

Paediatric Inpatient Wards

		Reported to the Board in November 2022						Calculated during spring 2023 cycle						Calculated during autumn 2023 cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2022)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2022) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2023 cycle**		**Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2023 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)				**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)									
PCH	**Ward 31**	**E**	5	1	29,43	5,69	1	**E**	5	1	29,43	5,69	1		**E**	5	1	29,43	5,69	1		**Y**	**N**					
		L	5	1				**L**	5	1					**L**	5	1											
		N	5	1				**N**	5	1					**N**	5	1											
RGH	**Ward 17**	**E**	5	1	29,43	5,69	1	**E**	5	1	29,43	5,69	1		**E**	5	1	29,43	5,69	1		**Y**	**N**	**Increase RN at night to support winter acuity to review at**				
		L	5	1				**L**	5	1					**L**	5	1											
		N	5	1				**N**	5	1					**N**	5	1											
PoWH	**Childrens ward**	**E**	6	2*	35,11	7.72 2 HCSW M-F	1	**E**	6	2*	35,11	7.72 2 HCSW M-F	1		**E**	6	2*	35,11	7.72 2 HCSW M-F	1		**Y**	**N**					
		L	6	2*				**L**	6	2*					**L**	6	2*											
		N	6	1				**N**	6	1					**N**	6	1											

Agenda Item	8.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 23rd September 2025 09:00
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member University (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Patsy Roseblade	Independent Member Finance
	Hayley Proctor	Independent Member Trade Union
In Attendance	Dom Hurford	Executive Medical Director
	Gethin Hughes	Chief Operating Officer
	Greg Dix	Executive Director of Nursing, Midwifery and Patient Care
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Science
	Philip Daniels	Executive Director of Public Health
	Hywel Daniel	Executive Director for People (In part)
	Cally Hamblyn	Assistant Director of Risk and Governance
	Emma Walters	Head of Corporate Governance and Board Business
	Gaynor Jones	RCN Convenor
	Lucie Owen	Care Group Nurse Director, Primary Care and Communities
	Owen Weeks	Care Group Medical Director, Unscheduled Care
	Richard Hughes	Deputy Executive Director of Nursing
	Sharon O'Brien	Care Group Nurse Director, Planned Care
	Sallie Davies	Deputy Medical Director (In part)
	Suzanne Hardacre	Director of Midwifery
	Kellie Jenkins-Forrester	Head of Concerns and Business Intelligence

	Hannah Wilton	Director of Pharmacy & Medicines Management
	Chris Beadle	Assistant Director of Health Safety and Fire
	Lloyd Griffiths	Head of Mental Health and Learning Disabilities Nursing
	Claire O'Keefe	Head of Safeguarding (In part)
Meeting Observers	Deborah Matthews	Care Group Nurse Director, Unscheduled Care (In part)
	Rhiannon Dubberley	Corporate Governance Officer
	Hannah Jones	Audit Wales

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	C. Donoghue 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 hybrid form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Ana Llewellyn, Care Group Nurse Director • Becky Gammon, Assistant Director of Nursing
1.3	**Declarations of Interest**
	There were no interests declared.
2.	**CONSENT AGENDA BUSINESS**
2.1	C. Donoghue reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 8) that the Committee Members wished to bring forward to the main agenda for discussion. There were none.

3.	**MATTERS ARISING**
3.1	**Action Log**
	K Palmer requested that the action log was updated to reflect that updates on Stroke Services would be included in future Highlight Reports from the Unscheduled Care Group in order to demonstrate the Committees commitment to maintain focus and oversight on this area. Members agreed to support the proposed closure of the actions identified subject to the change requested by K Palmer.
3.2	**Matters Arising Not Captured on the Action Log**
	There were no matters arising.
4.	**STAFF AND SERVICE USER EXPERIENCE**
4.1	**Shared Listening & Learning Story - Domestic Violence**
	C O'Keefe shared a presentation with Members which outlined some stories shared about survivor experiences of Domestic Violence and the support they received from the Independent Domestic Violence Advocate (IDVA) service. C Donoghue welcomed the excellent presentation which she found to be, succinct and indicative of the impact of the work being undertaken by the service. R Hughes advised that he was proud of the Safeguarding Team and the work they had undertaken and advised that the Team had secured funding for the IDVA service across all three regions within Cwm Taf Morgannwg. In response to a request made by R Hughes, C O'Keefe provided the following explanations for MAPPA, MARAC and BAROD: • MAPPA – Multi-Agency Public Protection Arrangements which related to the process for managing people released from prison, focusing on their reintegration into the community and assessing any risks they may pose, their housing needs and rehabilitation needs; • MARAC - Multi-Agency Referral Assessment Conference which focussed on high-risk victims of domestic abuse, with agencies such as police, health, and others collaborating to share information, assess risks, and make joint decisions to ensure the safety of victims and any children involved. • BAROD – was one of a number of local Drug and Alcohol services, which was funded through Value Based Healthcare, which the Health Board were looking to undertake some joint work in regard to signposting. L Edwards extended her thanks to C O'Keefe for sharing the presentation which highlighted the impact this had on people's lives and their future quality of life. L Edwards advised that she had not been aware that support was available to staff within the Health Board who were experiencing domestic violence and advised that she would be happy to link C O'Keefe with the Chair of the Women's Network in order to promote the work being undertaken by the Team to keep people safe. C O'Keefe advised that she welcomed the opportunity to connect and emphasised the importance of communicating awareness of the service to

ensure staff know how to access support, given that a significant proportion of referrals come from staff.

G Hughes also welcomed the story and advised that it was equally important to recognise that domestic violence also happened to men who also needed to be supported in speaking up easily. G Hughes highlighted the need to support staff working in domestic violence advocacy roles due to the intensity of their work and emphasised the importance of securing ongoing funding for these important roles and making a case for their inclusion in future plans.

D Hurford reflected on the importance of raising awareness of domestic violence and advised that violence against women is included in the mandatory safeguarding training for all staff which needed to be promoted, and suggested that a revisit was undertaken of the training session that had previously been provided to the Executive Team to enhance awareness amongst leaders. D Hurford added that awareness also needed to be raised amongst front line staff, particularly in Emergency Departments, in relation to the discreet ways that victims could seek help and be supported safely.

In response to the comments made by D Hurford, C O'Keefe highlighted there was an 'Ask for Annie' initiative in place which had been rolled out in some pharmacies and added she would welcome more initiatives like this and acknowledged the need for staff and managers to become more confident in addressing domestic abuse. C O'Keefe advised that working with a health advocate should help upskill staff and reduce barriers and advised that she would be happy to explore innovative approaches given that the current funding was only secured until March 2027.

S Hardacre highlighted that Cwm Taf Morgannwg had a relatively young female population and noted that domestic violence often starts or escalates during pregnancy. In response to a query raised by S Hardacre as to whether training for all staff would consider this aspect, C O'Keefe confirmed that this is being addressed and advised that new staff induction included time in maternity settings given the increased risk of domestic violence during pregnancy.

K Palmer raised the issue of how to encourage men to come forward about domestic violence, noting that men may feel increased shame and often keep the abuse hidden. C O'Keefe advised that male victims were a priority for the team and added that some men had been supported, mainly in cases of observed abuse in hospital settings, especially among elderly patients, and acknowledged the need to explore more ways to reach hidden victims, including men.

R Hughes acknowledged that the current funding for the IDVA roles was fixed term and emphasised that this provided an opportunity to evidence impact using a value-based healthcare approach and to explore sustainable funding options over the next two years. R Hughes also advised that this work was linked to the

	three-year safeguarding strategic plan and added that the Committee would be kept updated on progress. In response to a query raised by G Hughes as to whether GP's could refer into the IDVA service, C O'Keefe advised that whilst GPs could refer into the service, within Cwm Taf Morgannwg there was also an IRIS service which was funded through primary care and added that she would see these two services working together to decide on where a patient was best supported depending on their needs and which service could provide the most appropriate support. In response to a query raised by C Donoghue as to whether there were any particular learning points from the case studies presented, specifically seeking insights or things that could have been done differently, C O'Keefe advised that the presence of the IDVA was crucial, given that emergency department staff in busy environments may not be able to do more than a quick assessment and referral, and highlighted the importance of immediate safety planning, noting that without on-site support, opportunities to help victims could be lost. C O'Keefe also mentioned unconscious bias among staff, where repeated attendances by victims might lead to assumptions, and stressed the need for a supportive approach each time. Members supported the suggestion made by C O'Keefe to return to the Committee in one year to provide more evidence on learning points. C Donoghue extended her thanks to C O'Keefe for sharing the presentation and her thanks to the women who were willing to share their stories.
Resolution:	The Listening & Learning story was NOTED.
Actions:	Link up Head of Safeguarding with the Chair of the Women's Network in order to promote the work being undertaken by the Team to keep people safe Head of Safeguarding to return to the Committee in one year to provide more evidence in relation to learning points
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. P Roseblade extended congratulations to the Team for the excellent outcome across all three sites of the Human Tissue Authority Act unannounced inspection and added this clearly identified that there were robust systems and processes in place. P Roseblade referred to page 4 of the report and the update provided in relation to the work being undertaken to clarify and implement a sustainable approach for Band 2/3 Healthcare Support Workers, and advised that whilst the update suggested there was an issue it did not identify what the issue related to. G Dix advised that in some neighbouring organisations there had been some challenge in regard to Band 2 Healthcare Support Workers potentially undertaking activity

	that could fall within Band 3 roles and not receiving the appropriate remuneration for this. Members noted that work had been undertaken nationally over the last few months to align core Job Descriptions from Band 2 up to Band 8 and noted the work had commenced as a result of NHS Trusts in England re-banding Band 2 posts to Band 3 which resulted in concerns being raised within Health Boards in Wales. G Dix advised he would be happy to provide a more detailed update at a future Board Briefing session if required. G Jones advised that an All-Wales job description had been developed that would take Band 2 Healthcare Support Workers up to a Band 3 for those who choose to, with not all Band 2 staff wishing to go up to this banding. Members noted that the Health Board had until June 2026 to implement this within the organisation by area of priority. H Proctor referred to the update provided in relation to Physicians Associates and advised she was pleased to hear that a meeting would be held with this vulnerable staff group to provide them with support and assurance and advised that she would welcome further information on this matter. D Hurford advised that he would be happy to develop a report on the current position regarding the proposed changes to the roles and remits for Physicians Associates and would be happy to present this to a future meeting. H Proctor advised that she felt it was evident from reading the papers for this meeting that there were concerns that sustainable funding was not in place for a number of projects being undertaken within the Health Board, with the projects being relied upon in order to achieve strategic goals and aims and could potentially result in the loss of staff if future funding was not secured, which was concerning. C Donoghue also expressed concern regarding the position in relation to the risk of sustainable funding routes for key projects/services which were subject to short term funding and requested that this matter was included in the alert/escalate section of the Committee Highlight Report to Board. C Donoghue also suggested some positive areas for escalation within the highlight report which included the positive inspection carried out by the Human Tissue Act Authority and the recent HIW visits to the Emergency Department at Royal Glamorgan Hospital (RGH) and to Maternity services at Princess of Wales Hospital (POWH) which were both positive. C Donoghue also welcomed the positive developments within Infection, Prevention and Control and the partnership between the Dietetic PIPYN Team in Merthyr and Merthyr Junior Parkrun which she felt was an exceptional initiative.
Resolution:	The Committee **NOTED** the report.
Actions:	Report on the current position regarding the proposed changes to the roles and remits for Physicians Associates to be developed and presented to a future meeting. The position in relation to the risk of sustainable funding routes for key projects/services which were subject to short term funding to be included in the alert/escalate section of the Committee Highlight report to Board. Positive items

	for escalation to also be included in relation to the positive inspection carried out by the Human Tissue Act Authority and the recent HIW visits to the Emergency Department at Royal Glamorgan Hospital (RGH) and to Maternity services at Princess of Wales Hospital (POWH).
5.2	**Care Group Highlight Reports**
5.2.1	**Primary Care & Communities Care Group**
	L Owen presented the report and highlighted the key matters for Members attention. The Committee were alerted to concerns regarding the 'Comprehensive Care for Paediatrics within Dental Services', it was noted that at present, children requiring comprehensive care within dental services are referred to Cardiff & Value UHB (CAVUHB) for treatment under an existing service level agreement. However, at the Paediatric Managed Clinical Network meeting held on 7th May 2025, CAVUHB informed the service that they have not been accepting these referrals. The Committee were informed that as there is no capacity within CTMUHB for these patients to be seen this matter has been escalated to the planning team to address this with CAVUHB to enable formal processes to be followed. In response, to this update C Donoghue expressed confusion given that previous positive reports had been shared with Committee members in relation to reinstated theatre lists for complex paediatric dental surgery and sought clarity as to whether the newly highlighted issue regarding referrals changed the previously reported positive position. L Owen provided assurance that the reinstatement of theatre slots for complex surgery had been resolved and was separate from the current reported issue. In response to a question raised by P Roseblade as to the reasons behind the change from 11 to 9 patients on the dental appointment list, L Owen advised that adjusting to 9 reflected a realistic and practical estimate of how many patients could be seen per session to ensure appointments were manageable, taking into consideration the time needed for cleaning and possible overruns with appointments. L Owen provided assurance that this was an adjustment as opposed to a decrease from 11 to 9 and advised the position would be kept under review and there could be a possibility that the numbers of patients could increase to 11 if it was felt this would be manageable.
Resolution:	The Committee **NOTED** the report.
5.2.2	**Diagnostics, Therapies, Pharmacy & Specialities**
	H Wilton presented the report and highlighted the key matters for Members attention. H Proctor highlighted to Members that it would be National Allied Health Professionals Day on the 14 October which would create an opportunity to celebrate this staff group within the Health Board.

	K Palmer made reference to the ICU Psychology service and sought clarity as to whether funding had now been sourced for this service given that posts were currently being funded by the CTM Charity. G Hughes provided assurance that charitable funded was approved in accordance with the Charity objectives and this was considered an appropriate use of Charitable Funding at this time. G Hughes added that discussions were ongoing with Diagnostics, Therapies, Pharmacy & Specialties and Planned Care, Care Groups to identify efficiencies in other areas that could be reinvested to support the psychology service recurrently, with an aim to secure ongoing funding for the next financial year. C Donoghue referred to the concerning increase in blood transfusion incidents and queried whether it would be best for the review of the incidents to be concluded prior to the Committee escalating this as an area of concern to the Board. D Hurford recommended that the review of the incidents be concluded so that there was clarity on the root causes and a clear understanding of the issues identified. It was agreed that an update would be provided to the next meeting regarding the position. L Edwards added that the report had already been presented to the Executive Leadership Group, including information on the incidents and assurance about actions taken. C Donoghue made reference to the update provided in relation to the lack of Occupational Therapy cover at Ysbyty George Thomas Hospital and sought clarity as to how this was being addressed given that patients were being transferred into the hospital for rehabilitation. In response, H Proctor and L Owen clarified the clinical model at Ysbyty George Thomas is for patients awaiting onward care (e.g. care home or package of care) and not for further rehabilitation care. C Donoghue welcomed the clarification provided.
Resolution:	The Committee **NOTED** the highlights outlined in Section 3 of the report.
Action:	Update to be provided to the next meeting regarding the reasons behind the increased blood transfusion incidents
5.2.3	**Mental Health & Learning Disabilities Care Group**
	L Griffiths presented the report and highlighted the key matters for members attention. K Palmer welcomed the update provided in relation to the review of patient absconsions and also the updates provided on the learning disabilities services within the Health Board and added that she would welcome further updates on Learning Disability activity within future highlight reports. In response to a query raised by C Donoghue as to whether there was a timescale for the ligature risks identified to be resolved, L Griffiths advised that this work was ongoing and was aligned to ward moves and reconfigurations, with consideration being given to having one functional ward on each site which was made ligature safe, which was dependent on various factors, such as capital

	funding. Members noted that the national Mental Health Improvement Programme featured a ligature workstream. C Donoghue advised that she was pleased to see that William Turner had been shortlisted for the Royal College of Nursing Nurse of the Year award, which was something the organisation should be proud of.
Resolution:	The Committee **NOTED** the report.
5.2.4	**Planned Care Care Group**
	S O Brien presented the report and highlighted the key matters for Members attention. C Donoghue extended her thanks to S O'Brien for presenting the report and advised that she had recently visited the Theatre Suite at the Princess of Wales Hospital prior to opening which she felt was impressive and advised that it would be good to see the impact of the new set up, given there was great scope for efficiency and improvement. P Roseblade made reference to the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate and sought clarity as to why this decision had been made, whether it would create additional resource costs given that each Directorate would require its own Directorate Management Team and whether these costs would be covered within existing budgets. S O'Brien confirmed that the split was being covered from within the existing budget and explained that the decision had been made to split into two Directorates due to the size and complexity of the original Directorate, which was larger than some Care Groups. Members noted that the aim of the split was to improve governance, concerns compliance and operational management, particularly given the strategic changes and workforce requirements and noted this change would be a temporary measure for 12 months, with each Directorate having a Directorate triumvirate. D Hurford confirmed that he was supportive of the approach being taken given that there are a number of challenges and opportunities for improvement, which would be difficult to address as one Directorate at present. C Donoghue advised that it would be important to see the outcome and impact of this after the 12-month trial period at a future meeting.
Resolution:	The Committee **NOTED** the report.
Action:	Outcome and impact of the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate to be presented to the Committee after the trial period of 12 Months
5.2.5	**Unscheduled Care Care Group**
	O Weeks presented the report and highlighted the key matters for Members attention. Members noted that D Matthews had successfully been appointed as the Care Group Nurse Director and would be presenting this report at future meetings.

	P Roseblade extended congratulations to the Team in achieving a reduction in lost hours and noted that this puts the Health Board in almost the best position across Wales and acknowledged that this must have taken a significant effort to achieve this. G Hughes confirmed that improved handover performance was leading to better response times within communities across Wales and added that the impact within Cwm Taf Morgannwg was still being evaluated. Members noted that for two consecutive months, the new purple category ambulance response time, especially for time-critical cases such as out-of-hospital arrests, had been met and noted that discussions were being undertaken with Welsh Government in relation to re-engaging the population to call 999 for stroke cases, given that improved handover performance now allowed the ambulance service to respond more effectively. Members also noted that Prince Charles Hospital had recently achieved 100% of all crews handed over within 45 minutes, with focus now being placed on reducing the time patients spend in the Emergency Department waiting for treatment. L Edwards referred to the update provided within the report in relation to Ysbyty George Thomas (YGT) which differed from the update provided in the Diagnostics, Therapies, Pharmacy and Specialties Highlight Report and suggested that a conversation needed to be held between care groups to discuss the discrepancies. O Weeks clarified that whilst the report mentioned support for rehab and recovery, the focus at YGT is on encouraging patients to be active and interact, rather than providing formal rehabilitation. O Weeks committed to having a discussion to clarify any discrepancies and ensure understanding of the patient support model at YGT. C Donoghue advised that whilst she was concerned in relation to the increase in pressure ulcers, she was assured to see that a detailed action plan had been developed to address the position. C Donoghue added she was also pleased to see that the Care Group Nurse Director had been appointed and the improvements made within stroke services.
Resolution:	The Committee **NOTED** the report.
Action:	Discussion to be held with DTPS Care Group to clarify any discrepancies and ensure understanding of the patient support model at YGT
5.2.6	**Children & Families Care Group**
	S Hardacre presented the report and highlighted the key matters for Members attention. C Donoghue acknowledged the fantastic outcome of the Health Inspectorate Wales (HIW) Unannounced visit to the maternity unit at Princess of Wales Hospital Bridgend with no immediate assurances given, which she felt was a significant credit to all staff involved given the pressures that had been faced by the Team.
Resolution:	The Committee **NOTED** the report.
5.3	**Reducing Health Inequalities**
	P Daniels shared a presentation with Members and highlighted the key areas of focus.

	C Donoghue extended her thanks to P Daniels for sharing the presentation which contained some stark figures and illustration. K Palmer expressed strong support for the importance of addressing health inequalities, noting the stark data presented. K Palmer highlighted challenges in primary care, particularly around GP access, and suggested a national conversation was needed to enable GPs to spend more time with those most in need. K Palmer pointed out opportunities within CTM to redesign services with a focus on user input and person-centred care, especially as services shift closer to home. K Palmer agreed on the need to apply an inequalities lens to all service reviews and redesigns, recognising resource constraints but stressing the quality and safety implications for those unable to access services, and referenced positive outreach examples, such as the Wound Clinic bus. P Daniels advised that whilst more data could have been provided, the main goal was to retain health inequalities on the agenda and ensure it is considered at each meeting. C Donoghue supported this point and emphasised the importance of applying an inequalities lens to all reports and discussions in order to address the position.
Resolution:	The Committee **CONSIDERED** and **DISCUSSED** the information in the presentation and the implications for CTM.
6.	**DELIVERING OUR PLAN**
6.1	**Patient Safety, Quality & Experience Dashboard**
	K Jenkins-Forrester presented the report and highlighted the key matters for the attention of members. P Roseblade noted that the report highlighted that there was a cluster of incidents resulting in catastrophic harm or death compared to previous months and expressed concern that the report did not explain what actions or learning resulted from these incidents. P Roseblade also highlighted that there is still a large volume of incidents being overstated initially regarding harm and added that she felt concerned that overstating harm in initial reports could lead to triggering the duty of candour more frequently or seriously than necessary, and suggested more training may be needed to address this. K Jenkins-Forrester explained that work was being undertaken on an all-Wales system to provide more guidance at the initial reporting stage and clarified that the duty of candour is triggered at the management review assessment, not the initial report. Members noted that whilst training has been provided in relation to incident reporting, further work is required in this area as staff often report harm based on the patient outcome rather than any acts or omissions in healthcare that may have led to the incident. K Jenkins-Forrester advised of the upcoming changes in Putting Things Right regulations and data systems to support more accurate harm assessment and committed to providing more detailed breakdowns of assessments and learning in future reports.

	K Palmer welcomed the inclusion of the patient experience activity report and emphasised the importance of hearing patients' experiences. K Palmer highlighted the value of the recent value-based healthcare event, which showcased projects demonstrating how the organisation listens to service users and understands the impact and outcomes of services. P Daniels referred to Dyfodol, substance misuse and alcohol service and advised that whilst there was an intention to recommission services in coordination with His Majesty's Prison Service, the timelines did not align. P Daniels expressed concern about prisoners, especially women, being initiated on treatment and then returning to the area, noting the lack of a women's prison locally and the need for national leadership on the substance misuse strategy, which would not be in place until at least after the next Senedd election. P Daniels emphasised that while there is goodwill among agencies, the issue cannot be solved at the health board level and requires a national strategy.
Resolution:	The Committee **NOTED** the report.
6.2	**Committee Referral - Details of the medical negligence claims from the losses and special payments report**
	K Jenkins-Forrester presented the report and explained that whilst the number of clinical negligence cases had remained relatively consistent, redress cases had increased year on year, which aligned with the implementation of duty of candour. Members noted that the number of settled clinical negligence cases had increased, partly due to delays and lack of progress during COVID-19, however, this was expected to stabilise. Members noted that as the duty of candour becomes more embedded, whilst redress cases may continue to rise, clinical negligence claims should decrease. Following K Jenkins-Forrester's update the Committee were assured from the explanation and evidence provided that the potential increase in claims was as a result of administrative factors and backlog management and not as a result of quality and safety issues leading to an increase in clinical negligence cases being received. In concluding this update, C Donoghue requested that a summary report be submitted to the Audit, Risk & Assurance Committee confirming the review outcome. P Roseblade agreed with the approach suggested by C Donoghue in order to close the loop and demonstrate the issue had been reviewed as sufficient assurance provided.
Resolution:	The Committee **NOTED** the report and the next steps.
Action:	Summary report to be submitted back to the Audit, Risk & Assurance Committee confirming the review outcome discussed at the Quality, Safety & Experience Committee
7.	**GOVERNANCE, RISK AND ASSURANCE**
7.1	**Organisational Risk Register – Risks Assigned to Quality & Safety Committee**
	C Hamblyn presented the report and highlighted the key matters for members attention.

	P Roseblade expressed concern about reducing the risk score for stroke, despite acknowledging and welcoming the ongoing work and improvements. P Roseblade highlighted that some performance metrics in the unscheduled care highlight report, for example, only one out of 53 stroke admissions going directly to a ward, did not seem to justify a reduced risk score and stated she did not feel all the expected outcomes were being achieved to support the reduction. C Donoghue echoed the concerns raised by P Roseblade as to whether it was appropriate to reduce the risk score given the current metrics. L Edwards agreed with the concerns raised and stated she had a similar conversation with the team and suggested reviewing the risk from a whole pathway perspective, not just within unscheduled care, and recommended a conversation to ensure proper categorisation. G Hughes clarified that the red and green indicators in the data reflect improvement, not compliance and stated the original stroke risk related to service sustainability due to running two services with minimal staff, which had now been mitigated by consolidating the service onto the Royal Glamorgan Hospital site, recruiting additional staff, and improving the consultant rota. G Hughes acknowledged that the stroke service was not currently delivering SSNAP-level performance and that improvement was needed, along with a focus on time to scan and time to Acute Stroke Unit as key metrics. G Hughes suggested the risk narration should be reviewed given that the original risk had been addressed and emphasized that analysis should include both performance metrics and reports of harm, noting that high harm levels are not being reported, which should factor into the risk assessment. In concluding this discussion, the Committee requested that the risk description be reframed from a sustainability to a performance perspective. In response, to queries raised by P Roseblade and C Donoghue on the escalation of the replacement of the aged beverage trolley fleet risk, G Hughes advised that this risk was escalated and assigned to this Committee due to the patient hydration risks associated with it. He also noted that since the risk had been escalated a replacement programme is now in place which should reduce the risk score upon next review.
Resolution:	The Committee **REVIEWED** and **DISCUSSED** the risks escalated to the Organisation Risk Register.
Action:	Stroke risk narrative risk description to be reframed from a sustainability to a performance perspective.
7.2	**Health Inspectorate Wales (HIW) Audit Tracker Report**
	C Hamblyn presented the report and highlighted the key matters for members attention. K Palmer welcomed the significant improvement made in relation to the progress against actions within the tracker and encouraged continued follow-up on areas where responses were still required, acknowledging that some overdue actions were quite old, and expressed appreciation for the spotlight on this area given

	its importance for providing assurance. G Dix stated that whilst significant work had been undertaken to address overdue actions, focus now needed to be placed on periodically checking the ongoing implementation of these actions in practice, which would be a focus for the team over the next six months. C Donoghue echoed the comments made by K Palmer and also acknowledged the significant focus from unscheduled care in relation to updating their actions which was evident within the report. C Donoghue recognised the ongoing improvement work being undertaken in this area.
Resolution:	The Committee **NOTED** the report and activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.
7.3	**Coroner's Inquest – Case Activity & Lessons Learned**
	K Jenkins-Forrester presented the report and highlighted the key matters for Members attention. C Donoghue advised that she noted from previous discussions there had been an increase in workload due to coroner's office efforts to clear backlogs and queried if the complexity of cases was also increasing. K Jenkins-Forrester confirmed that complexity was increasing, with more witnesses being required for statements and evidence, and more cases moving from documentary to multi-day hearings, which take up a significant proportion of time. D Hurford confirmed that there was a backlog of cases in addition to the complexity of inquests being significantly higher, with more court cases occurring. D Hurford advised that the coroner was increasingly asking the health board to provide internal expert opinions, which adds substantial work, particularly for clinical directors. D Hurford expressed appreciation for the small team managing this workload and raised concern about the ongoing impact on staff time and resources as this upward trend continued. C Donoghue emphasised the need to continue reporting on this issue due to concerns about the resource impact on the team and the pressure on staff required to attend multi-day hearings, noting the stress involved and the importance of monitoring and ensuring support is in place for those staff involved.
Resolution:	The Committee **NOTED** the report.
7.4	**Internal Audit Review - Duty of Candour**
	K Jenkins-Forrester presented the report and highlighted the key matters for members attention. C Donoghue referred to the overdue dates within the action plan and sought clarity as to whether these timescales had now been met. K Jenkins-Forrester advised that there had been some delay in completing actions due to high-priority work related to inquests and learning from events reports and confirmed that the work on the overdue actions was now being addressed and progressed, and added that adjustments to the time scales will be undertaken.

	P Roseblade suggested that future reports capture the update on actions being taken in response to findings as this would provide assurance to Members that actions were being taken to address concerns raised in the internal audit. P Roseblade advised that the area of activity would not be subject to an immediate follow-up internal audit review given that the overall outcome was reasonable, with just one limited assurance area being identified. K Palmer sought assurance as to whether GPs were using the Duty of Candour system and complying with it, noting that GPs used different systems and sometimes had to duplicate data entry. L Owen confirmed there was a lack of reporting within the system by GP practices and that this was recognised as an All-Wales issue. L Owen advised that the NHS Wales Executive was developing a suite of Key Performance Indicators and targets, including incident reporting, for GPs and advised that the team had met with all practices to offer training on incident management and duty of candour. Members noted that when incidents were submitted, even though GPs were independent contractors, the Health Board responds with a rapid meeting or formulates a duty of candour response to determine if it has been triggered.
Resolution:	The Committee **NOTED** the report.
7.5	**Health, Safety & Fire Sub Committee Highlight Report 4 September 2025**
	H Daniel presented the report and highlighted the key matters contained within the alert/escalate section of the report. C Donoghue welcomed the improvements in hospital environments, especially during recent visits, and acknowledged the significant amount of work involved in achieving this. K Palmer sought clarity as to where assurances regarding cleaning and catering were being reported and emphasised the importance of both in relation to quality and safety. In relation to cleaning, G Dix confirmed that compliance against national standards was discussed at the Infection, Prevention & Control Committee, with any issues highlighted being escalated into Quality, Safety & Experience Committee. In relation to catering, C Donoghue questioned where it is most appropriately reported and queried whether this would come up in ward audits or through patient feedback. L Edwards referred to the Nutrition and Hydration Steering Group, which includes catering input from a clinical perspective, and agreed that it would be helpful to have further clarity on reporting, which C Hamblyn agreed to take forward as an action. L Owen supported the need for a clear reporting route, noting that currently issues are only picked up as they arise, and that incidents related to nutrition are managed locally but would benefit from structured oversight.

	G Hughes highlighted that the hospital food provision was fully compliant with Welsh nutritional standards, following a major review led by the Divisional Director of Facilities and the Dietetics team and added that CTM hospital food is fully compliant with Welsh nutritional standard. G Hughes also referenced the NHS England PLACE programme as a possible model for independent review of food and cleanliness.
Resolution:	The Committee **NOTED** the report and **APPROVED** the Organisational Health and Safety Policy for a further 3-year period and approve the Health, Safety & Fire Sub Committee Terms of Reference.
Action:	Further clarity on reporting routes to be obtained for nutrition and catering activity.
7.6	**Ombudsman's Annual Letter and Annual Report**
	K Jenkins-Forrester presented the report and highlighted the key matters for Members attention. In response to a query raised by C Donoghue regarding the offer of free complaints training, K Jenkins-Forrester confirmed that the offer of free training had been take up by the Health Board and would be utilised over the next 12 months.
Resolution:	The Committee **NOTED** the report.
8.	**CONSENT AGENDA**
8.1	**FOR APPROVAL**
8.1.1	**Unconfirmed Minutes of the Meeting held on 22 July 2025**
	It was noted that the Minutes of the meeting held on 22 July 2025 would need to be amended to reflect that K Jenkins-Forester attended this meeting. The Minutes were APPROVED subject to the above amendment.
8.1.2	**Unconfirmed Minutes of the In Committee Meeting held on 22 July 2025**
	The Minutes were APPROVED.
8.1.3	**Putting Things Right Annual Report**
	The Putting Things Right Annual Report was APPROVED.
8.1.4	**Organ Donation Sub Committee Highlight Report, Annual Report and Terms of Reference**
	The Committee **NOTED** the report and **APPROVED** the Organ Donation Sub Committee Terms of Reference which had been amended as a result of their annual review.
8.1.5	**All Wales IPFR Policy (2025)**
	The Committee **ENDORSED** the revised All Wales IPFR Policy (2025) and **APPROVED** its implementation within CTMUHB.
8.1.6	**All Wales Prior Approval Policy (2025)**
	The Committee **ENDORSED** the revised All Wales PAR Policy (2025) and **APPROVED** its implementation within Cwm Taf Morgannwg UHB with immediate effect.
8.2	**FOR NOTING**
8.2.1	**Non-Routine Committee Business (Forward Plan)**

	The Non-Routine Committee Business Forward Plan was NOTED.
8.2.2	**Annual Cycle of Business**
	The Annual Cycle of Business was NOTED.
8.2.3	**Joint Commissioning Committee - Quality Safety and Outcomes Sub-Committee Highlight Report 31 March 2025**
	The Committee **NOTED** the highlights outlined in Section 3 of the report.
8.2.4	**Infection, Prevention & Control Annual Report**
	The Committee **NOTED** the IPC Annual Report.
8.2.5	**Research & Development, Innovation & Improvement Bi Annual Update**
	The Committee **NOTED** the report.
8.2.6	**Individual Patient Funding Request Annual Report** The Committee **NOTED** the contents of this report and the need to recruit Lay representation to the CTM IPFR panel.
9.	**CLOSE OUT BUSINESS**
9.1	**Committee Highlight Report to the Board**
	C Hamblyn summarised the Committee Highlight Report to Board by noting positive escalations: the role of the IDVA advocates, two positive HIW inspections with no immediate assurances, the HTA inspection, and significant improvement in handover times. C Hamblyn also highlighted a concern regarding sustainable funding for ongoing projects and invited members to suggest any additional items.
9.2	**Meeting Feedback**
	C Donoghue advised that she would welcome feedback from members and attendees following the meeting.
9.3	**Any Other Business**
	C Donoghue noted that it was G Dix last meeting, thanked him for his contribution to the committee and the health board, and expressed that he would be missed. C Donoghue also thanked E Walters and C Hamblyn for their work in preparing meeting papers and setting the agenda, acknowledging the significant effort involved and expressing appreciation.
10.	**PRIVATE / CLOSED SESSION BUSINESS**
	The following items would be received In Committee: • Maternity and Neonatal Leadership and Culture Plan • Organisational Risk Register - Closed Risks • Update on Special School Nursing (to include an update on timescales for achieving a solution)
11.	**DATE & TIME OF THE NEXT MEETING**
	18th November 2025 at 9:00am

Agenda Item	8.1.2

Unapproved Minutes of the Quality, Safety & Experience In Committee

Date and Time of Meeting	Tuesday 23rd September 2025 12:00
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member University (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Hayley Proctor	Independent Member Trade Union
In Attendance	Dom Hurford	Executive Medical Director
	Gethin Hughes	Chief Operating Officer
	Greg Dix	Executive Director of Nursing, Midwifery and Patient Care
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Science
	Philip Daniels	Executive Director, Public Health
	Carl Verrecchia	Care Group Service Director
	Cally Hamblyn	Assistant Director of Risk and Governance
	Emma Walters	Head of Corporate Governance and Board Business
	Lucy Collins	Head of Nursing, Children & Young People
	Richard Hughes	Deputy Executive Director of Nursing
	Suzanne Hardacre	Director of Midwifery
Meeting Observers	Rhiannon Dubberley	Corporate Governance Officer

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	C Donoghue welcomed everyone to the meeting.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Becky Gammon – Assistant Director of Nursing • Patsy Roseblade – Independent Member Finance
1.3	**Declarations of Interest**
2.	**MAIN AGENDA**
2.1	**Culture and Leadership Plan Maternity Service Update August 2025**
	S Hardacre presented the report and highlighted the key matters for Members attention which included assurance around improvements in quality metrics at the Princess of Wales Hospital Site. K Palmer noted the action plan which she found to be comprehensive and enquired about the key themes that needed to be addressed. S Hardacre advised that the issues experienced appeared to be isolated and were not site-specific and added that there had been no surprises from the learning events. The Committee noted that areas of learning and improvement will be captured in the Culture and Leadership Plan in Maternity services and noted that ongoing progress will be monitored through the Care Group Maternity and Neonatal Programme Board and Care Group Quality & Safety meetings. C Donoghue commended S Hardacre and the current leadership team for the work undertaken to address the issues.
Resolution:	The report was **NOTED**
2.2	**Special School Nursing**
	S Hardacre presented the report and advised that this was a complex and challenging position with the service remaining fragile. C Donoghue acknowledged the complexity of the issue and enquired about the next steps required to address the position. Following a detailed discussion, the Committee identified several routes for the team to explore to ensure the challenges being faced are escalated appropriately.
Resolution:	The report was **NOTED.**
2.3	**Organisational Risk Register – Closed Risks**
	C Hamblyn presented the report and highlighted the key matters for members attention. C Hamblyn agreed to review outside the meeting the suggestion made by K Palmer as to whether the Special School Nursing position should be included as a risk.
Resolution:	The report was NOTED.

Action:	Review to be undertaken outside the meeting as to whether the Special School Nursing position should be included as a risk.
3.	**ANY OTHER BUSINESS**
	There was no other business to report.
4.	**DATE AND TIME OF NEXT IN COMMITTEE SESSION**
	Tuesday 18th November 2025.

Agenda Item
8.1.3

Quality, Safety & Experience Committee

Organ Donation Sub Committee - Terms of Reference

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Dr David Deekollu Assistant Medical Director – Quality and Governance
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
Engagement with Organ Donation Committee Chair, Vice Chair, Clinical Lead	13/10/2025	Approval provided

Acronyms / Glossary of Terms	
SNOD	Specialist Nurse Organ Donation
CLOD	Clinical Lead Organ Donation
NHSBT	NHS Blood & Transplant

1. Situation /Background

1.1 The Organ Donation Sub Committee submitted its updated Terms of Reference to the September 2025 Quality, Safety and Experience Committee (QSEC) following consultation with Committee members. The Terms of Reference were approved by QSEC. On circulation of the updated TOR it was noted that there had been an omission in the 'In Attendance' section.

1.2 The purpose of this paper is to seek approval for minor changes to the Organ Donation Sub Committee's Terms of Reference which were omitted in the previous version submitted to QSEC for approval in September 2025.

2. Specific Matters for Consideration

2.1 The Terms of Reference submitted have been amended to reflect updates that have been made in the 'In Attendance' section. Additional membership to be included are:

- Executive Medical Director (or representative)
- Regional Clinical Lead Organ Donation (CLOD)
- Regional Team Leader
- CTM wide Senior Nurse for Emergency Medicine (this will replace the individual site Senior Nurses for Theatres representation).

The Terms of Reference can be made available to Members on request.

3. Key Risks / Matters for Escalation

3.1 QSEC members are asked to note that the Organ Donation Sub Committee Terms of Reference will be reviewed annually.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:

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

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

5. Recommendation

5.1 The Committee are being asked to **APPROVE** the amendment made to Terms of Reference as outlined in section 2.1.

6. Next Steps

6.1 The Terms of Reference will be circulated to Organ Donation Sub Committee members and relevant stakeholders.

Agenda Item
8.1.4

Quality, Safety & Experience Committee

Safeguarding Annual Report 2024/2025

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Claire O'Keefe – Head of Safeguarding
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Richard Hughes – Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes – Executive Director of Nursing

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
Safeguarding Executive Group	21/07/2025	Approved

Acronyms / Glossary of Terms	
CTMSB	Cwm Taf Morgannwg Safeguarding Board

1. Situation /Background

1.1 The Cwm Taf Morgannwg University Health Board (CTMUHB) annual report has been produced to reflect how it has achieved its outcomes against the three-year strategic plan and the associated priorities agreed to as in partnership with the Cwm Taf Morgannwg Regional Safeguarding Board (CTMSB). The report also summarises and aims to inform the public and other practitioners of how priorities for the year have been achieved and learning from inspections/reviews integrated into practice.

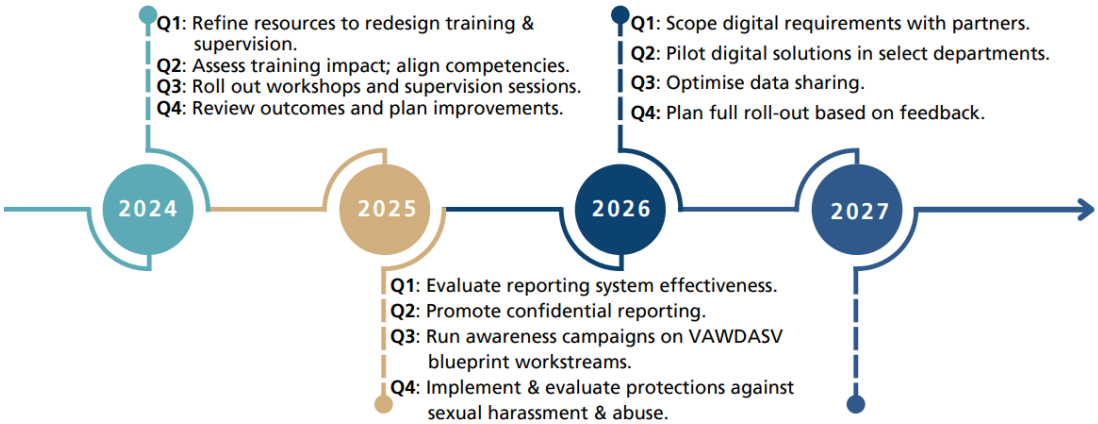
2. Specific Matters for Consideration

2.1 The Health Board's Safeguarding Annual Report (Appendix A) has been produced to give an overview of the safeguarding activity undertaken throughout the health board in 2024/2025. Reflecting learning and actions taken from Single Unified Safeguarding reviews, incidents and concerns. The report demonstrates the effective leadership, commitment and operational support in all aspects of Safeguarding and Public Protection across Cwm Taf Morgannwg University Health Board and how the Health Board complies with legislation, external standards and good practice guidance.

2.2 The Cwm Taf Morgannwg Safeguarding Board (Appendix B) has also produced an Annual Report for 2024/2025, this has been produced to reflect multi-agency safeguarding activity across Cwm Taf Morgannwg. All partner agencies have contributed to the board work and worked collaboratively to meet the objectives and priorities of the Boards' strategic plans. This Annual Report presents an overview of the work that the Cwm Taf Morgannwg Safeguarding Board carried out in 2024/2025 in pursuit of the aim to ensure that the people of Cwm Taf Morgannwg are safeguarded from abuse, neglect or other forms of harm.

2.3 In addition to working toward regional priorities, the corporate safeguarding team have also collaborated with the National Safeguarding Service through its implementation groups, to deliver on recommendations set out in the "Strengthening Safeguarding in Health Review" conducted in 2024 & commissioned by Welsh Government.

2.4 The health board's three year safeguarding strategic plan positions the priorities for the next three years. For 2024/2025 the priorities are detailed in the below diagram.



3. Key Risks / Matters for Escalation

3.1 Key areas of work undertaken this year have included the implementation of the all Wales safeguarding supervision policy. This incorporated the development of a CTMUHB policy, supervision request forms and supervision feedback forms to enable quality assurance in respect of advice and support offered to practitioners.

3.2 In collaboration with the School Nursing service, a safeguarding standard operating procedure was developed. Thus, ensuring that the health board evidence an appropriate response to the recommendations set out within the Joint Inspection for Child Protection Arrangements (JICPA) and safeguarding rapid review undertaken by Care Inspectorate Wales (CIW) and Health Inspectorate Wales (HIW).

3.3 An annual audit plan was undertaken across multiple services to provide assurance that the health board appropriately respond to safeguarding concerns, can identify opportunities for early intervention and evidence duty to report in line with the Social Services and Wellbeing (Wales) Act 2014

3.4 Data collection and subsequent dashboards have been adapted to align with the agreed national safeguarding metrics required by Welsh Government. This data collection will be further strengthened once all health boards in Wales fully embed the Once for Wales safeguarding module.

3.5 In July this year the safeguarding team restructured to include all Clinical Nurse Specialists for safeguarding from the Children and Families Care Group. This has ensured a coordinated and collaborative approach to safeguarding across services, professional development and quality improvement. This has been successful, demonstrated through a whole team approach. In addition, the re structure ensured opportunity for the appointment of a dedicated practice educator for safeguarding.

3.6 With recurrent funding from Welsh Government, a continued effort has been made to reduce the Deprivation of Liberty Safeguards backlog and Mental Capacity Act awareness throughout the organisation. This funding has also enabled recruitment of a Court of Protection Lead.

4. Assessment

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

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

5. Recommendation

5.1 The Quality, Safety & Experience Committee are asked to **NOTE** and **ENDORSE** for Board approval the Safeguarding Annual Report.

Safeguarding & Public Protection Annual Report

2024/2025

Prepared by
Claire O'Keefe, Head of Safeguarding

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

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Foreword

This report demonstrates the effective leadership, commitment & operational support in all aspects of Safeguarding & Public Protection across Cwm Taf Morgannwg University Health Board & how the UHB complies with legislation, external standards & good practice guidance.

What does Safeguarding & Public Protection look like in Cwm Taf Morgannwg University Health Board (CTMUHB)?

Since April 2019 Cwm Taf Morgannwg Health Board incorporates the local authority areas of Bridgend, Merthyr Tydfil & Rhondda Cynon Taf with a total population of almost 440,000. Services are also provided to those living within neighbouring authorities.

Safeguarding in Cwm Taf Morgannwg involves working with our colleagues & partner agencies to protect & prevent children & adults at risk of abuse, neglect or other kinds of harm.

Public Protection seeks to protect, promote & improve the health, safety & well-being of our population across Cwm Taf Morgannwg.

Strategic Objectives for Safeguarding & Public Protection:

- **There are effective measures in place within CTMUHB to safeguard people & protect children & adults at risk who are accessing its services.**
- **There is effective inter-agency co-operation in planning & delivering safeguarding & public protection services & in sharing information.**

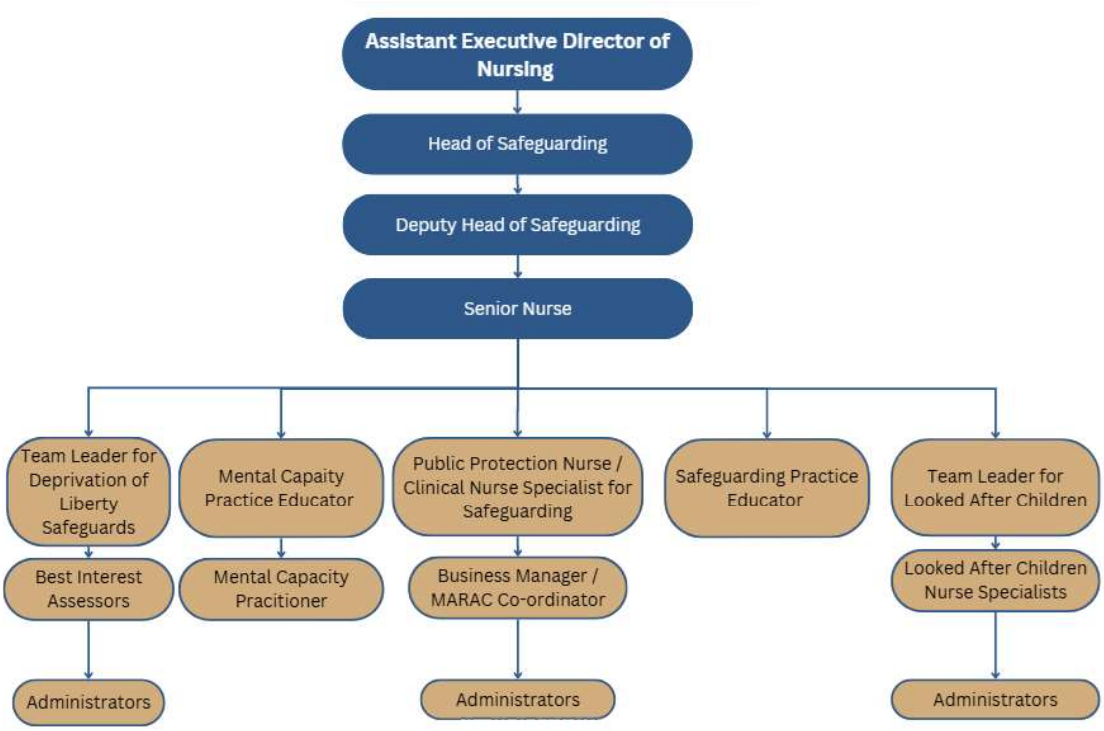
The Health Board works within regional partnership arrangements throughout Cwm Taf Morgannwg

Key Areas of Work

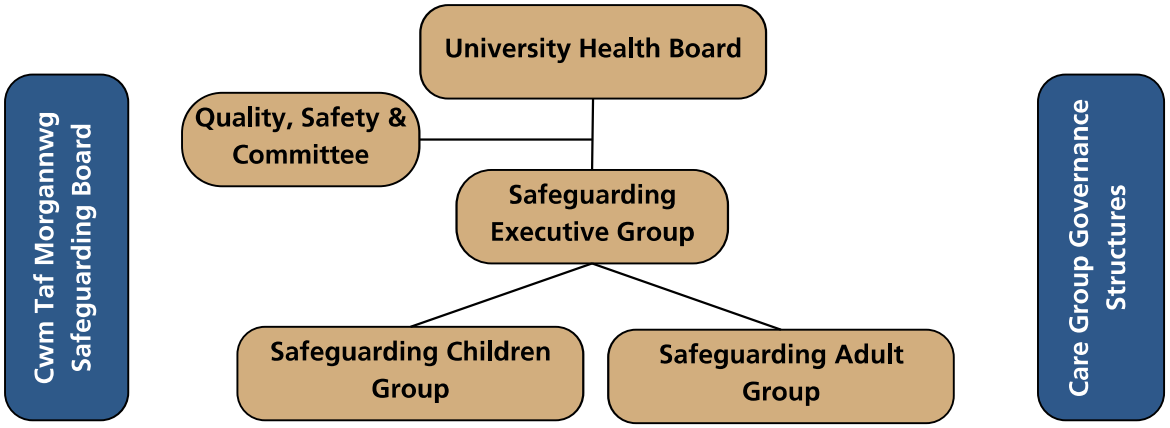
Digital questionnaires have been launched to capture the views of children and young people in respect of their experiences of health assessments	Joint bespoke training between Safeguarding & Mental Capacity Act Practice Educators to share learning from incidents and reviews	Development of guidance and flowchart to guide practitioners in the management of ano-genital warts in children and young people. In addition, information leaflets to guide children, young people and their parents and carers
In response to learning from Child T's practice review, in collaboration with Paediatric services a 'Jump' pathway was developed to ensure colleagues are aware of appropriate escalation processes	Numerous events delivered to colleagues across health and partner agencies throughout safeguarding week	An annual audit plan was developed and delivered to reflect recommendations from the Joint Inspection of Child Protection Arrangements and Rapid Review
Level 1 and 2 Mental Capacity Act & Deprivation of Liberty Safeguards training completed as an all Wales collaboration via the All Wales Task & Finish group	Development of a safeguarding supervision request form and feedback form to measure quality of supervision provided	During safe sleep week stands and displays were set up in various sites to reinforce safe sleep practice. Safe sleep audits were also undertaken evidencing that 88% of documentation reflected safe sleep advice being provided to new parents
High compliance of women being asked about Domestic Abuse by health board staff and support sought from the hospital based Independent Domestic Violence Advocate when disclosures were made to gain the appropriate support and advice	Review and development of updated bruising and injuries in non-independently mobile children for secondary care services. Following feedback from parental experiences of safeguarding processes, developed a leaflet to support those affected	A number of health board colleagues from safeguarding and mental health have supported practice, domestic homicide and offensive weapon reviews. Learning from these reviews has been shared across multiple forums
Welsh Government funding was again utilised to commission an external agency to support with the completion of DoLS assessments, significantly reducing the backlog	As partners of the Multi-Agency Safeguarding Hub, contributed to an independent review of Cwm Taf MASH. Collaboratively exploring improved ways to communicate and share information in the absence of a co-located MASH	Redesign of the health boards safeguarding intranet page to ensure colleagues are supported during and out of hours to respond to safeguarding concerns

Organogram Structure

Corporate Safeguarding & Public Protection Team



Governance Arrangement & Reporting Structure



This chart illustrates the governance arrangements that supported the CTMUHB Safeguarding Team in fulfilling their statutory duties during 2023/2024. Quarterly reports were shared with the Safeguarding Executive Group for oversight & scrutiny

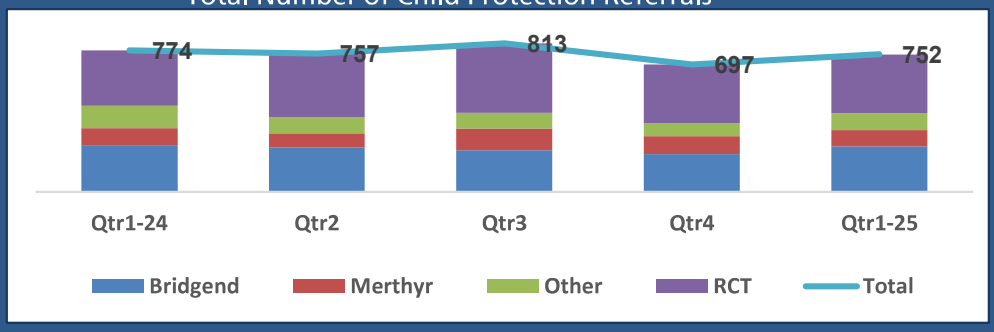
Safeguarding Children

Our Aim

To ensure that children and young people in Cwm Taf Morgannwg, up to the age of 18, are protected from abuse, neglect or other kinds of harm and are prevented from becoming at risk of abuse, neglect or other kinds of harm and they live in an environment that promotes their wellbeing.

To ensure that the UHB complies with the related legislation & Procedures:

- Social Services & Wellbeing (Wales) Act 2014 – Part 7
- Children Acts 1989 & 2004
- Wales Safeguarding Procedures 2019



During 24/25 CTMUHB have continued to strengthen safeguarding arrangements, building on the recommendations from the Strengthening Safeguarding in Health Review (2024).

A significant amount of work has been undertaken to look at how data and themes are captured throughout the health boards services. This work has included how CTMUHB increase visibility to services across the organisation, deliver data and quality assurance in respect of safeguarding.

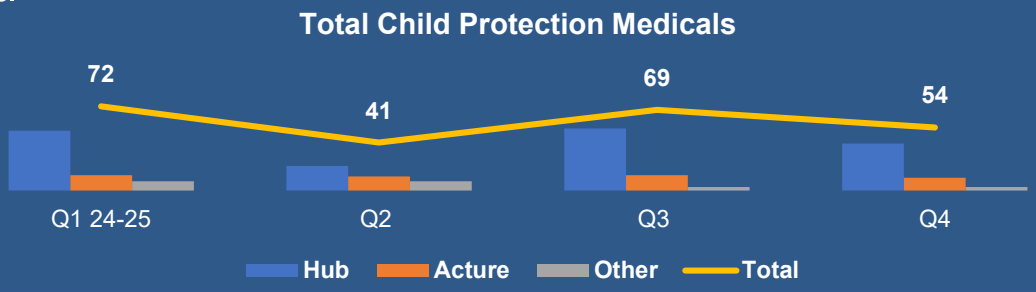
During 24/25 all safeguarding specialists restructured under the management of the corporate safeguarding team. This has ensured the delivery of the health boards priorities within the safeguarding strategy. In addition, supported wider delivery of training and education, ensuring professional development for all of those individuals working within safeguarding.

Secondary Care Bruising Injuries Policy & Leaflet.

In response to learning and incidents, a secondary care policy for bruising and injuries in non mobile children was renewed in partnership with the Named Doctor for Safeguarding, paediatric and emergency care colleagues. This ensures a consistent approach to the reporting arrangements and information sharing across agencies. A leaflet was also designed for use by parents and carers.

What did we do

- Learning events and skills days were delivered by safeguarding specialists to colleagues in Specialist Community Public Health Services. These sessions shared learning from incidents, audits and practice reviews. Building on identified good practice and influencing change in identified areas for improvement.
- This year the corporate safeguarding team have worked closely and in partnership with the school nursing service to develop processes and procedures that support a consistent approach in safeguarding school aged children.
- To ensure improvements within child protection processes are driven by the experiences of children and young people, questionnaires have been enhanced and made digitally available. These feedback opportunities have been extended to all three Paediatric wards, this ensures that experiences and improvements are aligned across both the Hub and wards.
- Led by the named Doctor for safeguarding a multi-agency training day was delivered in partnership with South Wales Police, education and Bridgend Local Authority. With the support of some external speakers covered topics such as exploitation, Sexual Assault Referral Centre, injuries in children non independently mobile and fabricated illness. The day was evaluated well and was delivered a second time in April 25. This training was in addition to a catalogue of training delivered to Paediatric and Emergency Department medical colleagues.
- The School Nursing Service have held workshops across the service to improve the focus of their conference report writing. The emphasis on the workshops to ensure that practitioners are providing relevant and proportionate information, and are able to interpret, analyse and explain their information for the benefit of the child and other professionals.
- An annual audit plan was undertaken in partnership with Health Visiting, School Nursing and Paediatrics to provide quality assurance in respect of child protection processes.



https://youtu.be/nfxD7F9LsH0

A video has been produced by a safeguarding specialist nurse based at the child protection medical hub with the support of medical illustrations at CTMUHB. This video is aimed to take children and young people through the journey of a child protection medical.

Safe Sleep Week 2025

- Stands with posters were arranged within Community Hospitals
- Resources were given out to staff, parents and carers
- Cots were set up in each location with props to demonstrate safe sleeping.
- Engagement from new parents, grandparents and other relatives.
- Posts by the Lullaby Trust were regularly shared through out the maternity service platforms.

WHAT'S NEXT?

In response to learning from reviews, revision of the health boards multiple birth pathway and training

Utilising safeguarding supervision feedback forms and logs, measure the safeguarding teams visibility to the CTMUHB workforce

Continue to strengthen partnership working between the corporate safeguarding team and wider services in in identifying improvement opportunities to safeguard children within Cwm Taf Morgannwg

Develop communications, training and resources to support the launch of the regional exploitation strategy

Drive improvements in the quality of child protection referrals through audit and training

Looked After Children

Our Aim

To guarantee that Children in Care have their physical, emotional, and mental health requirements fulfilled. This includes conducting timely assessments, making referrals, & providing access to necessary healthcare services.

To ensure that the UHB complies with the related legislation & Procedures:

- Social Services & Wellbeing (Wales) Act 2014 – Part 6
- Towards a Stable Life & Brighter Future 2007 [statutory health assessments]
- The Care Planning, Placements, & Case Review (Wales) Regulations

What did we do

- Completed an audit plan to measure the quality of health assessments and health care needs form
- Developed a leaving care leaflet to support young people
- Launched the CIVICA survey. The results will be used to ensure service improvements are led by the voice of those who receive the service.
- CTMUHB signed the Corporate Parenting Pledge, and developed strategic health plans
- Streamlined and improved processes that have reduced the back log
- Completed bespoke work with health visiting to improve the quality of the under-five review health assessments.
- Worked with the Quality Improvement (QI) team to redesign the database to feed into a power BI data dashboard to reflex data for executive group, corporate parenting board and Welsh Government data

- 1443 Looked After Children in CTMUHB
- 200 Health Assessments completed outside CTMUHB
- 232 Children placed outside CTMUHB
- 1307 (>16.2%) Health Assessments completed by CTMUHB

WHAT'S NEXT?

Build on digital resources for both CTMUHB staff and forward facing intranet pages

To eradicate any backlog by the end of the year through continued improvement strategies

Devising resources to introduce the role of the Looked After Children Nurse and health assessment expectation to young people entering care

Explore possibilities within the service to redesign. Ensuring the service continues to meet the healthcare needs of children and young people, who are care experienced

Build closer working relationships with partner agencies to strengthen joined up working. Promoting the role of the Looked After Children Nurse to foster carers and develop more joined up foster carer training

Safeguarding Adults

Our Aim

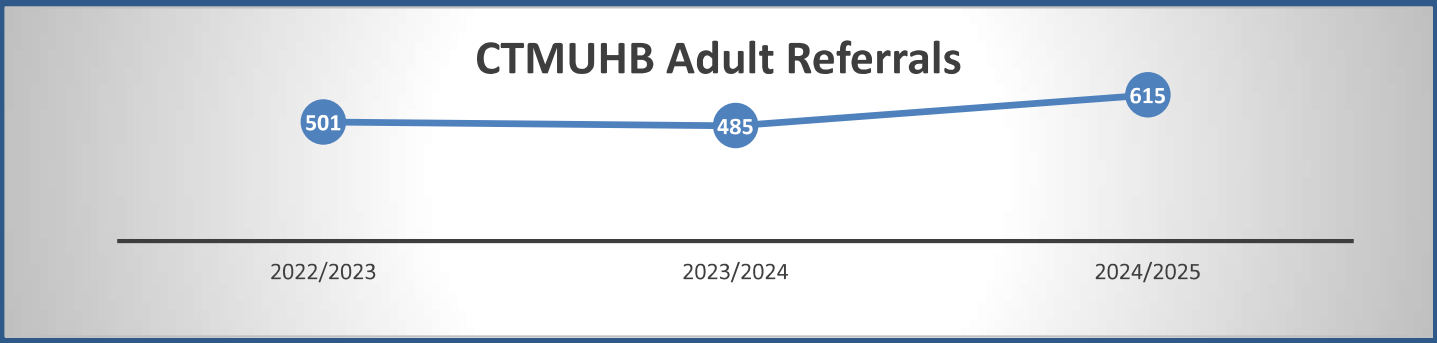
To ensure that adults in Cwm Taf Morgannwg, over the age of 18, are protected from abuse, neglect, or other kinds of harm and are prevented from becoming at risk of abuse, neglect, or other kinds of harm, and they live in an environment that promotes their wellbeing.

To ensure that the UHB complies with the related legislation and Procedures:

- Social Services & Wellbeing (Wales) Act 2014 – Part 7
- Health & Social Care (Quality & Engagement) (Wales) Act 2020

What did we do

- CTMUHB took over the health services at HMP Parc in October 2024. To ensure an integrated response to safeguarding concerns, training was delivered in partnership with wider multi-agency colleagues to HMP Parc staff, sharing learning from incidents and concerns. In addition, pathways were developed to strengthen safeguarding processes.
- Recognising the complexities around adult safeguarding and in response to learning from an incident, safeguarding supervision has been extended to district nursing and wider health services. A safeguarding supervision request form has been developed and embedded into the revised safeguarding supervision standard operating procedure.



- In response to learning around neglect and self neglect, a bespoke safeguarding and MCA training package was developed and delivered across the district nursing service in CTMUHB.
- This year, an adult safeguarding and mental capacity act practitioner role was recruited to lead on the management of complex adult safeguarding cases, ensuring improvements within adult safeguarding are equal consideration in the delivery of the health boards strategy.

Allegations made Against Professionals

Our Aim

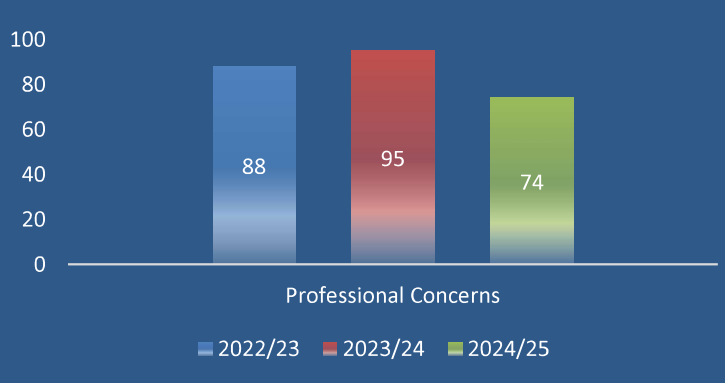
To ensure that patients/clients are safe in our care. To ensure that staff understand they have a duty to report concerns about the behaviour of other staff members.
Raise awareness with our staff that their behaviour outside of work can directly impact on their working role.

Ensuring that there are effective inter-agency safeguarding processes and practice in place. That these are supported by robust workforce processes and risk assessments to ensure a proportionate response to concerns whilst safeguarding our patients/clients.

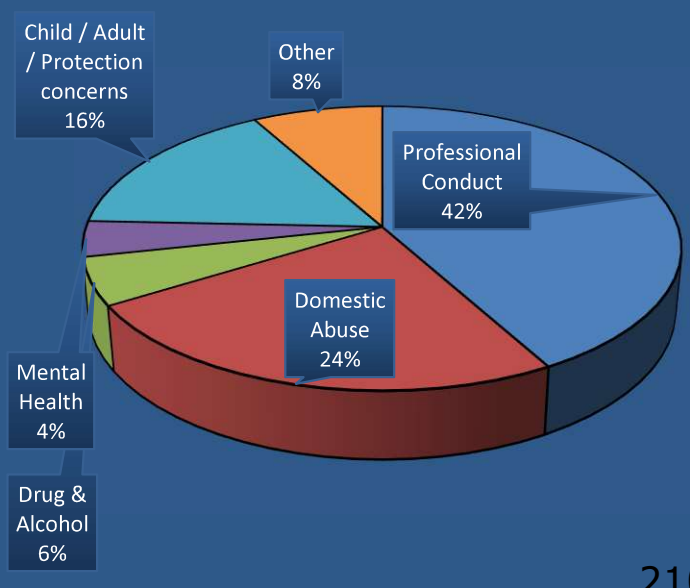
What did we do

- The health boards policy was updated to ensure colleagues have access to clear guidance in the management of concerns for those in a position of trust. Also, ensuring those subject to these procedures are signposted to appropriate support for their wellbeing.
- A training package was developed to support managers in ensuring a consistent and equitable approach to the management of reported concerns. This was delivered to managers through the senior nurse forum, safeguarding operational groups and care group quality, safety and patient experience forums.
- A number of staff from safeguarding, people services and care groups attended training in respect of the Disclosure and barring service.

Total Referrals



Concern / Allegation



WHAT'S NEXT?

This year CTMUHB are committed to utilising the Once for Wales safeguarding module for the management of allegations made against a person in a position of trust

Continue to promote a culture of safety where safeguarding concerns can be raised across all areas of the health board

Safeguarding will be working with colleagues within the care groups and people services to develop a sexual safety policy. This will include the management of staff alleged to have been a perpetrator of sexual abuse and assault

In partnership with adult services across CTM align the reporting and management of avoidable pressure damage with the revised All Wales Pressure Damage Guidance 2024

The training package for reporting persons in a position of trust will be delivered through a Link and Learn session. It will also be made available through the health boards redesigned intranet page

Violence Against Women Domestic Abuse Sexual Violence

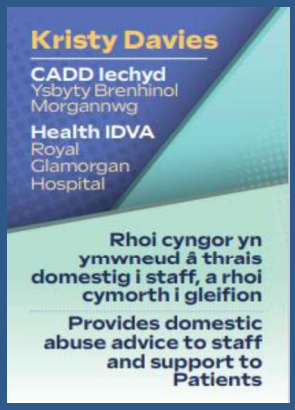
Our Aim

Individuals who are victims of violence against women, domestic abuse, and sexual violence are treated and supported in a way that optimises their potential and life chances.

To ensure that the UHB complies with the related legislation & Procedures:

- Violence Against Women Domestic Abuse & Sexual Violence (Wales) Act 2015
- Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015)
- Domestic Abuse Act 2021

What did we do



136 Number of new victim referrals to support services in the reporting period

76 Number of new victims supported in the reporting period

101 Total number of supported victims (new and existing) during the reporting period

62 Number of victims who have concluded support and exited the service within the reporting period

White Ribbon Week

- The health Independent Domestic Violence Advocate (IDVA) attended Community Hospitals in partnership with Samaritans to raise awareness of individuals who may be at a higher risk of suicide due to domestic abuse.
- Training sessions were delivered on hidden victims
- Promoted the week on health board intranet site with contact numbers for staff support

I can't thank the IDVA service enough for being there and all the support I have had I can finally see the light at the end of the tunnel after 17 years when you are in it you never think you will get out

- Survivor of Health IDVA

Routine Enquiry Audit – Maternity

An audit was undertaken using 100 randomly selected set of maternity records showed that 91% of women were asked about Domestic Abuse in pregnancy and of the 91%,83% were asked more than once. This is slightly less that the 95% compliance for 23/24. However, out of the sets of records audited where 10 women were not asked about domestic abuse, there was evidence that the women attended their appointment accompanied on numerous occasions, so the opportunity to ask routine enquiry was not available.

Ensure staff have the confidence to routinely ask service users if they feel safe, in anyone is harming them or if they need help. This will be achieved through a training plan for 24/25

In line with the health boards safeguarding strategy, deliver awareness sessions to staff to include blueprint workstreams. In particular, children and young people, older people and work place harassment

Utilising Value Based Health Care funding expand the health IDVA provision across CTMUHB

Expand routine enquiry to wider service groups and embed the routine enquiry audit in line with all Wales routine enquiry standards

Deprivation of Liberty Safeguarding

Our Aim

Ensure that the UHB follows the defined legislative processes and discharges the functions of the Supervisory Body and the Managing Authority.

To protect people who for their own safety and in their own best interests need care and treatment that may deprive them of their liberty but who lack the capacity to consent and where detention under the Mental Health Act 1983 is not appropriate at that time.

1547 DoLS applications (15% increase on previous year)

Of 1547, 87% (1348) of referrals were an Urgent Authorisation

581 DoLS authorisations granted

What did we do

- Utilised an external agency to reduce the DoLS backlog
- Collaborative work with the Public Health Wales (All-Wales) Mental Capacity Act and Deprivation of Liberty Safeguards NHS Workforce Group
- Participation in the Consent Working Group, the Ethics Committee and Adult Frailty Group.
- Publication of the CTMUHB DoLS Policy and Standard Operating Procedure
- Development of a new DoLS audit to be used on the hospital wards
- Created a new streamlined database for monitoring and reporting
- Collaborative work with BCUHB and SBUHB to create an All-Wales DoLS Form 1, which is currently under a pilot phase
- Continue to embed MCA and DoLS practices across CTMUHB

WHAT'S NEXT?

Commissioning of an external agency to further reduce the DoLS backlog

Roll out of a new DoLS audit to be used by wards throughout the Health Board

The commencement of a Court of Protection Lead Nurse for CTMUHB

Continue to embed MCA and DoLS practice throughout CTMUHB

Lead on a new joint contract with the Local Authorities for Relevant Person's Representative (RPR) that facilitates the transfer of the RPR with the patient from hospital to care home and vice versa

Implementation of a new DoLS Power BI dashboard that will be used in conjunction with the Electronic White Board on the wards improving authorisation compliance

Mental Capacity Act

Our Aim

The Mental Capacity Act provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.
Everyone working with and/or caring for an adult who may lack capacity to make a specific decision, must consider and comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

What did we do

- Appointment of a Safeguarding / MCA Nurse Specialist.
- Ongoing MCA and DoLS training continues with training compliance (Mandated since Sept 2023) increasing again this year. Currently to be undertaken 2 yearly for level 3, and 3 yearly for levels 1 & 2.

  Overall compliance is 67.71%.

  Level 1 is 79.73%

  Level 2 is 86.17%

  Level 3 is 53.17%
- In collaboration with Safeguarding and DoLS teams, safeguarding days were undertaken where joint learning had been identified. Training was facilitated for those groups, this included at least 6 sessions in 2025 for district nursing teams. This offered opportunities to increase knowledge around safeguarding and the application of MCA, with the use of real life anonymised experiences.
- Development of a digital MCA assessment form, ensuring a robust and holistic assessment is made throughout CTMUHB services.
- Colleagues across CTMUHB services have been supported with undertaking and completion of MCA assessments; these services include tissue viability, diabetes, medical and nursing staff. Feedback in respect of support is captured through the use of a Microsoft form.

WHAT'S NEXT?

Completion of a summarised relevant court of protection caselaw library in SharePoint for Healthcare staff

Update SharePoint site to include practical tips and caselaw summaries for all MCA related subjects and common issues

In collaboration with colleagues across NHS Wales health boards, continue to progress with alignment of level 3 MCA & DoLS training with the updated Adult Safeguarding: Roles and Competencies for Health Care Staff: intercollegiate document (2024)

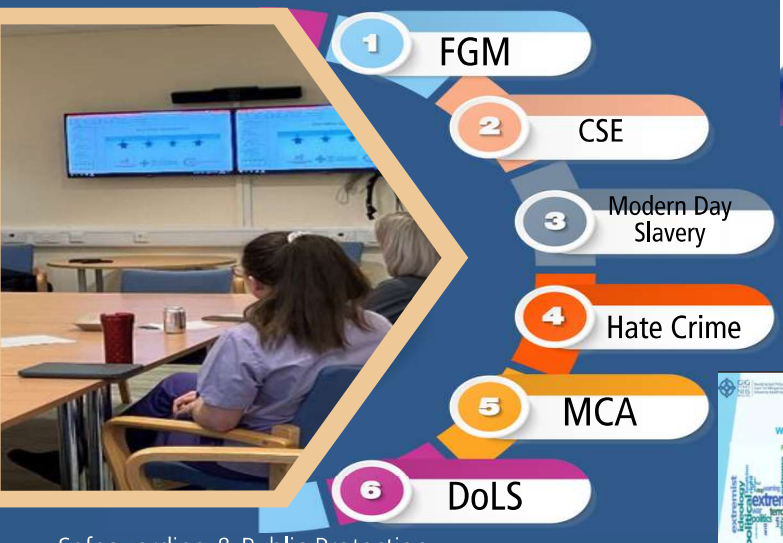
Training & Learning

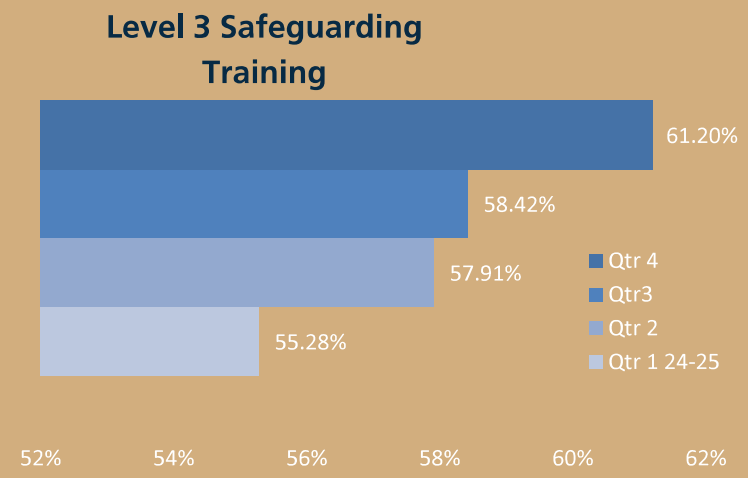
Our Aim

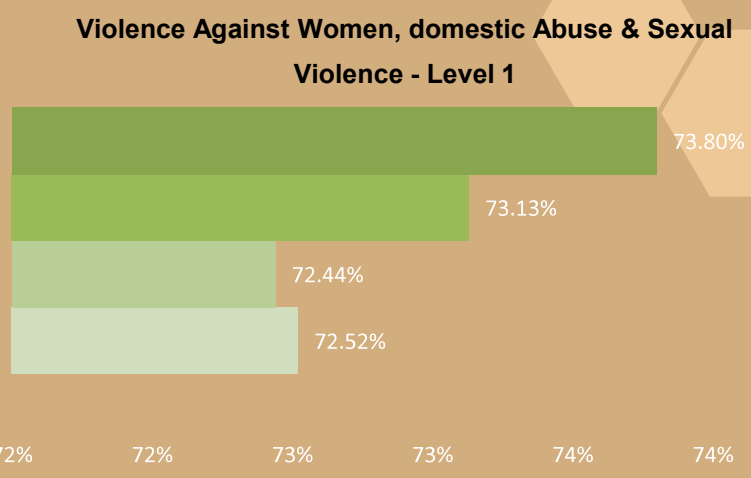
To ensure CTMUHB staff are sufficiently trained and competent to be alert to the potential indicators of abuse, including concerns about the behaviour of staff, and know how to act and report on those concerns in order to fulfil statutory safeguarding duties under the Children Act 1989 and 2004, the Social Services and Well-being (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence Act 2016, and the Counter-Terrorism and Security Act 2011.

What did we do

- In July 2024 a practice educator was appointed to the safeguarding team to ensure delivery of the health boards safeguarding training strategy
- Level 3 safeguarding training compliance was increased from 51.39% to 61.20% with all services within Children and Families Care group exceeding 80%
- Additional bespoke multi agency level 3 training sessions with the Clinical Practice Educator for MCA & DoLS, and the Independent Domestic Violence Advocate have been completed with Primary Care (District Nursing Service Across CTM, and the General Practitioners).
- Redesign of SharePoint page to include a training and education resource library
- Level 3 competencies and compliance are reviewed regularly to ensure they are in line with the Intercollegiate Documents and National Training Frameworks.
- A quarterly Newsletter has been launched providing updates on topical issues and training opportunities.
- Quarterly meetings are currently being held with Primary and Community Care Education and Training Academy to provide training and Education across CTM. This is in joint partnership with the named Doctor for Safeguarding, and includes the Foundation Doctors across the Health Board.
- The Safeguarding and Training Learning group has been initiated and will meet 3 monthly at this time to allow for growth in numbers, and diversity of services. This will allow all staff across CTM to have an overhaul voice in their training and educational needs.
- The development of a CTMUHB monitoring group to ensure actions and learning from reviews and incidents are shared across services and embedded.







Monthly Link and Learn sessions are in development with colleagues across health to facilitate an array of learning opportunities for both nursing and medical colleagues across CTMUHB services

All short training packages will be recorded and made available within the safeguarding training and education intranet pages. Work is in progress with the communications team to ensure these resources reach staff on the frontline

Development of a training plan to deliver the Violence Against Women Domestic Abuse and Sexual Violence National Training Framework

Explore opportunities to deliver and measure compliance for level 3 safeguarding across CTMUHB workforce

Work with colleagues across the network and National Safeguarding Service to establish a consistent approach in the delivery of PREVENT training

Partnership Arrangements

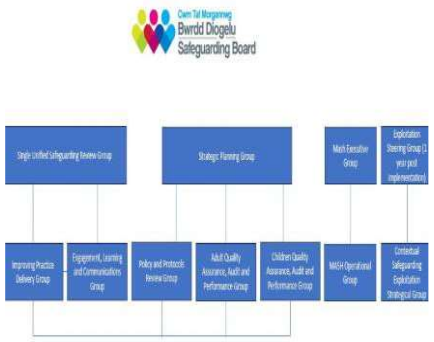
Our Aim

Through collaborative working with our partner agencies, that children and adults at risk in the Cwm Taf Morgannwg area are able to live safe lives.

Safeguarding in Cwm Taf Morgannwg is overseen by the regional multi-agency Cwm Taf Morgannwg Safeguarding Board with responsibility for:

- Safeguarding Children and Adults at Risk
- Deprivation of Liberty Safeguards
- Multi-Agency Safeguarding Hub (MASH)

The responsibilities & functions of the Board are set out in the statutory guidance under Part 7 of the Social Services & Wellbeing (Wales) Act 2014



What did we do

- CTMUHB is represented on the Safeguarding Board by the Deputy Director of Nursing and the Head of Safeguarding.
- Individuals from the corporate safeguarding team represent CTMUHB at all sub groups of the Regional Safeguarding Board and Community Safety Partnership, including; Channel Panel, Exploitation meetings, MAPPA and the suicide prevention steering groups. To ensure there is effective inter-agency co-operation in planning and delivering protection services and in sharing information.
- In collaboration with partners of the Safeguarding Board CTMUHB contributed to the Boards development day to develop priorities and review the current sub structures. The Head of Safeguarding, Deputy Head of Safeguarding and Senior Nurse all contribute to the delivery of sub groups through chairing or vice chair arrangements.
- Jointly developed policies with the regional safeguarding board and contributed to multi-agency audits.

MAPPA
Multi Agency Public Protection Arrangements

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

Home Office

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

Prevent Strategy

Multi-Agency Safeguarding HUB

Our Aim

Through collaborative working with our partner agencies, that children and adults at risk in the Cwm Taf Morgannwg area are able to live safe lives.

MASH facilitates safeguarding by working together, in one place, sharing information and making collaborative decisions. Through MASH, a timely and proportionate approach to the identification, assessment and management of safeguarding, child and adult protection enquiries can be achieved. MASH is the 'front door' for all adult and child safeguarding referrals, including high risk domestic abuse.

What did we do

- There currently remains two different working models across both the MASH in Bridgend and Cwm Taf. CTMUHB took part in an independent review of the effectiveness of MASH, contributing to new ideas to enhance multi-agency working.
- CTMUHB are working closely with partners to ensure effective communication and Information sharing in the protection of children and adults.
- The CTM MASH Health Team have continued to locate themselves within Bridgend MASH and maintain a presence on a hybrid basis at Cwm Taf MASH.
- A review of current health processes has been undertaken to ensure quality assurance is effective in the health board's referrals, database management and the management of allegations against a person in a position of trust.
- In addition to this Health have developed a Duty Desk model to ensure a consistent, proactive approach is available to all health staff accessing advice and support. This model includes a Public Protection Nurse allocated on a rota basis to managing the MASH health inbox, quality assuring all referrals and receiving telephone calls from health staff. Ensuring early communication and intervention with colleagues in the identification of those who may be at risk

Development of a MASH Health standard operating procedure, ensuring robust processes are in place to enhance multi-agency working arrangements

Establish any new processes and multi-agency working arrangements for Health, following the Cwm Taf Morgannwg MASH review

Further exploration in to the use of Once for Wales safeguarding module to improve data collection and identify themes and trends in safeguarding

The development of new data collection dashboard and reporting template to align with National Data Assurance Framework

Glossary

Child & Adolescent Mental Health Services	CAMHS	Specialised health services that assess and treat young people with emotional, behavioural or mental health difficulties.
Child Protection Conference	CPC	A multi-agency meeting between a child's parents/carers, the child (if appropriate) and practitioners involved in the child's care, organised by the local authority. The aim of the conference is to look at all the relevant information and decide what steps need to be taken to ensure the safety and welfare of the child.
Child Sexual Exploitation	CSE	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur using on line technology including social media platforms.
Joint inspection of child protection arrangements	JICPA	Joint inspections to assess how local authorities, police and health services in Wales work together to help and protect children. The joint inspection of child protection arrangements (JICPA) is a Welsh only inspection and is similar to the joint targeted area inspections (JTAI) in England.
Looked After Children	LAC	A child who has been in the care of their local authority for more than 24 hours.
Multi-Agency Safeguarding Hub	MASH	The purpose of a MASH is to bring together different agencies to enable fast information sharing with the purpose of making an efficient and fast decision to safeguard vulnerable children.
Multi-Agency Public Protection Arrangements	MAPPA	A set of statutory arrangements to assess and manage the risk posed by certain sexual and violent offenders.
Multi-agency risk assessment conference	MARAC	A meeting involving statutory safeguarding partnerships and other services to share information and discuss those at the highest risk of domestic abuse to create a coordinated action plan.
Prevent		One part of the governments overall counter-terrorism strategy.
Procedural Response to Unexpected Deaths in Childhood	PRUDiC	This procedure sets a minimum standard for a response to unexpected deaths in children and young people up to the age of their 18th birthday. It describes the process of communication, collaborative action and information sharing following an unexpected death.

Summary and Conclusion

The 2024/2025 Safeguarding and Public Protection Annual Report for Cwm Taf Morgannwg University Health Board (CTMUHB) highlights the extensive efforts and significant achievements in safeguarding children, looked after children, adults at risk, and addressing violence against women, domestic abuse, and sexual violence (VAWDASV). The report underscores the Health Board's commitment to ensuring compliance with legislation, promoting good practice, and fostering effective inter-agency cooperation.

Key Achievements

1 Training & Education

- Bespoke safeguarding training delivered across services to both medical and nursing staff groups.
- Development & dissemination of educational resources to embed Mental Capacity Act principles, along with joint training with safeguarding.
- Enhanced safeguarding supervision with a restorative approach.

2 Partnership Working

- Ongoing collaboration with nursing & medical colleagues, regional safeguarding boards, & external agencies.
- Contributions to regional & national safeguarding initiatives, including child & adult practice reviews.
- Development of regional policies and procedures

3 Operational Improvements

- Reduction in the Deprivation of Liberty Safeguards assessment backlog through external support.
- Implementation of policies and standard operation procedures to provide a consistent and equitable approach to safeguarding.
- Introduction of safeguarding duty desk to provide additional scrutiny of safeguarding referrals.

4 Special Initiatives

- Development of resources & training to support the management of concerns for those in a position of trust.
- Ongoing review into health representation at Multi Agency Risk Assessment Conference (MARAC) to improve multi-agency responses to domestic abuse & violence.

5 Audit & Compliance

- Extension of the annual audit plan to include DoLS & Paediatrics. In addition, enhancement of current safeguarding and routine enquiry audits.
- Enhanced procedures for managing allegations against professionals & improving data collection.

6 Innovative Practices

- Utilisation of technology & feedback mechanisms to ensure the voice of the child is central to service delivery.
- In partnership with the health boards quality improvement team, redesigned and streamlined systems for improved data collection and quality.

Conclusion

CTMUHB has demonstrated strong leadership and commitment in safeguarding and public protection, addressing both immediate needs and long-term improvements across multiple areas. The health board's proactive approach, evidenced through extensive training, robust partnership working, and innovative solutions, ensures that children, adults at risk, and victims of domestic abuse receive the necessary protection and support. Moving forward, CTMUHB aims to build on these successes, continuously enhancing their safeguarding framework to adapt to emerging challenges and maintain high standards of care and protection for all individuals within their remit.

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

Annual Report
2024/2025

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0. Introduction and Foreword - Chair of the Regional Safeguarding Board

Welcome to the 2024-2025 Cwm Taf Morgannwg Safeguarding Board Annual Report.

In March 2023, the Board published a three-year Strategic Plan and each year publishes an Annual Plan CTMSB Annual Plan 2024-25 setting out its key priorities for the coming year. These priorities stem from the lessons that we have learnt over previous years and an analysis of the prevalent and emerging safeguarding issues affecting the region. There remains a strong focus on developing our strategical approach to exploitation both in relation to children and adults at risk, with the Board launching its regional Exploitation Strategy this year. The new, regional Exploitation Strategy will support agencies and those in our communities to effectively identify all forms of exploitation and understand how to report any concerns, as well as introducing a robust toolkit for professionals to assess risk and agree effective interventions to reduce this for all those affected. The implementation of the Strategy will be overseen by revised governance arrangements which will ensure implementation is effective and which will be responsible for undertaking post-implementation review and evaluation to support that this is fully meeting the needs of all those at risk of exploitation.

Recognising early intervention and prevention to reduce and eradicate abuse and neglect are crucial in meeting the needs of people we support, so a key focus this year has continued in respect of raising the profile of this across the region. We continue to work successfully in partnership with the NSPCC and other key stakeholders to raise and promote public awareness campaigns, supporting communities to recognise signs of abuse and neglect and how to report any concerns.

The Board has also supported the implementation of the Single Unified Safeguarding Review (SUSR) framework this year including improvements in recording learning outcomes and key recommendations which support practice improvements where harm to adults or children has occurred. The Board published six Safeguarding Reviews during 2024/25 and will continue to work with key stakeholders in 2025/26 to support future learning at a regional and national level.

Finally, I would like to thank all staff who work tirelessly across the region to protect our most vulnerable people in a time of significant demand. Their wellbeing remains a priority for the Board and we continue to seek assurances from partner agencies that staff are adequately supported.

If anyone is interested in finding out more about the Cwm Taf Morgannwg Safeguarding Board, or if you'd like to get involved in informing our priorities, please contact our Business Unit by e-mailing: ctmsafeguarding@rctcbc.gov.uk

Lisa Curtis-Jones
Chair of the Cwm Taf Morgannwg Safeguarding Board

1. Safeguarding in Cwm Taf Morgannwg

The region of Cwm Taf Morgannwg covers the local authority areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf with a combined population of approximately 427,000[1]

The **Cwm Taf Morgannwg Safeguarding Board** is a statutory partnership made up of the agencies that are responsible for safeguarding children and adults at risk in Cwm Taf Morgannwg. The aim of the Board is to ensure that people of all ages are protected from abuse, neglect or other kinds of harm. This also involves preventing abuse, neglect or other kinds of harm from happening.

The two key **safeguarding** objectives of **protection** and **prevention** underpin the work of the Board and inform the priorities each year.

The responsibilities and functions of the Board are set out in the statutory guidance under Part 7 of the Social Services and Wellbeing (Wales) Act 2014. It has an overall responsibility for challenging relevant agencies so that:

- There are effective measures in place to protect children and adults at risk who are experiencing harm or who may be at risk as the result of abuse, neglect or other kinds of harm; and
- There is effective inter-agency co-operation in planning and delivering protection services and in sharing information.

Safeguarding Children

Section130 (4) of the Social Services and Well-being (Wales) Act 2014 defines a child at risk as a child who:

Is experiencing or is at risk of abuse, neglect or other kinds of harm;

a) Has needs for care and support (whether or not the authority is meeting any of those needs).

What do we mean by Harm?

Harm is defined as:

- ill treatment - this includes sexual abuse, neglect, emotional abuse and psychological abuse
- the impairment of physical or mental health (including that suffered from seeing or hearing another person suffer ill treatment).
- the impairment of physical, intellectual, emotional, social or behavioural development (including that suffered from seeing or hearing another person suffer ill treatment).

Types of Harm

The following is a non-exhaustive list of examples for each of the categories of harm, abuse and neglect included in vol 5 Working Together to Safeguard People: Volume 5 – Handling Individual Cases to Protect Children at Risk:

[1] Source: Office for National Statistics (Census 2021)

- **Physical abuse** - hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions;
- **Emotional/psychological abuse** - threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks, witnessing abuse of others
- **Sexual abuse** - forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening, including: physical contact, including penetrative or non-penetrative acts; non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways;
- **Financial abuse** - this category will be less prevalent for a child but indicators could be:
  - not meeting their needs for care and support which are provided through direct payments; or
  - complaints that personal property is missing.
- **Neglect** - failure to meet basic physical, emotional or psychological needs which is likely to result in impairment of health or development.

Safeguarding Adults

S126(1) of the Social Services and Well-being (Wales) Act 2014 defines an adult at risk as an adult who:

a) is experiencing or is at risk of abuse or neglect,
b) has needs for care and support (whether or not the authority is meeting any of those needs), and
c) as a result of those needs is unable to protect himself or herself against abuse or neglect or the risk of it.

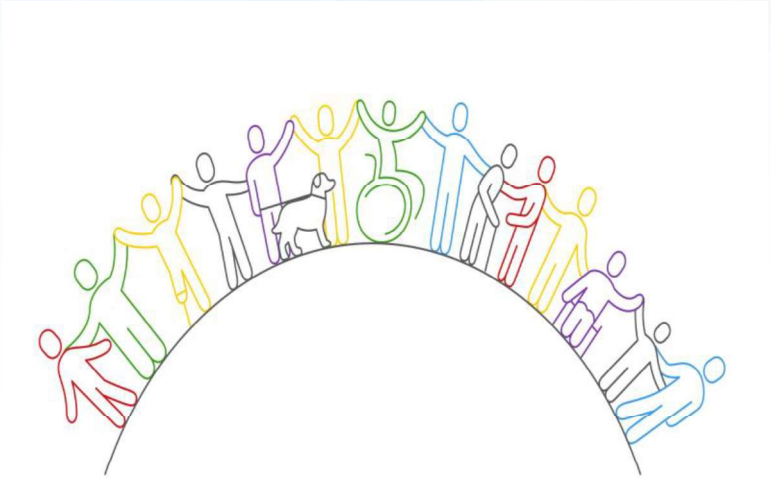
Abuse can be physical, sexual, psychological, emotional or financial (includes theft, fraud, pressure about money, misuse of money) and can take place in any setting, whether in a private dwelling, an institution or any other place.

Neglect describes a failure to meet a person's basic needs physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health). It can take place in a range of settings, such as a private dwelling, residential or day care provision.

Multi Agency Safeguarding Hubs

In the Cwm Taf Morgannwg region there are two Multi Agency Safeguarding Hubs (MASH) that report to the Board: **The Cwm Taf (Merthyr Tydfil and Rhondda Cynon Taf) Multi Agency Safeguarding Hub (MASH) and the Bridgend Multi Agency Safeguarding Hub (MASH).**

The purpose of the MASH is to act as the single point of contact for all professionals to report safeguarding concerns. MASH provides the opportunity for a higher standard of safeguarding by providing all professionals with more information on which to make better, more informed, and more timely decisions. This enables the effective sharing of information between agencies, helping to protect children and adults from abuse and neglect.



Whilst the Bridgend MASH operates a fully co-located model with staff located at Bridgend County Borough's Civic Centre, within Cwm-Taf, agencies operate a hybrid model based out of Pontypridd Police Station. Working arrangements have evolved following the COVID-19 pandemic but have not compromised prompt information sharing and effective actions to safeguard people. The MASH services continue to embrace new communication/information sharing technology that support both in-person and remote working.

The collaboration of both Multi-Agency Safeguarding Hubs continues to be a key focus of the Board to streamline multi-agency safeguarding across the Cwm Taf Morgannwg region. Recent collaborative projects include:

- An ongoing multi-agency working group to support a consistent approach to modernised, operational MASH models utilising best practice and aiming to build on further, effective collaboration. The Terms of Reference and MASH Operating Protocols will continue to be subject to review into 2025/26 to ensure the key aims of protecting children and adults effectively are being maximised.
- A multi-agency working group to develop Multi-Agency Children's Services Threshold Guidance to support shared understanding of threshold decision making and eligibility support across the three local authority areas in Cwm Taf Morgannwg.
- Ongoing work to establish clear pathways for signposting and referrals for professionals (for both Children and Adults).
- Contributing to the National Independent Safeguarding Board's development of the National Multi-Agency Performance Framework. This will provide assurances to the Board on the efficacy of multi-agency safeguarding practice across the region.
- The successful implementation of a new MASH information sharing system that is fit for purpose for both Cwm Taf and Bridgend. The system is supported by dedicated online TEAMS channels, providing multi-agency online workspaces for real-time collaboration and decision making. A review of the revised MASH Information sharing system implemented in 2023, is also scheduled which will include a comprehensive consultation with system users to scope further system improvements during 2025/26.

2. Members of the Safeguarding Board

The Lead Partner for the Board is Rhondda Cynon Taf County Borough Council and the membership complies with the statutory guidance issued under Part 7 of the Social Services and Well Being Act 2014.

The lead partner hosts the Board's Business Unit and holds the Board budget on behalf of the statutory partner agencies.

A list of Board members is attached as Appendix 1.

3. What did the Board do in 2024-2025 to meet its Outcomes?

Governance

The Safeguarding Board has, during 2024/25 undertaken a full review of its former governance structure (detailed at Appendix 2) and created a revised sub-structure which will be implemented in 2025/26. The new structure will more effectively support the Board's ability to carry out its core functions to achieve positive outcomes for children and adults at risk in Cwm Taf Morgannwg.

Challenge and Scrutiny

The Board holds partner agencies to account in relation to their safeguarding activities through effective monitoring and challenge via its Safeguarding Board and Sub-Group meetings, reviews, inspection reports and audit activity. The Board also utilises its Risk Register to support the timely identification of any safeguarding risks and to ensure the efficacy of appropriate mitigating actions to address identified risk.

The Board encourages partner agencies to share individual inspections and reviews that relate to safeguarding and fosters a strong culture of learning and collaboration in respect of driving improvements in safeguarding activity. In 2024-2025, the Board received and reviewed the following reports and improvement plans from agencies:

- Probation Services Re-Set
- South Wales Police Cyber Crime
- NHS Wales National Safeguarding Service
- CTM Multi-Agency Professional Forum - Review of Suspicious & Unexplained Injuries (Children)
- Cwm Taf MASH Report – Michelle McManus, Professor Safeguarding Violence Prevention, Manchester Met University
- CIW – Rapid Review of Child Protection Arrangements
- Parc Prison – "Six to Fix" Priorities for Improvement Plan
- HMIP CTM Youth Justice Report

Performance

The Board has a performance framework in place to capture safeguarding data which is consistently scrutinised via its sub-groups. Work has been ongoing during 2024/25 with partners to ensure that we have a consistent, regional, multi-agency framework. The Board has also ensured representation at a range of national forums this year in respect of keeping abreast of developing workstreams, national guidance and good practice to support the delivery of effective safeguarding. This has included:

- National Independent Safeguarding Board workshops in relation to the development of a National Performance Framework for Children
- Welsh Government Steering Group for Missing Children
- Wales Procedures Project Board
- Single Unified Safeguarding Review Implementation Group
- Centre of Expertise on Child Sexual Abuse

The Board has a Children's Quality Assurance and Performance Group (CQAP) and an Adult's Quality Assurance Group (AQAP) that receives and analyses multi-agency performance metrics, scrutinising, respectfully challenging data and reporting on key thematic sources of harm. This ensures that the triangulation of qualitative and quantitative data is analysed, focused on outcomes

and the lived experience of the child and/or adult through the journey of their intervention. Moving into 2025/26, the Board will seek to increase its focus in respect of "transitional safeguarding" with the aim of evaluating services and the effectiveness of support including the lived experience of children subject to safeguarding arrangements transitioning into adulthood.

Children's Safeguarding

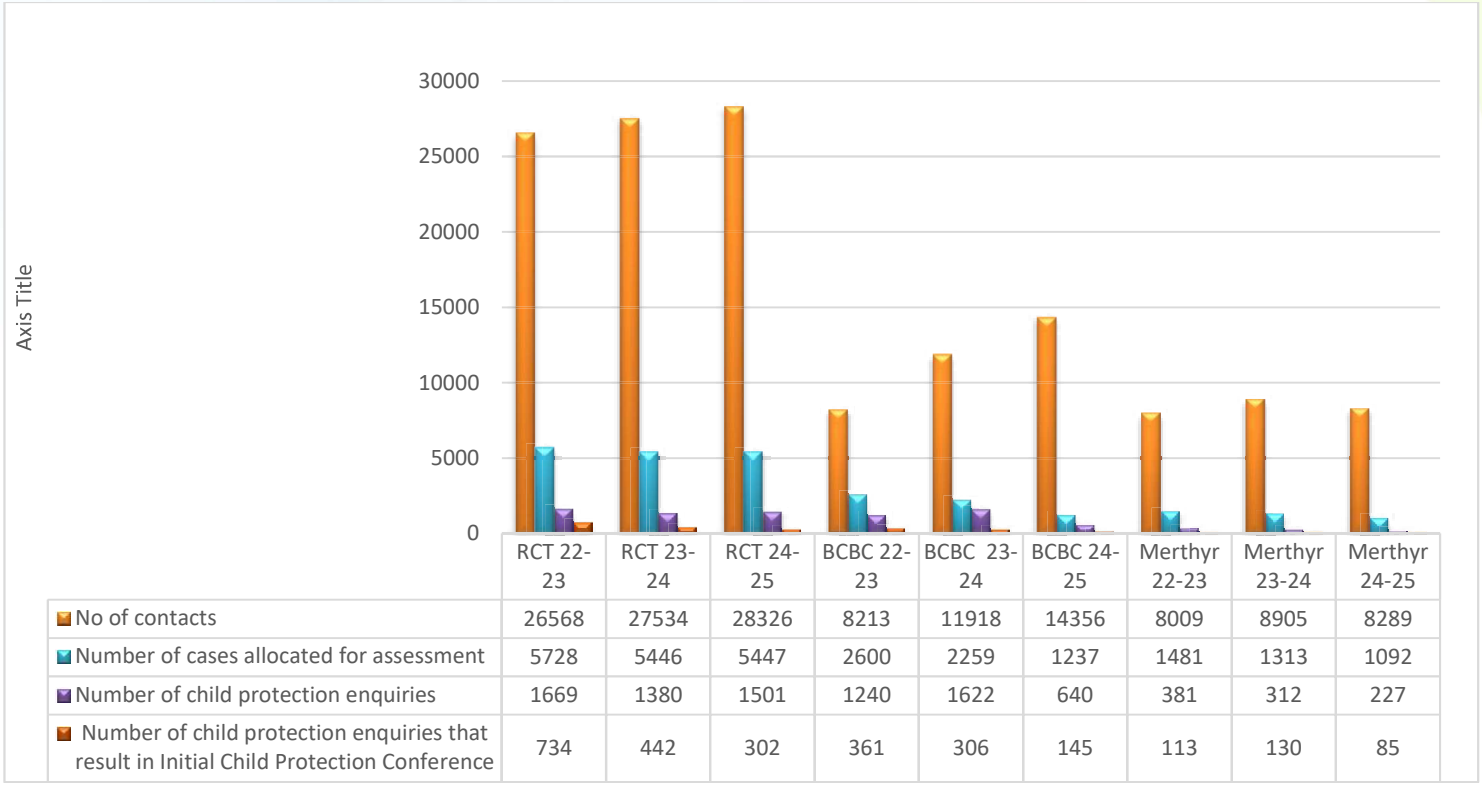
In 2024-2025, there has been a continued increase in the demand at the front door across RCT and Bridgend. Merthyr has seen a small decrease in the overall number of contacts received and this was attributed to the work undertaken with Education Services in relation to early help, prevention and quality referrals. Bridgend has seen the most significant increase of 32% throughout the year, although this is directly related to changes in service structures with Early Help and Prevention moving into the Children's Services directorate. The joint campaign with NSPCC on raising public awareness on signs of safeguarding and how to report safeguarding concerns has continued this year which may also have impacted on an increase in safeguarding contacts.

In **Bridgend**, the Signs of Safety model has also led to the IAA Teams undertaking a greater level of activity when working with a family. The IAA Teams hold cases for the full 42 days where required and this increase in work with families is having a positive impact and often resulting in a step down to Early Help being appropriate. Routinely IAA undertake a Family Network Meeting, Words and Pictures and Mapping with families prior to determining next steps.

In **Rhondda Cynon Taf**, following a review of the Information, Advice and Assistance Service, RCT Children's Services have continued to develop the Right Help, Right Time, Right Place Strategy that has evidenced the need to transform Prevention, Eary Intervention and specialist statutory Children's Services, ensuring a graduated response to need and a whole (multi-disciplinary) system response to ensure sustainable service delivery.

In **Merthyr Tydfil**, the child exploitation process has been adapted and is in use prior to a formal launch of the CTM wide Exploitation Strategy due in 2025/26. This has been positively received by families and positive feedback from a family member included how the process has changed their view of Social Services and working with professionals.

Children's Safeguarding Data

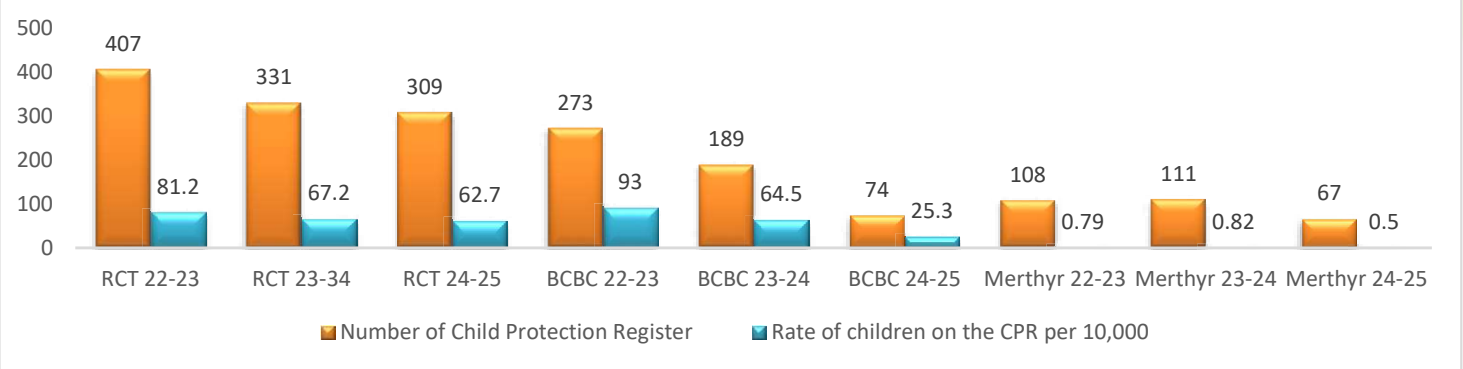


	RCT 22-23	RCT 23-24	RCT 24-25	BCBC 22-23	BCBC 23-24	BCBC 24-25	Merthyr 22-23	Merthyr 23-24	Merthyr 24-25
No of contacts	26568	27534	28326	8213	11918	14356	8009	8905	8289
Number of cases allocated for assessment	5728	5446	5447	2600	2259	1237	1481	1313	1092
Number of child protection enquiries	1669	1380	1501	1240	1622	640	381	312	227
Number of child protection enquiries that result in Initial Child Protection Conference	734	442	302	361	306	145	113	130	85

The number of contacts that proceed to an assessment is relatively low across the region with RCT progressing 21% (1432/6761), Bridgend 5% (223/4164) and Merthyr Tydfil 15% (297/1957). Merthyr Tydfil and RCT have remained relatively stable when compared with 23-24 data and Bridgend has seen a decrease of cases proceeding to assessment. This year there has been a focus across the region on strengthening the offer of prevention, early intervention and signposting (where appropriate), internal quality assurance work on Wales Safeguarding Procedures (WSP) determinations (thresholds) and the development of Multi-Agency Children's Services Threshold guidance to support shared understanding of threshold decision making and eligibility support across the three local authority areas. There has been continued development and implementation of social work models of practice across each local authority and whilst these models are localised, there are similarities, with a key focus on strengths, relationships, collaboration, trauma informed, whole family approaches. These developments are in line with the recommendations of the CIW/Estyn Rapid Review of Child Protection Arrangements. A revised Child Safeguarding Referral Form (C1) and support guidance was signed off by the Board in December 2024. It is hoped these will assist further in the provision of the right support at the right time, quality referrals and a shared understanding of agency decision making.

Cases proceeding to child protection enquiries has decreased across the region and this is in line with the model of practice approaches discussed above, ensuring interventions with families are based on what matters to them, ensuring proportionate decision making and earlier prevention and intervention to prevent escalation into child protection processes. As such, the number of children on the Child Protection Register has also decreased this year.

Child Protection Registration



For 2025-2026, we will continue to focus quality assurance work on child protection conferences, with a focus on multi agency contribution, child and family participation, including fathers, voice of the child, lived experience and re-registration and de-registration within the first six months to ensure recommendations from practice reviews and national reviews are taken forward.

Model of Practice

Bridgend Children's Services

The Signs of Safety practice model has supported our practice in this period; we have seen an increase in compliments received from families and partner agencies about the improved processes and relationships within the Bridgend MASH. This is especially pleasing given the significant increase in demand seen in this period. Our complaints have decreased and when received are resolved more quickly. We continue to hold weekly, monthly and quarterly meetings and interfaces with regional partners to support working together and shared learning. We have created and appointed a Principal Officer - Social Work Transformation and a Consultant Social Worker Signs of Safety to support the continued implementation of our practice model and strengthen the quality of our practice and child assessments.

Rhondda Cynon Taf Children's Services

RCT Children's Services Lead Manager for Practice continues to support the development of our model of practice in line with our vision. The new will strengthen practice, leading to safe reduction of entries to care; provide timely and responsive intervention to families to keep them together, de-escalating need and risk, safeguarding children and safely reducing the number of children who become looked after. The three key pillars of our practice are Relationships, Collaboration and being Trauma Informed. We have begun to roll out collaborative communication training across the workforce as part of the continued development of the model of practice and remain committed to providing a strength-based model, working alongside children and families, building on strengths to help them make the changes they need, whilst always prioritising our role in keeping children safe.

RCTCBC CASE STUDY PDF

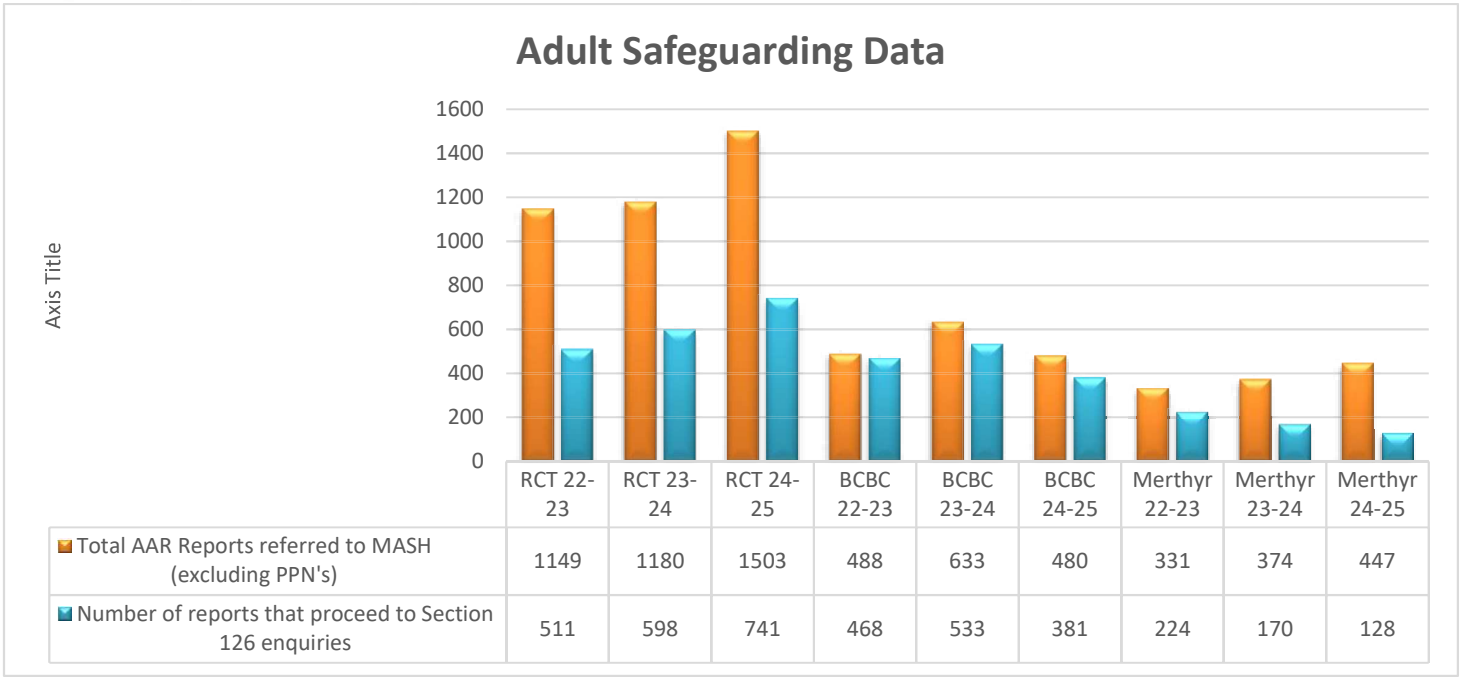
Merthyr Tydfil Children's Services

MTCBC children's services utilise systemic model to support our practice. This has led to work on improving the quality of chronologies and how we work with families. The model is being embedded through additional training offers, peer support and regular case discussions with systemic practitioners. The systemic model considers how all the systems interlink and interact around the family and individuals rather

than considering them in isolation. The use of genograms, enhancing relationships and working with the whole system will lead to a reduction in the number of entries to care and reduction in the length of time children's names remain on the child protection register.

Adult Safeguarding

Overall, there has been an increase in reports across RCT (24%) and Merthyr Tydfil (19%) whilst Bridgend has seen a decrease by 24% in 24/25. The percentage of reports proceeding to S126 continues to differ between the three local authorities. The overall percentage for Bridgend was 79%, 8% lower than 23/24 (87%), whilst it was 29% for Merthyr Tydfil, 16% lower than 23/24, and RCT remained consistent to 23/24 with approximately 50% of reports proceeding to S126.



	RCT 22-23	RCT 23-24	RCT 24-25	BCBC 22-23	BCBC 23-24	BCBC 24-25	Merthyr 22-23	Merthyr 23-24	Merthyr 24-25
Total AAR Reports referred to MASH (excluding PPN's)	1149	1180	1503	488	633	480	331	374	447
Number of reports that proceed to Section 126 enquiries	511	598	741	468	533	381	224	170	128

S126 completed within 7 working days 24/25					
RCT	85%	**MTCBC**	81%	**BCBC**	68%

All 3 local authorities continue to be committed to improving on the national KPI regarding S126 enquiries being completed within 7 working days.

RCT Adult Services have changed their referral process in the latter part of 24/25 and this has impacted on how data is collated. In January 25, a revised process where all enquiries/reports raising concerns about an adult at risk should be made to Safeguarding Duty via the submission of an A1 Referral Form only, with the only exceptions being WAST and SWP who have continued to use their own referral processes. This revised process will ensure consistent and accurate data reporting for the future. Work is also underway to address the percentage of cases proceeding to S126 including consideration of developing practitioner consultation and alternation provider reporting pathways.

RCT Adult Services Case Study PDF

In **Bridgend Adult Services**, changes have been made during 2024/25 to the management of Adult at Risk referrals, introducing a consultation process where referrers are encouraged to consult with the Adult safeguarding team before submitting an Adult at Risk Referral form (A1). This provides early advice and guidance prior to determining the need for a referral and also enables swift escalation of cases where required. This has improved partnership working with providers and developed confidence in staff and others to seek advice, ensuring informed decision, correct levels of interventions or support at the first point of contact. Changes made in 24/25 have effectively reduced the number of overall referrals being received. Some challenges remain in meeting the number of S126 enquiries being completed within 7 working days due to a small staffing team, but there are robust monitoring and escalation processes in place.

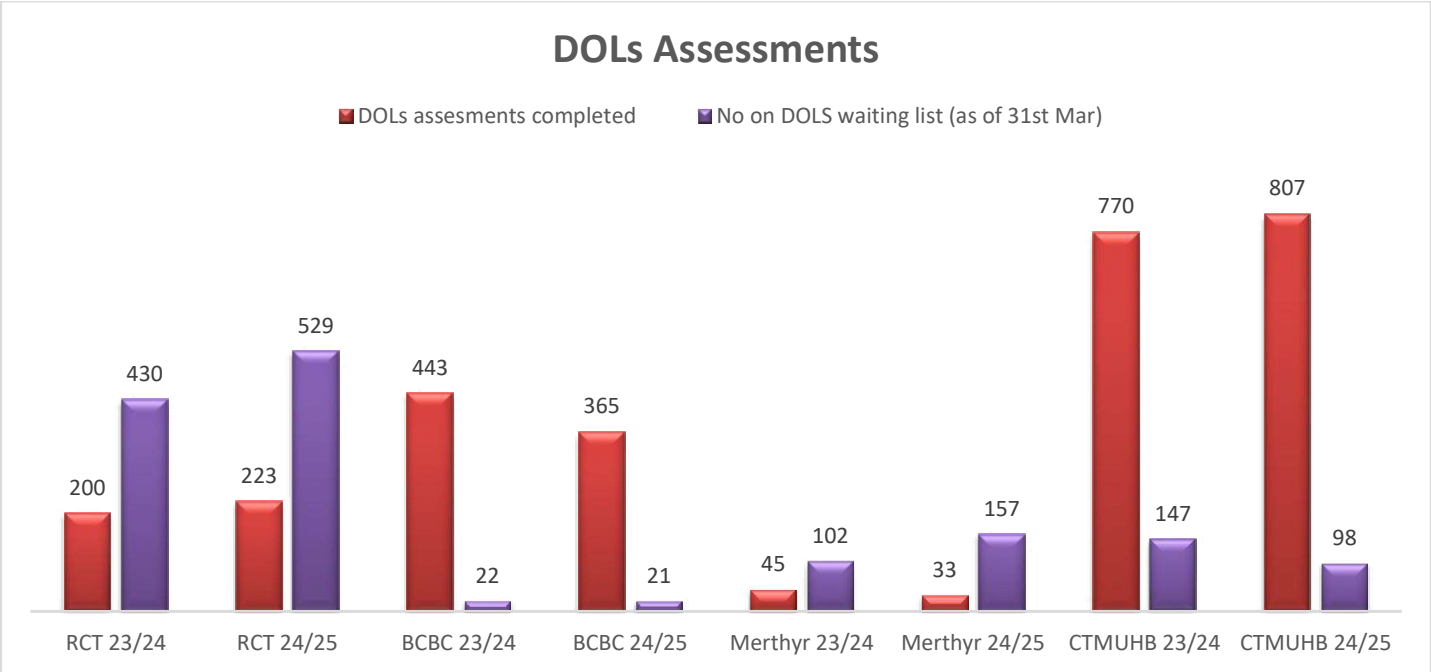
Merthyr Tydfil Adult Services have continued to see a rise in Adult at Risk referrals (A1). S126 has been identified as an area that requires future audit at the Adults Quality Assurance Panel (AQAP) to consider themes or trends and learning to improve practice. We have considered lessons arising from learning regarding the efficacy of recording safeguarding information in relation to adults at risk and this has been incorporated into the development of the new social care system MOSAIC that is due to be implemented regionally in January 2026. We also presented a case study to the AQAP highlighting that there is currently no formal adult protection medical process when an individual that's lacks capacity presents with unexplained injuries as is the case in Children's Safeguarding. This has now been escalated to an all-Wales level in partnership with our Health Board so that the Welsh Government is aware and can propose options to meet this un-met need in future.

Escalating Concerns

Reports from Local Authority Commissioning Departments were received each quarter in relation to service providers in escalating concerns. There were 5 in total during 2024/2025, a slight decrease from 6 during 2023/24.

RCT	1	**MTCBC**	1	**BCBC**	3

Deprivation of Liberty Safeguards (DoLS)



The Health Board had a 4.8% increase in the number of DOLs assessments completed during 24/25.

Bridgend has completed a programme of training to staff to enable them to undertake DOLs assessment. This has seen a reduced waiting time as evidenced by an 18% reduction in the waiting list as of 31st March 2025, comparative to the same period in 2023/24.

Rhondda Cynon Taf and Merthyr Tydfil have seen an increase in the waiting list for DOLs assessments this year however a programme of work is underway aligned with the strategic priorities to address the backlog.

RCTCBC DoLS Case Study PDF

Self-Neglect

In **Merthyr Tydfil**, there has been no Self Neglect panel held in 24/25 as the threshold was not met in line with the existing Guidance. A review of Self Neglect pathways and procedures will take place in 2025/26 in line with expected, updated national Guidance and improved reporting capability provided by the new Mosaic safeguarding database due to be implemented from January 2026. Similarly, in **RCTCBC**, the Self Neglect Panel was paused during 2024 due to the retirement of the Service Manager who co-ordinated this and also the withdrawal of the administration support from the Safeguarding Board. Following the appointment of the new Service Manager in October 2024, work has been underway to re-establish the Panel and an internal RCT process for managing Self-Neglect referrals. A generic email inbox for referrals has been put in place in the interim which is monitored and responded to by the Head of Service/Service Manager

Bridgend have maintained Self Neglect Partnership Panels. A generic email address for referrals is in place and we have reviewed the existing Policy and referral process. We have developed a clear criteria for Panels however we also encourage ongoing consultations, discussions for support and guidance on self-neglect cases outside of the Panel.

Adult Services throughout the region will continue to progress improvement work with the Safeguarding Board's Adult Quality Assurance Panel into 2025/26 to support the implementation of a consistent and improved approach to self-neglect. The future development of Adult Thresholding Guidance for the region which incorporates the signs and severity of self-neglect will better support agencies and professionals to identify self-neglect concerns.

Professional Disagreements

The Board's Concerns Regarding Inter Agency Safeguarding Practice (CRISP) Protocol supports practitioners in finding a resolution when they have a professional disagreement or concern in relation to another agency's safeguarding practice.

A review of the current Protocol (last reviewed in 2023) is due to take place during 2025 via the Board's Protocols and Procedures sub-group. The 2025 review will focus on simplifying the current guidance and will be supported by a communication strategy to ensure all key stakeholders and professionals are better aware of the Protocol. This will clearly outline a requirement for, wherever possible all inter-agency differences to be resolved directly between agencies under good practice arrangements. During 2024/25, there were no Stage 2 CRISPs referred to the Safeguarding Board.

4. How did we implement our Annual Plan and what were our key achievements?

The Board published a Three Year Strategic Plan (2023/2026) on the 31st March 2024, setting out its priorities for safeguarding children and adults at risk in Year Two CTMSB Annual Plan 2024-25
In relation to the Boards Strategic Priorities, a summary of our work during 2024/25 is detailed below:

Strategic Priority 1: We will re-set and establish where we are and where we need to be.

Any pertinent safeguarding risks that the Safeguarding Board's partners identify are added to the Board's regional Risk Register which is overseen by the Executive Steering sub-group.

Agencies are able to add risks to the Register with Board supporting the appropriate scrutiny of these with the aim to reduce any safeguarding risk and support partners to identify resolutions or overcome challenges which may impact on effective safeguarding within the region.

RCTCBC Education

RCT Education Services work with a range of partners to develop their safeguarding approach.

Annually all schools must review and evaluate their own safeguarding procedures and the Board's School Safeguarding Policy is also reviewed each year. To ensure this is robust, we insist that this is taken to the Governing Body for ratification in the Autumn Term. Following previous good practice noted within the use of the 'My Concern' system across RCT we have extended the Contract for all schools for an additional year until May 2026.

Bridgend's EEYPP Directorate

All schools and maintained early years settings are required to undertake annual safeguarding audits which are scrutinised by the Education Engagement Team. These audits are completed as a self-evaluation tool for schools in collaboration with the Education Engagement Team (EET). For the school year 2024-2025, 56 schools rated themselves as green in their self-assessment safeguarding audits. There were no schools identified in the red category.

MTCBC Education

Merthyr Tydfil's Education Department fulfills its statutory duties and contributes towards the Board's priorities by:

- Working in partnership to identify the best outcomes for learners and supporting a greater level of partnership work with Children Services to develop joint pieces of work.
- Disseminating and sign posting relevant information such as toolkits, assessments and training to the designated Safeguarding Lead within all schools and education staff.
- Providing advice, information and guidance in relation to safeguarding concerns with schools and supporting them to act accordingly and follow reporting procedures.
- Taking action to reduce safeguarding concerns at the earliest opportunity.

This year, partners of the Safeguarding Board have continued to support further roll-out of the regional partnership campaign with the NSPCC to raise public awareness on how to report safeguarding concerns. This originated from a recommendation within an earlier Child Practice Review. This has included, in

partnership with Education departments across the region, the development of the '***It's Not Love***' play throughout a number of secondary schools which focused on healthy relationships helping children and young people to recognise the signs of abuse in order to better safeguard themselves.

RCTCBC Adult Services

The Director of Social Services and the Head of Service are members of RCT's Corporate Safeguarding Board and continue to work with colleagues in the Social Care Workforce Development Partnership and Corporate Human Resources to embed the work of National Safeguarding Training and Learning Standards for all staff groups across the Council. RCT's Corporate Safeguarding Board has also developed publicity material to raise awareness of abuse and/or neglect across the Council, with staff and commissioned providers.

RCT Adult Services continues to offer an 'Early Help' service option for South Wales Police, via the Community Development Team.

The wellbeing of staff continues to be a priority for RCT Adult Services. Alongside the support available corporately from RCT Council, Adult Services offers regular staff forums with Heads of Service, where staff escalate issues of concern.

Bridgend Adult Services

Adult Services have fully embedded the outcome-focused approach to care and support planning, identifying their outcomes and building on a person's strengths to achieve this. There is a greater focus on what matters most to the person and how their strengths, family, friends, and community can help them achieve their goals, empowering those we support and promoting choice.

Merthyr Tydfil Adult Services

During 2024/25, all safeguarding training within the Authority was provided via an interactive application (BOB's Business). This enabled training to be provided to all staff and supported monitoring compliance and maintain knowledge within the workplace.

During the year they have reviewed data surrounding the number of referrals and caseloads within the Safeguarding Team. This data has supported further, successful recruitment within the Team.

Within the wider context of the safeguarding environment, they have reached out to significant stakeholders such as Cardiff City FC and Cardiff Blues RFC to explore areas of development within their current community resources.

RCTCBC Children's Services

RCT Children's Services have robust partnership working arrangements across Cwm Taf Morgannwg Safeguarding Board and the Community Safety Partnership with attendance and contribution at the CTM Community Safety Partnership and relevant subgroups. i.e. Contest and VAWDASV including workshops on the development of the Violence Prevention Board.

They are represented on the CTM Emotional Health and Wellbeing Group of the Regional Children's Services Programme Board which aims to take a lead on emotional wellbeing and mental health services and developments across the region of Cwm Taf Morgannwg for children and young people.

They have continued to contribute fully to the NSPCC/CTMSB campaign on raising public awareness and supported and contributed to the launch of '**It's Not Love'** Play across the region.

RCT Children's Services have continued to contribute significantly to the exploitation subgroup (MACE)

and the development of the CTMSB Exploitation Strategy including creating training that was shared with the CTMSB Exploitation Group for consideration of its use regionally. They continue to attend the Pan Wales Exploitation working group on behalf of the CTMSB.

Following a review of the Information, Advice and Assistance Service, RCT Children's Services have continued to develop the Right Help, Right Time, Right Place Strategy that has evidenced the need to transform Prevention, Early Intervention and specialist statutory Children's Services, ensuring a graduated response to need and a whole (multi-disciplinary) system response to ensure sustainable service delivery as the data demonstrates continued high and increasing demand at the 'front door' where a determination of 'no further action' has exceeded 50% over the last 3 years.

Positively in RCT, when compared to the same period last year there has been a 21% decrease in the number of children on the Child Protection Register (CPR) and the number of children becoming looked after has remained relatively stable, decreasing by 3% last year.

They have continued to contribute to the National Independent Safeguarding Board's ongoing, national work on a multi-agency performance framework attending national meetings and holding localised discussions with the facilitators on behalf of CTMSB.

RCT Children's Services continue to develop our model of practice in line with their vision. A new model will strengthen practice, leading to safe reduction of entries to care; provide timely and responsive intervention to families to keep them together, de-escalating need and risk, safeguarding children and safely reducing the number of children who become looked after.

During 2024/25, RCT Children's Services have improved their Children's Services webpages for parents and carers and begun to develop bespoke webpages for children and young people including those who are care experienced so that information is in an accessible language and format.

Bridgend Children's Services

Bridgend has worked to the priorities set by the CTMSB during 2024/25. They continue to progress their quality assurance framework and facilitate workshops to fully embed learning and share good practice examples.

The Quality Assurance Officer represents the Directorate on the Board Protocols & Procedures Sub-Group (PPG) and CTMSB Children's Quality Assurance and Performance Sub-Group.

They have fully embedded the information sharing platform "GOSS" within the Bridgend MASH and the IAA Team.

During 2024/25, they have worked with multiagency partners to develop Multi-Agency Children's Services Threshold Guidance. This Guidance will provide a framework for professionals who are working with children, young people and families and aims to help practitioners identify when a child may need additional support to achieve their full potential. This will be signed off via the Safeguarding Board later in 2025.

Merthyr Tydfil Children's Services

Merthyr Tydfil Children's Services has supported the Board by contributing to the Board's Risk Register including the identification of any risks that will require recording into 2025/26. They have also been involved in raising the profile of neglect and multiagency working by supporting the regional NSPCC campaign, working with a range of multi-agency partners to contribute to this. They have also worked consistently with partners on the CTM Exploitation Strategy, future Cwm Taf MASH development and the SUSR process since implementation in October 2024. This has included nominating Chairs and Reviewers to support and lead on the Board's Safeguarding Reviews this year.

Cwm Taf Morgannwg University Health Board (CTMUHB)

Each year, the Health Board reviews workplans aligned to its Safeguarding Maturity Matrix. The CTMUHB three- year Safeguarding Strategy aligns to the priorities of both the Health Board and Regional Safeguarding Board. Progress of work is monitored quarterly through the Board's Executive Group within the Health Board. This year, safeguarding resources have been reviewed and realigned to ensure effective multi-agency working, information sharing and communication.

Through an Annual Audit Plan, the CTMUHB review how improvements and learning are embedded into practice. In order to share learning from incidents, concerns and complaints, bespoke training and safeguarding supervision has been provided to areas within primary and secondary healthcare. Joint work has been undertaken with Local Authorities and South Wales Police in respect of specific cases where there has been identified multi-agency learning.

CTMUHB colleagues have continued working with agencies and third sector colleagues to identify key resources to share throughout services in the Health Board. The continued development of the hospital-based Health IDVA has been key in identifying opportunities for early intervention, prevention and effective safeguarding of those suffering domestic abuse who present at the secondary healthcare setting Accident and Emergency department within the Royal Glamorgan Hospital.

CTMUHB work in partnership with BCBC to safeguard those individuals who have had a near miss in respect of suicide or self-harm. This forms part of the regional approach to reducing the risk of suicide.

Welsh Ambulance Service Trust (WAST)

The **WAST** Safeguarding Team participate in an annual benchmarking exercise with the National Ambulance Safeguarding Assurance Group (NASAG), as well as continuing to engage alongside NHS partners in the completion of the Safeguarding Maturity Matrix. These workstreams support benchmarking of their current position, horizon scanning of emerging themes and inform the workplan to continue to adapt and support safeguarding priorities in WAST and with partners. The WAST support the work of the Safeguarding Board by a presence at Board meetings and by contributing to relevant Safeguarding Reviews.

Probation Service

During 2024/25, the Probation Service has contributed to the redesign of the CTM Safeguarding Board's governance structure. The Probation Service are committed to being represented at all levels of the Board and to developing and enhancing their contribution. They have volunteered to vice-chair two of the Board's new sub-groups in further support of the Board's work moving into 2025/26 contributing to effective governance for the Board, leadership and engagement.

South Wales Police (SWP)

SWP enters each year with a clear mission: to protect, serve, and reassure our communities, with a specific focus on those most vulnerable. Their Delivery Plan 2025–29 anchors this mission in practice, providing a strategic framework for continuous improvement and strong governance.

Our contributions are shaped by our values: courage, integrity, and compassion. We deliver against our priorities through joint action, intelligence sharing, and an unwavering focus on victim-centered outcomes. SWP contribute to the Board's governance and safeguarding priorities by providing a consistent presence within the Board's structure, working with key stakeholders and supporting the effective delivery of work priorities. For example, during 2024/25, SWP have supported the development of the regional CTM

Exploitation Strategy and the future modelling of the Cwm Taf MASH. The MASH Executive Group is currently chaired by the SWP Safeguarding Lead who also attends Board meetings and CTMSB Executive Group meetings.

As SWP re-set for the year ahead, their direction is clear: to be an outstanding police service, visibly committed to safeguarding, and relentless in protecting the most at risk in our communities.

Strategic Priority 2: We will re-learn by reflecting on the past year and agreeing how what we learn as a Board can make a difference to safeguarding practice :-

RCTCBC Education Services

Learning Framework – Education is in ongoing discussion with Welsh Government and Social Care Wales around the training framework and implications for school-based staff. This includes new draft training for Group B practitioners.

Communication and Engagement – pupil and parental voice activities are planned in one school per Cluster to capture the voices of children and parents/carers which includes lines of questioning around safety and safeguarding in schools. The findings of this will be developed into the next Education Strategic Plan.

Bridgend's EEYPP Directorate

There is a focus on providing regular safeguarding training to education staff and school governors with enhanced resources for professional learning and supervision. This training is delivered by the Education Engagement Team and reviewed every year to align with strategic improvements and changes. The Education Engagement Team provide safeguarding support and challenge to schools by acting as a 'critical friend' to help identify and address areas for development, this includes termly visits and oversight of safeguarding audits. Training for Governors has been expanded and is offered both online and face to face. Further sessions with schools are planned into 2025/26 to continue to enhance joint working and develop shared understanding.

Recommendations from child practice reviews and regulatory inspections are implemented and embedded into the EEYYP Directorate Safeguarding Board meetings, annual audits, Team Bridgend to ensure learning is shared and practice is improved across all settings.

Safeguarding outcomes and risks are monitored through the local authority Corporate Safeguarding Board and reported through the annual Corporate Safeguarding Report.

The Education Engagement Team have scheduled 2 hour 'drop in' sessions for Children and Families Services each week to support the educational provision of children looked after. Making sure children are aware of their opportunities and are signposted appropriately to support services.

Children and Family Services are working with the Education Engagement Team, Bridgend Youth Justice Service and South Wales Police on incidents within schools to review current practice and process. The intention is to identify whether there are alternative ways to intervene earlier and prevent issues escalating. The professional consultation line in the Bridgend Multi-Agency Safeguarding Hub (MASH) is live for schools to use for information, advice and guidance on safeguarding concerns.

Bridgend Children's Social Services have implemented reflective sessions. This allows an opportunity for agencies to learn from one another in how to support and work with families.

The EEYYP Directorate's work is integrated with the priorities for safeguarding corporately and that of the Cwm Taf Morgannwg Safeguarding Board, ensuring consistency and shared learning across the region.

Bridgend Youth Justice Service

Bridgend Youth Justice Service (BYJS) undertook a comprehensive review of its strategic direction at the start of 2024–2025, aligning internal goals with updated Youth Justice Board priorities and the needs of children and families in Bridgend. Key actions included:

- Annual development day with Board members and staff
- Implementation of new KPIs and a strengthened performance monitoring framework
- Continued focus on governance and accountability, with improved Board attendance monitoring and cross-agency collaboration.
- A clear aim was reaffirmed: to prevent criminalisation through early intervention, ensure children's voices shape services, and to embed trauma-informed practice across all levels of delivery.

- BYJS actively used audits, data, and case learning to improve its safeguarding practice during 2024/25 some examples of which were:

  - The 'All About Me' child feedback tool captured lived experiences and directly shaped practice development, including trauma-responsive planning and education support.
  - An internal review of restorative justice feedback from victims identified gaps in emotional support and information clarity. As a result, BYJS is formalising a trauma-informed, victim-centred response pathway.
  - Learning from specific cases, such as those involving children with undiagnosed neurodivergence, led to better cross-agency pathways (for example, SALT and neurodevelopmental referrals).

RCTCBC Adult Services

The development of a regional Power BI dashboard has enabled us to begin to analyse and interpret available data more effectively, both in terms of our internal performance activity, and in comparison with partner local authorities.

RCT Adult Services has established a practice learning and reflection group, attended by Team Managers from across adult services. The group shares learning from published reviews, including those from other areas, as well as from other opportunities to learn, such as complaint investigations or coroner's inquiries. The Team Manager from the Adult Safeguarding Team attends these sessions. Team Managers are then able to disseminate the learning to their teams.

Merthyr Tydfil Adult Services

During 2024/25, Merthyr has been successful in the recruitment of a new Adult Team Manager. This has brought improved consistency and stable leadership for the existing Team. This has resulted in the following:

- A review of existing processes and decision making
- An improvement in the documentation of practice specifically for Section 5 (Professional Concerns) referrals by using WCCIS to record these. This has resulted in data and thematic information to facilitate future planning.
- Improvements in Welsh Government returns with over 70% success in making decisions within 7 days whilst also receiving an increase in safeguarding referrals over the year.
- The Safeguarding Team is now fully staffed and developing training strategies to support and encourage positive practice throughout our adult services.

RCTCBC Children's Services

RCTCBC has a strong corporate safeguarding framework that ensures all employees, elected members, commissioned services, suppliers and contractors are aware of their safeguarding responsibilities. This includes RCT Council Safeguarding Training Standards to ensure all staff and commissioned providers in RCT have consistent and good quality training that is relevant to their roles and responsibilities. RCT are committed to supporting the CTMSB's multi agency training, RCT Children and Adult Services facilitate multi-agency training on Section 5, Wales Safeguarding Procedures, safeguarding allegations/concerns about practitioners and those in a position of trust across the CTM

RCT Children's Services have representatives on all subgroups of the Board and we have been fully committed to the new SUSR process and committed staff across the service directorate to attend the chair, reviewer and panel training. Learning and good practice from reviews is valued and shared via management forums on a regular basis and cascaded throughout the organisation in a number of formats. RCT Children's Services hold whole service mandatory summer safeguarding session to ensure key messages from reviews, audits and wider national work enabling space for practitioners to reflect on effective practice and learning.

RCT Children's Service remain committed to hearing the voices of those with lived experience and although the loss of our Participation Officer this year has caused some challenges, we have continued to engage with CYP's, parents and families. This year we consulted with a number of Looked After Children on participating in CLA reviews, attended Foster Wales network meetings to meet with foster carers on supporting children and young people to participate in their review and their digital My Voice My Review consultation.

During 24/24 RCT Children's Services have improved our Children's Services webpages for parents and carers. The developed webpages were launched in May 24 for parents, carers and families and 16+ and a communication plan was developed through the corporate website and the development of posters and QR code at various locations across RCT. They have begun to develop bespoke webpages for children and young people including those who are care experienced so that information is in accessible language and format.

Merthyr Tydfil Children's Services

Merthyr has been involved in highlighting areas of concern, risks and workforce pressures where appropriate. Staff attend training including preventative services.

Communication is undertaken with staff and safeguarding issues highlighted. Child practice reviews are shared with the teams and managers.

Joint work with Education continues with joint audit work identifying areas of strength and areas of development. From an Early Help perspective, we have seen an increase of referrals from Education that are proportionate and the correct referrals for preventative support.

Wales Ambulance Service Trust (WAST)

WAST colleagues have attended SUSR learning events which has ensured the voice of our practitioners have directly contributed to the review process and supported reflection of events and helped to identify learning for future practice.

Our Safeguarding Team has a close collaborative relationship with the WAST "*Putting Things Right*" team and any safeguarding themes identified are shared throughout the organisation and inform learning and training opportunities within the WAST.

Probation Service

Essentially, the Probation Service promotes the Safeguarding Board's Training agenda alongside the mandatory training provided by HMPPS, ensuring staff are appropriately trained and briefed to undertake the important role they play in safeguarding their community.

South Wales Police (SWP)

South Wales Police is firmly rooted in a culture of continuous improvement. SWP recognise that safeguarding is complex and evolving, and SWP must remain open to learning if they are to protect the most vulnerable effectively.

SWP's dedicated review and learning team provide critical scrutiny and support to ensure that insights and recommendations are translated into meaningful change. This includes ensuring learning reaches operational teams through guidance, supervision, and practical tools to improve frontline delivery.

Learning is embedded in how SWP lead, supervise, and improve.

As active members of the Regional Safeguarding Board, SWP are committed to collaborative learning, continuous reflection, and driving improvements that strengthen our collective safeguarding response.

Strategic Priority 3: We will agree on how we can re-develop as a Board to maximise opportunities to improve how we safeguard people.

RCTCBC Education Services

Cybercrime – discussions have taken place with all schools led by RCT ICT around the issue and prevalence of cybercrime and the importance of safeguarding school systems from this threat.

Extremism – a number of schools and central Education staff participated in extremism workshops to more fully understand this issue and the Prevent agenda so that schools/staff can make effective referrals for cases of concern.

Regional Consistency – RCT Education has worked closely with Bridgend and Merthyr Education over the last year to form strong partnership working and approaches to safeguarding including drafting a consistent school Group B training package and the annual review of the CTM School Safeguarding Policy.

Bridgend's EEYPP Directorate

BYJS has taken substantial steps to develop safer, more responsive services:

- Expansion of health triage partnerships to strengthen early identification of mental health, communication, and substance misuse needs.
- Ongoing development of the Trauma Recovery Model (TRM) and trauma-informed leadership, including a trauma lead role, has enabled targeted interventions for care-experienced children and those with complex trauma.
- The service implemented the practice of writing reports "to" children, not "about" them.
- Volunteers and young people are now actively involved in recruitment panels, service development, and co-producing restorative and information resources.
- BYJS is also working toward service sustainability post-YEF by identifying alternative funding and formalising key community partnerships (for example, The Bridge Community Hub and Fighting Homelessness).

In summary, BYJS has demonstrated a clear commitment to resetting priorities around safeguarding, learning from practice and performance data, and redeveloping services in line with trauma-informed, child-centred principles. Multi-agency collaboration, innovation, and lived experience have been central to delivering safer outcomes for children and young people during 2024–2025.

RCTCBC Adult Services

Adult Services nominated a number of managers to attend the SUSR training that was held in July 2024. We are therefore well placed to support the work of the Board in establishing and supporting the SUSR process.

Since the appointment of the Service Manager for Safeguarding, Careers and Advocacy they have concluded work to revise RCT's advocacy guidance for staff. 'Lunch and Learn' sessions have been developed to launch the guidance, accompanied by a 7-minute briefing.

RCT Adult Services will continue to participate in the work to review the Cwm Taf MASH operating model and are committed to maintaining a physical presence in the MASH base, whilst acknowledging that staff report a hybrid model of working contributes to support their wellbeing, and that, corporately within RCT, the effectiveness of hybrid working in terms of time-efficiency have been recognised.

Merthyr Tydfil Adult Services

Merthyr Tydfil Adult Services acknowledge the paramount importance of working together in the Cwm Taf MASH and sharing information at a leadership level. This has resulted in:

- The Safeguarding team has a duty service to offer practitioners advice and support.
- Developmentally they are using information / lessons learnt from the SUSR process to share via team briefings to reflect and learn positive practice outcomes.
- The Team Manager is working with partners to develop an adult exploitation strategy for the region.
- Team manager is also the lead worker for the region to develop an all-Wales A1 referral form.
- They also support further learning via the Board's Adult Quality Assurance Panel which they also Chair.

RCTCBC Children's Services

Following a review of the Information, Advice and Assistance Service, RCT Children's Services have continued to develop the Right Help, Right Time, Right Place Strategy that has evidenced the need to transform Prevention, Eary Intervention and specialist statutory Children's Services, ensuring a graduated response to need and a whole (multi-disciplinary) system response to ensure sustainable service delivery.

RCT Children's Services continue to develop our model of practice in line with our vision. The new model will strengthen practice, leading to safe reduction of entries to care; provide timely and responsive intervention to families to keep them together, de-escalating need and risk, safeguarding children and safely reducing the number of children who become looked after. The three key pillars of practice are Relationships, Collaboration and being Trauma Informed.

RCT Children's Services have continued to be responsive to emerging concerns and/or significant incidents occurring in the community where Exploitation and Serious Youth Violence were a significant concern. This has led to a multi-agency contextual safeguarding approach to safeguard vulnerable individuals and spaces within the community.

There was regional collaboration with British Transport Police as part of a multi-agency response to Criminal Exploitation and County Lines. The operation successfully engaged with 54 children through prevention, assistance and protection efforts, provided support to 22 vulnerable adults through advice, direct assistance and treatment. It also successfully seized weapons and drugs and disrupted an unbranded county line

Bridgend Children's Services

Bridgend Children's Services continue to make great strides in the embedding of the Signs of Safety practice model and we have created and appointed to a post of Consultant Social Worker-Signs of Safety. The strength-based approach to working is benefitting children and families they work with and this can be evidenced in audit activity and feedback from families. . They have fully embedded Sign of Safety Child Protection Case Conferences and will be taking forward Care Experienced Reviews being conducted under the practice model.

They are piloting the "Most Significant Change" model and will be able to report on this moving forward.

BCBC have further developed their response to exploitation and have a monthly panel which supports multiagency collaboration in responding to exploitation. This is also going to be extended to Adult Services and this process is in its early stages.

Wales Ambulance Service Trust (WAST)

WAST have continued to develop their digital reporting mechanism ("Doc-works") and explore further opportunities to support and protect vulnerable persons in our communities. Within this reporting period they have:

- Observed increased numbers of PREVENT referrals since the implementation of an internal digital Prevent reporting mechanism to assist our colleagues to share concerns of radicalisation with Counter-Terrorism Policing Wales.
- We understand from partnership working with Alzheimer's Society Cymru that Dementia referrals are supporting people affected by dementia through the diagnostic process, where families are being given support and advice around early detection and are guided through the diagnosis pathway.

- Doc-works is currently supporting the development of an innovative new bespoke digital platform for recording all safeguarding enquiries which will automatically collect data and produce data reports. This advanced system will provide a secure platform to maintain records whilst capturing data to provide clear case management governance.
- Created a bespoke Safeguarding Mailbox specifically for Safeguarding Allegations/Concerns about practitioners and those in positions of trust, to support managers and maintain highest levels of confidentiality.

Probation Service

The Probation Service continues to work collaboratively with members of the Safeguarding Board to develop pathway to ensure safeguarding checks are undertaken at the point of first contact with the Probation Service. This has enabled much improved risk assessment and management and the protection of children and vulnerable adults. We are reviewing our commitment to MASH arrangements and appreciate the benefit of multi-agency collaborative working.

South Wales Police (SWP)

SWP are committed to continuous innovation in safeguarding.

They remain alert to opportunities that allow them to enhance how they identify, assess, and respond to vulnerability. This includes maximising the use of technology, improving the quality of multi-agency information sharing, and building capability within our teams to act decisively and with compassion.

Their safeguarding approach is intelligence-led and victim-focused. Across safeguarding functions, they have strengthened supervisory oversight, created pathways for early intervention, and embedded more consistent risk management practices.

SWP also understand that effective safeguarding cannot be achieved in isolation. Our success depends on mature partnerships, shared accountability, and a willingness to re-develop practice together. As part of the Regional Safeguarding Board, SWP are fully invested in improving system-wide coordination and creating the conditions for long-term, sustainable improvements in how we safeguard those most at risk. SWP have committed resources to attend and support the SUSR process within the Board ensuring consistent support from designated Police lead officers in supporting learning from serious case reviews to improve future safeguarding outcomes.

Other Board Priorities

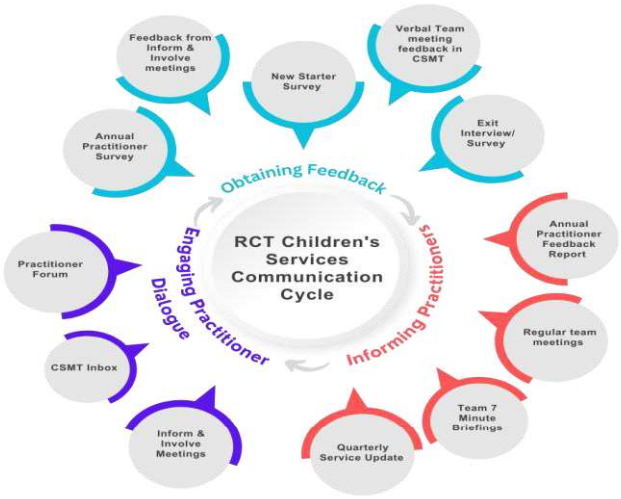
Workforce and Wellbeing

Recruitment, retention and the wellbeing of staff remains a key priority. All staff working across our partner agencies should feel valued and supported, in particular, at a time when there are continued pressures and increasing demand on our services. We continue to promote staff well-being through a range of different means and ask partner agencies to report to the Board on how they are ensuring that this priority is being addressed.

RCTCBC Children's Services

Workforce and wellbeing remains a key priority for RCT Children's Services with a workforce strategy and a regular steering group in place with a key focus on staff wellbeing, staff development and retention. Staff development and career opportunities remain an integral part of the workforce plan with the continued development of a children's social work academy and children's residential academy as part of our 'Grow our Own' agenda.

RCT recognise the importance of an engaged, motivated and healthy workforce. Over the last two years, Children's Services has introduced a range of mechanisms through the introduction of a Communication Cycle to capture the voice of practitioners. The aim of the Communication Cycle is to improve communication and well-being across the service, and it is now firmly embedded.



Staff have access to a psychology led, reflective spaces forum, mental health self-service platforms as well as formal support through occupation health. RCT Children's Service are also piloting an enhanced flexible working pilot.

RCTCBC Adult Services

The wellbeing of RCT's workforce remains a priority. All staff working in the Council have access to a range of wellbeing services, both online and in person, via Occupational Health and Vivup service. Staff are able to self-refer or can be referred by their manager. There are a range of Corporate Policies in place, which are intended to support staff in the workplace, such as the Council's Leave of Absence policy, Working Carers Policy and Reasonable Adjustments scheme. During 2024-2025, a number of members of staff from the Adult Safeguarding Team have accessed additional support via these arrangements. Staff within the Adult Safeguarding Team receive regular supervision, in-line with the Adult Services Supervision Framework. During the latter part of 2024-25, the team were involved in team development sessions with an external facilitator. This work will continue in 2025-26, with the aim of supporting the team with the increased level of activity in recent years.

Merthyr Tydfil CBC

Staff are our biggest asset, and we want to ensure we support them as a priority**.** Staff wellbeing remains a core focus in Merthyr Tydfil, with all agencies committed to promoting a healthy, resilient workforce. A wide range of health and wellbeing initiatives are now in place and reported bi-annually to the Cwm Taf Morgannwg Safeguarding Board (CTMSB). These include caseload management, access to counselling and employee assistance programmes, wellbeing apps, development sessions, and supervision, as well as tailored strategies to support individual needs. MTCBC offer hybrid and refresher training to ensure accessibility for all staff, including foster and kinship carers. New staff benefit from a robust induction programme aligned to the All-Wales Induction Framework, with clear pathways to qualification. Over 800 staff across various services accessed training last year, reflecting our commitment to workforce development. In addition, we continue to support anti-racism and cultural competence through cross-departmental action planning, contributing to a more inclusive and culturally aware workforce.

South Wales Police (SWP)

Recognises that its staff operate in a high risk and high threat environment and are exposed to traumatic incidents regularly. We therefore support the provision of the Trauma Risk Management (TRIM) pathway where all Officers should be referred following any traumatic incident. There is a dedicated counselling service available via our Occupational Health Unit with additional private counselling through the Police Federation. We have a number of workforce champions who support a range of staff welfare issues including mental health, pregnancy and menopause and provide dedicated welfare officers for those staff subject to any investigative procedures. SWP also provide a support network which further supports staff with issues of diversity and neurodiversity. In addition, there are national support services eg. Oscar Kilo and Police Care UK and the Police Benevolent Fund which can provide financial aid and support for members.

Bridgend Council Adult Services

Staff wellbeing remains a priority. The Council Health and Wellbeing Group meets every quarter, with the Adult Safeguarding & DoLS Team Manager a member of this group. Employees can access a 24/7 employee assistance programme. Also provided is a range of wellbeing support resources and workshops.

The Local Authority develops an annual Health and Wellbeing Calendar which promotes opportunities to improve health and wellbeing. In addition, a Health and Wellbeing Newsletter is published monthly, and Wellbeing Champions have been trained across directorates. The Local Authority is holding its first Health and Wellbeing Event in September 2025, focussing on interactive stalls to support mental and physical wellbeing. Additionally, the Directorate has made available bespoke wellbeing training and support for teams via SCDWP, and specialist trauma informed support for staff who require it. Staff have had access to individual coaching and mentoring and a bespoke leadership management and development programme has been established for managers in social care.

Suicide Prevention

During 2024/25, there have been some challenges with progressing regional work in respect of suicide and self-harm prevention primarily due to a requirement to review the former governance of this work-stream. BCBC developed a localised Suicide and Self-Harm Prevention Group to support enhanced working arrangements and responses to suicide and self-harm within their area with an intention to review this in line with revised regional arrangements in due course. To this end, during the latter part of this year, significant work has taken place via the Suicide and Self Harm Steering Group in partnership with Public Health Wales to progress revised governance arrangements within the CTM region to support the future, robust delivery of the suicide and self-harm prevention work-stream. Work continues to progress to a fully agreed governance structure which will robustly support the suicide and self-harm agenda within the region into 2025/26. This has been further supported by a new all Wales Suicide and Self-Harm Prevention Strategy which was published on the 1st April 2025 Suicide prevention and self-harm: strategy and delivery plan | GOV.WALES

The Board's Business Unit continues to support the provision of the Immediate Response Group meetings in partnership with South Wales Police. These support a robust, multi-agency critical incident management response and community support model where serious incidents likely to result in high level impact to communities within the region occur.

CTMSB Protocols and Procedures

The Board has a Policy and Protocols Review Group (PPG) that has strong representation across the multi-agency partnership. The PPG review and evaluate the Board's policies, procedures and guidance to ensure that these comply with legislative requirements and good practice developments. These are also key to providing additional support for partners and practitioners in respect of the delivery of effective safeguarding within the region. The work of the PPG also links closely with recommendations from the Board's practice reviews and national reviews and multi-agency audits with regards to the review and/ or development of policy and practice guidance.

The following Board protocols and guidance documents were reviewed and updated during 2024-2025:

- CTM DoLS Policy (Deprivation of Liberty Safeguards)
- Complex Abuse Protocol
- Guidance in relation to Pre-Birth Referrals and Child Protection Conferences
- Section 47 Joint Enquiries Protocol
- Working with Parents or Carers who Misuse Substances
- Adult Protection & Support Orders Protocol
- Managing Adult Large-Scale Safeguarding Investigations
- School Safeguarding Policy

Partner Agency Achievements

In addition to the joint work that is undertaken as a multi-agency Board, individual partner agencies also share their achievements in relation to safeguarding.

Bridgend Council Children's Services

We continue to operate our monthly Exploitation Panel in advance of the formal launch of the regional Exploitation Strategy which supports multi agency collaboration and solution focused practice for children and young people at risk of exploitation.

Bridgend Council Adult Services has worked in successful collaboration with a range of key stakeholders including Parc Prison this year to support improved safeguarding within the secure estate resulting in a significant reduction in the level of self-harm and related deaths within the prison in the latter part of 2024/25.

Merthyr Tydfil CBC - work has continued in 2024/25 on developing our regional strategic approach to exploitation, both in relation to children and adults at risk. Partner agencies have worked together to develop our governance arrangements and agreeing appropriate tools to support the identification and assessment of all forms of exploitation. Recognising early intervention and prevention is crucial in meeting the needs of people we support; a key focus this year has been raising the profile of abuse and neglect. We have successfully worked in partnership with the NSPCC and other key stakeholders to raise and promote public awareness campaigns across the region.

Rhondda Cynon Taf Children's Services - RCT are continuing to develop access to information and advice for families and professional including a high-quality digital offer, ensuring accessible information and advice that is reliable and trusted and supports families to help themselves. RCT data indicates they are responding to high levels of local need and increasing complexity in the families they work with and positively the data and quality assurance work evidences an improvement in performance with 98% of assessments having what matters and there is evidence of timely, consistent and stable use of thresholds

applied at the 'front door'. Positively in RCT, when compared to the same period last year there has been a 12% reduction in the number of section 47 enquiries and a 21% decrease in the number of children on the Child Protection Register (CPR) and our children becoming looked after has remained relatively stable, decreasing by 3% last year. This is driven by the strengthening of early intervention/signposting and CASP interventions (where appropriate).

Rhondda Cynon Taf Adult's Services - As a result of an adult practice review, Service Managers from Adult Services developed guidance for staff supporting and safeguarding adults at risk that are disorientated in the community. Three 'lunch and learn' sessions were held to launch this guidance, which was co-produced with staff and managers.

Cwm Taf Morgannwg University Health Board - As below:

Good practice/case studies/key achievements
CTMUHB

CTMUHB have improved their secondary care pathway for the management of bruising and injuries in immobile children, including the development of a family leaflet.

To ensure the voice of the child drives improvements in health services CTMUHB have made feedback questionnaires available digitally for use by children, young people, parents, carers and professionals. A video has been developed to provide a visual tool to children attending the health boards child protection medical hub.

The Health Board's Annual Audit Plan has identified areas of good practice in respect of safeguarding and learning from these, incidents and reviews inform training and education resources. The Annual Audit Plan was developed following key recommendations from the Joint Inspections of Child Protection Arrangements. This year CTMUHB have appointed a practice educator to evaluate current practice in sharing learning and develop materials that will support wider learning across CTM services.

Utilising funding from Welsh Government the Health Board have successfully increased the number of DoLS authorisations and raised awareness across its services in respect of MCA.

CTMUHB safeguarding and mental health teams worked in partnership with the WAST and SWP to review the care of a young woman in mental health crisis. Identified learning influenced changes in practice, improving partnership arrangements.

Joint work was undertaken between the Health Board and Children's Services to explore further opportunities to improve communication and information sharing. Work was also undertaken to establish a pathway for children and young people who require safe care while awaiting child protection medicals.
The Health Board have developed new roles to support adult safeguarding, MCA, training and education. These posts support colleagues across the Health Board to support learning in respect of safeguarding.

Good practice/case studies/key achievements
Wales Ambulance Service Trust (WAST)

We have reviewed and updated both the Trust's Safeguarding Children and Adults at Risk of Harm Policy and the Violence Against Women, Domestic Abuse and Sexual Violence Ask & Act Policy. These revised

policies, together with the associated Standard Operating Procedures (SOPs), have been approved through full internal processes during this reporting year.

Microsoft Forms were utilised in the consultation process to collate and evidence responses. This proved a new and innovative way to complete a Trust wide consultation, with our Policy Team expressing interest to explore utilising this method with other consultations.

The Terms of Reference (TOR) for our Safeguarding Strategic Group (SSG) were refreshed in 2024 to build on an established framework, providing influence, strategic direction, leadership and governance to provide assurance WAST meets all safeguarding statutory duties. The TOR now also reflect the group's commitment to the Welsh Government Corporate Parenting Charter.

Good practice/case studies/key achievements

Probation Service

The Probation Service continues to chair the Cwm Taf MARAC illustrating our commitment to leading multi-agency collaboration and safeguarding victims of domestic abuse. We have also committed to the role of Vice-Chair for the Board's new SUSR sub-group and Improving Practice Delivery Group in 2025/26 further supporting the deployment of the SUSR framework within the region. Also, in collaboration with the CTM University Health Board, we have promoted the use of sexual health kits to people on Probation and are exploring the implementation of follow up care from a sexual health nurse. We are looking to commence blood borne virus testing in Bridgend to improve health outcomes of people on Probation.

The Probation Service has actively contributed to the safeguarding of Youth to Adult community justice transition cases by facilitating and chairing robust MAPPA arrangements which have safeguarded both the young people and existing and future victims and worked collaboratively with Board partners during this year to ensure robust safeguarding arrangements were in place linked to the Government's early release of offenders from the secure estate.

Good practice/case studies/key achievements

South Wales Police have continued this year to work collaboratively with the CTMSB and a range of partners to minimise the impact of critical incidents that have occurred within the region. We have instigated regular briefings with professionals to ensure vulnerable individuals and communities are supported and to minimise community impact issues. We provide dedicated Safeguarding lead officers working within the region who support the work of the Safeguarding Board which this year has included collaboration in respect of the regional Exploitation Strategy, Cwm Taf MASH Review and the audit work of the Board. We continue to lead on Immediate Response Groups supported by the Board's Business Unit and a range of key stakeholders. We are committed, moving into 2025/26 to continue effective joint working on a range of safeguarding priorities within the region including exploitation, cyber-crime, VAWDASV, sexual harm and suicide/self-harm prevention.

5. Safeguarding Themes

Audit Activity

Achieving improvement in safeguarding policy, systems, and practice is a core function of the Board. Audit work is carried out via task and finish groups set up by the Quality and Performance Sub-Groups. Any recommendations made by case audits are monitored by these groups to identify how practice needs to adapt to reflect any learning. The key learning themes from audits completed this year are summarised below:

AUDIT ACTIVITY	THEMES IDENTIFIED
Adults Non-Attendance / Out of Timescale at Strategy Discussions	*Reason for Audit: Where Strategy discussions have taken place outside of seven days following a determination being made. To explore the reason for being out of 7-day timescale along with highlighting the professionals that do not attend.* **Learning:** • A need to consider how the safeguarding process is ended when a death occurs during the s126 enquiries in order to share any lesson learned and for reflective practice to take place. • Where a strategy is delayed due to a professional's annual leave, there is a need to document what other options have been explored and who else could attend. • Information regarding the views and wishes of the person is basic and isn't reconsidered throughout the process. • How the current Performance Indicator can be improved with clear information as to rationale where it is not achieved. **Areas of Effective Practice:** • Evidence of robust, effective S126 enquiries that resulted in no requirement for a strategy discussion and reduced pressure on all agencies who would usually be required to attend. • There were clear, immediate safeguards put in place for each case prior to the strategy meeting/ discussion taking place. This was documented.

	• In general, all strategy meetings were carried out within the required time. • Overall good multiagency attendance at strategy discussions. • All strategy minutes were comprehensive and set out the concerns and what was being done to address them. • Care support and protections plans were implemented as part of the process. • All enquires were thorough and well written and considered the persons immediate safeguarding needs. **Areas for Development:** • To agree within staff teams that if someone is unable to attend a strategy, they explore if someone else is available who can attend on their behalf as opposed to delaying a meeting. • Documenting clearly why there has been a delay and what actions have been completed to prevent the delay. • Ensure that the views and wishes of the adult at risk are consistently obtained and updated as the process progresses. • How local authorities and partners can better manage diary availability to support the effective and timely convening of strategy meetings. • Clear escalation pathways where concerns are identified.
Adults Number of cases that required criminal investigation	**Learning:** • A significant percentage of perpetrators were related to victims • The highest proportion was in respect of sons as perpetrators • Only 4 cases in RCT where the perpetrator was unknown (thefts from the victim's home address)

	• The majority of offences took place in the community in home addresses, with a small proportion taking place in hospitals and care homes. Only 2 offences took place where victims lived in supported accommodation • The biggest proportion of crime was financial abuse • There were limited successful prosecutions – only 3 out of 34 • RCTCBC: 4 repeat victims • MTCBC: No repeat victims • BCBC: 1 repeat victim **Areas of Effective Practice:** • Where crimes had been committed these were recorded in accordance with Home Office Crime Recording Rules. • Where appropriate, PPNs were submitted and shared to Adult Services • There was evidence of effective investigations into sexual offences and the physical abuse. Albeit only 1 resulted in charge. • Appropriate safeguarding was noted to be considered and in place and documented on investigation logs. **Areas for Improvement:** • Police to be aware of the statutory time limitations. • Police to consider victimless prosecutions where there are independent witnesses to a crime even though family may not wish to pursue criminal charges (wider public interest) • Officers in the case to ensure regular updates are provided to Adult Safeguarding
Children Multi-Agency Professional Forum - Suspicious & Unexplained Injuries	**Introduction** Following the publication of the Child T review, which included recommendations for agencies to quality assure arrangements for child protection medicals, the Cwm Taf Morgannnwg Safeguarding Board decided to complete some further work. **Background** As part of the child T action plan, the University Health Board (UHB) had completed several areas of work which related to process, staff awareness, pathways and cultures within the organisation. This work prompted Board members to consider how these areas were conducted in all its constituent agencies

The Board's Executive Group decided to commission a Multi-Agency Professional Forum (MAPF) to complete this work.

Process

The process included the formation of a panel of agencies who oversaw the work which was backed with a Terms of Reference governing the project. A large amount of research was done including interviews with professionals, audits and reflective practice workshop sessions. There were also several meetings held with specific agency staff to establish 'benchmarks' for each agency.

The three specific areas of work concentrated on the pathway for Non accidental injuries, the identification of concerns and the governance and quality assurance aspects of the process.

Key Learning Points

It was evident that a large amount of work had been invested in establishing the current position in each agency and this had produced some very positive results across this area of work.

It also became apparent that the majority of this work had been completed on a single agency basis which led to a certain lack of consistency across the region.

Much quality assurance work, including audits, had taken place to provide agencies with assurances that pathways and processes were embedded in practice. Also, many policy documents, flowcharts and guidelines had been produced to ensure compliance.

It was established that most of this work had been completed by individual agencies within their own Local Authority areas.

Good Practice Highlighted

Partner agencies were keen to express their appreciation of the UHB hub which operates across the region and provides excellent facilities and service for users.

It was also noted that both Multi Agency Safeguarding Hubs (MASH) in the region provided a consistent approach to safeguarding concerns and were well organised when convening strategy meetings and other responses to suspected suspicious and unexplained injuries in children.

Recommendations Include:

- A revision of policy documentation to ensure regional consistency
- A robust out of hours approach to cases of NAI
- To ensure the inclusion of health staff in out of hours meetings
- Multi agency training is amended to include information about NAI

- Guidance is provided for staff on good responses to disclosures
- An escalation process is developed to support resolution of differences in relation to CP medicals
- A 'deep dive' of cases to be completed to assure Board members of the position & the development of a multi-agency audit programme

Adult Practice Reviews, Child Practice Reviews and Single Unified Safeguarding Reviews

In 2024-2025, the Board published 3 Child Practice Reviews, 2 Adult Practice Reviews and 1 SUSR Mental Health Homicide Review.

The learning and recommendations from Reviews are recorded in an Action Plan overseen by the Safeguarding Board. This is cascaded across all partner agencies with the Board requesting agency updates of learning actions undertaken. Learning from reviews also informs the Board's annual Training Plan which further supports future learning opportunities for Board partners. Moving into 2025/26, the Board's revised sub-structure will create a new SUSR sub-group which will consider and agree future review referrals and a new Improving Practice Delivery group who will be responsible for bringing further efficacy to the oversight of recommendations, learning and actions from our reviews. This will provide a robust framework that fully supports the All Wales Single Unified Safeguarding Review implementation within the region.

The Board published the following Reviews during 2024/25. Further information relating to the Reviews and how our partner agencies have applied learning from these is detailed below:

Review	Case Type	Brief Case Summary
Adult W 7 minute briefing	**Adult Practice Review** **Bridgend**	**Date of incident: 27/04/22** **Death of an elderly female.**

CTMUHB - This Review has been shared through the Health Board's Safeguarding Operational Group, learning repository and integrated into bespoke Level 3 training. The Safeguarding Intranet page has been redesigned to ensure resources are made available within a learning library. Supervision request forms have been developed and one to one safeguarding supervision is now available to District Nursing teams. The MCA lead and practice educator within the Health Board has provided bespoke training to CTMUHB district nursing service.

Merthyr Tydfil Adult Services - During this year Merthyr is developing face to face, staff / team meetings to cascade information and learning with all practitioners.

Probation Service - The Probation Service were not actively involved in this review, however, the findings relating to professional curiosity, record keeping and line management responsibilities are congruent to the continuous improvement actions within the Probation Service's Delivery Plan.

RCTCBC Adult Services - This review concerned an adult who was open to adult services in RCT at the time of her death. The Review was sent to all managers and the social work teams in RCT. There have been a number of Peer Practice Meetings focusing on raising awareness of and embedding the learning, as well as recognising and sharing the positive practice that was noted in the review, so that this can be shared amongst other teams. As a result of these sessions, self-neglect champions have been identified across adult services in RCT to lead on this complex area of practice. The review has also been taken into account in our training needs analysis with additional training around self neglect being commissioned for delivery in 2025-26.

South Wales Police - South Wales Police chaired this review. Recommendations and the 7 minute briefing have been disseminated to front line officers as part of Op Amddiffyn and Learning Development Services concerning Right Care Right Person, Mental Capacity.

With particular focus on welfare checks, partner agencies are now aware of the legal restrictions placed upon South Wales Police. If there is risk to life and limb: Section 17 of PACE gives the police the power to enter premises without a warrant in order to save life and limb or prevent serious damage to property. This represents an emergency situation and it is for the police to exercise the power. However, it is not enough that the police should have a general welfare concern about somebody in order to use this power of entry, which may only be used in cases of emergency, not general welfare.

Wales Ambulance Service Trust - The action plan and recommended learning from this review was presented to WAST SSG in June 2024. A refreshed MCA training package is to be disseminated to all frontline operational staff during WAST's 25-26 Continuing Professional Development program. A dip sample of relevant clinical records where patients have been determined to lack capacity without onward conveyance, from both pre and post MCA training program taking place, will be audited to measure the effectiveness of this learning and positive impact on practice in relation to supporting patient's lacking capacity, decision making, agreed actions and documentation.

Child F **7 minute briefing**	**Child Practice Review** **Bridgend**	**Date of incident: 30/09/21** **Death of a 13 year old female child.**

CTMUHB - This Review has been shared through the Health Board's safeguarding operational group, learning repository and integrated into Level 3 training. The Safeguarding intranet page has been redesigned to ensure resources are made available within a learning library. Learning has been shared with the Care Experienced team. The Health Needs notification form was adapted to include a risk assessment, this has since been accepted nationally. The new form clearly articulates risk to care experienced children when they are moving around different authorities. Improvements have been made to CAMHS (*Child & Adolescent Mental Health Services*) reporting arrangements when care experienced children do not attend appointments or access the service, this ensures, as a corporate parent the Local Authority are aware of needs not being met.

RCTCBC Children's Services - RCT Children Services cascades Practice Review Learning via Children Service Manager Team meetings and Team Manager meetings. This is further disseminated and discussed in individual team meetings where practitioners reflect on the learning and practice.

BCBC Children's Services - Learning from the review has been incorporated into training to teams in regards to findings from this and other reviews. Staff involved were provided with de-brief sessions on the findings and the 7-minute briefing was circulated to all teams for awareness. In addition, the recommendations have been implemented into service plan improvements.

Merthyr Tydfil Children's Services - This was shared with the teams in a communication session and managers at ECSMT. Discussion held regarding learning and QA Team manager also considers

learning and may audit MTCBC case-files to ascertain if any issues in MTCBC are relevant for learning.

Probation Service - The Probation Service were not actively involved in this review, however, the findings relating to professional curiosity, record keeping and line management responsibilities are congruent to the continuous improvement actions within the Probation Service's Delivery Plan

RCTCBC Adult Services - The Review report has been sent to all team managers and was discussed in relation to the themes identified, and which are relevant to adult services. In particular, where we are working with adults who have lived experience of being looked after, the need for our practice to be fully trauma informed.

RCTCBC Education Service - The consideration of provision for out of county CLA learners is a key focus of our Virtual CLA Headteacher and the team. This additional support for CLA learners and oversight function ensures that we can follow up school places for CLA learners in other Local Authorities to ensure this is timely and appropriate.

South Wales Police - South Wales Police chaired this review. Good practice by SWP recognised – Report Recommendations and 7minute briefing disseminated to Learning Development Services and Missing Person Investigation Team. Highlighted the importance of informing the receiving area Police, Social Services and Education Services when a child under the care of the Local Authority is moved out of area. Promote sharing of information such as Care Plans, Assessments and awareness of previous referrals to CAMHS (*Child & Adolescent Mental Health Services*) in the previous area and access to child advocacy.

Adult V **7 minute briefing**	**Adult Practice Review** **Rhondda Cynon Taf**	**Date of incident: 07/07/20** **Death of an elderly female.**

CTMUHB - Training and education in respect of controlling and coercive behaviour is incorporated into all safeguarding training. Domestic Abuse is a priority within the Health Board's safeguarding strategy.

Recognising the value of the Health Independent Domestic Violence Advisor role within CTMUHB, funding has been granted through Value Based health care to expand this service. They have been involved in bespoke training delivered to community services. These roles are pertinent to sharing learning in respect of domestic abuse through training, advice and support.

The review was shared throughout the Health Board through leadership and operational groups.

Merthyr Tydfil Adult Services - During this year Merthyr is developing face to face, staff / team meetings to cascade information and learning with all practitioners.

Probation Service - The Probation Service were not actively involved in this review, however, the findings relating to professional curiosity, record keeping and line management responsibilities are congruent to the continuous improvement actions within the Probation Service's Delivery Plan

RCTCBC Adult Services - This review concerned an adult who was open to adult services in RCT at the time of her death. The Review was sent to all managers and the social work teams in RCT and was discussed at Peer Practice sessions, in line with established practice for disseminating the learning from reviews. As a result of this review, and the associated action plan, domestic abuse champions have been established across adult services. Their role is to act in a consultative capacity to colleagues who are dealing with practice issues around domestic abuse and coercive control. The champions themselves are being supported to develop a community of practice to share research, best practice and access additional training so that they can feel confident in their role.

South Wales Police - Recommendations and 7 minute briefing have been disseminated to front line officers as part of Op Amddiffyn and Learning Development Services. Partner agencies awareness of sibling domestic abuse, referrals to IDVAS and MARAC and importance of Lasting Power of Attorney and Office of Public Guardian.		
Child Y **7 minute briefing**	**Child Practice Review** **Bridgend**	**Date of incident: 31/07/21** **14 year old male child incarcerated following their involvement in the murder of another child within the family.**
CTMUHB - Good practice was identified in respect of joint working between mental health services and partner agencies. Effective practice has been shared through training and education resources and learning from this review disseminated across CTMUHB services. Bespoke training was provided to CTMUHB Members who often are the Exec on call to ensure they were familiar with processes such as PRUDiC, strategy meetings etc.. and the need for each to take place following a significant incident. This is to ensure that colleagues are confident in multi-agency working out of hours. The review was shared across child and adult services through our intranet pages, email and operational groups. **RCTCBC Children's Services -** RCT Children Services cascades Practice Review Learning via Children Service Manager Team meetings and Team Manager meetings. This is further disseminated and discussed in individual team meetings where practitioners reflect on the learning and practice. **BCBC Children's Services -** work has been completed with our Hubs and learning from the review has been incorporated into training to teams in regards to findings from this and other reviews. Staff involved were provided with de-brief sessions on the findings and the 7-minute briefing was circulated to all teams for awareness. In addition, the recommendations have been implemented into service plan improvements. **Merthyr Tydfil Children's Services -** This is shared with the teams in a communication session and managers at ECSMT. Discussion held regarding learning and QA Team manager also considers learning and may audit MTCBC case-files to ascertain if any issues in MTCBC relevant for learning. **Probation Service -** Whilst not involved with Child Y, the Probation Service was voluntarily involved with other family members during the review period. The 7 Minute briefing has been shared and learning discussed at team meetings. **RCTCBC Education Service -** The findings in this case highlighted regular communication from school during the pandemic. At this time in RCT, there was information shared on all known vulnerable learners with schools to ensure routine contact was made and the expectation of schools was made clear. There are clear learning steps if faced with a similar situation in future to ensure plans are robust where children are not attending school regularly. **South Wales Police -** Recommendations and 7 minute briefing have been disseminated to front line officers as part of Op Amddiffyn and Learning Development Services. Importance of physical visits and attendance at school impacted by Covid provided backdrop of disguised compliance. All agencies to evaluate full circumstances and background to determine causation of child injuries and importance of child protection medicals.		

Adult S **7 minute briefing**	**Mental Health Homicide Review** **Rhondda Cynon Taf**	**Date of incident: 21/11/21** **35 year old male with mental health needs incarcerated for the murder of a female unknown to him.**

CTMUHB - Learning from this review influenced many policy changes. The learning was shared widely with Mental Health colleagues through safeguarding and mental health operational groups and collaborative working in respect of the action plan derived from the review. The review will be made available through the health boards redesigned training and education pages and will form part of a learning event planned for mental health colleagues in 2025.

Probation Service - The Probation Service were not actively involved in this review, however, the findings relating to professional curiosity, record keeping and line management responsibilities are congruent to the continuous improvement actions within the Probation Service's Delivery Plan.

RCTCBC Adult Services - This review concerned an adult who was open to the mental health services in RCT at the time of the incident. Since then, ongoing work has been undertaken with colleagues in the UHB to learn the lessons drawn from this review and associated investigations. The Review has been sent on to the social work teams. In addition, learning is shared within Multi-disciplinary team meetings focusing on raising awareness of and embedding the learning from the Review and incorporating that learning into processes.

South Wales Police - Recommendations and 7 minute briefing have been disseminated to front line officers as part of Op Amddiffyn and Learning Development Services. Importance of promoting necessity to sharing information across agencies particularly with, by and across Health Boards. All staff within the Public Service Centre are trained effectively and understand the process. Management Support Team reviewed Misper reports for learning – specifically around circulation and individual learning fed back to the individual and their supervisors.

Child C **7 minute briefing**	**Child Practice Review** **Bridgend**	**Date of incident: 13/09/21** **Death of a 9 year old female child.**

CTMUHB - This review has been shared through the Health Board's safeguarding operational group, learning repository and integrated into bespoke Level 3 training. The Safeguarding intranet page has been redesigned to ensure resources are made available within a learning library.

A Standard Operating Procedure has been developed around conference attendance for school aged children, ensuring the most appropriate health representative attends conference. A new conference report was developed to ensure the voice of the child and a day in the life of child is captured. Bespoke training was provided to the school nursing service to share the learning from this review and key recommendations integrated into wider children and young people safeguarding training.

RCTCBC Children's Services - RCT Children Services cascades Practice Review Learning via Children Service Manager Team meetings and Team Manager meetings. This is further disseminated and discussed in individual team meetings where practitioners reflect on the learning and practice. Mandatory Summer Safeguarding Sessions were facilitated in 2024 with the 'Embedding Learning into Practice – Themes from Safeguarding Reviews' Child C review and learning was included in these sessions.

BCBC Children's Services – learning event and 7 Minute Briefing completed

Merthyr Tydfil Children's Services - This is shared with the teams in a communication session and managers at ECSMT. Discussion held regarding learning and QA Team manager also considers learning and may audit MTCBC files to ascertain if any issues in MTCBC relevant for learning.

Probation Service - The Probation Service were not actively involved in this review, however, the findings relating to professional curiosity, record keeping and line management responsibilities are congruent to the continuous improvement actions within the Probation Service's Delivery Plan.

RCTCBC Education Service - The learning from this review was disseminated via email. RCT Education form key partners in Core Groups with school staff attending wherever possible. Other internal Education services are also represented where they are involved with the family. Periods of school closures provide difficulties for Core Group attendance particularly during the summer holidays but it is hoped, with the rollout of a new Management Information System, that it may be possible to gather safeguarding information in the future even when schools are closed.

South Wales Police - Recommendations and 7 minute briefing have been disseminated to front line officers as part of Op Amddiffyn and Learning Development Services. Importance of promoting necessity to sharing information across agencies and quoracy at Child Protection and Safeguarding Multi Agency meetings.

Complaints

The Board's Complaints Procedure provides families and individuals with the opportunity to make a complaint with regards to the multi-agency child protection conference process and procedures, the multi-agency adult protection meetings process and procedures and Section 5 Wales Safeguarding Procedures complaints in relation to practitioners. Where such complaints satisfy the requirements of the Board's Complaints Procedure, an Independent Panel will usually be convened to consider the complaint and provide a written outcome to any complainant.

CTM Safeguarding Complaints Procedure

During 2024/25, there were 4 complaints received in relation to the Child Protection Conference process and 1 in relation to Section 5 WSP Practitioner Concerns. Of the 5 complaints received, the following outcomes were made by the Board's Independent Complaints Panel:

- **4 complaints were upheld**
- **1 complaint was not upheld**

Information and outcomes in respect of complaints are shared with the Board's Children or Adult Quality Assurance sub-groups with any learning or recommendations to inform improved practice. In 2025/26, a full review of the Complaints Procedure is scheduled which will enhance the existing policy for both professionals and service users. This will include best practice guidance for services and partners in terms of ensuring a robust response to complaints at the first point of contact to minimise any escalation to the Board's Complaints Procedure.

6. Information Training and Learning

Board partner agencies are required to review the training needs of practitioners in the area and the Board to ensure that there is a coordinated approach to safeguarding training, taking into account themes and learning arising from the delivery of the Boards functions. This work is monitored by the Board's Training and Learning Sub-group (TALG).

Multi-Agency Safeguarding Training

The Local Authority Workforce Development teams (Cwm Taf and Bridgend) are the main source of reporting on safeguarding training, although all partner agencies must ensure that adequate safeguarding training is delivered to staff. The Board supports a range of training provision to support partners and professionals in safeguarding practice utilising a range of training options including on-line and face to face delivery.

During 2024/25 the Board supported the delivery of a range of training sessions aimed at improving safeguarding practice and supported an extensive training delivery package to support the implementation of the Single Unified Safeguarding Review Framework implemented in October 2024. We also worked in partnership with other agencies and professionals to promote wider, multi- agency safeguarding training. This included working with the regional VAWDASV Advisor in respect of Coercive and Controlling Behaviour and Domestic Abuse training provision and the RCT Community Safety Lead to support "Prevent" awareness raising sessions across the region. In addition, during Safeguarding Week 2024 further training sessions were supported across the region.

The Board also works with a range of national safeguarding stakeholders to support training and good practice delivery including Social Care Wales, Care Inspectorate Wales, the National Independent Safeguarding Board, Centre of Expertise on Child Sexual Abuse, Welsh Government and the Home Office.

Moving into 2025/26, the Training and Learning Group will be amalgamated into a new Engagement, Learning and Communications sub-group which will support an enhanced 2025/26 Training Plan on behalf of the Board. The aim of this will be to ensure that the Board is able to fully support and deliver multi-agency safeguarding training across the region, in closer partnership with a range of delivery providers and further enhance required training identified from our SUSR review recommendations. The new ELC group will work closely with the new Improving Practice Delivery Group to ensure a cohesive join-up in respect of any learning needs from our practice reviews, audits and improvement plans.

National Training Framework on Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The table below outlines Cwm Taf Morgannwg's progress regarding the VAWDASV National Training Framework in 2024-2025:

Group	Numbers completed
1 eLearning	3848
2 Ask and act	310
3 Ask and act champions	6
4 Specialist provider training	2
5 Specialist managers	1
6 Senior leaders	75

Welsh Government Training Grant

The Board receives an annual grant from the Welsh Government to support additional safeguarding training activities. This year the grant enabled us to support training arising from recommendations from our Practice Reviews, audits and other Board priorities. Some of this year's training included: (**not an exhaustive list*):

- Hidden Men
- Safeguarding Children with Disabilities
- Working with Disguised Compliance
- APSO Awareness
- Self-Neglect and Hoarding

Multi Agency Practitioner Events:

Extremism and Radicalisation sessions

Information and awareness raising sessions were offered throughout the region in collaboration with the CTM Community Safety Partnership. **Shout Out UK** held sessions for parents and professionals about extreme narratives, ideologies, radicalisation methods, protective measures and Prevent.

With a current trend in the radicalisation of younger people, and the internet and social media being a major factor, these sessions aimed to equip professionals and parents / carers with increased knowledge in respect of radicalisation tactics, with a particular emphasis on social media use.

13 face to face sessions were held throughout the region and six sessions were held online, reaching a total of 790 people.

Improving the Response to Child Sexual Abuse: The Child Sexual Abuse Response Pathway

The National Centre of Expertise on Child Sexual Abuse hosted an online session on 'Improving the response to Child Sexual Abuse: The Child Sexual Abuse Response Pathway'.

This Pathway is an interactive online resource that sets out how to respond to concerns of child sexual abuse at key points: From first concerns and early help safeguarding through to child protection and criminal justice. It focuses on meeting the needs of children and their families and is designed to empower professionals to understand the role they, and their colleagues, can play to best protect and support children.

Briefing on the National Review into CSA within the Family Environment

In March 2025, the National **Centre of Expertise on Child Sexual Abuse** delivered an online briefing to highlight the key findings from the **national report.** Anna Glinski, one of the authors of the report, presented the key findings and recommendations to multi-agency practitioners. This report was commissioned by the Child Safeguarding Practice Review Panel to explore the challenges in identifying,

assessing and responding to child sexual abuse within the family environment. 155 professionals from Cwm Taf Morgannwg signed up to join this event.

Dissemination of Learning

As part of developing a positive culture of learning, the Board uses a range of methods to disseminate best practice and learning within the workforce, including Multi-Agency Practitioner Forums, information within the Board's e-bulletin, Safeguarding Updates, use of Twitter, Facebook and the Safeguarding Board's website. The Board's Business Unit and Communications and Engagement Officer support the dissemination of learning events available for professionals and work in partnership with a range of agencies to secure training and best practice opportunities.

Safeguarding Updates

The Safeguarding Board's website continues to host 'Safeguarding Updates' and the information on this web-page is used to generate e-mails to the Board and partners, with encouragement for these updates to be shared widely. Information includes:

- Recently published policies and protocols
- Recently published practice review reports
- Safeguarding Campaigns
- Good Practice Information
- New legislation
- Consultations and National Reports

Safeguarding Week 2024

Wales National Safeguarding Week campaign is an annual campaign that aims to raise awareness of and provide training on safeguarding issues. Safeguarding is about protecting vulnerable children and adults from abuse and neglect and ensuring their wellbeing. Making sure people are supported to live full and happy lives is also an important part of safeguarding. In 2024, the campaign took place between 11th and 15th November. The theme in Cwm Taf Morgannwg was '**Safe Spaces**'.

Some of the highlights of the week are listed below:

Play Your Part/Chwarae Dy Ran

The 'Play Your Part/Chwarae Dy Ran' campaign is the joint campaign between the NSPCC and the Safeguarding Board that was developed following a recommendation from a **Child Practice Review** that was undertaken by the Safeguarding Board. The official launch of this campaign took place online during Safeguarding Week, with over 100 people joining the session to receive an overview of its objectives, logo and name.

Elements from the campaign were shown to partners and people working or volunteering with children and young people to raise awareness of 'Chwarae Y Dan/Play Your Part' and to encourage them to get involved, assist with the promotion of information and resources and to take up the offers of training and awareness raising through the '***Listen Up, Speak Up'*** initiative, the '***It's Not Love***' play and the '***Talk Pants'*** programme.

"Out of Control"
An exploration of CSE through a different lens

During Safeguarding Week, **Spectacle Theatre** joined forces with **Barnardo's Better Futures** to bring practitioners in the region who work with children and young people, an opportunity to enhance their understanding of Child Sexual Exploitation and help them to identify and provide proportionate responses to meet children's needs. This was be done by a rehearsed reading by members of the Spectacle Theatre group of the play '**Out of Control'**, followed by a participatory workshop exploring the issues around grooming and Child Sexual Exploitation.

The session was well received and feedback included:

- "*The play was very useful in terms of recognising signs and reacting to them.*
- *"Very informative and a lot of information to consider for my role".*
- *"Really useful training. Loved the interactive aspect and the performance".*
- *"I thought the play delivering the training was an excellent idea".*
- *"I work with children and young people a lot and all of the content in today's session was relevant".*
- *"Useful, up to date info to share back at our service".*

During Safeguarding Week, the **'Centre of Expertise on Child Sexual Abuse'** hosted an online session on **'Improving the response to Child Sexual Abuse: The Child Sexual Abuse Response Pathway'.** This Pathway is an interactive online resource that sets out how to respond to concerns of child sexual abuse at key points: From first concerns and early help safeguarding through to child protection and criminal justice. It focuses on meeting the needs of children and their families and is designed to empower professionals to understand the role they, and their colleagues can play to best protect and support children.

Merthyr Tydfil Education Services Safeguarding Week Activities

As part of the activities for Safeguarding Week, Merthyr Tydfil County Borough Council's Education Safeguarding Officer delivered 'Safeguarding Hero' training to over 60 pupils from 14 primary schools throughout the County Borough.

Spectacle Theatre delivered an interactive performance followed by workshops on various safeguarding themes for students from two of the High Schools in Merthyr Tydfil – Cyfarthfa and Afon Taf.

Positive Risk and Shared Decision Making for older people at Home and in the Community

This in-person event was arranged by **Age Connects Morgannwg** and was aimed at professionals and volunteers working with older people in various settings.

This provided an opportunity to network with colleagues from different sectors from across Cwm Taf Morgannwg and included a formal workshop from **Social Care Wales**, an information session, best practice lightening talks from different organisations and information stands.

Feedback was positive, with 96% of respondents rating the event as '**excellent**' and included:

- ***"The talk by Jay was brilliantly delivered and the subject matter was something that we all probably know but it is good to hear and be reminded of in a formal setting".***
- ***"Many thanks for doing this event, it was very enjoyable and exactly what we all need to be thinking about in our work!".***

"Talk PANTS"

During Safeguarding Week, the **NSPCC** delivered an online session on **'Talk PANTS'**,. The "**Talk PANTS"** campaign is about supporting professionals and those with caring responsibilities of children aged 3-11 to have simple, age-appropriate conversations with children that will help keep them safe from sexual abuse.

- *"Excellent presentation with lots of really good information, which I will share".*
- *"Very thought provoking".*
- *"Very informative, very knowledgeable staff delivering".*

CTMUHB

As part of Cwm Taf Morgannwg University Health Board's comprehensive Safeguarding Week 2024 Events Programme, their Children's Nursing Team were providing advice to parents in their homes regarding safe sleeping spaces for babies.

7. How have we collaborated with others?

Working in partnership with others is integral to the work of the Board as safeguarding is an issue that cross-cuts many different services and can have a significant impact on our communities. We work in partnership in a number of ways, with individuals, agencies, partnerships and organisations both within and external to Cwm Taf Morgannwg. Regional partnership working across Cwm Taf Morgannwg has remained strong, whether it involves planning workforce needs and training requirements, safeguarding services, integrating service provision or responding to region-wide challenges.

Public Service Board
The Public Services Board (PSB) acts as the principal strategic leadership forum for the planning, commissioning, and delivery of public services across organisational boundaries to achieve better outcomes for people.

Community Safety Partnership
The Board works closely with the CTM Community Safety Partnerships on common areas of interest, such as domestic violence, substance misuse, anti-social behaviour, preventing serious violence and domestic homicide reviews.

Public Health Wales
The Board has been working this year with PHW and a range of other statutory and voluntary partners to reinvigorate the Suicide and Self-Harm work-stream in the region including revised governance arrangements. The Board also collaborates with PHW in respect of its practice reviews.

Wales Safeguarding Procedures Project Board
Members of the Board participate in the Wales Safeguarding Procedures (WSP) Project Board to ensure that the WSP for children and adults, along with the accompanying practice guides, remain fit for purpose and are adopted appropriately.

Welsh Government
The Board works closely with the Safeguarding and Advocacy Division of the Welsh Government on matters including the Single Unified Safeguarding Reviews that include Adult and Child Practice Reviews, Domestic Homicide Reviews and Offensive Weapon Homicide Reviews and safeguarding-related legislation and policies and as part of wider networks across Wales. This includes other Welsh Safeguarding Boards.

National Independent Safeguarding Board (NISB)
A member of the NISB attends each Board meeting and provides advice and guidance in relation to safeguarding from a national, independent perspective.

Social Care Wales
The Board has contributed to the development of the National Training Framework, led by Social Care Wales and has continued to work pro-actively with SCW this year to support information dissemination in respect of Group B and Group C Safeguarding Training.

Advocacy Providers
Advocacy providers sit on the Board's Adult Quality Assurance and Performance Sub-Group to ensure that the voices of adults at risk are heard and to support the delivery of best practice.

Third Sector
We continue to work with a range of third sector partners who bring added value and expertise to the Board and its work. We continually seek opportunities to work with the third sector to improve safeguarding approaches in the region.

NSPCC
Joint partner in respect of child safeguarding activities and awareness raising campaigns

University of South Wales
Supporting Safeguarding Reviews and enhanced joint working arrangements

8. Participation and Involvement

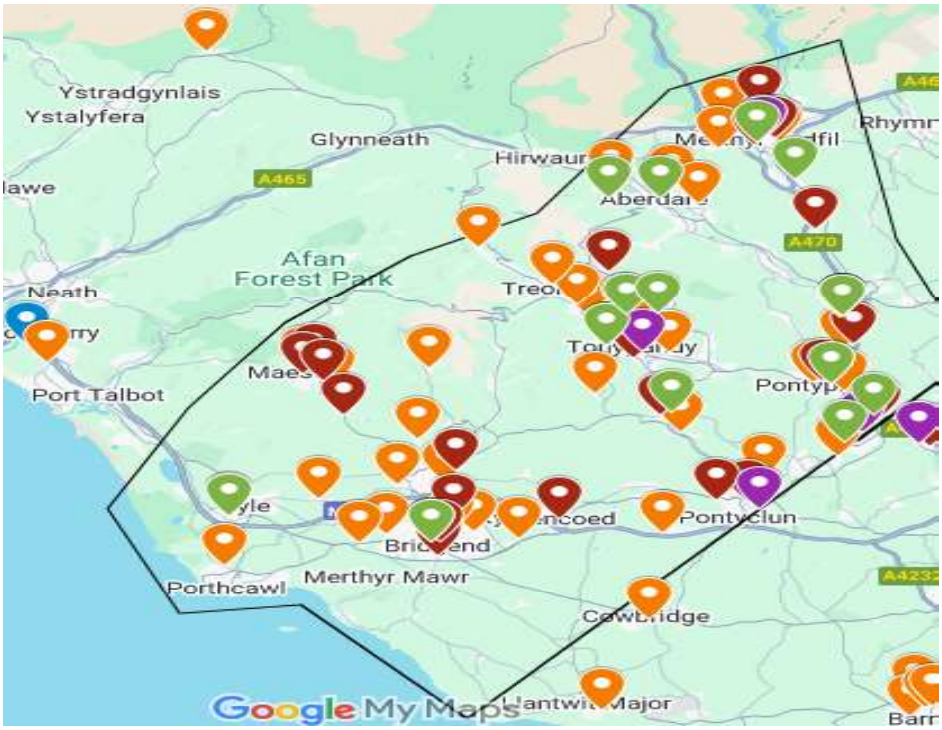
Children, young people and adults who are affected by the exercise of the Safeguarding Board's functions should be given the opportunity to participate in the work of the Board. We recognise that this is an area where we would like to extend the reach of the Board in collaborating more effectively with those with lived experience. As we progress into 2025/26 it will be the aim of the Board to actively seek out enhanced opportunities with our children, young people and adults to participate in our work.

The information below highlights some of the work that has been carried out during 2024-2025:

NSPCC "It's Not Love" Play and Campaign

As part of the 'Play Your Part' campaign, the Safeguarding Board and the NSPCC collaborated with three groups of children in each local authority area in the region to localise the play script before the two week '**It's Not love'** play tour. The play which was delivered to over 1,500 young people and 100+ professionals across multiple schools throughout the region was well received. The feedback from pupils highlighted their concerns in relation to healthy relationships and their views on different elements of what consisted of healthy and unhealthy relationships. The feedback has been used to inform the next stage of the campaign, which will focus on challenging unhealthy norms, promoting respectful relationships, and empowering boys to reflect on masculinity and allyship.

"It's Not Love Launch Activity"



NSPCC CTMSB Full Report:

Play Your Part Campaign PDF

Social Media

Throughout this year, information on a range of safeguarding issues for both the public and professionals has continued to be shared via the Board's Social Media. The Board aims to support a consistent awareness of how to identify safeguarding concerns, particularly for those in our communities and how to access relevant help, guidance and support. We also utilise our social media to promote information and important safeguarding information from partner agencies that aim to keep children and adults safe.

CTMSB Website

The Board is aiming to revise its current website to support a more user-friendly version where key safeguarding information and support can be accessed quickly and easily.

Contributions of Board Members

Each Safeguarding Board partner has a responsibility to ensure that the Board is operating effectively. There are clearly defined Terms of Reference for the Board and each sub-group as well as role profiles for Board Members.

The Board continues to review the effectiveness of measures taken by partners and other bodies in relation to safeguarding via its quality assurance work, audits, and performance management. All the required statutory partner agencies in Cwm Taf Morgannwg are represented on the Board and its sub-groups with positive attendance. Whilst the majority of Board meetings take place on-line, it is the intention to increase some of these to face to face moving forward.

The Board's Development Day which took place on the 18th February 2025 to set the priorities of the Board for 2025/26 was well attended with partners contributing fully to the event. Board Members have been working pro-actively to support the revised CTM Board structure due for full implementation in 2025/26 with members supporting the new Chair and Vice-Chair requirements for this.

The Board provides induction information for new members which includes:

- The Board's Induction Pack
- 7 Minute Briefing
- Board Structure
- Terms of Reference for Board and its sub-groups

CTMSB Induction Pack PDF
7 Minute Briefing CTMSB Business Unit PDF

Partner agencies also provide the Board with an annual report demonstrating their contribution and commitment to safeguarding. This is summarised below.

Merthyr Tydfil County Borough Council (MTCBC)

MTCBC's Education Services - The Education Department has consistently attended Board and relevant sub-group meetings throughout the year and contributed when required.

MTCBC Adult Services Post September 2024, Merthyr is providing representation to every appropriate forum and subgroup within the Boards region. This is an active participation committed to representing and demonstrating the Boards values and its thematic areas of priority.
Merthyr's Director of Social Services is the Chair of the Board and our Adult Services Lead Manager Chair's the Board's Adult Quality Assurance Panel.

MTCBC's Children's Services MTCBC attend the Safeguarding Board and relevant sub-groups including the CQAP, SUSR and MASH Executive Group. MTCBC provides data and information when required. We have been involved in developing the regional Exploitation Strategy have piloted the new work process for this. MTCBC has committed representatives to the designated SUSR training as reviewers, panel members and Chairs.

Bridgend County Borough Council (BCBC)

BCBC's Education, Early Years and Young People (EEYYP) Group continue to demonstrate a strong and consistent commitment to the work of the Safeguarding Board. The group is actively represented at all levels of the Board, including core meetings and across all relevant subgroups. This ensures that multi-agency perspectives, particularly those relating to education and youth justice, are embedded in safeguarding decision-making and strategic planning.
The EEYYP Directorate have supported the board's three-year Strategic Plan and annual priorities focusing on exploitation, early intervention and prevention. Agencies have adapted to new ways of working including remote and hybrid models without compromising the quality or timeliness of safeguarding responses.

BCBC Adults and Children's Services

The Corporate Director of Social Services and Wellbeing for Bridgend is the senior lead officer who holds corporate responsibility for safeguarding. The Director and Heads of Service for Adults and Children's Social Care attend the CTM Safeguarding Board alongside Heads of Service from Education and Housing.

The Director and officers of the Council are active participants within the Board's sub-groups with representatives from both adults and children services having both chairing and vice chair responsibilities. The Director chairs the Exploitation sub-group and is a member, alongside the Head of Adult Social Care of the Suicide and Self Harm Prevention Steering Group.

Representatives from the Directorate have attended workshops, planning days and team meetings which have contributed to the setting of actions to meet the boards priorities for its annual plan.
There are regular reports to the Board and its sub-groups regarding safeguarding performance in Bridgend. Particularly, the Executive Steering group of the Board.

BCBC has also contributed fully to participating in SUSRs and the dissemination of learning from reviews.

Rhondda Cynon Taf County Borough Council (RCTCBC)

RCT Education Services - We have representatives on each sub-group of the Safeguarding Board. Any significant safeguarding issues are placed on the SMT agenda for wider discussion. Information from the Board is fed down into schools via a termly Cluster Convenor Safeguarding meeting with escalation of concerns also possible in the opposite direction.

RCT Adult Services - The retirement of the Service Manager for Safeguarding in April 2024 has presented us with some challenges in maintaining our previously high levels of participation in Chairing/Vice-Chairing activities for the Board. The post was vacant until October 2024, by which time, discussions were underway for nominations for the new Board structure.
Despite these difficulties, Adult Services maintained representation at sub-group meetings this year. The Director of Social Services chaired the Joint Operational Committee during 2024-25. The Director of Social Services, Director of Adult Services and Head of Service for Safeguarding, Care and Support all attended Board this year. Adult Services have had a Panel member on all relevant Adult Practice, Domestic Homicide and Mental Health Homicide Reviews and since October 2024, SUSRs that have commenced under the new process.

RCT Children's Services

RCT Children's Services continues to provide a high level of contribution to the work of the Board through regular attendance at and participation in the work of all of the Subgroups. This includes:

- Continued to host the CTMSB Business Unit
- Supported the CTMSB to develop a new substructure and contributed to the revision of the Terms of Reference for each of the new subgroups.
- Chaired the Children's Quality Assurance Panel
- Undertaken a lead role in the development of the Exploitation Strategy and relevant practice guides and tools, chairing T&F groups and attendance at strategical meetings.
- Chaired the Engagement, Participation and Communication Group.
- Chaired the PPG in the absence of permanent chair/vice chair and contributed to the evaluation and revision of amended policies.
- Been a member of all other subgroups of the CTMSB.
- Contributed to the delivery of multi-agency training by facilitating Section 5, Professional Concerns Training
- Attended and contributed to Immediate Response Groups.
- Contributed to Adult and Children Practice Reviews, Domestic Homicide Reviews and Offensive Weapons Homicide Review under the Single Unified Safeguarding Review (SUSR), MAPFs and other recommended audits such as the NAI audit.
- Contributed to delivery of the MASH Review workshop and the ongoing development of a modernised MASH, including attendance and contributions at MASH Executive Group
- RCT have also been a representative on behalf of the CTMSB in relation to national work, e.g., National Performance Framework, Pan-Wales Exploitation Group and the National Single Agency Referral Form and the Welsh Governments, Missing Children from home and care Steering group.

Cwm Taf Morgannwg University Health Board (CTMUHB)

CTMUHB have organisational representatives that either chair or vice chair the Board's sub-groups. These include the Joint Review Group and Children's Quality and Performance Group. For 2025/26, in line with the Board's sub-structure restructure, CTM UHB colleagues have again put themselves forward to Chair groups and drive work and improvements through these groups. The Deputy Executive Director of Nursing is now Vice Chair for the Safeguarding Board.

Colleagues within health have led and participated in the development of joint policies and multi-agency training. The health board developed and facilitated multi-agency training with the support of partner agencies, this training included bruising and injuries in children, exploitation, Sexual Abuse Referral Center and fabricated illness.

The Health Board led on the revision of the Safe Sleep Policy, ensuring learning from PRUDiC (*Procedural Response to Unexpected Death in Childhood*) was included, a number of resources were also developed, including a 7-minute briefing and video. In addition, the Health Board have contributed to Board development days, audits, the Cwm Taf MASH review and the development of the regional Exploitation Strategy.

Attendance at the localised BCBC, Joint Operational Groups has ensured that partnership improvements have been embedded within Bridgend following the CIW JICPA (*Joint Inspection of Child Protection Arrangements* Overview Report: Joint Inspection of Child - Protection Arrangements 2019 – 2024)

Probation Service

Safeguarding continues to be over and above a key statutory responsibility, at the very heart of the work undertaken by the Probation Service in Wales. We continue to embed safeguarding practices and responsibilities within all aspects of day-to-day activities, as evidenced by the now mandatory safeguarding enquiries which are completed both pre and post sentence. We wish to thank our CTM Safeguarding partners for the clear progress we have made in 2024/25 on information sharing in this area to drive better outcomes for our communities and vulnerable groups.

Welsh Ambulance Service Trust (WAST)

The Welsh Ambulance Services University NHS Trust (WAST) is committed to supporting the work of Cwm Taf Morgannwg Safeguarding Board. WAST Safeguarding Team have engaged with the Board's safeguarding work streams and relevant agencies to ensure good outcomes for those who have had contact with our services within the Board region.

Our team have provided panel member representation on Practice Reviews commissioned by the Board and one of our Safeguarding Specialists is aligned to the Board area, for further representation on relevant Sub-Groups and collaborative multi-agency workstreams to improve safeguarding practice.

South Wales Police (SWP)

South Wales Police remains fully committed to supporting the work of the Cwm Taf Morgannwg Regional Safeguarding Board and is proud to have played a central role in delivering its aims over the past 12 months.

We regularly attend Board meetings and subgroups, not only as participants but also in leading roles, chairing and coordinating where appropriate. Our officers actively support the learning agenda of the Board through meaningful participation in Child and Adult Practice Reviews, Multi-Agency Professional Forums (MAPFs), and the role out of the new SUSR process.
Audit activity is another area where our contribution is consistent. We participate in multi-agency audits across all key safeguarding themes, offering data, case insights, and operational perspective. These audits help drive improvements in local practice and ensure accountability in protecting the most vulnerable in our communities.

A significant area of work we lead on is the coordination and activation of the Incident Response Group (IRG) process. Over the past 12 months, we have invoked this process on multiple occasions following critical incidents. The IRG process ensures rapid multi-agency mobilisation, a shared response plan, and coordinated communications with the public and media.

We continue to support the periodic review process and regularly liaise with Board partners to strengthen operational and strategic safeguarding.

9. Managing our Resources

The Cwm Taf Morgannwg Safeguarding Board uses the funding formula set out in the Social Services and Wellbeing (Wales) Act 2016 statutory guidance. This allows us to assess and identify annual financial contributions from our statutory partner agencies.

This is calculated as follows:

Agency	% Split	% Split
Rhondda-Cynon-Taf CBC	60%	55%
Bridgend CBC		32%
Merthyr Tydfil CBC		13%
Cwm Taf Morgannwg UHB		25%
South Wales Police		10%
Probation Service		5%
Totals		100%

In 2024-2025 expenditure was as follows:

Staff	£400,318
Premises	£9,480
Other	£51,680
WG Grant Income (SUSR)	-£ 42,000
Total	£419,478

Training costs are not included as this sits outside the Board budget.

Other Board Activities

Adult Protection and Support Orders (APSOs)

Adult Protection and Support Orders have been available since the 2016 implementation of the Social Services and Well-Being (Wales) Act 2014 but have been used rarely. There were no APSO applications APSOs in 2024-2025.

Guidance and Advice received from Welsh Ministers and/or National Board

The Board continues to work closely with Welsh Government and the National Safeguarding Board and responds promptly to requests for information or support. A good relationship has been established with both in terms of the work of the Safeguarding Board with both the Chair of the Board and the CTMSB Business Manager contributing to national meetings as required. In addition, Board partners support various national work streams on behalf of the region. The Board has worked pro-actively with these as key stakeholders with other regional Safeguarding Boards to support the effective implementation of the All Wales Single Unified Safeguarding Review framework.

Section 137 requests for information

Section 137(1) of the Act provides a Safeguarding Board with the power to request specified information from a qualifying person or body provided that the purpose of the request is to enable or assist the Board to perform its functions under the Act.

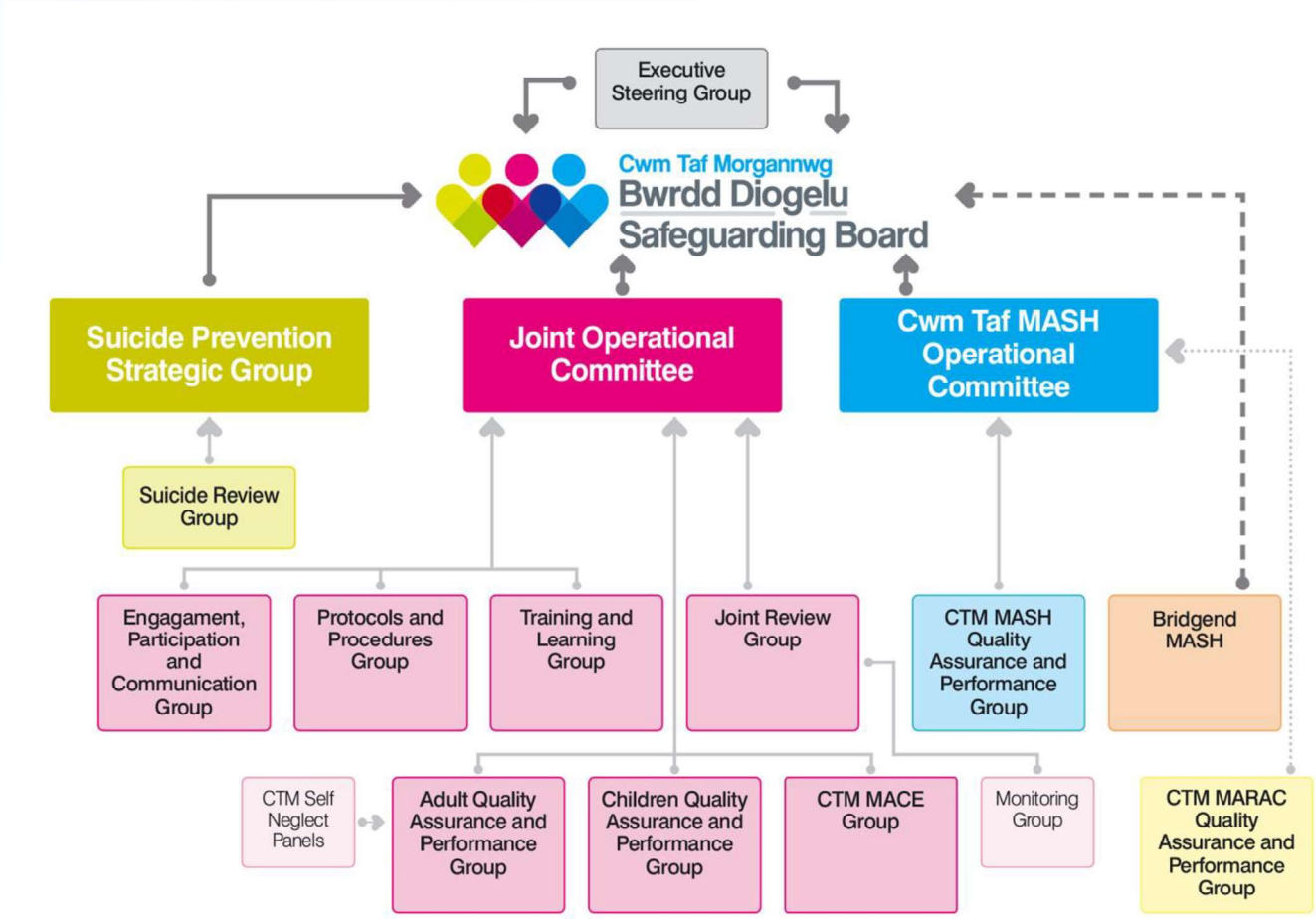
In 2024-2025 the Board did not use its Section 137 powers to access information.

APPENDIX 1 - BOARD MEMBERSHIP

TITLE	AGENCY
Director of Social Services (Chair)	Merthyr Tydfil County Borough Council
Director of Social Services and Wellbeing	Bridgend County Borough Council
Director of Social Services	Rhondda Cynon Taf County Borough Council
Head of Safeguarding (Adults)	Rhondda Cynon Taf County Borough Council
Director Public Health	Rhondda Cynon Taf County Borough Council
Head of Safeguarding (Children)	Rhondda Cynon Taf County Borough Council
Director of Education and Inclusion Services	Rhondda Cynon Taf County Borough Council
Service Director Children Services	Rhondda Cynon Taf County Borough Council
Head of Legal - Community Care and Children	Rhondda Cynon Taf County Borough Council
Prison Director	Parc Prison
Head of Safeguarding	Cwm Taf Morgannwg University Health Board
Named Doctor	Cwm Taf Morgannwg University Health Board
Deputy Executive Nurse Director	Cwm Taf Morgannwg University Health Board
Head of Service	Cwm Taf Youth Justice Service
Head of Service	Youth Justice Service, Bridgend
Named Lead for Safeguarding	Public Health Wales
Designated Nurse (National Safeguarding Team)	Public Health Wales
Head of Probation	Probation Service
Director of Education	Merthyr Tydfil County Borough Council
Head of Public Protection	Merthyr Tydfil County Borough Council
Head of Adult Services	Merthyr Tydfil County Borough Council

Principal Safeguarding Manager	Merthyr Tydfil County Borough Council
Head of Children Services	Merthyr Tydfil County Borough Council
Head of Adult Social Care	Bridgend County Borough Council
Head of Children's Social Care	Bridgend County Borough Council
Head of Education and Family Services	Bridgend County Borough Council
Group Manager	Bridgend County Borough Council
Head of Public Protection	Bridgend County Borough Council
Head of Adult Safeguarding and Secure Estate	Bridgend County Borough Council
Superintendent	South Wales Police
Head of Protecting Vulnerable Persons	South Wales Police
Assistant Director Quality, Safety & Patient Experience	Welsh Ambulance Service Trust
NISB Member	National Independent Safeguarding Board
Safeguarding Lead Officer	South Wales Fire & Rescue Service

APPENDIX 2 – BOARD STRUCTURE 2024/2025



Glossary of Terms

Single Unified Safeguarding Review

Is a single review process incorporating all reviews in Wales which came into being on the 1st October 2024. The Safeguarding Board must commission an SUSR where the following criteria is met:

- Adult Practice Review
- Child Practice Review
- Domestic Homicide Review
- Mental Health Homicide Review
- Offensive Weapons Homicide Review

Adult Practice Review

The Regional Safeguarding Board must commission an Adult Practice Review in cases where an adult at risk has died, sustained potentially life threatening injury or sustained serious and permanent impairment of health.

Child Practice Review

The Regional Safeguarding Board must commission a Child Practice Review in cases where a child has died, sustained potentially life threatening injury or sustained serious and permanent impairment of health.

Domestic Homicide Review

A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by: a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or a member of the same household as himself or herself.

Mental Health Homicide Review (MHHR)

MHHR's take place when a homicide is committed and the alleged perpetrator has been in contact with primary, secondary or tertiary mental health services within the last year.

Offensive Weapons Homicide Review (OWHR)

An OWHR takes place when the death of a person aged 18 or over occurs using an offensive weapon.

Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual activities or others performing sexual activities on them.

Children Looked After

A child is looked after by a local authority if a court has granted a care order to place a child in care, or a Council's Children's Services department has cared for the child for more than 24 hours.

Community Safety Partnership
Statutory partnership to develop and implement strategies to tackle crime and disorder including anti-social and other behaviour adversely affecting the local environment.

Exploitation
Exploitation is a type of abuse. Exploitation involves being groomed, forced or coerced into doing something that you don't want to do for someone else's gain.

Immediate Response Groups (IRG)
A group which is convened to provide a rapid, multi-agency response to managing the consequences of a critical incidents, such as the unexpected death of an adult and is led by the Police Superintendent (or a suitable deputy).

MARAC
A weekly risk management meeting where professionals share information in respect of high risk cases of domestic violence and abuse and put in place a risk management plan.

Modern Slavery
The illegal exploitation of people for personal or commercial gain. It covers a wide range of abuse and exploitation including sexual exploitation, domestic servitude, forced labour, criminal exploitation and organ harvesting.

Multi-Agency Practitioner Forum (MAPF)
Multi-agency professional forums are a mechanism for producing organisational learning, improving the quality of work with families and strengthening the ability of services to keep children safe. They utilise case information, findings from child protection audits, inspections and reviews to develop and disseminate learning to improve local knowledge and practice and to inform the Board's future audit and training priorities.

Public Protection Notice (PPN)
The forms have two main purposes. One is for police officers to make referrals to partner agencies when they have concerns about vulnerable people. The PPN is also used as a risk assessment tool for victims of domestic abuse and stalking and harassment (DASH).

Prevent
Prevent is about safeguarding and supporting those vulnerable to radicalisation or extremism.

PRUDiC
This procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

Quality Assurance and Performance Groups
Two separate groups for adults and children whose objectives are to monitor the effectiveness of agencies' practice within the processes of safeguarding and encourage high standards of practice by all those involved in safeguarding work, promoting agency and individual accountability through the monitoring and evaluation of performance.

Self-Neglect
Self-neglect is a general term used to describe a vulnerable adult living in a way that puts his or her health, safety, or well-being at risk.

Social Services and Wellbeing (Wales) Act 2014
The Social Services and Well-being (Wales) Act is the law for improving the well-being of people who need care and support, and carers who need support.

Strategy Discussion / Meeting
A meeting for social workers and other professionals to discuss risks against an adult or child and to discuss how any risks will be addressed to protect someone from harm.

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)
The Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015 focusses on the prevention of these issues, the protection of victims and support for those affected by such issues.

Are You Concerned About Someone?

If you suspect that a **child or young person** is being harmed or is at risk of being harmed, then you have a duty to report it immediately. All calls concerning worries about children are treated seriously. Contact your local Safeguarding Team on the numbers provided below:

In Rhondda Cynon Taf: 01443 425006
In Merthyr Tydfil: 01685 725000
In Bridgend: 01656 642320

Opening Hours:
Monday - Thursday 8.30am - 5.00pm
Friday - 8.30am - 4.30pm

If you suspect that an **adult** is being harmed or is at risk of being harmed, then you have a duty to report it immediately. All calls concerning worries about vulnerable adults at risk are treated seriously. Contact your local Safeguarding Team on the numbers provided below:

In Rhondda Cynon Taf: 01443 425003
In Merthyr Tydfil: 01685 725000
In Bridgend: 01656 642477

Opening Hours:
Monday - Thursday 8.30am - 5.00pm
Friday - 8.30am - 4.30pm

To contact **Children or Adults Services outside office hours, at weekends and bank holidays,** ring the Cwm Taf Morgannwg Emergency Duty Team on 01443 743665 or 01443 657225.

If you suspect that a child, young person or an adult is at immediate risk of harm call 999 and speak to the Police.

Further information on how to report any concerns relating to a child or adult at risk is available here:

Rhondda Cynon Taf County Borough:
RCT Children: Reporting a concern about a Child | Rhondda Cynon Taf County Borough Council
RCT Adults: Report a concern about someone at risk | Rhondda Cynon Taf County Borough Council

Bridgend County Borough:
Bridgend Children: Child protection
Bridgend Adults: Safeguarding adults at risk

Merthyr Tydfil County Borough:
Merthyr Children: How to report a child/young person you believe is at risk of/experiencing abuse and neglect | Merthyr Tydfil County Borough Council
Merthyr Adults: Adults at Risk of Abuse or Neglect | Merthyr Tydfil County Borough Council

If you would like to report a non-urgent incident, or have a problem or general query, you can call 101, the 24 hour non-emergency number for the police. ***Use 101 when the incident is less urgent than 999.***
Remember - safeguarding is everybody's business! For more information and advice visit: About Us | Safeguarding, Cwm Taf Morgannwg

Quality, Safety & Experience Committee – Non Routine Committee Business Forward Plan

(1st January 2025 to the 31st December 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
16 May 2024	Suggested at the 16 May 2024 meeting that report would be presented to a future meeting on this item	Chief Operating Officer	CTM Escalation Policy	Suggested at the 16 May 2024 meeting that report would be presented to a future meeting on this item	Chief Operating Officer	Chief Operating Officer	18 September 2024	**Proposed for Closure** The revised Escalation Policy was presented to the October 2025 meeting of the Operational Delivery Committee and has been made available to QSEC members via the documents folder on Admincontrol
14 August 2024	Request received by email for this to be presented as a spotlight presentation to a future meeting of the Committee	Senior Nurse Acute Deterioration and Outreach Services	Spotlight Presentation Decision Making around ACP/DNACPR/TEP	Case presentation to highlight the need for more resource in end-of-life education and training	Senior Nurse Acute Deterioration and Outreach Services	Executive Medical Director	25 March 2025	**In progress** Consideration being given to governance reporting routes for RADAR. In this respect this item may be removed from to forward plan for Quality, Safety & Experience Committee
11 March 2025	Request made by an Independent Member at the January 2025 QSEC for this report to added to future meeting agenda's	Executive Director of Nursing	WAST Produced Quality Report	USC Care Group to provide a report on the joint working with WAST looking at the People's Experience and Quality of care as this is work that is undertaken jointly with the central team and sits within USC portfolio.	USC Care Group Nurse Director	Executive Director of Nursing	20 May 2025 22 July 2025 Now November 2025 **Now January 2026**	**In progress** Interim Executive Director of Nursing for CTMUHB to meet with Director of Nursing at WAST to discuss what quality data sets were now available within WAST that could be shared with Committee members.
10 April 2025	Request made at the agenda planning session held on 10 April 2025	Committee Chair	Stroke Services Progress Report	Stroke Services report to be presented to the July meeting of the Committee	Executive Director of Allied Health Professionals & Healthcare Sciences	Allied Health Professionals & Healthcare Sciences	22 July 2025 – 23 September 2025 – **Now January 2026**	**In progress** Presentation received and discussed at the meeting held on 22 July 2025. Further report on progress to be presented to the meeting taking place on 23 September 2025. **Following the agenda planning session held in August 2025, it was agreed that the USC**

								Care Group Highlight report for September would include an update on Stroke KPI's with the next detailed update on Stroke to be presented to the January 2026 meeting
22/07/2025	Request made at the July meeting for this item to be brought back to a meeting in 2026	Interim Executive Director of Nursing	Listening & Learning Story - Carers	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed, with further discussion required as to what could be done to address the issues	Carers Lead	Interim Executive Director of Nursing	Date to be confirmed	**In progress** Date to be confirmed with Carers Lead
7 August 2025	Suggestion made at agenda planning session held on 7 August 2025	Deputy Director of Nursing	Quality focussed report on Commissioned Services	To be presented to Committee for discussion and awareness	Executive Director of Strategy & Transformation	Assistant Director of Transformation	18 November 2025	**Proposed for Closure – On agenda** This item is on the agenda for discussion at the November 2025 meeting
7 August 2025	Suggestion made at agenda planning session held on 7 August 2025	Closure Report - Inpatient Mental Health Improvement Programme	Report to highlight progress made since the update presented to the July 2024 meeting	To be presented to Committee for assurance purposes	Mental Health & Learning Disabilities Care Group Nurse Director	Mental Health & Learning Disabilities Care Group Nurse Director	23 September 2025 18 November 2025 **Now deferred to 20 January 2026**	**In progress** This has been deferred to 20 January 2026
23 September 2025	Request made at the meeting held on 23 September 2025	Listening & Learning Story - Domestic Violence	Head of Safeguarding to return to the Committee in one year to provide more evidence in relation to learning points	To be presented to the Committee for assurance purposes	Head of Safeguarding	Executive Director of Nursing	22 September 2026	**In progress** Scheduled for September 2026
23 September 2025	Request made at the meeting held on 23 September 2025	Physicians Associates	Report on the current position regarding the proposed changes to the roles and remits for Physicians Associates	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	Date to be agreed	**In progress** Report unlikely to be available until early 2026
23 September 2025	Request made at the meeting held on 23 September 2025	Planned Care - Care Group Highlight Report	Outcome and impact of the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate to be presented to the	To be presented to the Committee for awareness	Planned Care Group Nurse Director	Executive Director of Nursing	22 September 2026	**In progress** Will be presented to the September 2026 meeting

			Committee after the trial period of 12 Months					
24 September 2025	Email request received from the Assistant Director of Governance Risk following discussion held at the September 2025 meeting	Focussed review on Ambulance Handover times improvement	Report to identify whether the improvement on handover times has not had any adverse effect on quality and safety i.e. increase in incidents, complaints, waiting time performance, patient experience feedback etc.	To be presented to Committee for assurance purposes	Unscheduled Care Group Service Director/Nurse Director	Unscheduled Care Group Service Director/Nurse Director	24 March 2026	**In progress** Will be presented to the March 2026 meeting
30 September 2025	Email request received from the Medical Directorate Business Manager	Organ Donation Sub Committee Terms of Reference	Further amendments required to membership and attendee section	To be presented to the Committee for approval	Medical Director Business Manager	Executive Medical Director	18 November 2025	**Proposed for Closure – On agenda** This item is being received for approval at the November 2025 meeting
6 October 2025	Email request from the Executive Medical Director	Clinical Effectiveness Update	To be presented to the Committee for awareness	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	18 November 2025 **Now January 2026**	**In progress** This item will be presented to the Committee in January 2026
28 October 2025	Email request from the Executive Medical Director	Adult Mental Health Cultural Challenges	To be presented to the Committee for awareness	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	18 November 2025	**Proposed for Closure – on agenda** This item is being received via In Committee session at the November 2025 meeting
4 November 2025	Request received from Interim Executive Director of Nursing	Spotlight Report - Quality Impact of the Health Board's new Escalation Framework	To be presented to the Committee for awareness	To be presented to the Committee for awareness	USC Care Group Nurse Director & Planned Care – Care Group Nurse Director	Executive Director of Nursing	20 January 2026	**In progress** This item will be presented to the Committee in January 2026
10 November 2025	Request received from the Assistant Director of Governance & Risk	Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents	To be presented to the Committee for approval	To be presented to the Committee for approval	Assistant Director of Governance & Risk	Director of Corporate Governance	20 January 2026	**In progress** This item will be presented to the Committee in January 2026
Completed Items								
18 February 2025	Committee referral made by the Audit, Risk & Assurance Committee at its meeting on 13 February 2025	Executive Medical Director	Details of the medical negligence claims from the losses and special payments report	A detailed discussion required on the reasons for the increases in medical negligence claims with the appropriate execs all being present to answer	Assistant Director of Quality & Safety	Executive Director of Nursing	20 May 2025 – 22 July 2025 – **Now 23 September 2025**	**Completed** Report received and discussed at the meeting held on 23 September 2025. ARAC Chair content that the Committee referral has been

				questions and provide assurance to the committee.				addressed and has requested that the report is now taken through Audit, Risk & Assurance Committee to demonstrate the referral has been addressed.
26 June 2025	Email request received from Director of Public Health requesting this item is discussed at future meeting	Executive Director of Public Health	Reducing Health Inequalities	Report to be presented to the September 2025 meeting for discussion	Executive Director of Public Health	Executive Director of Public Health	23 September 2025	**Completed** Presentation received and discussed at the meeting held on 23 September 2025
17 July 2025	Email request received from the Medical Directors office	Executive Medical Director	Organ Donation Committee Terms of Reference	To be presented to the Committee for approval	Executive Medical Director	Executive Medical Director	23 September 2025	**Completed** Terms of Reference were received and approved at the meeting held on 23 September 2025

Quality, Safety & Experience Committee – Annual Cycle of Committee Business

(1st January 2025 to the 31st December 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Quality, Safety & Experience Committee meets at **least 6 times per annum**.

Committee Chair:	**Committee Vice Chair**	**Executive Leads for Agenda Planning**
• Carolyn Donoghue, IM University	• Kath Palmer, Vice Chair	• Greg Dix, Executive Nurse Director / Deputy CEO

CTMUHB Committee Business:

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Committee Governance Arrangements																
1. Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑ If all actions are complete	⚑ If there are actions in progress / overdue actions
2. Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	X
3. Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	X
4. Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑ Except for the annual review in January	⚑ Annual Review only
5. Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually					⚑								X	⚑
6. Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually					⚑								X	⚑
7. Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually					⚑ Defer to Sept 25				⚑ Defer to Nov 25		⚑ Defer to Jan 26		X	⚑

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Staff and Service User Experience																
8. Shared Listening & Learning Story	Executive Director of Nursing / Deputy CEO	All Regular Meetings													X	
9. Outcome reports - Executive and Independent Member Patient Safety Walkabouts	Executive Director of Nursing / Deputy CEO	Twice per annum.			To be deferred to the May meeting						Defer to Nov 25				X	
10. Listening & Learning Stories – Annual Evaluation of Lessons Learnt	Executive Director of Nursing	Annually													X	
Setting the Scene – Service Delivery																
11. Thematic Spotlight Presentation • Compassionate Care (January 2026) • Nutrition & Catering (January 2026)	Lead Clinical Executive	All Regular Meetings													X	
12. Report from the Clinical Executives	Clinical Executives	All Regular Meetings													X	
13. Care Group Highlight Reports	Care Group Nurse Directors/Care Group Medical Directors	All Regular Meetings													X	
Delivering our Plan																
14. Quality Dashboard Report	Executive Nurse Director / Deputy Chief Executive	All Regular Meetings													X	
15. Stroke Services Progress Report *(also captured in the regular Unscheduled Care, Care Group report – it has been agreed that updates on Stroke Services can now be included in the Unscheduled Care Group Highlight Report moving forwards with no separate report required)*	Executive Director of Therapies & Health Science / Chief Operating Officer	Twice per annum													X	
Governance, Risk and Assurance																
16. Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All Regular Meetings													X	

17. Health Inspectorate Wales (HIW) Audit Tracker Report	Director of Corporate Governance & Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	**(consent)**		**(consent)**		**(consent)**		**(main)**		**(consent)**		**(consent)**			**(to be added to the main agenda on a 6 monthly basis)**
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**
Governance, Risk and Assurance Contd.																
18. Coroner's Inquest – Case Activity & Lessons Learned	Executive Medical Director Executive Nurse Director / Deputy Chief Executive	Bi Annually													X	
19. Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi Annually													X	
20. Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity. (to be placed on main agenda for 2026)	Executive Nurse Director / Deputy Chief Executive	Annually			To be deferred to the May meeting										X	
21. Infection, Prevention & Control Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually													X	
22. Infection, Prevention & Control Strategy Implementation Plan	Executive Nurse Director / Deputy Chief Executive	Annually													X	
23. Putting Things Right Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually							Defer to Sept							X
24. Non Clinical Policies for approval	Executive Portfolio determined.	As and when required														X
25. Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually														X
26. Safeguarding & Public Protection Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
27. Nurse Staffing Levels Wales Act 2016	Executive Nurse Director / Deputy Chief Executive	Twice per Annum														X
28. Medicines Management *(Including Controlled Drugs Local Intelligence Network*	Executive Medical Director	Annually plus exception reporting													X	

(CDLIN) / Prescribing Annual Report) Prescribing errors captured in quality dashboard)																	
29. Oversight on the delivery of the R&D Strategy	Executive Nurse Director / Deputy Chief Executive	Bi Annually					Defer to July						Defer to Jan 2026		x		
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**
Governance, Risk and Assurance Contd.																
30. Cancer Services Annual Report	Executive Medical Director	Annually														X
31. RADAR Committee Highlight Annual Report	Executive Medical Director	Annually plus exception reporting			Removed from the March agenda whilst reporting arrangements are being finalised						Defer to Nov 25		Defer to Jan 26			X
32. Clinical Audit Quarterly Report	Executive Medical Director	Quarterly														X
33. Clinical Audit Annual Plan	Executive Medical Director	Annually														X
34. Clinical Education Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
35. Individual Patient Funding Request Annual Report	Executive Director of Strategy & Transformation	Annually														X
36. Radiation Safety Committee Annual and Mid-Year Updates	Executive Director of Therapies & Health Science	Bi Annually			To be deferred to the May meeting											X
37. Ombudsman's Annual Letter and Annual Report	Executive Director of Nursing / Deputy Chief Executive	Annually														X
38. Human Tissue Authority Act Progress Report	Executive Medical Director	Bi Annually														X
39. CTM Carers End of Year Progress Report	Executive Director of Nursing / Deputy Chief Executive	Annually														X
40. Health, Safety & Fire Sub Committee Highlight Reports	Executive Director of People	All meetings following a Sub Committee											Defer to Jan 26		Unless there is an area for escalation	X

41. Health, Safety & Fire Sub Committee Annual Committee Report	Executive Director of People	Annually					Defer to July 25									X
42. Organ Donation Sub Committee Highlight Reports	Executive Medical Director	All meetings following a Sub Committee					Defer to July 25								Unless there is an area for escalation	X
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**
Governance, Risk and Assurance Contd.																
43. Organ Donation Sub Committee Annual Committee Report	Executive Medical Director	Annually					Defer to July 25		Defer to Sept 25		Defer to Jan 2026					X
44. Hosted Organisations Quality, Safety & Experience Updates	JCC Chief Commissioner NIAW Programme Director	TBD													Unless there is an area for escalation	X
45. Anti-Microbial Resistance reports	Executive Medical Director	Twice Per Annum														X
46. Harm Free Care Update	Executive Director of Nursing	Twice Per Annum													**X**	
47. Annual Duty of Quality Report	Executive Director of Nursing	Annually					Defer to July								**X**	
48. Research & Development, Innovation & Improvement	Executive Director of Nursing	Bi Annually													**X**	
49. Patient Experience Forum Update	Executive Director of Nursing	Bi Annually													**X**	

Agenda Item
8.2.3

Quality, Safety & Experience Committee

Clinical Policies Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Dr David Deekollu, Assistant Medical Director Quality & Safety Beverley Howell, Medical Directorate Support Manager
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 Since September 2023, a new process for the approval of Clinical Policies has been in place. The new approach allows Care Groups to review and approve policies first and then present directly to Operational Management Board for approval without further delay.

1.2 Approved policies that have been taken to the Operational Management Board are collated by the Assistant Medical Director for Quality and Safety and presented to Quality, Safety & Experience Committee for information. They are also added to SharePoint.

1.3 The purpose of this report is to provide the Committee with an outline of the policies approved at Operational Management Board in the last six months.

2. Specific Matters for Consideration

2.1 In relation to the process put into place for the approval of clinical policies, the following policies have been approved during the period May - October 2025:

- Guidelines for Advance Practice Portfolio Mentors, Mentees and Line Managers
- Point of Care Testing Policy
- Outreach Standing Operational Procedure
- Peripheral Noradrenaline Administration Guideline for Use in the Emergency Department
- All Wales Thromboprophylaxis Policy
- CTMUHB Emergency Department Young Adult Referral Guide
- Major Trauma Repatriation Pathway
- Inter Hospital Transfer
- Psychological Interventions Supervision Policy
- Guideline for the Extended Learning Period
- Managing Multiple Births within the Health Visitor Service
- Protocol and Guidance for the Provision of Beds for Children & Young People
- Evaluation of Suspected Ventriculoperitoneal Shunt Malfunction Guideline
- In Patient Pain Guideline - Pain Assessment and Analgesic Prescribing for Adult In-Patients with Acute or Chronic Pain
- Primary and Secondary Care Assessment and Treatment Guidelines for Headache and Migraine in Adult Patients
- Multidisciplinary Guidelines for the Management of Patient's Receiving Intravenous Patient Controlled Analgesia
- Management of the School Nursing Team During Periods of Vacant Caseloads and Sickness
- Management of Perinatal Mental Health

- Transition of Young People with Epilepsy from Paediatric to Adult Services
- Paediatric Transfer and Escort Policy
- Toy Cleaning Policy
- Transition of Young People with Asthma And Allergies from Paediatric to Adult Services
- CTM Decision Making and Consent to Examination and Treatment
- Health Staff Multi Agency Safeguarding Hub
- Vitamin D Rapid Loading Protocol
- Infant Feeding
- Management of Caseloads during Periods of Reduced Staffing
- All Wales SCPHN Team SOP for Mobile Phones and Texting
- Loan of Breast Pumps in Community
- The Induction and Preceptorship of Newly Appointed Health Visitors
- Admission Pack for Child with Newly Diagnosed Diabetes
- The Trauma & Orthopaedics (T&O) Service in Princess of Wales (POW) Hospital – Paediatric Patients
- Guidelines for the Management of Eating and Drinking with Acknowledged Risk (Inpatient Services)
- Adult Acute Mouth Care
- Adult Acute Dysphagia Referrals (Pan CTM)
- Dogs Visiting Hospital Premises
- Infectious and Communicable Diseases Procedure for Health Care Workers
- Methicillin Resistant Staphylococcus Aureus (MRSA) Procedure
- Management of Diabetes in the Older Adult
- Glucose Management of Inpatients with Diabetes requiring Enteral Feeding
- Diabetes Management at End of Life.
- Internal Professional Standards (IPS) Document

2.2 The above clinical policies have been approved by the Operational Management Board and uploaded to SharePoint for implementation.

3 Key Risks / Matters for Escalation

No specific risks identified. This approval process of Clinical Policies is now operational which allows initial Care Groups' scrutiny and approval followed by presentation to the Operational Management Board. The Corporate Governance team have recently completed a consultation on the revision of the current Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents – an updated policy should be available shortly which will further improve the process for developing clinical policies.

4 Assessment

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

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

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

5 Recommendation

5.2 The Committee are asked to **NOTE** the contents of this report.

6 Next Steps

6.2 Submission of a Six-monthly report to Quality Safety & Experience Committee in April 2026.

Agenda Item
8.2.4

Quality, Safety & Experience Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME QUARTER 2 UPDATE 2025-2026

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit & Quality Informatics
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
CA&QI	Clinical Audit & Quality Informatics Department
PWH	Princess of Wales Hospital
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
AMD	Assistant Medical Director
AMaT	Audit Management and Tracking
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
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
CEC	Clinical Effectiveness Committee
NEIAA	National Early Inflammatory Autoimmune Diseases Audit
NRAP	National Respiratory Audit Programme
NLCA	National Lung Cancer Audit
COPD	Chronic Obstructive Pulmonary Disease
BTS	British Thoracic Society
PR	Pulmonary Rehabilitation
EEG	Electroencephalogram
MRI	Magnetic Resonance Imaging
HCL	Hybrid Closed Loop
MDT	Multidisciplinary team
CNS	Clinical Nurse Specialists
ANP	Advanced Nurse Practitioner
KPI	Key Performance Indicator
QoL	Quality of Life
BCUHB	Betsi Cadwaladr University Health Board
C&VUHB	Cardiff & Vale University Health Board
CYP	Children and Young People
NELA	National Emergency Laparotomy Audit

1. Situation /Background

1.1 The purpose of this report is to provide an update for the Quality, Safety & Experience Committee on progress against the CTMUHB Clinical Audit Forward Plan 2025-2026. The CTMUHB plan based on information from the HQIP directory of United Kingdom wide agreed audits and reviewed against the NCA&ORP for Wales (2025/26) published 17 June 2025.

1.2 **39** out of 41 national audits (tier 1) are green fully compliant and 2 amber (NEIAA, NELA) where the audits are delayed, a backlog exists work is ongoing to partially or fully comply with the national audit deadlines.

1.3 The CYP and Respiratory themed CEC meetings have taken place in Quarter 2. The main purpose of the CECs is to use national audit data to monitor quality of care across CTMUHB using evidence-based approaches.

1.4 The AMaT system continues to be extensively used across CTMUHB with significant work being undertaken to develop Business Intelligence (BI) dashboards based on a number of ward audits routinely undertaken for medicines management, falls and pressure ulcer monitoring and to explore the use of the Mortality Review module with colleagues from across Wales.

2. Specific Matters for Consideration

2.1 NCA&ORP for Wales (2025/26)

39 out of 41 national audits (tier 1) are green fully compliant and 2 amber (NEIAA, NELA) where the audits are delayed, a backlog exists work is ongoing to partially or fully comply with the national audit deadlines.

2.2 Clinical Audit Forward Plan 2025-2026 Current Position

Two audits have been highlighted as amber:

NEIAA due to clinical pressures and limited administration resources to support the service in the PWH. This resulted in case ascertainment falling below the minimum requirement for the 2024/25, work is ongoing to improve compliance for 2025/26.

NELA due to change in clinical leadership for the audit. Work is ongoing to improve compliance across CTMUHB in readiness for the audit deadline of May 2026.

2.3 Clinical Effectiveness Committee findings and actions

On the 24 June 2025 the CEC met to review outcomes from national audits relating to the Children and Young People's programme. The meeting, chaired by the AMD for Clinical Audit, brought together multidisciplinary professionals across all CTM sites (POW, PCH, RGH) to review data from Epilepsy12, the National Paediatric Diabetes Audit (NPDA), and the National Respiratory Audit Programme (NRAP) – Asthma.

In addition, during quarter 2 the CEC met on 9 September 2025 to review outcomes from key national respiratory audits, including the NRAP (COPD, Asthma, Pulmonary Rehabilitation) and the NLCA. The meeting was chaired by the AMD for Clinical Audit and attended by multidisciplinary representatives from across all CTMUHB sites (POW, PCH, RGH).

The purpose of the CEC meetings was to analyse audit results, share best practice, address local challenges, and agree quality improvement actions to enhance care delivery and data integrity across the respiratory pathway. This included a review of findings from the following national audits:

Children and Young People National Audit Programme

Epilepsy12 Audit

- High performance in access to Epilepsy Specialist Nurse (ESN) (CTM 92.2% vs National 80.7%).
- Strong ECG (81.1%) and tertiary input (61.5%) results.
- 100% completion of parental prolonged seizure plans.
- Challenges: Limited access to paediatricians with epilepsy expertise (29.4%), delays in EEG and MRI reporting, and gaps in care plan documentation (21.6%).
- Variation between sites due to neurophysiology capacity and MRI access for young children.
- **Actions:**
  - Increase First Fit and Epilepsy Clinic capacity.
  - Improve EEG and MRI turnaround through discussions with neurophysiology teams in Cardiff/Swansea.
  - Continue to strengthen School Individual Health Care Plans.
  - Establish adult transition pathways once adult neurology consultants in post.

National Paediatric Diabetes Audit (NPDA)

- Strong overall audit performance with >95% completion for all six NICE health checks across sites.
- High uptake of HCL technology (70%).
- Wales performing above UK average (79% vs 66%).
- **Challenges:**
  - Variations in urine and retinopathy testing uptake.
  - Workforce pressures in dietetics and obesity management.
- **Actions:**
  - Continue HCL rollout and participation in pilot retinopathy study.
  - Develop equitable obesity and weight management service.
  - Review MDT workforce capacity (dietetic, nursing, psychology).
  - Embed poverty-proofing initiatives to ensure equitable access.

NRAP – Children and Young People's Asthma

- Marked improvement in case ascertainment across CTMUHB (POW 94%, RGH 90%).
- Ongoing work to improve steroid administration within one hour and discharge bundle completion.
- **Challenges:**
  - Data discrepancies between sites due to staffing shortages and clerical access issues.
  - Over-inclusion of non-qualifying viral wheeze cases in some sites.
- **Actions:**
  - Continued audit department support with coding and case verification.

- Regular joint review meetings between audit facilitators and specialist nurses.
- Ongoing development of ward discharge checklists to improve compliance.

National Respiratory Audit Programme (NRAP) – COPD

- Case ascertainment improving across sites.
- Specialist review within 24 hours remains below target; accuracy of data questioned.
- Positive progress with oxygen prescribing and discharge bundles.
- **Action:** COPD clinicians to meet with audit facilitators across all sites to review data capture accuracy and methodology.

COPD Discharge Bundle Update

- Implementation ongoing with e-prescribing integration from October 2025 (starting POW).
- Positive engagement from pharmacy and clinical teams.

National Lung Cancer Audit (NLCA)

- Consistent high performance across CTMUHB lung cancer services.
- **Main risk:** insufficient CNS workforce impacting patient navigation, holistic needs assessments, and service sustainability.
- **Action:** Business case to be developed for CNS workforce expansion.

NRAP – Adult Asthma

- Improvement in smoking cessation referrals (24% to 46%).
- Persistent gaps in timely specialist review and access to dedicated respiratory wards.
- Workforce constraints identified (limited ANP/CNS capacity).
- **Action:** Asthma clinicians to meet with audit facilitators to review data accuracy.
- Directorate exploring creation of a dedicated respiratory ward at RGH.

NRAP – Pulmonary Rehabilitation

- Strong KPI performance, with CTM among top-performing Health Boards in Wales.
- 100% compliance for key indicators (exercise plans, QoL improvements).
- **Challenges:** Limited ability to complete dual walk tests; need to refine standard operating procedures.
- Service expansion underway to four community locations.

The forward plan of themed CEC meetings includes the following further 2 themed meetings for 2025:

October

Cardiology

November

Diabetes

2.4 **Clinical Audit Training**
To date over 876 Health Board staff have received training on the ward and area module.

2.5 **AMaT Implementation**

A review of the Mortality Review (MR) module in AMaT is currently underway in collaboration with BCUHB and C&VUHB. The module would provide greater capacity to learn from the MR process.

2.6 **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.

Work is currently underway to look at utilisation of the guideline module within the AMaT system with a focus on NICE guidelines related to medicines management.

3. Key Risks / Matters for Escalation

No key risks or concerns to note for quarter 2, 2025/26.

4. Assessment

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

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below: 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) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar 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) /*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

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 2025-2026, by the end of March 2026.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
8.2.5

Quality, Safety & Experience Committee

CTM Clinical Learning Academy Annual Report 24/25

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Janet Gilbertson Assistant Director Clinical Education
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Richard Hughes, Executive Director of Nursing & Midwifery
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes Executive Director of Nursing and Midwifery

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
CTMCLA Strategic Education Council	15/09/2025	Approved

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The 2024-25 Annual Report for Clinical Education at CTMUHB records a year of significant progress including the delivery of our strategic ambition to become the Cwm Taf Morgannwg Clinical Learning Academy (CTMCLA), which was approved by Board and launched in April 2025, marking a pivotal step in embedding a sustainable, interprofessional learning culture across the health board.

1.2 The CTMCLA Annual report 24/25 is presented in Appendix 1 for noting

2. Specific Matters for Consideration

2.1 Investment in education and training of our workforce underpins the required transformation to the way we work. Underpinning the CTM2030 strategy will be the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development. Education and support are key and as our workforce is forever changing, this is an ongoing need.

2.2 CTMCLA purpose is to create a collaborative, interprofessional learning environment that supports workforce development and service improvement to improve patient and population health outcomes.

2.3 Education Governance has been strengthened with the establishment of the Strategic Education Council and refreshed governance structures to ensure quality, assurance and alignment with organisational priorities.

2.4 The Advanced Practice Board has been integrated with CTMCLA to strengthen governance around enhanced, advanced and consultant professional practice.

2.5 The Primary Care Academy is now also more formally linked with CTMCLA to ensure alignment for education and training across acute and primary care.

3. Key Risks / Matters for Escalation

3.1 Educational Infrastructure and accommodation constraints;

3.1.1 There is a lack of permanent, accessible dedicated multi-professional education and training facilities across CTMUHB sites which limits capacity for clinical education delivery and interprofessional learning.

3.1.2 It is recommended that the creation of a dedicated multi-professional Education and Learning facility is included as part of the strategic site development plan.

3.2 Workforce Capacity for Placement Delivery;

3.2.1 There are increasing clinical placement demands across all health care professions without proportional growth in educator roles or infrastructure, which is placing a strain on clinical teams and a risk to patient care and placement quality. Strategic workforce planning and investment in educator roles is needed to support workforce capacity for training.

3.3 Advanced Practice Governance;

3.3.1 More robust assurance is required to support the development of enhanced, advanced and consultant level practice and roles across the health board. There is a risk of variation in job-planning, role clarity and portfolio development, inconsistent development pathways and potential service gaps. Work is underway, to be completed December 2025, to review the progress and position within CTM, identify gaps and recommendations for a way forward.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Inspiring People Sustaining our Future
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))*	Effective
	If more than one applies please list below: Efficient Safe Timely Person centred Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd	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: No policies or services are new or have been withdrawn
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 policies or services are new or have been withdrawn
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 It is recommended that the Quality, Safety & Experience committee notes the Clinical Education Annual Report 2024/25 and the contribution quality education and training makes to our services and improving patient care.

6. Next Steps

6.1 This report reflects CTMUHB's commitment to developing a capable, confident and compassionate workforce through excellence in education. The Clinical Learning Academy will continue to drive innovation, collaboration and transformation in education to support the delivery of CTM's 2030 strategy.

Appendix 1:
Clinical Learning Academy Annual Report 24/25

Clinical Learning Academy

Cwm Taf Morgannwg

University Health Board

Annual Report

Academic Year

2024/2025

What will this Annual Report tell you?

Our Annual Report provides you with information about the Clinical Education Activity across Cwm Taf Morgannwg University Health Board (CTMUHB), what we do, how we work in partnership with external organisations including Universities and Health Education & Improvement Wales (HEIW), 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 in 2024/2025 and how our Strategic ambition for Clinical Education will be realised over 25/26 with the launch the **CTM Clinical Learning Academy**, developing and embedding an organisational Learning Culture that enables staff to work flexibly and with agility to respond to the health needs of our population by;

- Encouraging life-long learning
- Generating openness to collaboration and effective co-design
- Developing a greater understanding of human intelligence.
- Promoting multi-professional learning.
- Developing staff to work at the "top of their licence" both registrants and support staff.

It is well recognised that there is a strong causal relationship between targeted and well-designed education and training, service improvement and patient outcomes and that quality healthcare for patients is supported by maintenance and enhancement of clinical, management and personal skills. (1)

Our Annual Report for 2024-25 includes:

- Current health education context in Wales
- Current Education context in CTMUHB
- Creating, Growing and Sustaining a Learning Culture in CTMUHB
    - Establishing Underpinning Processes for Education Quality, Governance and Sustainability
    - Developing our Future workforce
    - Developing and Transforming our Current Workforce
    - Developing a Culture of Interprofessional Learning

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Introduction

Health Education 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, resource and severe financial challenges as healthcare services continue to try meet the current health care need whilst also trying to promote prevention and wellness.

Health Education and Improvement Wales (HEIW) is the strategic workforce and statutory education body for Wales. Now in its seventh year, it is committed to addressing strategic and specialist workforce issues, making Wales a great place to train and work for health and care staff and maximising the contribution of all professions and occupations through their statutory function. Its purpose is; as part of the NHS, to work with partners to develop a skilled and sustainable workforce that improves care and population health. (2)

Reshaping and development of the healthcare workforce is fundamental to the successful implementation of the Welsh Government's vision for the NHS in Wales.

HEIW has a statutory function to produce an annual Education and Training Plan in partnership with the system, which details recommendations for education and training commissions to shape the future healthcare workforce on behalf of NHS Wales.

CTMUHB continues to work closely with HEIW to support the delivery of health care professional education and training in NHS Wales, along with other health boards and universities. Our health board benefits from external funding from HEIW supporting education delivery at all stages of health care workforce career pathways and workforce modernisation.

Context in CTMUHB

The resident population of CTMUHB was estimated at 446,514 (Stats Wales Welsh Government, November 2023). The region has high levels of deprivation, with 56.5% of the population of the Health Board area 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. The Health Board continues to work towards the ambitions outlined in the CTM2030 strategy, of which improving the health of our population is a key tenet. (3)

As at 31st March 2025 CTMUHB employs 11,501.3 whole-time equivalent (WTE) staff, with a headcount of 13,192. A significant percentage of our workforce live within the CTMUHB's area, making our staff not only the core of our organisation but representatives of the diverse communities that we serve. Widening access activities to enable more of our communities to achieve successful careers in health care are a key focus of activity for Clinical Education.

Figure 1

Underpinning the CTM2030 strategic goals is the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development.

An effective culture of learning at every level enables the workforce to re-frame their knowledge and includes developing a strong workplace learning infrastructure, cultivating a reputation for training and support and excellence in education.

Figure 2 Organisational Benefits of Excellence in Education

Creating, growing and sustaining a Learning Culture in CTMUHB

Strategic Direction Progress

This report reflects further significant progress made over academic year 24/25 including delivery of our strategic ambition to become Cwm Taf Morgannwg Clinical Learning Academy (CTMCLA), which was approved by Board and launched in April 2025.

Our Maturity Journey so Far

Since 2019 our Clinical Education Strategy maturity journey has been following a hierarchy of needs model, building capability at individual and the wider organisational system levels, supporting and nurturing the development of a Learning Culture in CTMUHB.

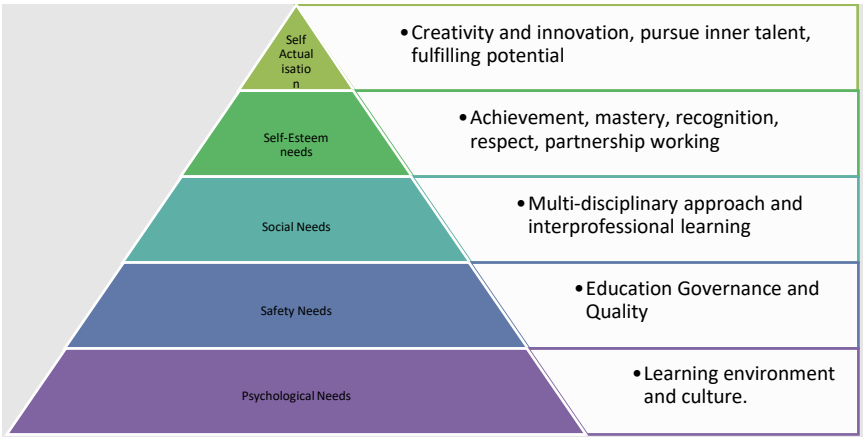


Figure 3 Heirarchy of Needs

Opportunity, Vision and Innovation.

Direction:
Cwm Taf Morgannwg Clinical Learning Academy.
A space where people could feel inspired to think, create and dream, build relationships and collaborate and learn together to improve practice and health.

A living manifestation of University Health Board Status, networked with multiple HEI partners, and HEIW creating a virtuous cycle of learning, innovation and improvement.

Delivery:

In April 2025 we achieved our ambition to deliver the Clinical Learning Academy.

CTMCLA
Cwm Taf Morgannwg
Clinical Learning Academy

Figure 4

Vision:

- Develop an ambitious and capable integrated multi-professional clinical workforce, improving patient and population health outcomes and wellbeing.

Purpose:

- To develop and deliver an inter-professional and collaborative learning approach, meeting the individual educational needs of each profession whilst also enabling and benefitting from diversity of thought and skill set.

Strategic Aims:

Figure 5

Following the launch of CTMCLA, roadshows have been held at sites across CTMUHB to engage with clinical colleagues informing them what CTMCLA currently has on offer and to find out what more staff would find helpful to support their development.
The Clinical Education intranet pages have been re-branded and refreshed and can be found as *Clinical Learning Academy*

CTMCLA Roadshows:

Figure 6

Figure 7

Learning Environment and Culture

Direction:

- *Quality and excellence in Education and Training is an established and valued part of organisational culture.*
- *CTMUHB is a Centre of Excellence for multi-professional learning.*
- *There are clearly defined, recognisable, flexible, accessible, up-to-date Clinical Education facilities that meet the learning needs of learners from all professional groups.*

Delivery:

The value of clinical education and training has been formally recognised in the health board with the establishment of the Clinical Learning Academy. Inclusive of all registered health care professions and their support staff, the CTMCLA has a clear direct reporting line structure through to Clinical Executives and Quality and Safety Committee.

The Executive Director of Nursing and Midwifery (EDoN) remains accountable to Executive Leadership Group for multi-professional Clinical Education activity. The Assistant Director Clinical Education has professional leadership and managerial accountability lines to the EDoN and additional professional accountability lines to the Medical Director and the Executive Director of Allied Health Professions and Health Science (EDAHPHS).

Progress continues to be made with defining our existing education and library facilities, at each of our acute hospital sites and Keir Hardie Academic Centre (Education). However

permanent training accommodation for all professions continues to be a challenge as the demand for increased clinical space becomes an issue across all sites and services.

It is recommended that the creation of a dedicated multi-professional Education and Learning facility should be included as part of the strategic site development plan.

Education Quality and Governance

Direction:

CTMUHB has established effective systems of educational governance and leadership

1. *A robust and established Clinical Education Governance infrastructure providing confidence and assurance for individuals and the organisation of excellence in Clinical Education and Learning activity.*
2. *A clear and well-developed understanding of Clinical Education, Training and Learning activity and risk management across the organisation.*
3. *Maturing organisational processes around clinical education commissioning, informed and aligned with service delivery priorities and training needs analysis, supporting the development of new models of care, innovative service redesign and workforce modernisation.*

Delivery

The newly established Clinical Learning Academy has a refreshed governance structure to ensure visible and clear leadership for Clinical Education activity across CTMUHB, clear governance and assurance reporting lines to Executives, and Quality and Safety committee through to the Health Board. The Strategic Education Council will provide senior leadership and direction for CTMCLA. Chaired by the Deputy Director for Nursing, its membership includes senior Care Group leaders, creating effective systems of educational governance and leadership that ensure optimal investment and resource utilisation in education activity to support and underpin the capability, capacity and confidence of our clinical workforce.

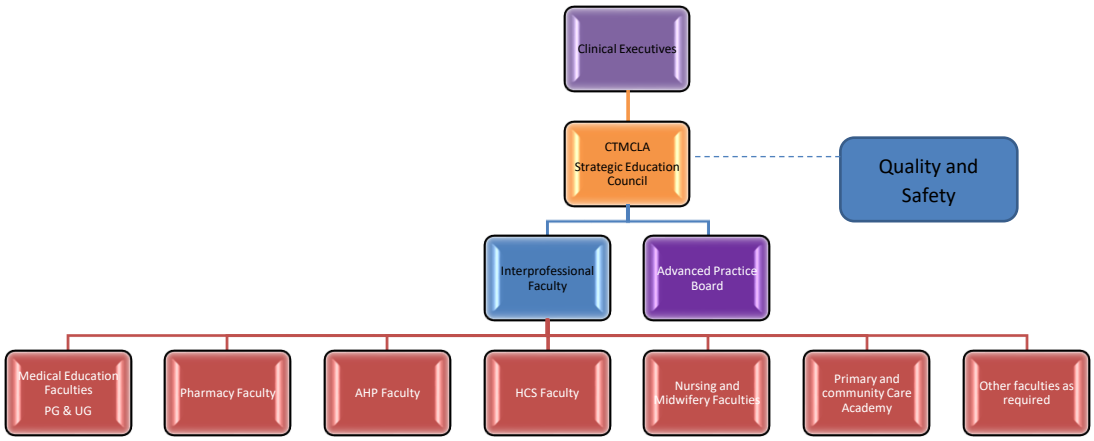


Fig 8 Clinical Education Governance Structure

Inter-professional Learning Approach

Direction:

*There is a high quality multi-professional education model that delivers equitably for **ALL** healthcare professionals and their support staff. Meaningful inter-professional learning and development is evident throughout the education model.*

Progress:

Significant progress has been made with interprofessional learning (see p 31)

Sessional time secured from Allied Health Professions and Pharmacy continues to embed our inter-professional approach.

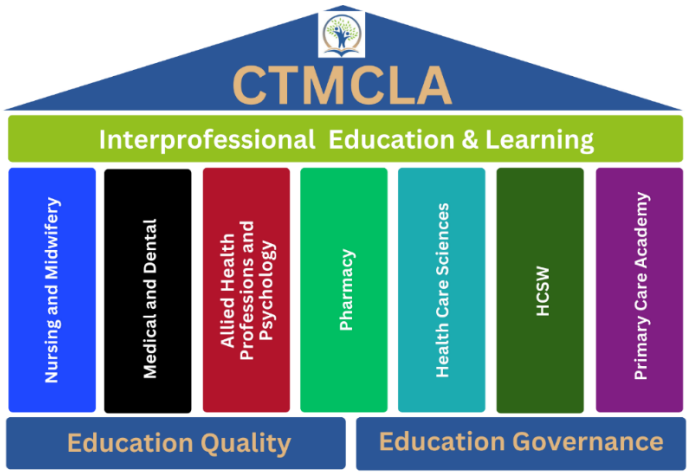


Figure 9

The Clinical Learning Academy has a remit across the whole of CTMUHB and includes the Primary Care Academy and the Advanced Practice Board continuing to ensure CTMUHB has a pan organisational view of education across primary, community and acute care settings.

The establishment of professional faculties feeding into an Interprofessional Faculty will enable the development and delivery of an inter-professional and collaborative learning approach, meeting the individual educational needs of each profession whilst also benefiting from the diversity of thought and skill set.

CTMUHB continues to lead the way in Wales developing interprofessional learning activity. Over 24-25 the Interprofessional and Simulation Education offer has grown, building on the success of the first multi-professional practice education facilitator post, with

additional multi-professional resource added to the team, which has enabled further progress with significant interprofessional learning activity.

Allied Health Professions and Pharmacy education are now linked into central clinical education support through sessional senior leadership roles and a senior support officer.

These roles have provided alignment and essential support to pharmacy and AHP workforce development, helping to streamline processes, collect and evaluate data, and enhance overall efficiency.

Achievement and Recognition.

Direction:

Our workforce are our most significant asset. There will be clear educational frameworks to support career development pathways in CTMUHB

Progress.

Development of the professional faculties will ensure direct alignment with the All Wales professional workforce strategies and career and advanced practice frameworks.

Developing our Future Workforce

CTMUHB as an organisation contributes significantly to the education and training of healthcare professional students in Wales. Each year our organisation delivers undergraduate clinical placement training weeks including:

- > 6000 medical student training weeks
- > 10,000 student nurse weeks
- > 1600 AHP student weeks
- > 340 Pharmacy student weeks across Primary and Acute care

Over 2024/25 we continue to work in partnership with 6 universities (HEIs) to deliver clinical placements for healthcare professional students:

- University of South Wales including–
  - Nursing & Midwifery, Operating Department Practitioners and Part-time Occupational Therapy & Physiotherapy courses.
- Cardiff University including
  - Medical, Physiotherapy, Occupational Therapy, Health Care Sciences & Pharmacy
- Swansea University including
  - Nursing, Paramedics and Physicians Associates.
  - Pharmacy Students
- Cardiff Metropolitan University including
  - Speech and Language Therapy, Dietetics, Podiatry.
- Open University (Part time distance learning) & Bangor University (Distance Learning) Nursing.

Focus on Nursing and Midwifery

The following preregistration routes are supported:

- Adult, Child, Learning Disability or Mental Health nursing
  - Full-time 3-year programmes
  - Flexible routes
- Full time Midwifery programme

CTM UHB support Approved Education Institutes (AEIs)with pre-registration Nursing and Midwifery students from the University of South Wales, Swansea University, the Open University and Bangor University. The below table shows the number of nursing & midwifery students allocated annually to CTMUHB over the last 4 years. The Practice Education Facilitator Team work collaboratively with all clinical areas and University partners to ensure students are allocated to clinical areas and are supported effectively in the provision of a positive learning environment to become our potential future nursing workforce. Monthly meetings are ongoing with our partner AEIs to assist in the identification of areas of development for the PEF team and Practice Learning environments (PLE) which includes Educational Audit renewals which occurs two years. Through this partnership working, we can identify areas who require additional provision to effectively support students who are

not achieving on placement and those areas who are excelling in their support of students throughout their placement period.

Student training Activity

Commissioned student placement numbers for both nursing and midwifery have remained consistent for CTMUHB over the last few years.

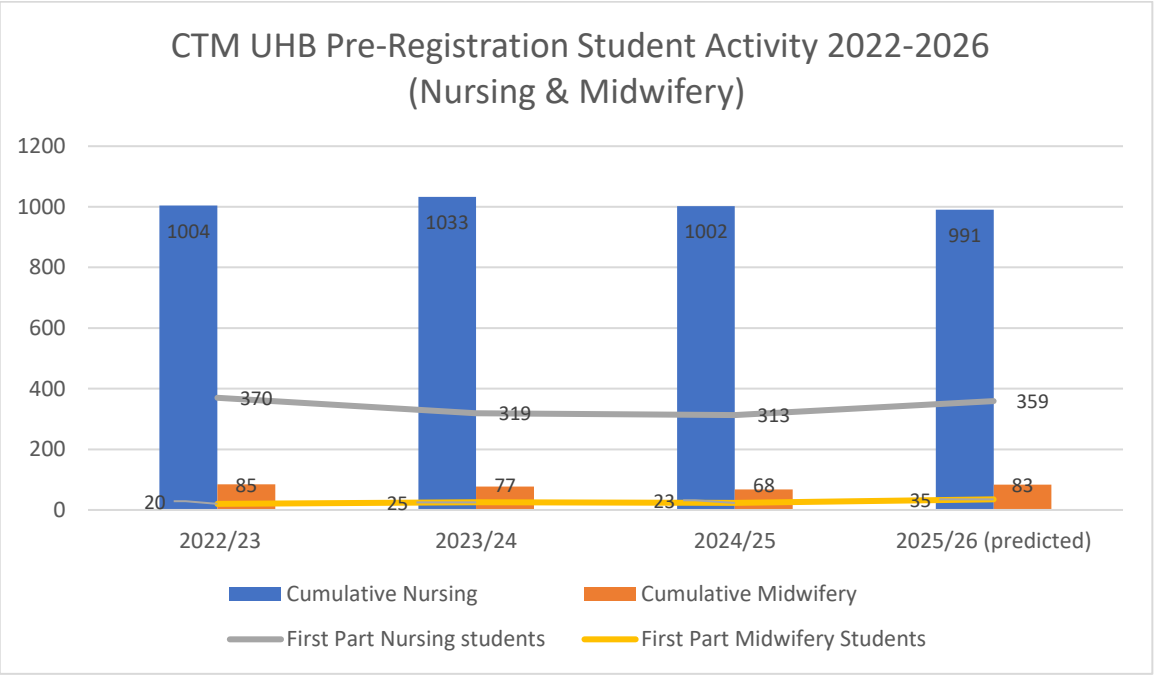


Figure 10

The Practice Education Facilitators (PEFs) actively support clinical placements within the health board and deliver clinical teaching at universities and also provide clinical skills sessions to deliver additional opportunities for our pre-registration students from all AEIs to gain skills outlined in the Once for Wales (2020) Nurse Inventory Annex B Framework. The PEF team support student matters both clinically and pastorally in collaboration with our clinical and AEI partners.

Collaborative Learning in Practice Placement (CLiPP) model is now embedded in 26 clinical areas across CTM UHB. Students have been aligned not only with the cohort above them but also within the same cohort. Feedback has overall been positive, however, there remains a requirement for additional CliPP training for our Practice Supervisors and Practice Assessors to have a greater understanding of the CliPP programme. This additional training has been implanted within PS and PA training to enable all registrants are aware of the programme. There is also a requirement for AEIs to allocate students appropriately in relation to CliPP student peers. Work is ongoing with our partner university to maximise the CliPP model in practice to optimise capacity throughout the placement timetable.

Midwifery

The Midwifery PEF role is now fully embedded into the PEF team. This role is pivotal in ensuring the quality of midwifery student clinical practice placements. Basing the role within the Clinical Education function alongside the nursing PEF roles has enabled sharing of experiences, learning and access to resources across the different professions and the opportunity to support with student concerns. The midwifery PEF continues to offer Practice Supervisor and Practice Assessor training in addition to allocating midwifery students to appropriate staff over several sites within CTM UHB. Collaboration between the nursing PEF and midwifery PEF has allowed for excellent learning opportunities between fields of practice. There are currently 62 midwifery students allocated across the Health Board.

International pre-registration student nurses

During 2023 and 2024, the health board supported two cohorts of 150 pre-registration student nurses from Kerala in India in undertaking their nurse education within Wales. This work remains ongoing but allocated numbers have reduced to approximately 42 within September 2025 cohort. There have been challenges with supporting the students in the welsh culture and learning through English rather than their native language. Strong collaboration with our AEIs has allowed for collaborative and partnership working to provide effective support from the AEI and Health board when any concerns arise. As PEFs we are continuing to learn how we can have a better understanding of cultural differences by speaking with and being educated by the International students. This cohesiveness will allow us to continue to build strong relationships as our students become registrants in the future.

Fitness to Practice (FtP)/Cause for concern

The PEF team and Senior Nurse work alongside AEIs and health board policies to refer students to 'cause for concern' and 'fitness to practice' panels. The PEF team are invited to such panels to provide witness statements and act within an unbiased manner to inform a necessary decision for the students' future education.

Collaborative working between AEIs and the PEF teams is essential in managing the issues effectively and efficiently.

The PEF team ensure students are supported in practice through the development of bespoke action plans to achieve required proficiencies and ensure safe and knowledgeable practitioners upon registration.

During the period of pre-registration nursing education, students are provided with multiple practice placements across numerous locations throughout the health board. To effectively support each PEF with student concerns, two weekly and monthly meetings occur to ensure any movement of students and concerns are shared to promote continuity and reflective practice.

As there is a demand to grow nursing numbers even further, then there is a continuing need to widen access to the recruitment pool. Investment in Practice Education Facilitator roles will be a key enabler in achieving successful registration for more people into the nursing profession.

Practice Supervisors and Practice Assessors

Nursing students on Practice Learning Environments require Practice Assessors (PA) and Supervisors (PS). The PEF team continue to deliver an annual schedule of PA and PS training to registrants to ensure they have the appropriate skills and knowledge to support our students in clinical practice and effectively complete the Electronic Practice Assessment documentation (ePAD). There are currently 3116 trained PAs' and PSs' on the database (NMC requirement) for CTMUHB (see graph below). The ratio of supervisors to students is 2.3:1 and assessors to student 1.5:1 across all care groups. The PEF team are offering ward and clinical base training opportunities to alleviate some pressures of staffing levels on wards to update staff.

New placement opportunities across CTM UHB have been obtained and include;

- Research and Development
- Womens Health Unit
- Rotational Placements with CNS teams at PCH

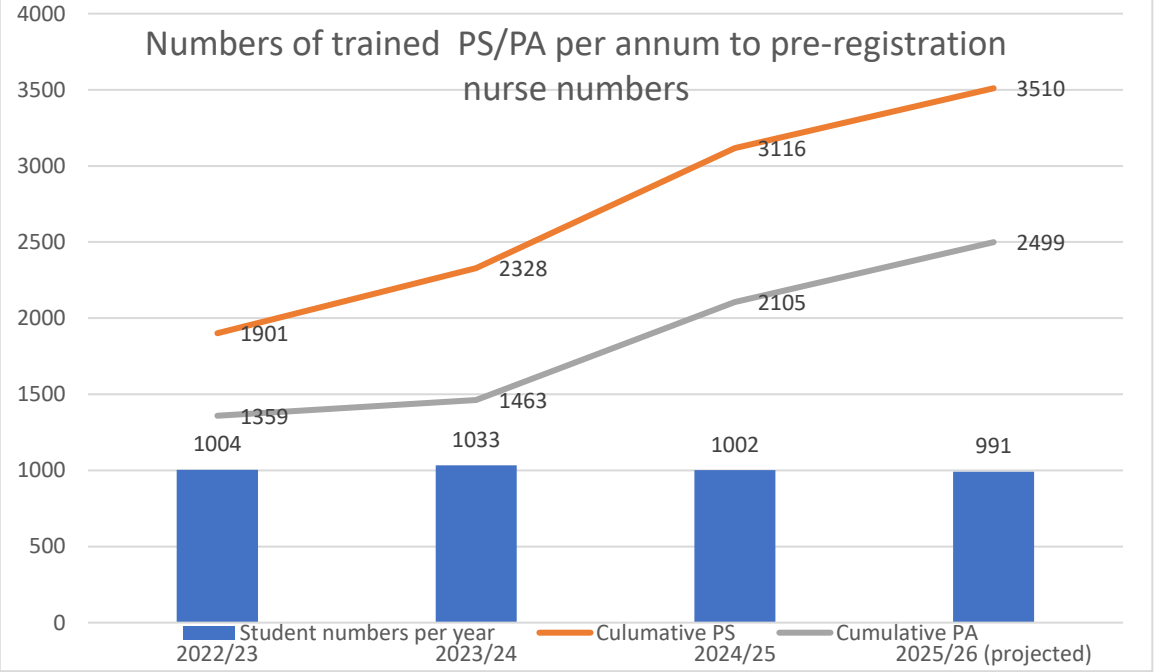


Figure 11

Pre-registration education

AHPs continue to provide 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. A move away from predominantly hospital-based placements to community-based services is equipping our future workforce with the experience they will require, to deliver roles aligned to the strategic drivers of improving population health and community-based management of long-term conditions and rehabilitation.

Clinical Placements form a significant part of the pre-registration training for many of the AHP professions. However, there are minimal funded Practice Educator roles for each Profession (only 0.2 WTE for Speech and Language Therapy) and so placements currently must be managed within existing workforce capacity. Along with other professions, in recent years the need to grow the workforce has been reflected in our recent Education Commissioning returns. However, the increased pressure this will cause in delivery of clinical placements will need to be recognised. The graph below shows the number of pre-registration education places that have been commissioning per profession each year since 2020.

Annual Pre-registration education commissioning numbers for AHP professions, 2020-2025

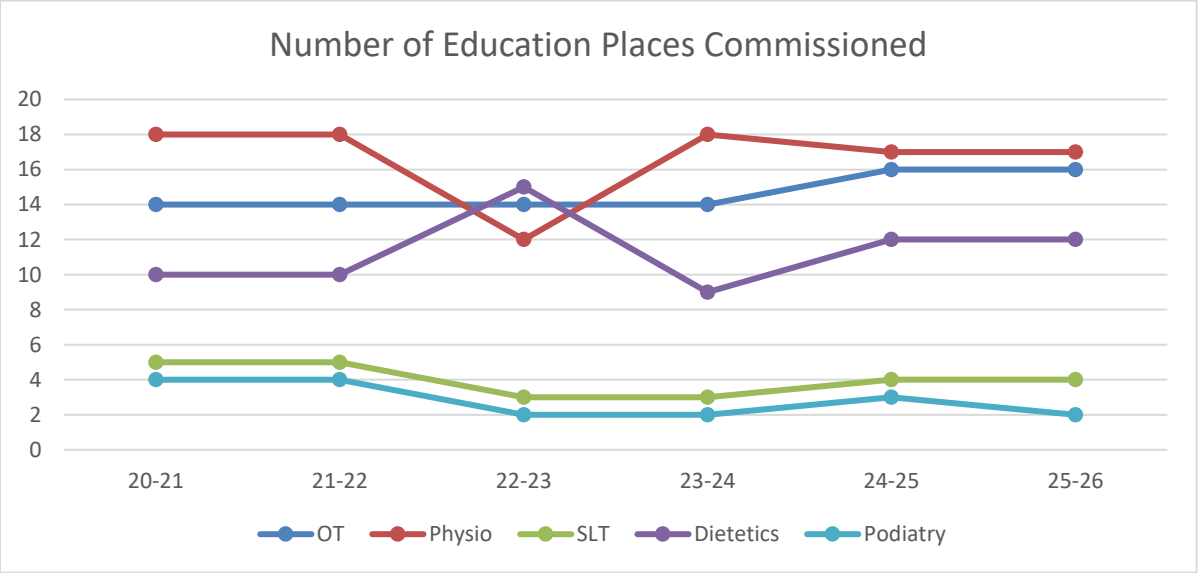


Figure 12

As expected, the larger professions commission the largest number of pre-registration training places and all professions maintained their commissioned places at the same level as 24-25, except podiatry who reduced by 1 place. Dietetics have implemented an innovative solution to increase placement capacity by offering placements with the Dietetic Public Health service. Students support in the delivery of the schools-based "food and fun" summer holiday enrichment programme which provides food and nutrition education and physical activity to promote healthy living. Learning outcomes can be assessed over the summer, reducing reliance on clinical settings and additionally showcasing the public health

speciality for attracting future workforce. Following successful evaluation last year this innovative model will continue to be offered across CTM.

Annual Pre-registration placement allocation for AHP professions, 2020-2025

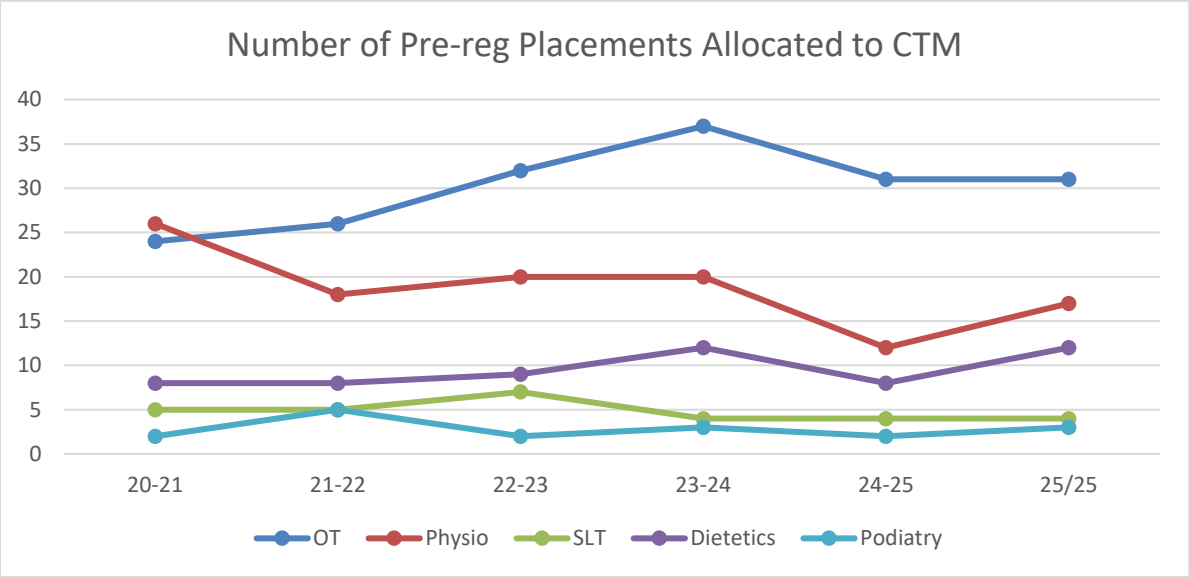


Figure 13

Physiotherapy have supported students from Cardiff university (BSc and MSc) and University of South Wales. We deliver a wide variety of placement opportunities and welcome a mixture of BSc and pre-reg MSc students. In the 24/25 academic year we were commissioned for 18 placements, in the 25/26 year we have been commissioned for 17 placements. This still allows for a mixture of BSc and MSc students, something we encourage as it enables diversity. This year we have developed placement opportunities in line with the AHP framework, we have completed two leadership placements and offered specialist placements such as First Contact Physiotherapy (FCP) and major trauma rehabilitation."

The South Wales Doctoral Clinical Psychology Training Programme, Cardiff University, has an intake of between 28-35 trainees each year. These training places are funded by WG and are hosted in a single health board; Cardiff & Vale UHB. A health psychology placement would be considered a third-year elective placement and is decided by trainee preference. Typically, trainees apply for their electives in their host health board. CTM Psychology representatives meet regularly with the university to address the consistent lack of third year trainees choosing CTM for their options. The university is looking into ways they can positively promote application other health boards, to address onward recruitment difficulties including offering teaching sessions to CTM Psychologists on the training course to promote visibility and awareness of services.

The 2025/26 intake has increased to 36 places this year and as such health psychology has been asked if they can accommodate 1st and 2nd year trainees on core placements (adult/older adult/ child). However, challenges remain due to the competencies these

trainees need to attain, decreasing the amount of time they are within the health psychology placements and increasing the level of supervision required of the health psychologist for the trainee.

In the last year there have been only 2 trainees on placement within CTM and these have been undertaking core placements. Such experience within CTM is vital in promoting the CTM Health Psychology Service with a view to future recruitment.

Orthotics and Prosthetics education is delivered in 2 Education Establishments in the UK and there are no places commissioned by Welsh Government. Orthotics is a shortage profession and historically employment was mainly in the private sector however in the latter years employment in the NHS is becoming more common. CTM Orthotics supports post graduate education by enabling shadow placements for externally employed graduate orthotists. We are also moving to an inhouse model and providing the shadowing has proved beneficial to the organisation as we have secured the appointment of one of these Orthotist.

Focus on Health Care Sciences: Undergraduate

Health Care Science (HCS) represents over 50 different professions. Training pathways follow Modernising Scientific Careers.

Within CTMUHB we have the following HCS professions:

- Audiologists
- Biomedical Scientists
- Cardiac Physiologists
- Clinical Engineers
- Clinical Scientists
- Medical Illustrators
- Neurophysiologists
- Operating Department Practitioners
- Radiographers
- Respiratory Physiologists

HCS in CTM contribute greatly to the delivery of high quality, patient focussed services and as such recognise the importance of developing our future workforce.

Regularly collaborating with HEIW and academia, the following are an example of future developments:

Audiology

- In house HE CERT training for B3 staff – one completed this year, and another will start next year
- Annex 21, part time PTP training under-way, BSc year 1 complete.
- Our first STP trainee started in post September 2024.
- A B5 audiologist was successful in gaining South Wales STP training place for 2025.

Radiology

Planned learning for 2025/26 include:

- MSc Leadership and Management
- MSc research module
- QCF Level 3 Clinical Healthcare
- QCF Level 2 in Clinical Healthcare Support
- Eden Learning introduction to CT
- Eden Learning intermediate CT
- MSc Radiography

Focus on Pharmacy - Pharmacy Undergraduates

Building on the success of the 2023-24 collaborative project between the Clinical Education and Pharmacy departments at CTMUHB to enhance undergraduate training capacity and promote interprofessional education (IPE), the focus for 2024-25 was shifted to expanding placements into primary care and increasing secondary care capacity.

Key changes included adaptation of the programme for primary care, increased placement numbers in secondary care using an allocation model with a maximum of 6 students per site and full rollout of placement workbook.

340 placement weeks were delivered in secondary care across 4 sites and 20 placement weeks in primary care. This was an increase from 313 placement weeks in 2023/24.

Results showed that

- 95% of students felt better prepared for future practice
- 79% expressed interest in returning to work at CTMUHB (others cited geography as a potential limiting factor)
- 75% of students found the workbook beneficial, particularly for guiding self-directed learning and documenting experiences.

Undergraduate placements: Student results - Preparedness for future practice 23/24 vs 24/25

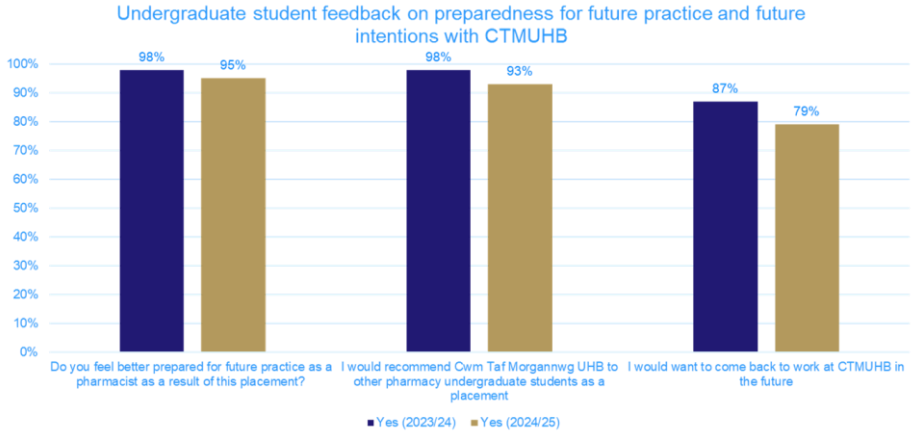


Figure 14

Undergraduate placements: Student results - Skills scores

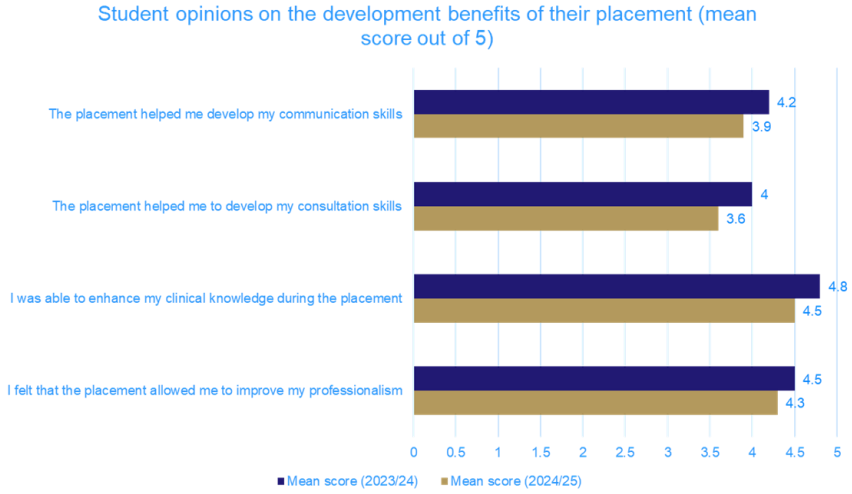


Figure 15

Undergraduate placements: Staff results – Student supervision

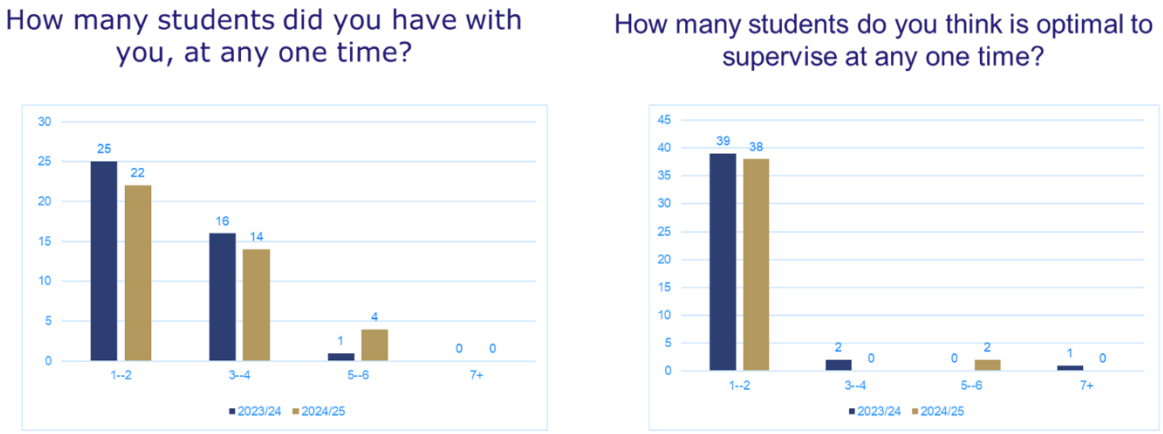


Figure 16

Undergraduate placements: Staff results – Perception and Culture

Figure 17

Outcome/ Impact of the changes made

The project is transforming the culture around pharmacy education and training, highlighting the significant shift needed to support high-quality clinical placements. Staff surveys show education is increasingly seen as a core responsibility. The average agreement score for the statement "I understand how pharmacy undergraduate placements are essential" rose from 4.2/5 to 4.5/5 in one year.

Organisational Impact

CTMUHB has become a more attractive employer. In a recent Band 6 recruitment round, 40% of applicants had completed placements with us, and 79% of students said they would like to return in the future. A structured delivery framework supports sustainability and continuity.

Stakeholders

The framework has influenced national policy, promoting standardisation through

agreements on EPAs and governance. This enables wider placement capacity and supports pharmacy workforce growth across Wales.

"CTMUHB has been incredibly enthusiastic regarding the FPUPP project from the outset, recognising the potential to advance both undergraduate provision and the profession of pharmacy itself. CTMUHB's can-do attitude from the start of the project has delivered a real shift in what can be achieved with placements. The collaborative approach...has made the delivery of the placement program far more straightforward than a complex project such as this had the potential to be. Students commend the placement experience...commenting on the excellent organisation of placement tasks and the training and experience of placement supervisors."
— Simon Wilkins, Clinical Placement Lead, Swansea University

"The sustained support of CTMUHB for undergraduate pharmacy placements has been central to our ability to expand experiential learning over recent years. Their early engagement, consistent collaboration, and practical, solution-focused approach have allowed us to deliver placements at a scale that would not otherwise have been feasible. Their commitment to student development and contribution to the future pharmacy workforce are recognised and greatly appreciated."
— Dr Robert James, Academic Placement Lead, Cardiff University

Future of the Pharmacy Workforce
Students are better prepared for practice due to earlier, consistent exposure, supporting the Royal Pharmaceutical Society's *Prescribing Progress* review.

"Managed to see a broad variety of specialties and roles... and were helpful in giving us guidance. We have nothing but positive, glowing feedback for the team." Student voice

Benefits to CTMUHB

- 79% of undergraduates would want to come back to work at CTM – promoting the HB as a great place to work.
- New collaborative links established in HB between pharmacy and clinical education, promoting interprofessional learning at all levels.
- Strong collaborative partnership working established between health boards, HEIs and HEIW.
- Work has been shared to develop further placement capacity.
- Culture shift promoting education and training in pharmacy.

National Recognition

The project has gained national recognition through several prestigious platforms, including wining an award at the Clinical Pharmacy Congress Awards for Excellence in Hospital Pharmacy Practice. It was also showcased at the Welsh Royal Pharmaceutical Society (RPS) annual conference, with a poster presented at the UK RPS conference. Additionally, a blog detailing the initiative was published on the RPS website. The framework developed is now informing pharmacy education strategy across NHS Wales. Furthermore, the project, *Transforming Pharmacy Undergraduate Clinical Placements into*

Future Workforce Solutions, has been shortlisted for the NHS Wales Workforce Sustainability Award at the NHS Wales Awards 2025.

Pharmacy technician workforce development

17 pre-registration pharmacy technicians have or are undertaking the 2-year level 4 University of East Anglia qualification across the 3 acute sites, RGH, PCH and POW, plus HMP Parc, Bridgend in 2024/25.

Further development opportunities for pharmacy technicians to upskill clinically include the Pharmacy Workforce Development South (PWDS) Clinical Prioritisation qualification. Once qualified pharmacy technicians can review patients before the pharmacist or other health professional and prioritise the patient according to a clinical prioritisation tool which is designed for specific clinical areas. As the first health board in Wales to send staff on this training course, we have had much interest from other health boards and HEIW have now agreed to fund the training for the Welsh cohort starting 2024.

Currently six pharmacy technicians have completed the qualification. They are working in areas such as the Emergency Department, Maternity, Frailty and Surgery and having a great impact. Five staff from all sites across the health board are currently undertaking the course and the plan is for all Band 5 pharmacy technicians to undertake the course over the next couple of years. One PCH Pharmacy technician presented on extended role at Clinical Pharmacy Congress, North, in November 2024 and has presented at APTUK.

> IMPACT INTENTION: This will release pharmacist and other health care professionals time to prioritise patients by risk according to a designated clinical prioritisation tool. It will release time for prescribing, MDT working and benefit patient care.

Other qualifications that pharmacy technicians have undertaken in 2024/25 are the level 4 diploma at Bradford college, Antimicrobial Stewardship training, Intensive Care training, Education and Training, Leadership, Analgesic Stewardship and 3 members of senior pharmacy technicians are currently undertaking the master's in leadership and management with USW.

Two members of staff are currently enrolled on the PWDS prescription validation qualification specifically for Homecare services. This will allow them to validate prescriptions and release pharmacist time.

> IMPACT INTENTION: For pharmacy technicians to lead and take on more clinical roles by increasing their scope of practice, releasing time for the pharmacist to use the IP qualification, run clinics, deprescribe and influence e.g. polypharmacy, and work with care groups to identify prescribing initiatives, and improve patient care and safety.

Career frameworks/ pathways for pharmacy technicians are being developed on a UK wide basis. Next steps would be for pharmacy technicians to provide basic clinical checks of prescriptions and to work within a designated scope of practice. Various courses are available and are currently being scoped.

Foundation Trainee Pharmacists

18 foundation trainee pharmacists on 3 acute sites across the health board undertook the HEIW multi-sector foundation training programme in 2024/25. The GPhC introduced changes to the Initial Education and Training of Pharmacists in 2021 with pharmacists on the 2025/26 cohort qualifying as independent prescribers. Over 2024, CTMUHB contributed to national work to update the curriculum for the multi-sector training programme. The new curriculum was piloted for 2024/25 in readiness for 2025/26. Currently there is one Training Programme Director employed by the health board and funded on a weekly sessional basis by HEIW who is responsible for the running of the multi-sector programme and the quality management of it.

Planning for the impact of independent prescribing at point of registration for pharmacists is underway including identification of a scope of practice for newly registered pharmacist prescribers.

Currently within the health board, a register of all Independent Prescribers is maintained and each prescriber on an annual basis completes a declaration that they have completed CPD and are up to date with their scope of practice as well as declarations to any expansions of scope of practice. It would be up to their manager to ensure the CPD they undertake is commensurate with their role as an IP. Any information submitted is annotated on the register annually.

Medical Student Placements

During the academic year 24/25 we hosted 1,231 medical students for a total of 6,234 placement weeks. Most students are from Cardiff University, with students from Swansea University's Graduate Entry programme final placement (SSA) plus their GEM Y3 Primary Care Academy students also joining us for secondary care opportunities. These student numbers are broken into year groups as follows:

Medical Student Numbers								
Year of Study	No. of Students				No. of Student Weeks			
	2021/22	2022/23	2023/4	2024/5	2021/22	2022/23	2023/4	2024/5
1	113	108	120	128	180	238	288	205
2	222	227	219	263	266	250	308	316
3	289	371	355	356	2312	2968	2836	2867
4	262	320	245	217	1952	2284	1960	1736
5	140	154	159	148	1120	1164	1200	1111

Figure 18

Medical student placement weeks have remained steady over recent years:

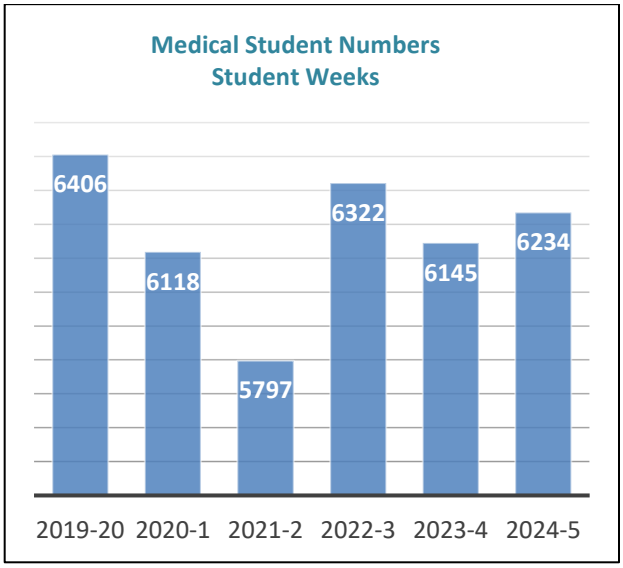


Figure 19

Cardiff University Feedback

The critical incident at Princess of Wales Hospital has impacted on the student evaluations this year, but due to the hard work of our Princess of Wales faculty, the clinical teaching fellows and the administrative team at MPEC, this impact was significantly minimised.

The overall positive score for the Health Board for the year is 95% positive, equal to the All Wales average.

The placement affected the most by the disruption to services in POWH was the Reproductive Medicine placement, resulting in most of these year 4 students being hosted at Prince Charles Hospital. The clinical team overhauled the placement opportunities to accommodate students equally, however, with the many different types of students on these wards, e.g. physician associate, midwifery, nursing, this is a challenging task. The minimal impact on feedback score is testament to how well the clinical team responded to this challenge.

One other area of concern highlighted in the evaluations is the Psychological Medicine placements offered to year students at RGH. Engagement with the clinical team has been difficult over the last few years, partially due to changes in staff, both in Psychiatry and Medical Education. In order to remedy this, Medical Education has made a change to the faculty structure, to have one Honorary Senior Lecturer overseeing the Psychological Medicine placement across all of CTM, to maximise all placement opportunities and enrich the students experience when placed with this clinical team.

A similar Honorary Senior Lecturer appointment has been made to oversee the year 3 Oncology and Surgery placement pan-CTM.

Similar to last year, Phase 1 placements continue to evaluate well, largely under the tutelage of the clinical teaching fellows who, as well as continuity, bring their near-peer knowledge and experience to the organisation and delivery of these placements. Year 1 received 96% positive feedback and Year 2, 99%.

We are, as always, grateful to our colleagues in Midwifery, Health Visitors, Mental Health, Physiotherapy, Cardio and Respiratory Physiologists and Palliative Care for their on-going support.

Out of 55 evaluation reports received this year from Cardiff and Swansea University 44 (80%) reports gave 100% positive feedback a rise from 66% last year. Prince Charles Hospital, received 100% positive feedback from all, bar 2, a fantastic achievement as they deliver placements for over 500 students.

All year 5 placements received 100% positive feedback, which is reassuring as an indicator that the experience and opportunities we provide to these students is useful and valued preparation for their imminent Foundation Year 1 roles.

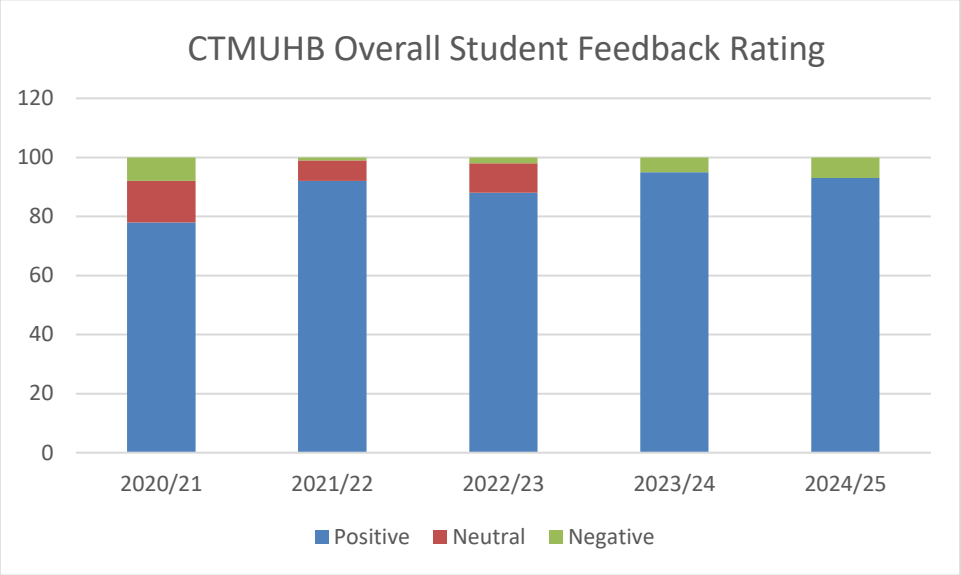


Figure 20

Overall Placement Rating by Hospital Site

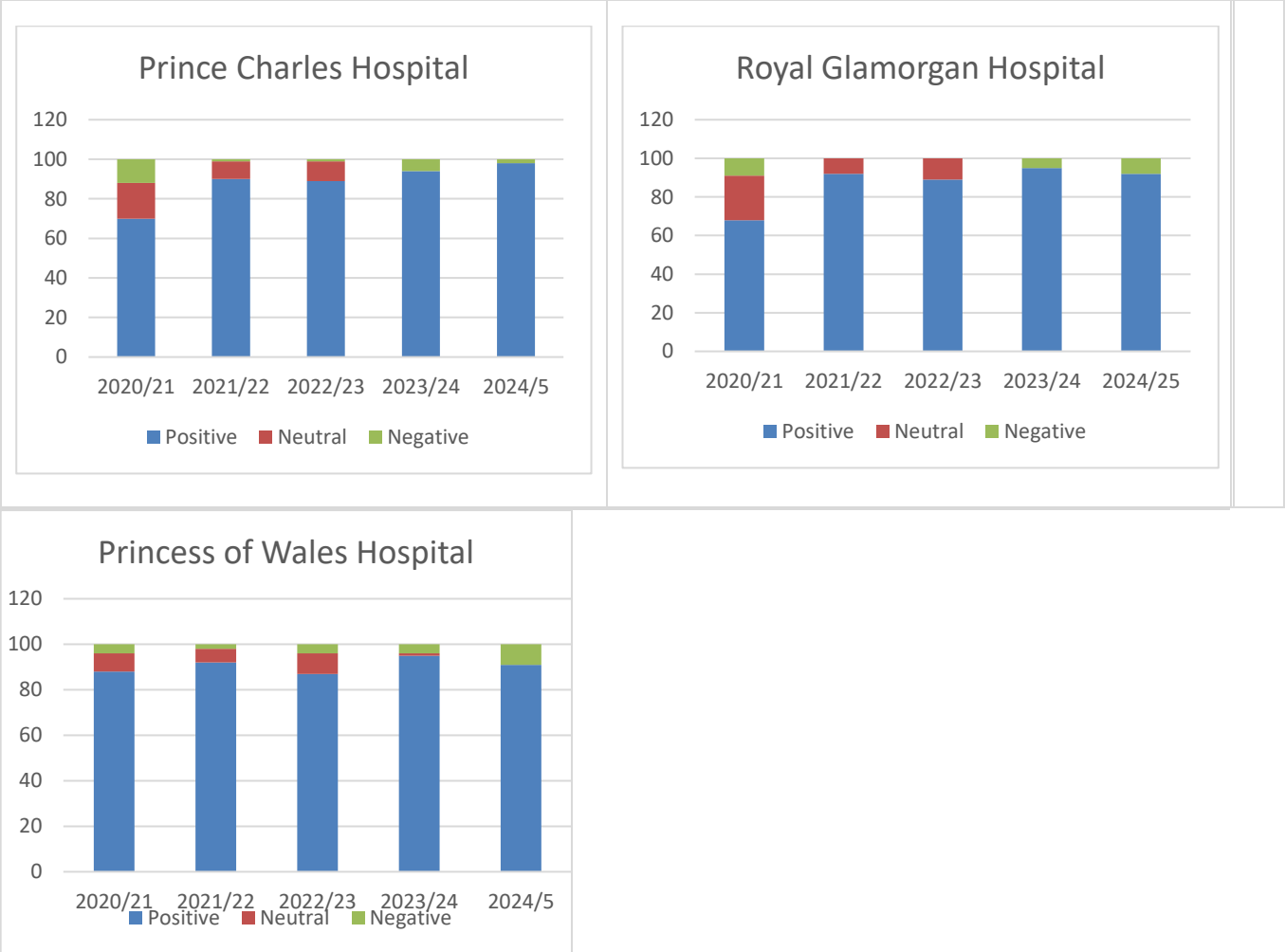


Figure 21

Clinical Fellows

Continuing the success of previous appointments, during the 2024/25 Academic year there were 6 new Clinical Fellows in Medical Education across CTMUHB, one-year tenures with an expectation to engage in a level 7 medical education qualification.

The Clinical Fellows continue to provide a solid and robust teaching resource, which again the feedback shows has been a significant success. In addition, the Clinical Fellows have produced significant quality improvement projects including a 'Year 3 SIM, introducing SIM to year 3 students outside of Hospital Front Door'. They presented this project to the University of Southern California and won the prize of 'Best cool idea.'

SIFT Reallocation

The work underpinning the review of allocation of Service Increment for Teaching (SIFT) continues.

As indicated in previous annual reports, the SIFT review work is to better identify the flow of SIFT funds to services, care group and directorate budgets, enabling the robust resource support of UG medical education activity, alongside enabling the organisation to have further clarity and assurance on utilisation of medical undergraduate SIFT funding (approx.£3.2m per annum).

The Clinical Education function continue to engage with Finance colleagues to further progress this work to establish a clear funding methodology that allows for flexibility to meet curriculum changes.

The following diagram illustrates the current UG Faculty structure.

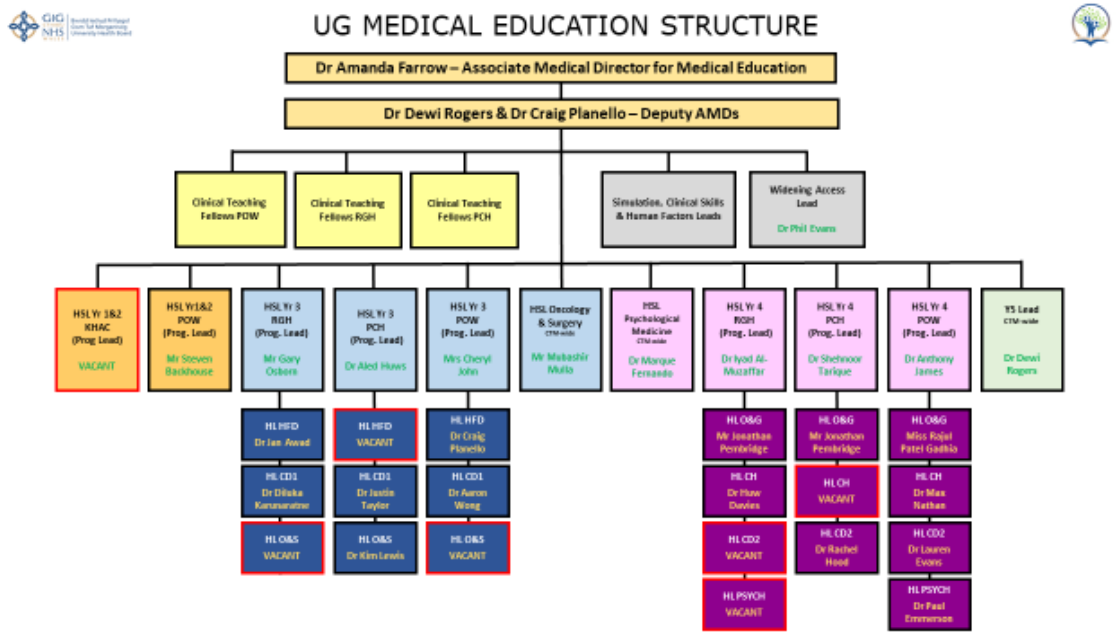


Figure 22

Physician Associate Students

The health board continues to provide clinical placements for Physician Associate (PA) students from Swansea University. Currently we take students on each of the health boards three main sites from year one and year two of the MPAS course, for both clinical placements and specialty placements, including Women's Health, Child Health and Emergency Medicine.

The feedback consistently highlights that students particularly value being placed within teams that already include practicing PAs. This arrangement provides them with invaluable mentorship, a clear understanding of the PA role in a real-world setting, and a supportive environment where they can see their future career path in action. While the feedback has been very good, some perennial issues remain, notably the challenge of managing the number of different students placed on a single ward. This can lead to competition for learning opportunities with the patients, potentially diluting the quality of their clinical experience. We continue to work closely with the university to address these logistical challenges, aiming to optimize the learning environment for every student.

Developing a Culture of Interprofessional Learning

Interprofessional Placement Activity

As a result of the HEIW re-commissioning of pre-registration for HCPs there is a requirement for each student to undertake at least 150 hours of interprofessional learning whilst on placement. The IPE team has grown this year due to secondment opportunities, allowing further opportunities for IPE experiences.
This structure has enabled us to design and deliver impactful, learner-focused programmes that are both evidence-based and operationally grounded. It has enabled the team to focus on undergraduate education, and has enabled exploratory work around IPE for postgraduates, and re-establishing the CTMUHB Interprofessional Simulation Education Group, which is progressing at pace.

The team is pivotal in collaborative working across professional groups, and is an anchor for advice, guidance, resource, and Interprofessional Education (IPE) development within the health board and for affiliated higher education institutions. CTMUHB are a driving force across Wales with regard to Interprofessional Education (IPE), with many health boards linking in for advice, support, and developed resources. We are proud to be a transformational conduit in the development of IPE opportunities across Wales.

Structured IPE placement opportunities

The focus of the structured placement opportunities is to ensure that the IPE placement is a valuable learning opportunity. Whilst many students will meet some IPE hours with "ad hoc" experiences, placements that have been facilitated for different professions by the IPE team, which are arranged in collaboration with university leads to ensure valuable learning occurs.

From September 24 – August 25, 2000 IPE placement days have been arranged across professions.

365 Clinics have been available to students across professions to attend and learn from other professions.

23 IPE connection sessions have taken place. These are bite sized learning sessions looking at case studies where MDT working could be improved to enhance patient experience and outcomes for all professions. The evaluations have been very positive.

28 Student learning sessions have been available for staff and students to attend. These are lecture theatre style training, with guest speakers who are experts in their scope of practice. Students reflect together at the end of the sessions, to learn how certain aspects

affect their work and improve their work across professions. It helps for students to gain a larger network and decrease placement anxieties.

Students as Educators

Involving students as educators in IPE offers a unique and valuable dimension to learning. By taking on teaching or facilitation roles, students develop leadership, communication, and reflective practice skills while reinforcing their own understanding of professional roles and collaborative care. This peer-led approach also fosters a supportive learning environment, where students can learn with, from, and about each other in a more relatable and engaging way. It's an empowering experience that contributes to their growth as future healthcare professionals.

Cardiac Physiology Student Teaching

As part of an interprofessional Learning initiative, we introduced Cardiology physiology students leading teaching sessions to support student nurses in developing their understanding and confidence in Electrocardiograms (ECG). The sessions focused on lead placement and waveform interpretations, to recognise key cardiac rhythms.

This collaborative approach has helped to enhance student nurses' confidence in patient assessments and monitoring, allowing mutual respect between professions, highlighting the value of shared learning within clinical practice. The sessions yielded positive results with student's confidence surrounding ECGs showing a positive impact when comparing pre and post session evaluations. The initial sessions allowed us to scope the level of knowledge of the students, adapting the session to suit the students' needs and understanding of the student.

Medical / Nursing Skills Sessions

Following the success of our other student led education sessions, we further expanded this initiative whilst working alongside the medical clinical fellows. From our planning we created clinical skills sessions aimed at bringing together student nurses and student doctors together for peer led skills sharing. During the session the student doctors were able to share their skills and understanding in cannulation. We then reversed the roles and had the student nurses educating the student doctors on female catheterisation a skill that they are highlight familiar with from their clinical placements.

This style of learning environment allowed open discussion within a psychologically safe setting. The session allowed for improvement in clinical skills whilst also enhancing appreciation of different professions' roles.

Physio/ OT Teaching Sessions

A new initiative trialled this year was a Physiotherapy and Occupational Therapy clinician led learning session for Adult Nursing Students.

The aim of this session was to support student nurses to develop their skills in preventing deconditioning and encouraging independence for patients in hospital wards. The clinician's provided education on deconditioning, combined with clinical based case studies, to improve students' understanding of the impact this can have. The session was held in a simulation suite to allow students to practice techniques and enhance student confidence in supporting their patients. The session was facilitated by a member of the MPPEF team to reinforce the importance of collaborative team working throughout. Evaluations have been positive with ideas for improvement. Further sessions are planned for the next academic year.

Interprofessional Education Simulation

Different simulation opportunities to allow for IPE time in practice, have been introduced, providing valuable training opportunities in a safe learning environment.

In addition to our established projects, this year we worked with Cardiff Metropolitan University, and the University of South Wales to develop and facilitate an afternoon of simulation activities for student nurses, and biomedical science students, following the *Journey of a Blood Sample.*

Cross-university simulation is a valuable approach that brings together students and educators from different institutions to collaborate in realistic, multidisciplinary scenarios. This shared learning environment fosters a broader understanding of diverse professional roles, enhances communication skills, and promotes consistency in educational standards. Working across universities, also encourages innovation, shared resources, and builds stronger academic and clinical partnerships that ultimately benefit learners and patient care alike.

The event was a huge success, with positive evaluations from both sets of students. As a team we felt that collaboration with universities brought significant benefits, enriching both educational and clinical environments. These partnerships enable the sharing of expertise, research, and innovative teaching methods, ensuring that learning remains evidence-based and forward-thinking. Working closely with academic institutions also supported the alignment of theory and practice, aiming to enhance placement experiences, and foster a pipeline of well-prepared, confident healthcare professionals.

We collaboratively presented this project at the HEIW Simulation Conference, June 2025.

The CTMUHB Simulation Education Group work has progressed at pace since January 2025, when the group was re-established, with the first initial 6 months focussing on:

- Establishing a solid membership with representation from across professional groups.
- Focus on simulation training within the group membership.
- Scoping simulation resources, and national frameworks.
- Initiating Phase One of the strategy.
- Developing a CTMUHB Simulation Education Strategy for the next 3 years. This is in its final draft stages.

Interprofessional Education Training

This year we have liaised with the PDN team, to provide "How to Facilitate IPE in clinical practice" on the newly registered nurse programme. This will allow clinicians to feel more confident supporting students with their mandated IPE requirements, and themselves as practitioners, promoting mutual respect. It is a good stepping-stone in terms of embedded IPE as part of everyday practice in the health board.

Over the next academic year, the IPE team will be facilitating bite sized educator sessions for clinicians across professions, in relation to IPE facilitation.

- **Pharmacy & Medical Undergraduate interprofessional Learning**

To improve prescribing amongst junior doctors, improve patient safety and communicate key prescribing initiatives Pharmacy have provided 10 sessions for year 5 Medical undergraduates to help support their prescribing training. Junior doctor F1 and F2 induction and clinical sessions have also been delivered in 2024/25.

A pilot IPE session held on 22nd May 2025 at Princess of Wales brought together Year 5 medical students and trainee pharmacists to work through clinical prescribing scenarios in pairs. The session aimed to build and enhance prescribing competence and confidence, foster interprofessional collaboration, and support the development of a more integrated, patient-centred healthcare workforce. Feedback from trainees and facilitators highlighted increased confidence, improved understanding of prescribing processes, and the value of hands-on, practical teaching. Pharmacy input was noted to challenge ingrained prescribing habits and improve safety. Future sessions will consider earlier delivery in placements, digital adaptation for e-prescribing, and ongoing involvement of experienced pharmacy educators.

Trainee Pharmacist POW

"*I felt that the prescribing session was a nice opportunity to work alongside the Year 5 medical students and learn from each other. I found it helpful to see how medics think when it comes to prescribing, especially what they prioritise when filling out the drug chart and their rationale behind certain decisions. I was able to support my partner with things like filling the antimicrobial section …. I picked up a lot about warfarin management and INR monitoring that I hadn't understood before. It was a great opportunity for interprofessional learning and it helped me feel more prepared to work collaboratively in a clinical setting*".

- **Allied Health Professions**

The AHP services play a pivotal role in fostering a culture of IPE by promoting collaboration and mutual respect amongst the different professions. An annual Band 5/ new graduate induction package was created in 2021 to provide IPE opportunities on a rolling 12-month programme for all therapy staff joining the health board. In CTM, multi professional education, development and communication is well-established in our day-to-day practise.

Therapy service participates in and contribute to the wider IPE programme across the organisation. For example, OT led Student learning sessions on sensory processing, sleep hygiene, reablement, falls & frailty, palliative care, prehabilitation and discharge planning. In addition, there are IPE shadowing and structured placement opportunities for students' therapies and Nursing, Pharmacy, Neurophysiology. Simulation session to nursing students on increasing independence in a hospital ward have also been undertaken.

Examples of feedback from led IPE sessions

- The session was really helpful, and all the activities and case studies made us think out of the box.
- Really engaging session
- Loved the session, lovely members of the team. Learnt a lot in today's session and will use this knowledge for the future
- Today's IPE was extremely valuable as I was not fully aware of exactly how the prehabilitation team ran. It was interesting to see how OT and the MDT works and consider what role a nurse may be able to play in the future of the incentive.

Future work

IPE Team Goals for Aug 25- July 26

Through the next academic year, the IPE team will look to expand the current portfolio by:

- Complete CTMUHB IPE Framework – and work towards delivering it.
- Host Student and Educator Celebration Event – October 2025
- IPE team to undertake Simulation Training.
- Introduce further student led IPE opportunities.
- Expansion on Cross University Simulation Experience.
- Work towards the Simulation Strategy- Phase 1.
- Pilot a Cross University, and Health Board placement experience within the palliative care setting – currently in early development stages
- Continue to provide, improve, and monitor the current IPE opportunities available.
- Present our work at the HEIW IPE conference, June 2026.
- Plan, develop, and deliver bite sized training sessions for CTM clinicians around "How to Facilitate IPE."
- Introduce IPE drop-in sessions for clinicians, and students across CTMUHB.
- Integrate the team within the CTMCLA structures

Widening access and promoting the professions

Several initiatives have been undertaken to widen access and promote the professions.

Access to Medicine

CTMUHB represents communities with significant areas of deprivation. The Medical Education Faculty and "Widening Access" team are committed to provide support for students from these under-represented areas, with the aim of:

- raising awareness of opportunities within the local and wider healthcare service
- encouraging talented students to believe in their ability
- removing barriers, perceived or real, to enable students, to gain fairer access to higher education, particularly from backgrounds where pupils do not generally go to university
- prioritising pupils from state schools in deprived areas or from a 'widening access targeted background' within CTMUHB

As a faculty we are trying to develop a programme extending from school years 6 to 13, which will help local children develop an interest in medicine, maintain that interest and finally support the route to medicine.

The current annual timetable is seen (Appendix 2), but the elements are as follows:

Information for pupils, parents and teachers

The Medical Education Faculty provide information on studying medicine, including routes to medicine, entry requirements and cost. This is held in the late afternoon and facilitated via schools/colleges for Year 11, and 12 pupils followed by an early evening event for parents. The faculty also holds a similar information event for school careers officers and 6th form leads.

In addition, over the last 12 months, two of the Medical Education clinical fellows have developed an online resource, which hosts all of the relevant information required when considering an application to medicine, from medical school information including entry requirements, UCAS application procedure, entrance examinations, to funding questions. This is available bilingually in Welsh and English.

Primary schools

Each year a group of Year 3 and Year 4 medical students provide an interactive session to Year 6 primary school pupils on topics related to health and the body. This is undertaken as part of the "Widening Access" Special Study Component (SSC)

Secondary schools

As part of trying to maintain and encourage an interest in studying medicine the faculty aims to continue to support the delivery of a Year 10 clinical skills simulation event annually. This was run for the first time in February 2024 and repeated this year, again with very positive feedback, with participating secondary schools already in contact with the medical education faculty to request further sessions this academic year.

Medical Work Based Observation Scheme

The Medical Work Observation Scheme for pupils of Year 12+ ran for the first three weeks of July, following a full day's induction held in June. The content is mainly site-based, with time spent in theatres, the emergency department, clinics as well as clinical skill teaching, CPR and a reflection section to support including this experience into their personal UCAS statements. For some, the week is a crucial tool in helping to decide whether to pursue a career in Medicine or Dentistry.

In 2025 we had 108 learners attend, an increase of 10 from last year.

Mock interviews

Provision of mock medical school interviews for pupils from CTMUHB catchment area, including Multiple Mini Interviews (MMI) and 1:1 feedback takes place annually, and has been well received. Attendees are also encouraged to inform the faculty on their success at interview, and to date, this has been very encouraging.

Future:

The "Widening Access" faculty is now able to expand the opportunities available to pupils from CTMUHB catchment schools by closer collaboration with Cardiff medical school "Widening Access to Medicine Mentoring Scheme" (WAMMS). Talks are in progress with the University to see how we can best work together to maximise support for future medics.

New for 2026 is our year 8 opportunity, similar to the experience we provide for year 10 learners, but importantly connecting with this year group before they make their G.C.S.E. choices.

Pathology

Recognising the importance of attracting the future Pathology workforce, the department has committed to promoting the profession of Biomedical Science and the various, excellent career pathways available.

External Events:
Since the commencement of 2025 the Pathology Department has attended the following external events:

- Merthyr College Careers Fair
- Swansea University Careers Fair
- Cardiff Metropolitan University Careers Fair
- Bryn Celynnog School Sixth Form Careers Talk

- Maesteg Comprehensive School Sixth Form Careers Talk
- Bryntirion Comprehensive School Year 7 Science Event

Work Experience:

CTM Pathology hosted its first ever Virtual Work Experience event in July 2025 where learners were invited to a host of talks from discipline specific professionals. The following feedback was collected:

- 4.8/5-star rating for overall experience at event
- 100% of attendees would recommend the session to others
- 100% of attendees agreed, or strongly agreed that they had a better understanding of how to become a Biomedical Scientist/ Clinical Scientist following the session
- 100% of attendees agreed, or strongly agreed that their knowledge of Pathology had increased following the event

In addition to virtual events, CTM has hosted four work experience students this year, with an additional three students commencing placement this August.

Pharmacy Careers

Several initiatives have been undertaken to widen access and promote the pharmacy professions.

Date	School	Activity Type
16/12/2024	Bryntirion Comprehensive School	Careers Day
19/12/2024	Coleg Cymunedol Y Dderwen	Careers Day
	2025	
23/01/2025	Tonyrefail Community School	Year 9 Career carousel
04/02/2025	Cyfarthfa High School	Year 7 - Uniform Worker Day
12/02/2025	Archbishop Comprehensive School	Careers Day
10/04/2025	Porth Community School	Careers Day
20/05/2025	Pencoed Comprehensive School	Careers Day
11/06/2025	Llanhari School	Careers Day
08/07/2025	Measteg Comprehensive School	Careers Day

Figure 23

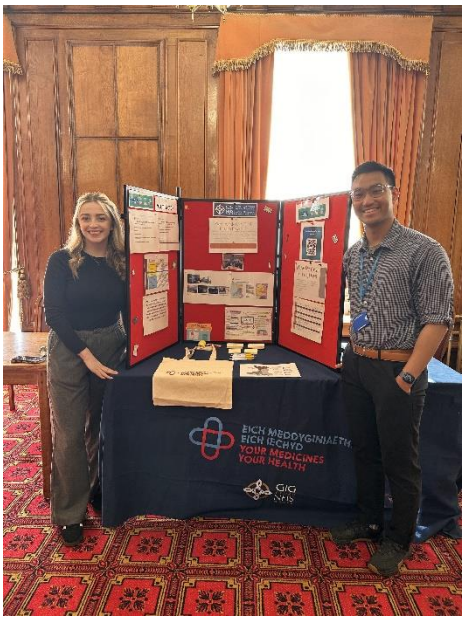


Figure 24

Events attended included ORIEL university open days and as part of a Clinical Education team, school events. For the school events, bilingual information leaflets were produced on careers and benefits to working in the NHS plus separate specific information for the different careers available. The aim is for representatives of the clinical education team to attend as many careers fayres as possible and promote all careers not just their own. The plan is also to target younger pupils and look at multidisciplinary work experience opportunities. Work experience placements are offered in primary and secondary care in conjunction with the Learning and Development department and through individual requests. Pharmacy also took part in a national careers online event targeted at year 9 and above school children in March 2025 in conjunction with Learning and Development.

Supported internships and project to continue employment

- Working with L+D team to place supported interns 16-21 within pharmacy department
- 3 interns so far who have been employed in band 2 roles at PCH and POW

figure 49

Supported internships and project to continue employment

- Working with L+D team to place supported interns 16-21 within pharmacy department
- 3 interns so far – 2 will stay on in band 2 roles at PCH
- Winner for Welsh Sustainability awards in June

Widening access - Collaborative Working

Recognising that our partner HEIs are challenged to recruit into the Pre-registration programme and an eagerness from our local colleges for their Level 3 Health and Social Care Students to have clinical placements, we have been working in partnership to promote nursing and midwifery as potential career choices by continuing to offer college students a 2x day Nursing Academy, followed by 37.5 hours of clinical placements for Merthyr and Bridgend College.

In September 2024, 20 year1 college students from Bridgend College attended the Nursing Academy held at Princess of Wales Hospital. And in November 2024, 27 year1 college students attended Prince Charles Hospital Nursing Academy from Merthyr College.

The two-day programme includes interactive sessions, clinical skills workshops and information sharing led by clinical colleagues. This programme continues to be well received by college students.

In March 2025 clinical work experience placements were arranged for college students from Merthyr and Bridgend College.
12 Merthyr college students attended Prince Charles Hospital clinical work experience, and 5 students attended clinical work experience at Princess of Wales / Royal Glamorgan Hospital from Bridgend College.
Following on from their experience attending Princess of Wales Nursing Academy in June 2023, all seventeen Bridgend college students were successful in attaining places at their chosen university. We will continue to liaise with the college leads for an update on career progression.

Feedback from Clinical Work experience placement from March 2025:

Bridgend Nursing Placement

- *"I like seeing how recovery section of ODP worked. Seeing how they handled the patient and made sure everything is correct. I didn't know much about this before compared to the other roles in ODP so seeing how it works was interesting."*
- *"I have enjoyed speaking to the nurses and getting to know what it is like to be a nurse. The past week has made me realise that paediatric nursing is definitely what I want to do in the future"*
- *I enjoyed "Being involved with staff and the team, working with staff and asking questions and being involved in the care of patients"*

Merthyr Nursing Placement

- *I enjoyed mixing in with different nurses/teams to do what they do daily.*
- *I enjoyed "Seeing how the different roles work together, learning the basics of patient care"*
- *I enjoyed "Meeting new people, learning what happens on the ward, seeing patients with different needs"*

Following the success of previous Nursing Academies, we will continue to offer this programme for 2025-2026.

Nurse Education Team, in collaboration with Learning and Development colleagues supported the Introduction to Health Care Event held at university of South Wales in July 2025. 78 students from across RCT attended. Due to the success of this event, we will continue to collaborate with colleagues for next year's event in 2026.

Nurse Education continues to work with Careers Wales and have supported facilitation at 16 career fayres and 9 days of mock interviews across local schools during 2024-2025. These days are facilitated and supported in collaboration with many professionals across CTMUHB. The teams value attending these events as an opportunity to inspire others and raise awareness about available career pathways. Our involvement has been well received by Careers Wales and local schools.

Figure 25

We have also attended several careers events at Merthyr College and in schools in the area with Health Board colleagues. We are busy collecting information and resources together so that we can represent the professions that can't attend on a given day and signpost the students to guidance or contacts in the Health Board.

<u>RCN Cadets</u>

We have also continued our involvement with the Royal College of Nursing Cadet scheme and look forward to further schemes in the future.

- October 2024- 1 Cadet based at Princess of Wales Hospital. February 2025 - 21 Cadets at Prince Charles Hospital and a variety of adult and Mental Health community teams
- April 2025 – 12 Cadets based at Princess of Wales Hospital and Glanrhyd Hospital.
- June 2025 – 7 Cadets within Royal Glamorgan Hospital ward areas.
- August 2025 –4 Army Force Cadets at Princess of Wales Hospital, Royal Glamorgan

Developing our Current Workforce

Health Care Support Worker (HCSW) Education

The Cwm Taf Morgannwg Clinical Learning Academy supports the skills and career development education pathways for health care support workers across CTMUHB as defined in the HCSW Framework, including clinical roles in primary and secondary care settings.
External funding is received from HEIW and utilised for HCSW education across the following areas; All Wales HCSW Induction Program, National Early Warning Score (NEWS Cymru) and wide range of Continuing Professional Development (CPD) training for HCSW in Nursing & Midwifery, Healthcare Sciences, Allied Health Professions, Facilities, Pharmacy, Primary Care and Primary Care Academy. The HCSW education team works closely and collaboratively with Learning & Development department regarding career and qualification progressions for HCSW's within CTMUHB.

The 2024/25 HCSW Conference was a successful event enjoyed by all attendees. The conference showcased the diversity of HCSW roles across CTMUHB, promoted career progression pathways, built staff confidence, and highlighted the passion and commitment of the workforce. Feedback confirmed that the event strengthened professional identity, relationships, and staff morale across HCSW education.

HEIW Funding for HCSW Education, Resources & Staffing

CTMUHB receives allocated funding from HEIW to support the education and development of HCSWs Band 2-4 in line with the All Wales Skills and Career Framework for HCSW. Quarterly monitoring and reporting on expected and actual expenditure internally within CTM and externally with HEIW continues, allowing early identification and reallocation of any potential underspend.
The following graph shows the HEIW funding that has been allocated to the HCSW education within CTMUHB since April 2021 – March 2026.

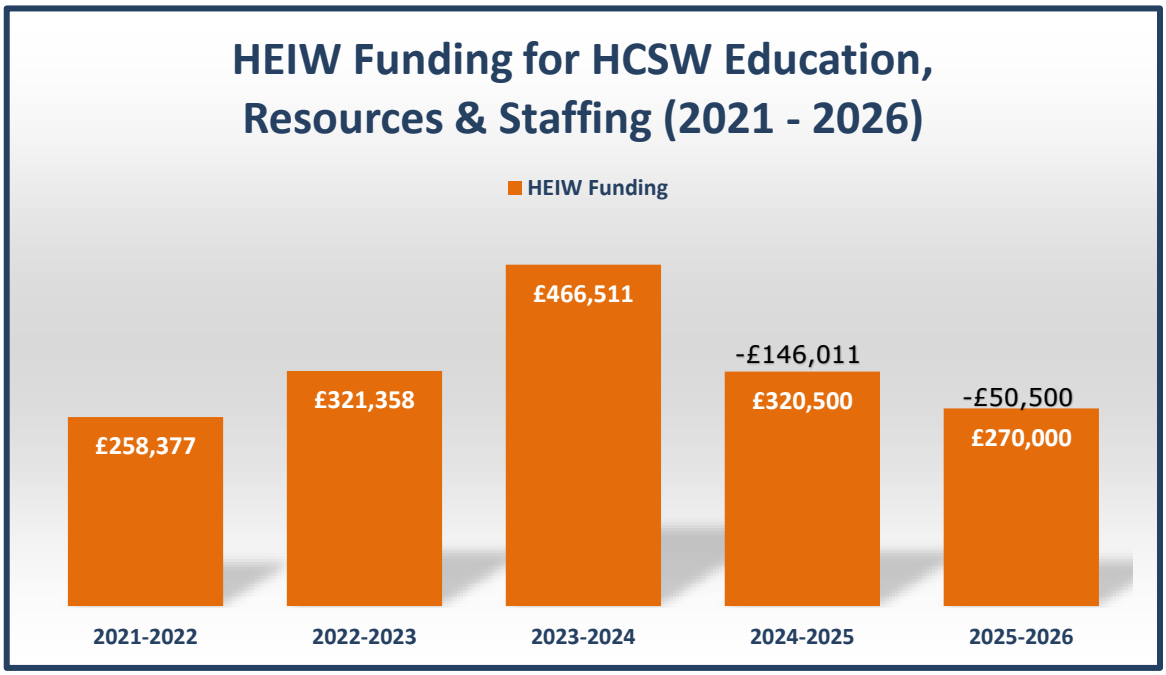


Figure 26

HCSW All Wales Induction Framework (AWIF) Programme

All new HCSW including those recruited to the bank undertake the in-house All Wales Induction Framework programme.

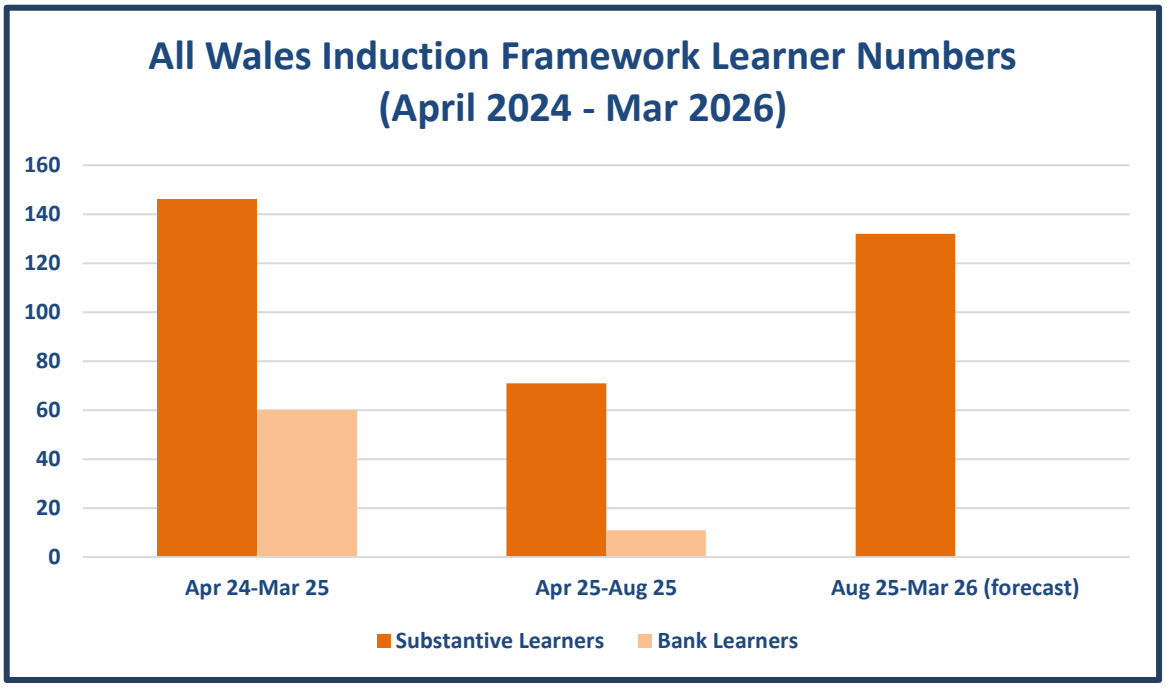


Figure 27 - (April 24-Aug 24 number trained so far)

Numbers were high in 21-22 due to increased recruitment of HCSWs to manage the impact of Covid. Numbers have now re-stabilised at just over 200 a year.

In June 2024, the NEWS Cymru training programme for HCSW clinical staff at CTMUHB resumed. This programme equips HCSW staff with essential knowledge and skills related to physiological measurements and the use of the NEWS Cymru tool in clinical practice.

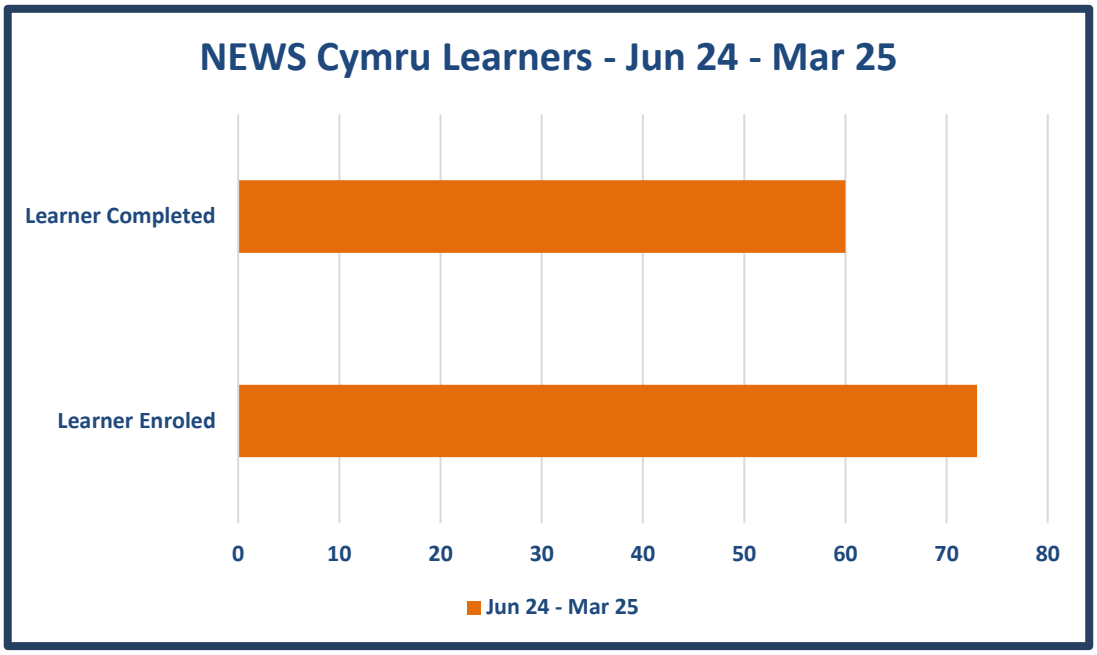


Figure 28

Between December 2024 and March 2025, the number of NEWS Cymru accreditations and courses delivered decreased due to the introduction of the NEWS2 Cymru document. While some accredited sessions continued, additional non-accredited learning was provided in collaboration with the Acute Deterioration Lead and Outreach Teams. These face-to-face sessions, held within clinical settings, focused on supporting staff with the transition to the new documentation and the implementation of NEWS2 across acute areas of the health board.

With the NEWS2 document now fully implemented, accredited NEWS2 training is scheduled to restart in September 2025.

Level 4 Certificate of Higher Education

To promote development and further progressions into Level 4 and flexible route to nurse registration we have developed strong affiliations with the University of South Wales (USW) and Grwp Llandrillo Menai (GLM) who provide these Level 4 qualifications for our HCSWs.

The HCSW Education Team has developed better collaborative working relations with the Learning & Development Department and Apprenticeship Academy to support career and qualification progression for HCSWs, central data collection, ensuring alignment with organisational workforce needs and professional development pathways.

The Certificate of Higher Education program offers HCSWs within CTMUHB a valuable Level 4 qualification to enhance their skills and knowledge, with an option to progress to the BSc (Hons) Nursing (Flexible Learning) program.

In September 2024 & February 2025 we enrolled a total of 33 HCSW applications to the University of South Wales (USW) & GLM Level 4 programme which has continued to increase from previous years, now the largest cohorts to date. Additional to this, we forecast a further 34 HCSW's enrolling on Cert He Level USW and/or GLM across Sept 2025 & Feb 2026.

The majority of HCSW's see this pathway as a steppingstone to progression to the Part Time Flexible Route to Nursing either via USW or Open University.

The following graph illustrates the Cert He Level 4 enrolments and completions for both USW and GLM. Both these routes show very good completion rates and provide an excellent pipeline for pathways into nursing.

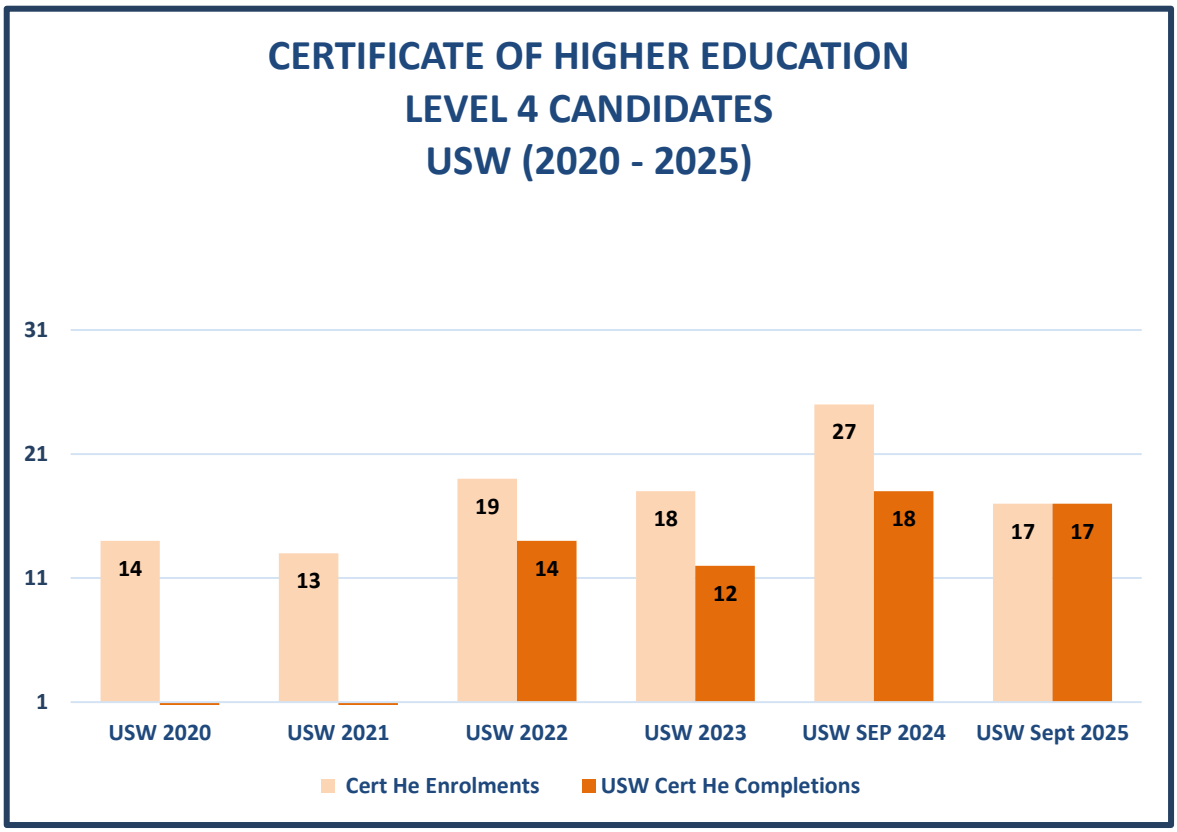


Figure 29 - (USW L4 course (2 years to completion)

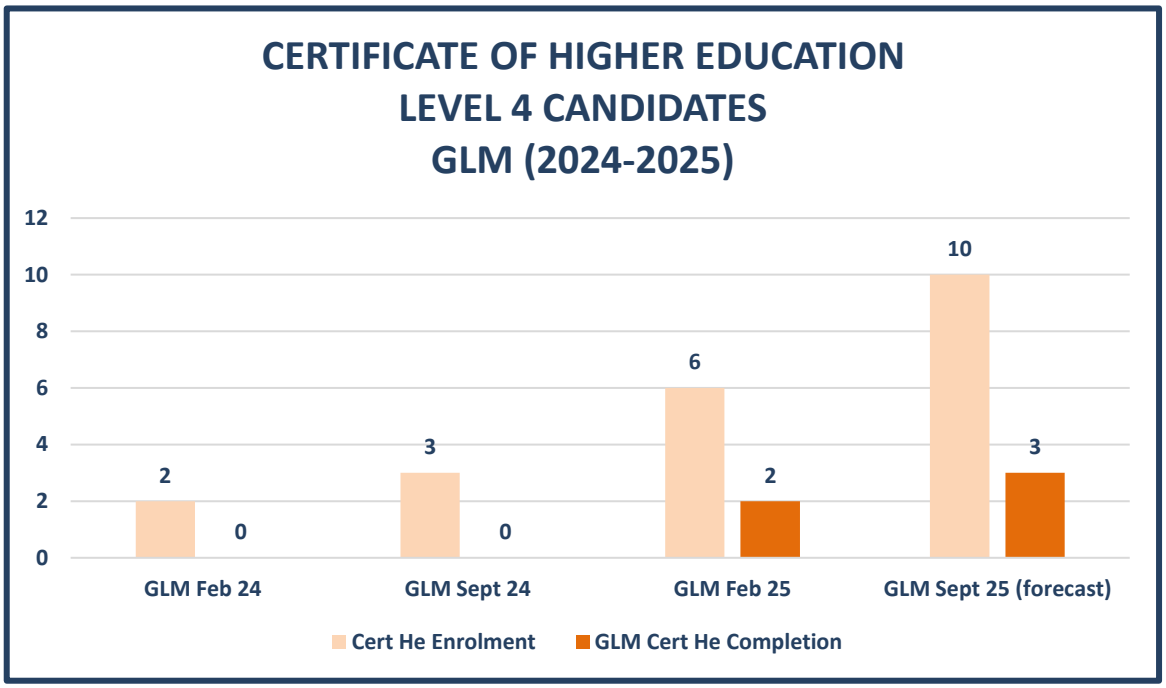


Figure 30 - (GLM L4 course (1 year to completion)

BSc (Hons) Nursing (Flexible Learning) –

Part Time Flexible Route to Nursing

This course, accredited by the Nursing and Midwifery Council, allows eligible candidates to work toward Registered Nurse status and obtain a degree in one of four nursing specialisations, all while continuing their employment as healthcare support workers. CTMUHB has been supporting the flexi route since its instigation in 2017.

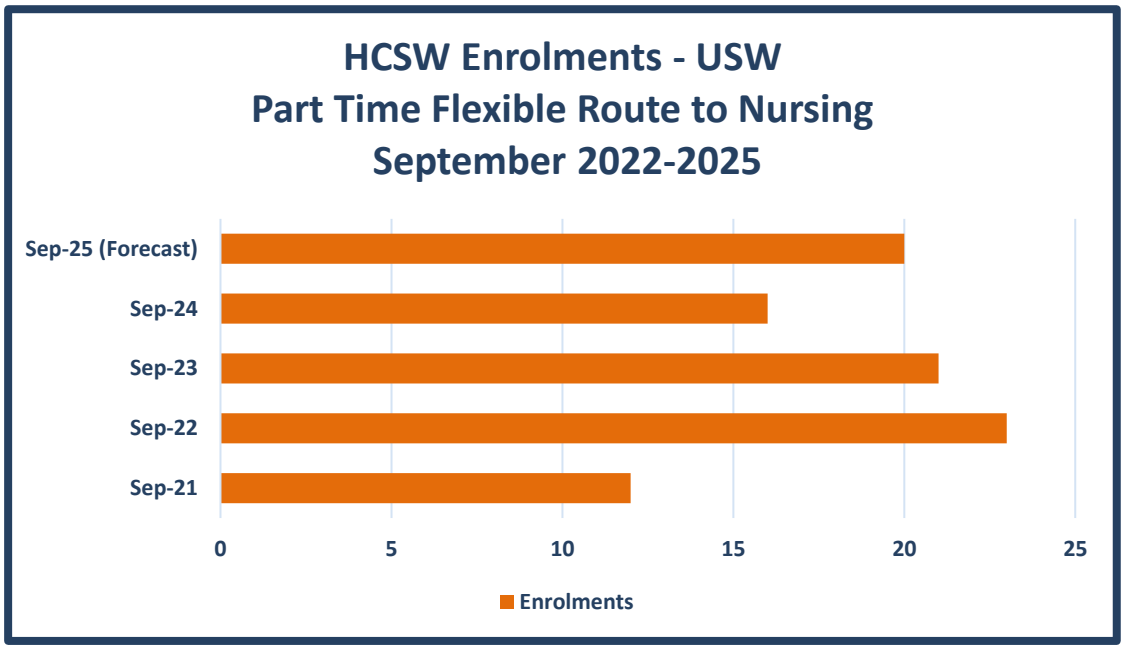


Figure 31

The graph above illustrates enrolments from Sep-21- Sep25. Enrolments onto the Part-Time Flexible Route to Nursing have reduced in both September 2024 and September 2025, primarily due to a decrease in the number of commissioned places available. For example, in September 2025 there were 30 potential applicants for the programme; however, only 20 available places allocated. There is increasing interest in and demand for this route for HCSWs to progress to become registered nurse professionals.

Those applicants who were not successful in gaining a place have been signposted to alternative study pathways. At present, there is no flexible route available for paediatric nursing, or to support flexible entry to midwifery. Work in these areas continues to be an important consideration for future workforce planning, to ensure staff across all fields of practice have accessible development opportunities.

AHP Healthcare Support Workers (HCSWs)

The number of posts within the AHP HCSW staff group has increased significantly over previous years, predominantly due to receiving funding to deliver community-based and public health services.

The Dietetic HCSW team increased by over 60% (from 19 to 31 posts) with new roles that educate on healthier behaviours in relation to healthy weight. This involves the delivery of nutrition education in community settings and so the focus of education for this staff group is achievement of the Level 4 "Preparing to teach" certification.

For 2025/26 Dietetics have achieved Agored accreditation to deliver Level 3 Dietetic Support Work. This will complement the current Level 4 diploma offering. One member of staff successfully completed the Level 4 Diploma in Dietetic Support Work in July 2025. This has enabled our community services to utilise this post at the top of their licence and consider alternative ways of service delivery due to enhanced skills. With the Level 3 offering being a new opportunity within 25/26 a further for 3 staff members are planned to enrol with a further staff member to enrol on the Level 4 diploma.

Across Occupational Therapy in 2024 there was a full review of the Agored Level 3 training due to a change in Agored lead. Due to changes in the Agored Level 3 modules and staff turnover, 32 registered Occupational Therapists received Agored Assessor training and 13 received internal verification training in 2024. Agored Level 3 Cohort 4 launched in 2024 with 19 new learners starting the qualification. This was a 111% increase in new learners from 2023, due to staff turnover at Band 3 and 4 level within the OT service. In 2024/2025 OT has submitted 90 marked units. 22 of these have been internally verified and a further 8 allocated to be internally verified.

Physiotherapy have made significant steps forward in relation to HCSW Agored training, with their work being shared nationally across their profession as an exemplar. Across the service they have introduced competency tiers for those not needing to do full diploma, with units chosen to enable eligibility to access level 4, increased attendance at standardisation meetings and Physios taking on training and education from February 2025. This has culminated in 5 new assessors/verifiers trained in 2025, 5 HCSWs achieving full Diploma

Certification and having 20 HCSWs currently undertaking the training (15 full Diploma, 2 undertaking 33 credits programme and 3 undertaking the 25-credit programme). From the original cohort the final learner will complete this year. Throughout 2025/26 we will be exploring the potential for external provision of Diploma via the CTM Apprenticeship Academy and there have been promising discussions with L&D pending discussion and assurances from external provider.

Despite this positive progress a number of challenges have been encountered; disruption due to business continuity, particularly with regards to POW temporary changes, and associated staff moving to RGH resulting in cessation of non-essential activity. In addition, staff turnover (learners and assessors) has created a challenge. Also, the change in Agored documentation prompted additional pressure. Despite this, in 2024 there were 166 credits submitted for certification, which is an increase on the 122 completed in 2023 (Figure 1). It is predicted that by March 2025 over 210 units will have been submitted. Not only has performance improved but capture of experience also reveals the impact of this work, as shown by the feedback from an assessor.

	Pre-2023	2023	2024	2025
Registrations	19	4	1	4
Total Ongoing	14	18	19	20
Completed Diploma	0	1	0	5
Eligible for 25 credits, Access to Level 4	0	4	0	5
Enrolling for 25 credits, Access to Level 4	0	0	3	2

Figure 32

	Pre 2023	2023	2024 (projected)	2024 actual	2025 projected
Credits Submitted for Certification	0	122	429	166	210
Active Assessors	7	18	23	18	19
Newly Trained Assessors	11	12	5	1	5

Figure 33 - Mapping of Submission of learning units and number of assessors within the delivery of the Agored Cymru Level 4 Diploma in Physiotherapy Support Qualification

Figure 34

Over the past year we've focused on the development of the future workforce by implementing robust training programmes, supervision and mentorship opportunities and continuous CPD initiatives, this has been underpinned by IPE. With the establishment of the AHP Faculty in September 2025 as part of the CTM Learning Academy it will support the further development of the workforce by making sure they have the right skills and knowledge to get the outcomes that matter to our population. The faculty will also support the transformation of the current workforce, develop a culture of IPE and improve the governance and quality of learning. This work will also be underpinned by a strategic workforce plan utilising the HEIW 6 step model.

Dietetics for the first time in 25/26 will have a complete offer for Level 3 and Level 4 Diploma in Dietetic Support work and Therapies Assistant Practitioner Qualifications. We have seen from recent successful achievements that these qualifications significantly enhance staff professionalism and clinical practice within their professional scope. Consideration is given to all vacancies where skill mix of support worker posts is appropriate. This approach has been successful within our Diabetes services where staff have been recognised nationally with award winning delivery methods and outstanding feedback from the local community.

Following a successful interview process the OT Service is supporting another Band 4 OT Technician through the part-time OT degree in USW. This means that from September 2025 a total of 4 OT Technicians are being supported by the service.

Due to a national recruitment shortage of band 6 speech and language therapy posts into the adult services, CTM have converted 4 band 6 vacancies to annex 21 posts which has increased the opportunity for newly qualified S&LTs to enter the profession. It is hoped that this will improve retention and progress their careers within CTM.

Pharmacy

Pharmacy Assistant Technical Officer (ATO) Development

Five pharmacy assistants across three acute sites have undergone the new HEIW Medicines Management training. This qualification enables them to work at the top of their licence and become integral members of ward-based pharmacy teams.

The aim is to free up time for pharmacy technicians to advance their skills, and for pharmacists to fully utilise their prescribing qualifications—participating in ward rounds, running clinics, and taking on specialist roles. In areas where ward-based pharmacy assistants are already applying this qualification, early outcomes include reduced medicines waste, fewer dispensing tasks, and increased capacity for pharmacy technicians to counsel patients and support services such as cardiac rehabilitation—activities traditionally carried out by pharmacists.

Three pharmacy assistants have also undertaken "Access to" courses in Maths, English and Science which would enable them to apply for student pharmacy technician courses in the future.

Scoping is underway within CTMUHB for Pharmacy assistants to undertake a Final Accuracy Check qualification with NHS Pharmacy education and training provider, Pharmacy Workforce Development South (PWDS). The future dispensary workforce will feature pharmacy assistants for dispensing and final accuracy checking allowing this staff group to work at the top of their license and releasing time for pharmacy technicians to undertake a more clinical role in patient care.

Pharmacy continues to access the HEIW HCSW funding for pharmacy assistants. This funding has so far been used for NVQ level 2 courses which is a GPhC regulator requirement for all staff working in pharmacy that are not registered with GPhC. It provides key knowledge and skills appropriate for the activities they perform and, in the pharmacy setting that they work. In collaboration with Clinical Education, pharmacy is scoping other course pathways and development opportunities appropriate to the banding of the pharmacy assistant.

Postgraduate/ Post registration Education and Training.

The Clinical Education Service manages the education, training and development of registered clinical healthcare professionals including:

- Design and delivery of bespoke in-house education programmes to meet training needs e.g. New Registrant Nurse programme, education packages in response to Clinical Incidents e.g. Nasogastric training, Fluid Balance training
- Delivery, Management and co-ordination of Education pathways for Foundation Medical Trainees.
- Management of Health Education Improvement Wales Advanced Practice & Non-Medical Prescribing funding streams.
- Management of HEIW (HEIW) Nursing CPD allocation.
- Recognition of Acute Deterioration & Resuscitation and Clinical Skills including advanced programmes accredited by the Resuscitation Council and Royal College of Surgeons.

Focus on Nursing & Midwifery post registration

The new Nursing and Midwifery Council's (NMC) Standards of Proficiency and Education for Registered Nurses were launched in May 2018. The new standards made significant changes to proficiencies for registered nurses, standards for preregistration programmes, and student supervision and assessment. Two cohorts of these registrants are now working successfully in the Health Board.

The Practice Education Facilitator team and the Practice Development Nurses facilitate Student Streamlining (recruitment) events in the HEIs and hold in-house events. Staff from the clinical areas are invited to these events to showcase their area, induction programmes and share development opportunities that would be available, as well as the day-to-day information needed about ward life. The PEF team have been working in collaboration with the newly appointed Attraction and Resourcing lead to review our streamlining events and maximise attendance from the clinical teams and enhance the number of students recruited via these events.

Understanding the link between experience on placement and early years post registration development and retention into our registered nursing workforce, we offer a robust and comprehensive Newly Registered Nurse Programme (NRNIP) for all graduate nurses across all fields of nursing within the organisation. This has been reviewed in alignment with the CNO Welsh Circular regarding Preceptorship. The Role of Preceptor training commenced in August 2025, with NRNIP being mandated from Autumn 2025.

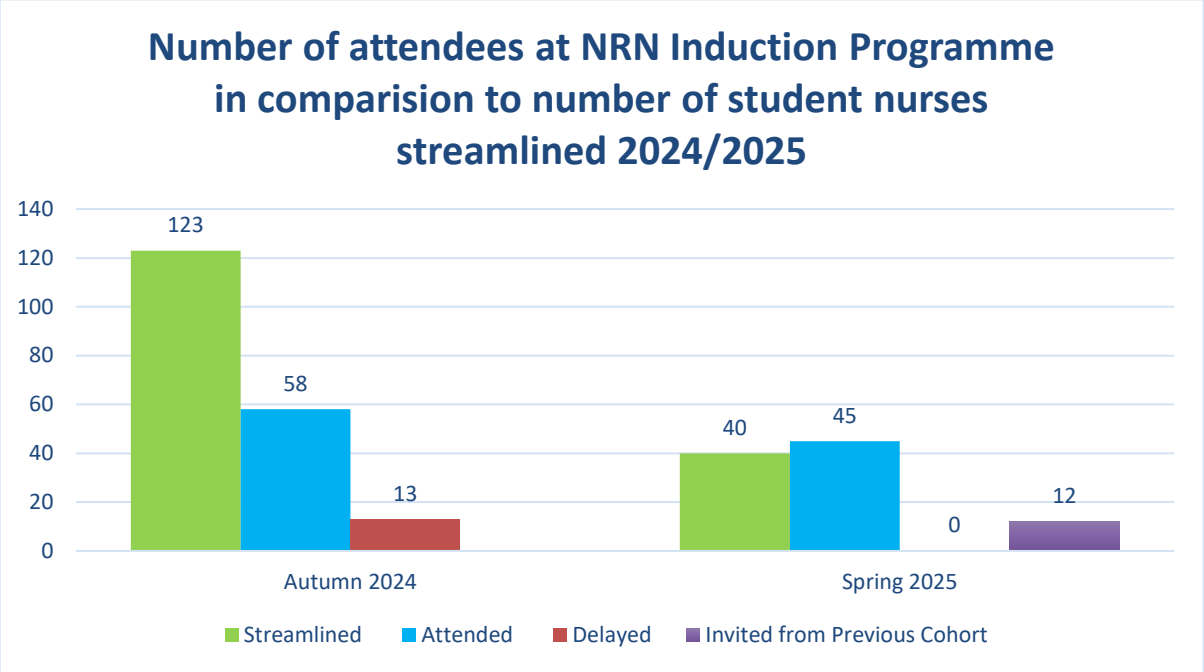


Figure 35

The other area of focus in response to the CNO Welsh Circular in 2024-2025 is Restorative Clinical Supervision training.

- Restorative Clinical Supervision- the CTM plan for implementation of Restorative Clinical Supervision has been submitted to the CNO and will be delivered from autumn 2025. All members of the Practice Development Nursing Team have attended RCS 'Train the Trainer Course' at Cardiff and Vale UHB in preparation to roll out a 3-day training programme that will be offered to Clinical supervisors across CTMUHB from September 2025. All potential supervisors will need to complete the e -learning package via ESR prior to attending training.
- RCS will be included in the NRNIP from autumn 2025 onwards

Supporting Career Progression:

The Professional Development and Innovation Programme, is a 2-day course targeted for nurses in band 6 roles, focusing on developing their experience of management, leadership and innovation roles to consolidate preparation for the next phase of their careers. The programme is a valuable resource in supporting our Band 6 Nursing workforce. The programme will be held again in December 2025.

A similar two-day programme has been successfully delivered for Band 7 registered nurses. This programme provides an opportunity to enhance knowledge and skills to support professional development for Band 7 registered nurses. The programme has received positive evaluations and has been well attended. The next programme has been arranged for December 2025.

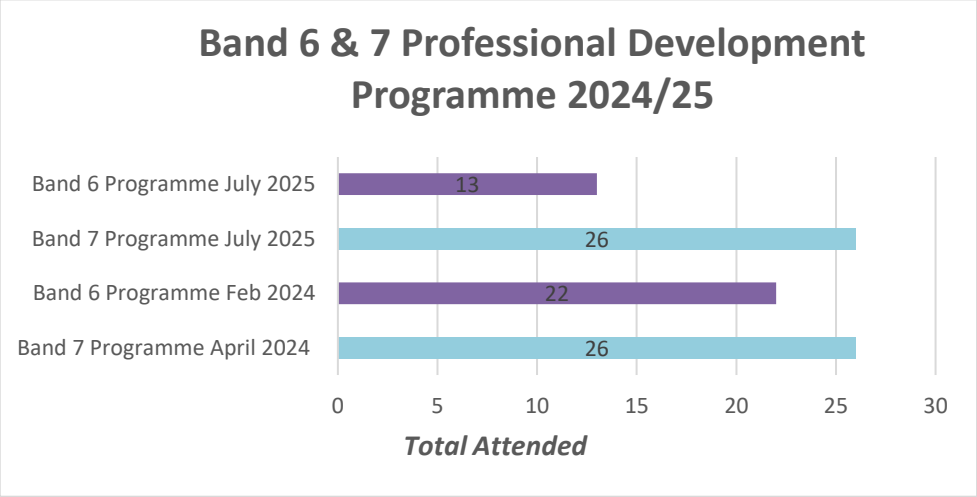


Figure 36

The Practice Development Team have developed several nurse education days. Continuing Professional Development session examples for 2024-2025 include:

- Falls training- a one day course for registrants and HCSW. The aim of the day is to provide greater understanding of the impact of falls and prevention of falls in hospital and community settings.
- The Day is planned to be delivered again in October 2025.

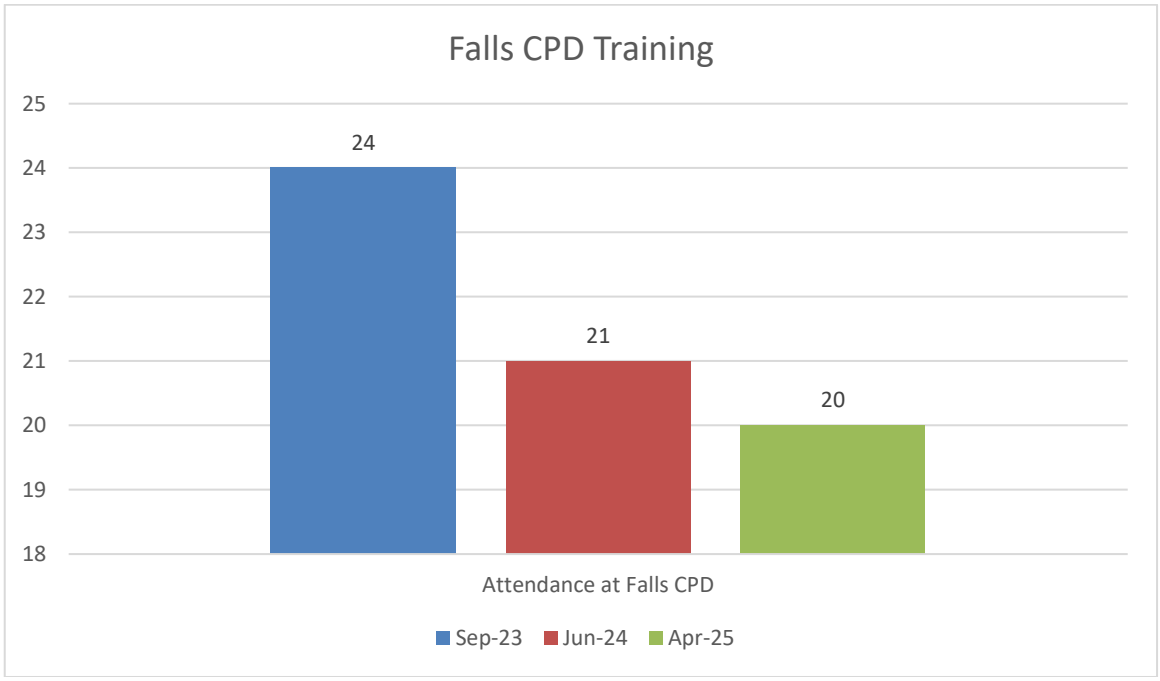


Figure 37

- In April 2025, 7 members of experienced nursing staff recently started with CTMUHB attended the 'New to Health Board' day. The aim of this study day is to welcome new member of nursing staff to the Health Board and to ensure information is shared on Cwm Taf Morgannwg values and behaviours, key policies and services.

Other CPD Education Training co-ordinated by PDN Team and delivered by subject matter experts included:

- Malnutrition CPD
- Palliative Care CPD
- Medicine Management Study Day
- Frailty CPD Micro session
- Diabetes Management
- Care after death Micro Session

Focus on Medical Postgraduate

In Academic Year 2024/25 CTM UHB had a total of 83 Foundation Year 1 (FY1) doctors and 84 Foundation Year 2 (FY2) doctors starting their rotations across the three acute hospital sites. There was some movement of these posts during the year as a result of the POW incident, with some Foundation doctors working during the day in RGH but doing their on-call in POW. However, with the exception of the stroke posts which will remain in RGH until April 26, the foundation posts will all be returning to their substantive bases imminently. In addition, throughout the academic year, we held induction for 234 junior doctors as they started with the UHB. August 2024 was the first trial of the new induction programme with it being split into three tiers, corporate induction, site induction and team induction. There was also IT presence and a number of relevant departmental stalls. The feedback was excellent, and we intend to replicate and improve at all subsequent inductions.

Foundation training for FY1 and FY2 took place weekly on specific, regular times on each acute site. In addition, we held frequent, speciality-related teaching and journal clubs through the year. We also continued with simulation afternoons for the FYs which proves to be very beneficial for the new curriculum. For junior doctors there is facilitated weekly teaching as well as ad hoc events and "Grand Rounds" for all trainees and consultants.

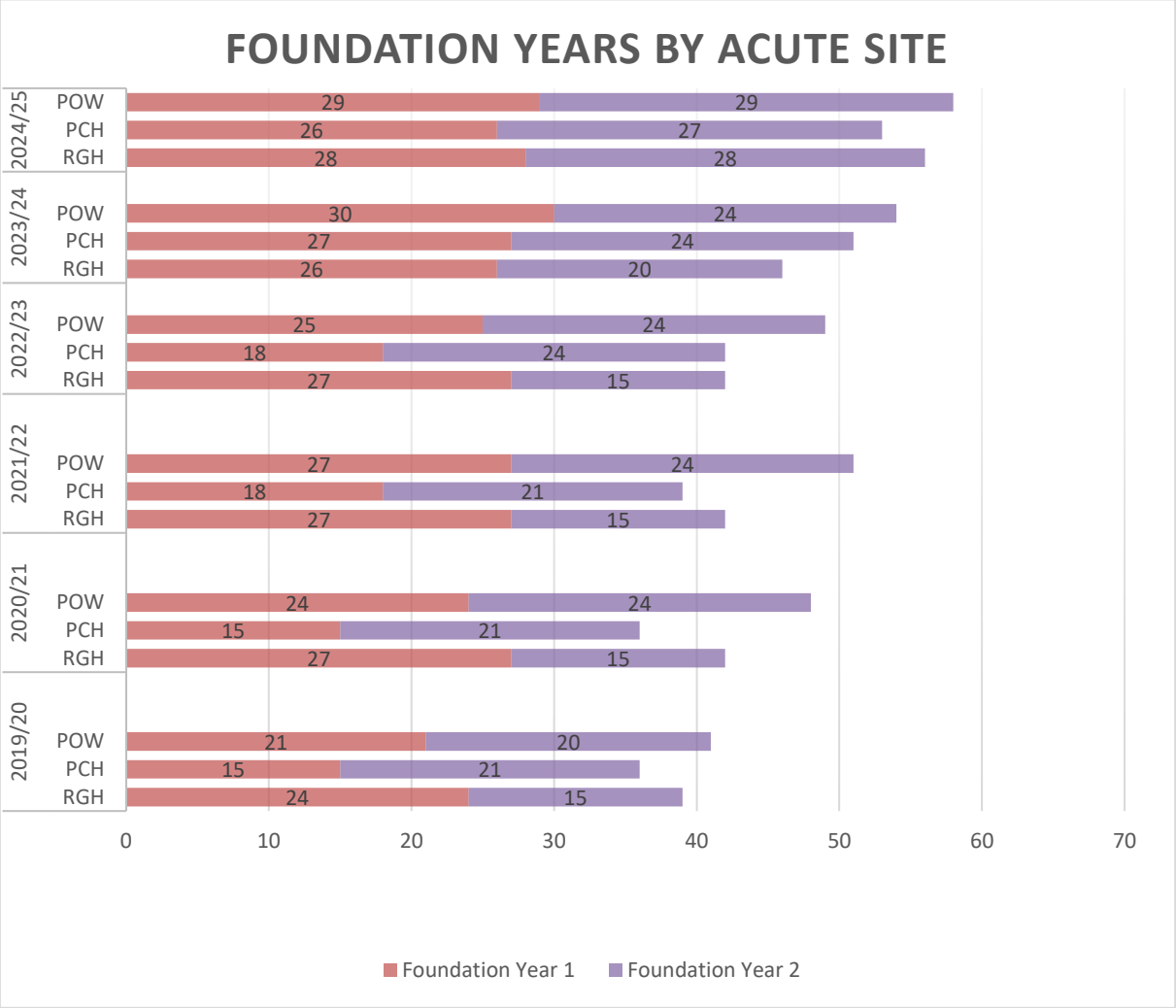


Figure 38

Performance

Performance is monitored via the HEIW Quality Unit. The HEIW CTM UHB "Risk register", maintained by the Quality Unit, records areas of concern through a number of different data sources, most notably the General Medical Council (GMC) National Trainee Survey.

The sources of concern can range from anecdotal evidence, to formally recorded results on GMC surveys, and the scope of the "risk" from a single point of contact, to covering the whole health board.

The following table provides the GMC Survey overall satisfaction rates by element over the last five years. It indicates relative stability over the period, with some small movement in each direction.

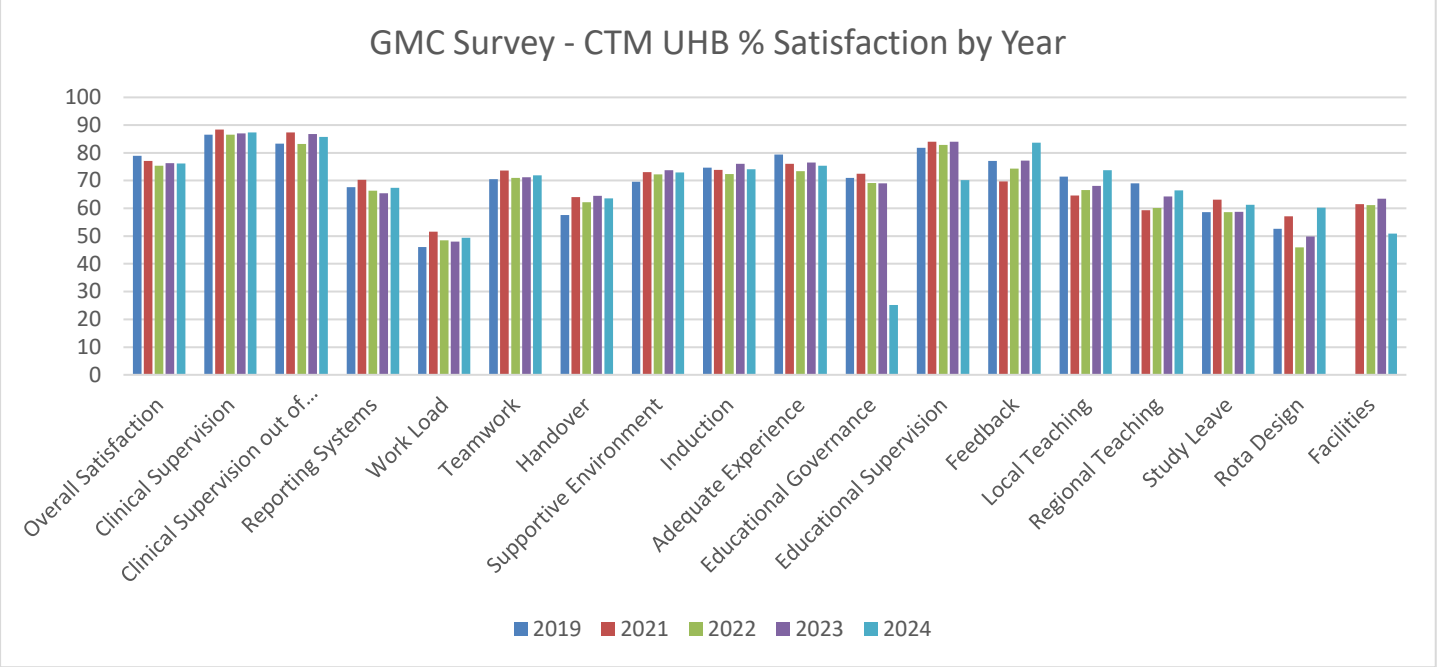


Figure 39

HEIW formally review risk position with the health board 3 times a year, operating on a traditional traffic light system. The current version of the risk register (July 25) has 24 risks (26 in August 24) with 10 being removed since August 24 and 8 being added. The Associate Medical Director (Education), the Local Faculty Leads and the Clinical Education Manager continue to tackle each individual risk, liaising with trainees and trainers as required, collecting and collating feedback and assisting Care Group service areas with the development of action plans. In 2024, a new process for feedback collection and collation was introduced with the use of Microsoft forms to encourage trainees and trainers to speak up about any concerns that they may have. This can be done anonymously if required. It has proved to be an effective way of engagement and has allowed a more proactive approach. In addition the AMD (Education) has presented at the PEG group, highlighting care group risk areas as part of the rotation of "deep dives," although this reporting process is expected to be modified for the next Academic Year with a new meeting structure to ensure triangulation of information from the Medical Directors, the Care Group Directors and the Medical Education Team. The matrices in appendix 1 show the risks from August 2024 to July 25. And Specialty Movement since August 24

Dental Education

As previously reported, in April 2023, Clinical Education, with HEIW's agreement, took on the responsibility for managing Dental PG within the Health Board. This involved assuming responsibility for managing Unit 3 Dental PG in PCH and the associated staff.

The staff continue to be integrated into the wider department to ensure that they have formal frameworks and policies within which to operate, and to secure adequate support for the activity. They now attend all-staff development days and utilise some bespoke IT systems (e.g. booking system).

Bespoke Education and Training activities

The Teaching skills for Doctors Course is an in-house development which has been so successful that an additional course was commissioned by HEIW. The course now runs least twice a year, and, with HEIW, we are investigating the possibility of franchising the course elsewhere.

The annual Teaching and Educators Development Conference (TED) was held in POW on the 27th June and was again opened out to all health-care professions and enjoyed a multi-professional audience providing rich and diverse learning opportunities.

Health Care Sciences

HCS within CTM recognise the importance of continued professional development and advanced clinical practice in the retention and development of motivated, highly performing staff and have achieved the following:

Audiology

- Awarded 8K in equivalence funding by HEIW in 2024, and 15K in 2025.
- 4 staff completed M level learning in 2024/25, in preparation for equivalence.
- 2 staff achieved equivalence in 2025 – Clinical Scientist and Consultant Clinical Scientist
- 4 staff are preparing for Advanced level training in 2025.
- 2 staff are preparing to submit their equivalence portfolio in 2025.

Clinical Engineering

- Clinical Engineering education underway:
  1 x MSc Leadership and Management including ILM 7 (Band 8b)
- 1 x ISM 4 Leadership and management – Band 5
- 1 x ILM 5 Leadership and management – Band 6
- 1 x Band 6 Annex 21 attending specific manufacturer service training courses
- Planned start for this September
- 1 x PGC education/training qualification – Band 6

Pathology

The Cwm Taf Morgannwg University Health Board (CTMUHB) Pathology Department is committed to the development of its employees through formal developmental and educational opportunities. In line with the NHS Wales Healthcare Science Framework

CTMUHB endeavour to provide career progression routes from band 2 to band 9, with a 'grow your own' ethos. The current qualifications being undertaken are as follows:

Level 3 Apprenticeship in Healthcare Science:

- One member of staff has commenced the Level 3 Apprenticeship in Healthcare Science. This qualification allows individuals with no prior scientific qualifications to commence their journey to becoming a Biomedical Scientist.

Level 4 Apprenticeship in Healthcare Science:

- Four members of staff have successfully completed their Level 4 Apprenticeship in Healthcare Science with a further two members due to complete within the month of August 2025.
- Three members of staff were successful at interview and are due to commence their Level 4 Apprenticeship in September 2025. All three students aspire to commence the second cohort of the Practitioner Training Programme (PTP) in Healthcare Science at Cardiff Metropolitan University.

Part time degree in Healthcare Science:

- Five members of staff are due to commence the first cohort of the Part time PTP in Healthcare Science at Cardiff Metropolitan University. Students will undertake the academic learning alongside the Institute of Biomedical Science (IBMS) Certificate of Competence to allow Health and Care Professions Council (HCPC) registration as a Biomedical Scientist following completion of the programme. This has been funded by HEIW commissioning processes.

Top-up Modules:
The Pathology department support and facilitate the completion of "top-up modules" for staff members who have not completed an IBMS accredited BSc in Biomedical Science/ Healthcare Science but have an alternative scientific degree. The student's degree is assessed by the IBMS and the relevant "top-up" modules determined to allow IBMS Certificate of competency completion and subsequent HCPC registration as a Biomedical Scientist.

- One student is continuing studies with Ulster University funded by HEIW Equivalence
- Three students are commencing studies with Cardiff Metropolitan University funded by HEIW commissioning processes.

IBMS Degree Assessments:

- HEIW Equivalence funding has been secured for four individuals to undertake degree assessment by the IBMS. This will determine required "top-up" modules required to commence study with Cardiff Metropolitan University in September 2026.

MSc:

- HEIW Advanced Clinical Practice (ACP) funding has been secured for two staff members to complete their first year of study on the MSc Biomedical Science at Greenwich University.

Scientist Training Programme (STP):

- One candidate is currently undertaking the STP in Histopathology
- One candidate is currently undertaking the STP in Biochemistry

Other:

- Funding has been obtained for one individual to complete their Equivalence Portfolio for dual registration as a Biomedical Scientist and Clinical Scientist
- Two candidates are enrolled on the NEBOSH General Certificate in Health and Safety
- Two members of staff have successfully completed the Level 2 Agored Cymru Train the Trainer Qualification
- One member of staff has successfully completed the Agored Cymru Introduction to Assessment to act as an assessor for Level 3 qualifications
- Two members of staff have successfully completed the Agored Cymru Level 3 Certificate in Assessing Vocational Achievement (CAVA)
- One candidate has successfully completed their ILM Level 3
- One candidate has successfully completed their IBMS Specialist Portfolio in Microbiology
- At least 5 individuals have completed their IBMS Certificate of Competency to allow registration with the HCPC as a Biomedical Scientist

Radiology

- ILM 7 Leadership and management (USW)
- ILM 5 Leadership and management (CTM)
- ILM 4 Leadership and management (CTM)
- PgCert Chest and abdomen reporting
- Assistant Practitioner Course Trained a radiographic assistant to be an Assistant Practitioner in POW

Pharmacy

Band 6 pharmacists – newly qualified post registration pharmacists

CTMUHB Pharmacy employs a number of Band 6 post registration health board wide pharmacists on 2-year fixed term contracts to undertake further study in post registration qualifications. From 2023, a new 2-year post registration foundation programme was funded by HEIW (HEIW PRF). For those pharmacists who started in August 2023, 4 started in the September cohort and have been successful in completing their IP qualification. They are currently awaiting results of their post registration Royal

Pharmaceutical Society credentialing panels. Three started in the January 2024 cohort and are currently undertaking the course. One undertook the Distance learning diploma with Queen's University Belfast (funded through Advanced practice monies) and has been successful in passing. To support the novice IP development and allow these Band 6s to gain further knowledge and be awarded a diploma, HEIW, from 2024 has provided additional funding for an optional 40 credits at Cardiff University.

For the 2024 intake, there are 5 pharmacists on the September 2024 cohort of the HEIW PRF programme, 1 pharmacist on the January 2025 cohort and 1 pharmacist undertaking the distance learning diploma with Queen's university, Belfast. From August 2025 new Band 6 pharmacists will undertake health board wide structured clinical training rotations to ensure that we work together as One CTM team. Sites included in the rotations are Princess of Wales Hospital, Prince Charles Hospital, Royal Glamorgan Hospital, Ysbyty Cwm Rhondda, Ysbyty Cwm Cynon and Parc Prison. They will undertake a post registration qualification alongside the health board rotations.

Pharmacy technician workforce development

17 pre-registration pharmacy technicians have or are undertaking the 2-year Level 4 University of East Anglia qualification across the 3 acute sites, RGH, PCH and POW, plus HMP Parc, Bridgend in 2024/25.

Further development opportunities for pharmacy technicians to upskill clinically include the Pharmacy Workforce Development South (PWDS) Clinical Prioritisation qualification. Once qualified pharmacy technicians can review patients before the pharmacist or other health professional and prioritise the patient according to a clinical prioritisation tool which is designed for specific clinical areas. As the first health board in Wales to send staff on this training course, we have had much interest from other health boards and HEIW have now agreed to fund the training for the Welsh cohort starting 2024.

Currently six pharmacy technicians have completed the qualification. They are working in areas such as the Emergency Department, Maternity, Frailty and Surgery and having a great impact. Five staff from all sites across the health board are currently undertaking the course and the plan is for all Band 5 pharmacy technicians to undertake the course over the next couple of years. One PCH Pharmacy technician presented on extended role at Clinical Pharmacy Congress, North, in November 2024 and has presented at the Association of Pharmacy Technicians UK.

This will release pharmacist and other health care professionals time to prioritise patients by risk according to a designated clinical prioritisation tool. It will release time for prescribing, MDT working and benefit patient care.

Other qualifications that pharmacy technicians have undertaken in 2024/25 are the level 4 diploma at Bradford college, Antimicrobial Stewardship training, Intensive Care training, Education and Training, Leadership, Analgesic Stewardship and 3 members of senior pharmacy technicians are currently undertaking the Master's in Leadership and Management with USW.

This will support pharmacy technicians to lead and take on more clinical roles by increasing their scope of practice, releasing time for the pharmacist to use the IP qualification, run clinics, deprescribe and influence e.g. polypharmacy, and work with care groups to identify prescribing initiatives, and improve patient care and safety.

Career frameworks/ pathways for pharmacy technicians are being developed on a UK wide basis. Next steps would be for pharmacy technicians to provide basic clinical checks of prescriptions and to work within a designated scope of practice. Various courses are available and are currently being scoped.

Continuing Professional Development Education and Advanced Practice

It is absolutely essential that continuing education for all staff is aligned to and centred on patient care and service developments.

Focus on Nursing

Clinical Education manages utilisation of a funding allocation from HEIW for continuing post-registration education for nursing and midwifery. The equivalent of circa. 204 modules were available in 2024-2025 via an internal application and allocation process.

The Graph displays the full master's programmes being undertaken. Additional courses selected for study include; PGCE, Postgraduate Diplomas, Postgraduate Certificates, and Standalone modules.

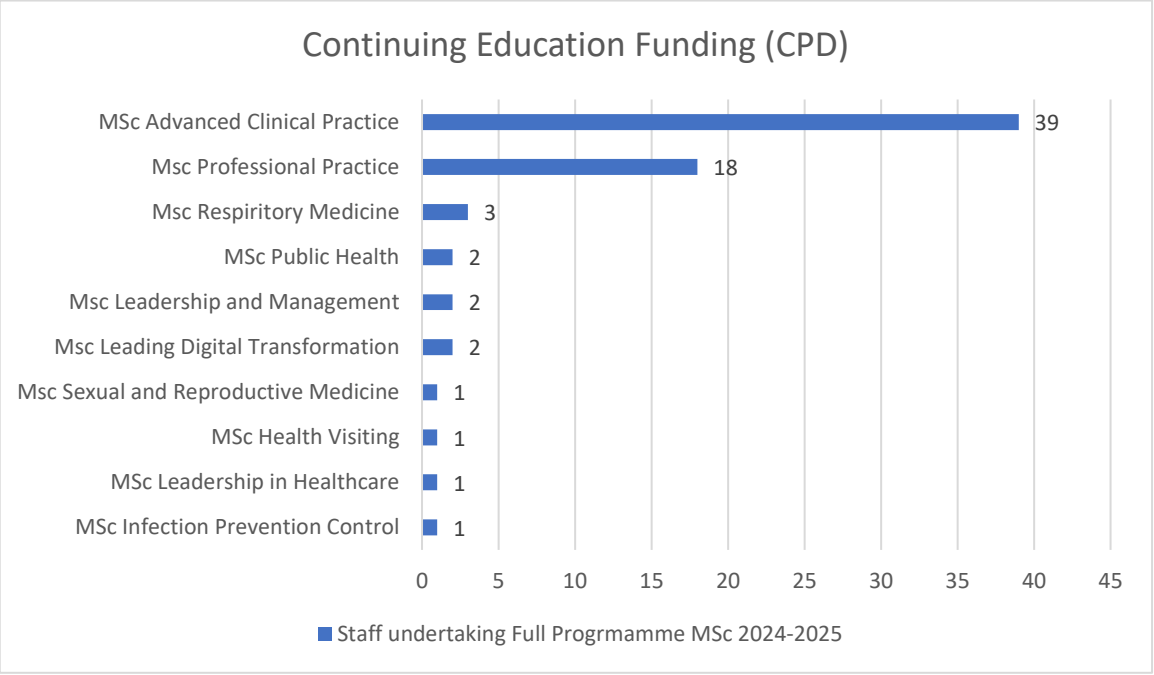


Figure 40

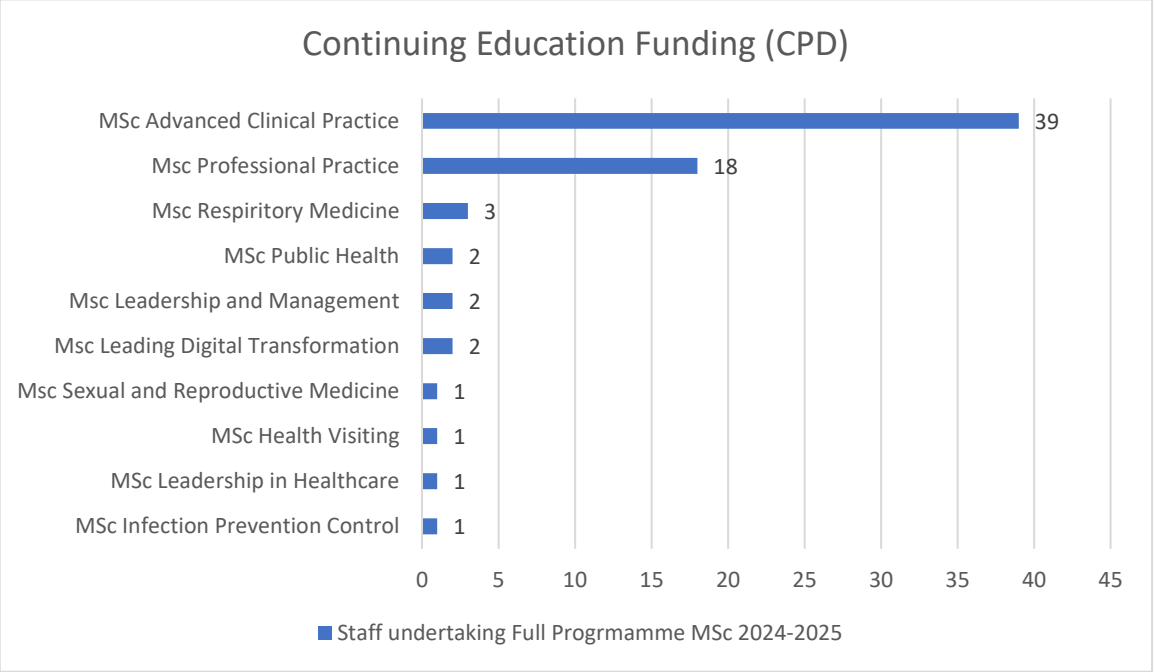


Fig 41 CPD USW Course Split 24/25

Focus on Multi-Professional Advanced Practice

Welsh Government via HEIW continue to invest in health professional education by providing annual funding for *Advanced Practice & Extended Clinical Skills.*

The funding provided by HEIW is to supplement our local investment to ensure that the appropriate staff can access the educational requirements as identified in our Integrated Medium-Term Plan (IMTP), in terms of advanced practice/extended skills education requirements and Independent Prescribing programmes. This funding is utilised across our organisation and is inclusive of nursing, midwifery AHPs & healthcare sciences. There is a separate funding stream for Pharmacy advanced practice and prescribing. We continue to work closely with the CTM Primary Care Academy.

The allocation is informed by an annual CTMUHB Education Commissioning return including undergraduate and advanced practice education requests. HEIW notifies the UHB of its Advanced Practice and Independent Prescribing allocation between April and May each year the allocation is split across primary care and priority areas in acute care settings.

Advanced Practice allocation is agreed via a multi-professional Allocation Group and managed via Clinical Education. All applications must describe the intended service impact to be achieved as a result of the educational request. We meet requests flexibly across both Advanced Practice and Nursing CPD funding streams where appropriate to maximise

access to funding for all health care professions and to enable optimal use of resources. For 2024/2025 the HB was allocated £217k split equally between primary and acute care.

Targeted funding was also allocated to specified areas including:

PG Cert for Critical Care, Reporting Radiography, and modules in Genomic Medicine and Independent Prescribing. In addition, there was funding to support the Mental Health Workforce Plan which was managed independently by the Mental Health team.

To reflect the organisational restructure, work continues to record advanced education uptake by Care Group.

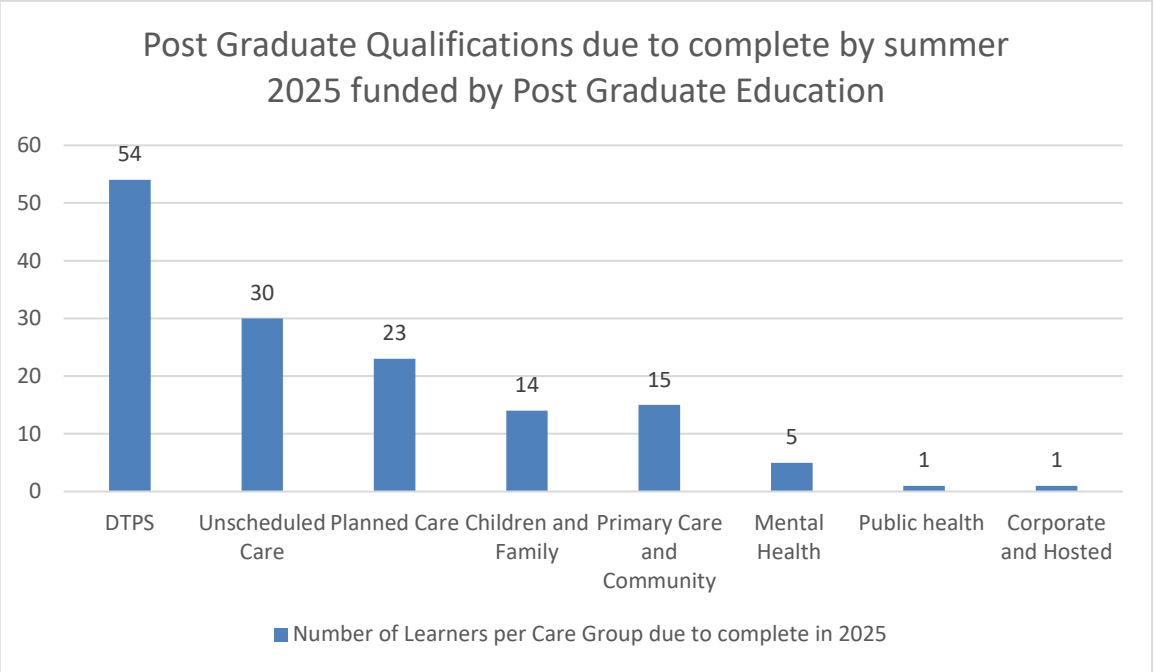


Figure 42

In 2024-2025 CTMUHB were allocated 26 HEIW funded places for Independent Prescribing. 5 places at Swansea and 21 places at University of South Wales. Out of the total allocated places, 25 places were utilised. 4 at Swansea University and 21 at University of South Wales.

The full allocation of 3 places for Independent Authorisation of Blood Products were utilised in 2024-2025.

Pharmacy Independent prescribing places are allocated directly to the pharmacy department

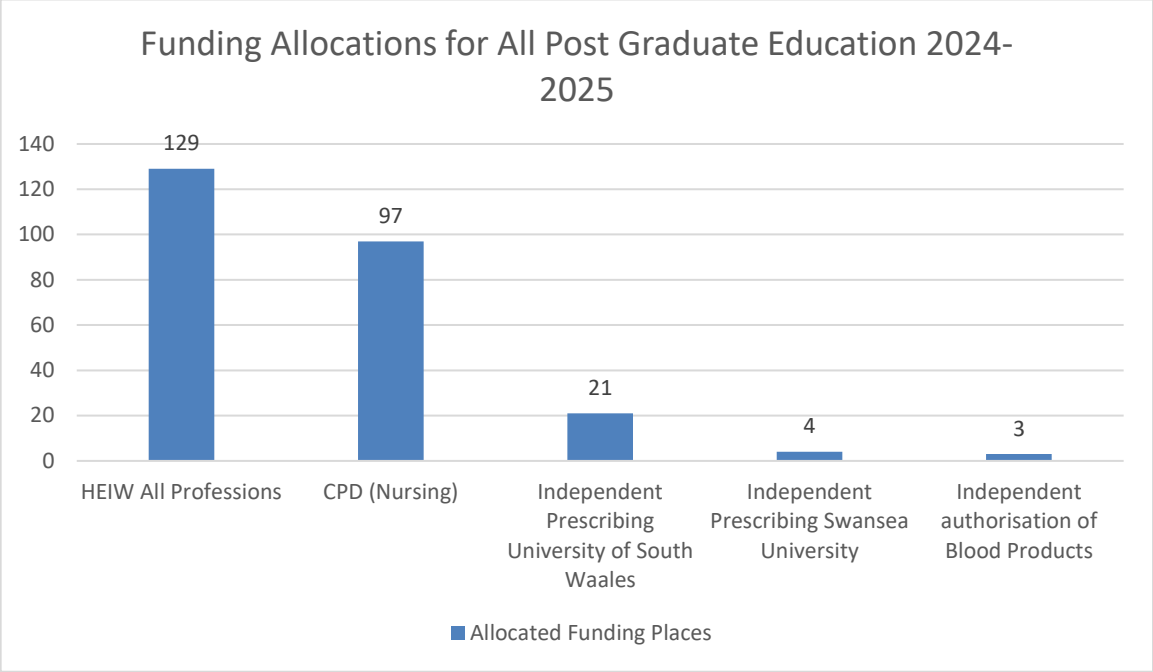


Figure 43

Allied Health Professions

Post-registration training will ensure the development of the AHP workforce in line with The Professional Framework for Enhanced, Advanced and Consultant Clinical Practice in Wales. https://heiw.nhs.wales/files/enhanced-advanced-and-consultant-framework

Post-registration education

AHPs continue to access HEIW funding for education in relation to extended roles and advanced practice. Programmes include Advanced Clinical Practice, Advanced Healthcare Practice, Dementia Studies, Occupation and Health and Leadership and Management in Healthcare. Learners also receive funding to study level 7 modules, again portfolios are varied, including work-based dissertation modules, knowledge and skills relevant to specialist roles, research methods, leading effective teams and transforming care and service through leadership.

Health Care Sciences Advanced Practice

The Medical Device Training manager has been working in collaboration with other UHB Medical Device Trainers to successfully develop and implement medical gas training course to be available via ESR which will improve compliance and competency in the safety of delivering treatment to patients and reduce the time away from clinical setting to achieve the training requirements.

One radiographer is currently in the 2nd year of MSc in Leadership and Management.

One HCS obtained ILM level 7 Diploma in Leadership and Management.

CTM collaborated with USW to provide a dedicated leadership course for both AHP and HCS leads.

One breast radiographer is attending an Ultrasound course is at St George's University of London, post-graduate module in breast ultrasound.

Priorities for 24/25

- To support Level 4 learners to complete qualification in order to access part-time HCS degree.
- Continue to support current BMS staff to achieve Specialist portfolios.
- Support HCSW onto the equivalence courses to top up their non-accredited degrees.
- To capitalise on funding opportunities from HEIW for STP equivalence funding
- Development of a level 3/4 apprenticeship programme specific to Neurophysiology in Wales

Risks

- Lack of resource/capacity to undertake training.
- Lack of part time degree scheme in audiology.
- Challenges with current workforce pressures to support training
    - e.g. Radiology - MRI reporting – Compelling case to progress radiographer reporting in MRI, potentially saving hundreds of thousands of £'s per year in outsourcing/insourcing. Unfortunately, the Radiologists are not able to support the training due current vacancies and workload.

Pharmacy

CTMUHB Pharmacy were allocated approximately £36k to support Advanced Practice in 24-25. The funding was used for a Clinical Diploma Advanced Technician Practice Level 4&5 (UEA), distance learning postgraduate diplomas for Band 6 pharmacist development, MSc in Digital Health Leadership, MSc in Professional Development for Pharmacy Practitioners, MSc in Leadership in Healthcare for senior pharmacy technician.

Following COVID and ensuring our workforce are upskilled in the ICU setting, several staff (pharmacists and pharmacy technicians) have undertaken or are undertaking UKCPA ICU training.

Advanced practice qualifications for pharmacists and pharmacy technicians offer a wide range of benefits, both for the individual staff member and the wider healthcare system

including enhanced clinical competence, improved patient outcomes and workforce development and system efficiency. Upskilling several pharmacists and pharmacy technicians to provide specialist clinical pharmacy service in ICU setting and ensure workforce is prepared for any future pandemics.

Pharmacist Independent Prescribing Activity

A workforce mapping exercise was undertaken in late 2023 across secondary care, primary care and the prison. This exercise was the first one undertaken across Medicines Management and provided baseline figures to create a gap analysis to target training. Analysis of the data has been undertaken for secondary care pharmacists particularly looking at Independent prescribing (IP) status. With the changes to the Initial Education and Training Standards for Pharmacists and trainee pharmacists registering as IP in 2025/26, there is a need for pharmacists who have 3 years recent prescribing experience and been prescribing within their scope of practice to act as Designated Prescribing Practitioners (DPPs). DPPs supervise the trainee pharmacists, or other health care professionals during their IP course and provide sign off on their competency to prescribe. It is also essential that existing staff working in clinical, patient facing roles have the opportunity to complete the IP qualification.

The analysis showed that 78% of Band 7 pharmacists and above in-patient facing roles are using IP. Those without IP in a patient facing role are either undergoing training or due to undertake training. Funding for the training is through HEIW funding and both the Band 6 HEIW post registration foundation course and the distance learning diplomas offer the IP course in the second year. It is therefore expected that this number will increase significantly in the next year. Findings at the time confirmed that 23 pharmacists across 3 acute sites met the requirements to act as a DPP.

Support for Pharmacists acting as DPPs

A number of pharmacy staff have now undertaken the DPP role. Plan to start up CTM Pharmacy peer support group for DPPs with intention of providing support and advice for those undertaking the role. Providing these resources will enable other pharmacists to undertake this role in the very near future as well as support with the governance around the role.

Advanced Practice Board Activity 2024-2025

The Advanced Practice Board continues to evolve the work around Advanced Practice within CTMUHB. Our on-going aim is to provide educational support and governance the growing number of clinical practitioners within the health Board both in trainee and fully fledged roles. Over the last year, the board has enabled several new supportive developments as well as evolving existing work. Moving forward this board will be part of the governance structure within CTMCLA.

Advanced Practice Board- has included additional members to support the board agenda around Advanced Practice which includes, Research and Development, Paediatrics, NMIP and Haematology. We also have a dedicated section for ACPs developing innovations in practice (clinical/educational) to come and present to the board to gain support and direction.

Advanced Clinical Practice Portfolio workshops- we continue to provide workshops three times a year which provide an opportunity to work through the requirements of developing a portfolio of evidence that supports the desired criteria under the four pillars of Advanced Practice as outlined in the Enhanced, Advanced and Consultant Multi-professional Framework (2023). There has a been a mix of attendees from Enhanced and Advanced roles over the pat 12months. Those who attend are, provided with an opportunity to discuss the type of evidence required to support their level of practice and provided with on-going support through a buddy system to develop the desired portfolio.

Advanced Clinical Practice portfolio mentorship workshops- in addition to the workshops that support clinicians to develop their portfolio's we have also developed a workshop to support those who provide mentorship. The premise behind this development being to ensure we have a standard and consistent approach to portfolio development and mentorship. A CTMUHB Guideline has been developed to support this position and can be located on share-point.

Advanced Practice (AP) Celebration Panel – on completion of a portfolio, the ACP has the opportunity present their role and portfolio of evidence to the panel. An evidence matrix is completed prior to the panel event to outline and support the level of practice presented within the individual's portfolio. Since August 2025 the AP panel has the privilege of celebrating 10 ACPs all of which have provided an opportunity the health board to recognise the value that the ACPs bring to services they work in. The panel has provided the individual ACPs feedback and an opportunity to feel empowered to move forward with innovations within their own practices.

Enhanced, Advanced and Consultant (EAC) CTM wide forum- we continue to host a health board EAC wide forum, to support all those that sit in Enhanced and Advanced Clinical Practitioner roles. It provides an opportunity for networking and interprofessional learning across all services, primary and secondary care, share good practice and receive updates locally and nationally around EAC development. The forum is held via Microsoft Teams to enable ease of attendance.

Enhanced, Advanced and Consultant Celebration event- We had a successful celebration event in November 2024 where 8 ACPs were formally recognised and celebrated in their roles. These events will take place on a yearly basis with our next event planned for October 2025 in RGH.

Development of new ACP role- the board also provides advice and support relating to new ACP role development with the health board; job planning, required education, clinical mentorship, appropriate leadership. In addition, the board is encouraging the use of the All Wales Generic JD's and associated scope of practice for Advanced Clinical Practice for all new roles. Note trainee roles will now be band 7 with an annex 21 applied to support the period of training. Shaping the future work force of ACPs being a key role of the AP Board.

Level 7 education (Clinical MSc) –the boards position on supporting Level 7 (Clinical MSc) remains unchanged in that the board has stipulated that services must have a clear service plan in place to support staff undertaking MSc AP's in trainee roles with a view that roles are required within the service going forward. This supports opportunities to develop and transform the current workforce to fit with service need how appropriate education can be accessed to support those in development roles.

Advanced Clinical Practice Share-point- space continues to be updated with all the relevant CTM and national guidance/documentation relating to Advanced Clinical Practice.

Guidance to support use of All Wales Generic Job descriptions and recruitment processes – a guidelines has been developed to support the use of the All wales JDs for ACP roles band 7 with Annex 21 Band 7 fully trained, band 8a Senior ACP and Band 8b Lead ACP. Further work is being undertaken around a band 6 CP and band 8C Consultant Clinical Practitioner roles via the All wales AP leads group. The guidance can be accessed on Share-point.

Completed developments:

Developed guidance around Treatment Escalation Planning (TEP/DNACPR) discussions and validation by ACP, Clinical Specialists and physicians- the guidance has been agreed and can be found on Share-Point.

Revision of Verification of Death Policy to support training competency sign off via a one off OSCE for all clinicians has been agreed and can be found on Share-Point.

Developments in progress:

Guidelines to support CPD time for those in clinical roles (ACP and CS).
Guidelines to support the use of ACPs employed in the hospital bank services

A review of the PDR documentation, aiming to create a document that supports the development of those in ACP and CNS roles in line with the 4 pillars of Advanced Clinical Practice alongside the need to support well-being. The document will aim to support the transition from Enhanced to Advanced level practice for those individuals wishing to progress along this pathway.

Common foundation training programme for new ACPs –this will enable the growth and development ACPs who will have the opportunity to work within a given speciality but grow a broad set of skills and knowledge in their initial 3 years of training. Post the common foundation phase ACPs will then be provided opportunity to develop skills and knowledge within in their given speciality following credentialing pathways e.g., RCEM, HEE older persons, palliative care, acute medicine. We are planning to pilot this with 1 COTE TACP and 1 CCOR TACP from September.

NMIP declaration and competency requirements- currently reviewing how we support those in NMIP roles to provide live evidence in relation to their prescribing practices to support the All Wales NMIP competency Framework. This piece of work links in with the NMIP CTMUHB forum and lead Andrew Davies.

Non-medical Requesting of Radiology declaration and competency requirements- currently reviewing how we support whose roles involve requesting of radiology in providing evidence of scope and competence in practice. This piece of work links with the All Wales Guidance for Non-medical requesting of radiology.

A review of our current position around Enhanced, Advanced and Consultant level practice is planned toward the end of the year.

Organisational governance around resuscitation and acute deterioration has been developed and aligned. The overarching CTMUHB RADAR Committee (Recognition of Acute Deterioration and Resuscitation) is responsible for the strategic management of all 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 several 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 Consultant appointed as the Clinical Lead. In the recent organisation restructure, there is now a Senior Nurse for Acute Deterioration and Outreach and established in the Planned Care Group. Additionally, there has been a secondment into a Lead Nurse for RADAR. This has enabled a structured and unified approach across Cwm Taf Morgannwg University Health Board (CTMUHB) in the identification, escalation and response to the acutely unwell patient.

RADAR reports directly to the Executive Leadership Group, via the Medical Director with links to the Quality & Safety Committee
The work of this governance structure is directly supported by the Assistant Director of Clinical Education, the Lead Nurse for RADAR.

Changes and Enhancements in Training and Governance.

Over the past year, significant departmental strides have been made to enhance the quality and accessibility of training across our learning organisation. The department has transitioned the majority of our external courses to midweek delivery to accommodate participants and improve attendance. The number of external courses has increased throughout the year.

To increase compliance rates for Basic Life Support (BLS) within the health board a refresh of the Train the Trainer approach was undertaken to enable the Care Groups to become self-sufficient for Basic Life-support training. As the Subject Matter Experts (SMEs) for resuscitation training, our team is responsible for:

- Ensuring consistent quality and standards across all trainers
- Maintaining an effective support system to keep trainers up to date with evidence-based practice
- Acting as the expert point of contact for advice, guidance, and reassurance during training delivery

This structured approach ensures that all trainers are well-equipped to deliver high-quality, safe, and effective resuscitation education across the Health Board. Further work on train the trainer is planned for next year.

Governance, Safety, and Training Initiatives

- Governance, safety, and training have been successfully embedded within HMP Parc Prison, significantly enhancing the standard of care and preparedness in the prison environment. These efforts have been well received and valued by both the Senior Team at Parc Prison and the Health Board Primary Care Team.

- A structured training programme has also commenced for the rollout of new defibrillators across community sites, ensuring staff are confident and competent in their use.

- CTMUHB has joined the National Cardiac Arrest Audit (NCAA), enabling the Health Board to:
    - Benchmark performance nationally
    - Contribute to quality improvement initiatives
    - Improve patient outcomes through data-driven insights

- All cardiac arrest data is collected in accordance with RCUK guidelines, which recommend participation in NCAA to generate comparative reports across health boards. This data is also incorporated into the Welsh Resuscitation Forum, supporting broader system-wide learning.

- As part of the audit process, cardiac arrests are reviewed using tools such as NEWS charts and other clinical data to determine whether the event was predictable or preventable. Collaboration with Critical Care Outreach Teams (CCOT) helps identify areas for improvement and informs targeted training interventions.

Partnership and Collaboration

The department has continued to strengthen their partnership with medical teams across the organisation and collaboration has been pivotal in organising and facilitating cardiac arrest 'Team Huddles' and debriefing sessions following urgent calls. These sessions provide an opportunity for teams to reflect on their performance and identify areas for improvement.

Cardiac Arrest Review Meetings (CARM) have been established in collaboration with the Outreach and Acute Deterioration Lead to support continuous improvement in patient care. These structured and constructive meetings focus on the analysis of cardiac arrest forms and patient notes, enabling the identification of missed opportunities that may require further escalation.

The reviews also highlight additional learning needs, which are subsequently integrated into resuscitation training across the health board. This ensures that staff are appropriately trained and supported in line with best practice.

Findings from CARM are incorporated into **RADAR presentations** within each care group's **Quality, Safety, Risk, and Patient Experience (QSRE)** meetings. This allows for any identified concerns to be raised and actioned appropriately.

Furthermore, CARM outcomes are used to prepare evidence for **Rapid Reviews** and **scrutiny panels**, reinforcing accountability and driving continuous improvement in clinical practice

Continuous Improvement and Auditing

Our team remains dedicated in supporting best practices in responding to cardiac arrest calls. By attending calls, auditing incidents, and investigating Datix queries, we proactively identify areas for improvement and training needs. As an example, we have revised the cardiac arrest audit form, which now provides a clearer trail of decision-making and highlights specific areas requiring enhanced training.

Resuscitation Debriefing

The Resuscitation Team actively offers debriefing sessions following resuscitation attempts, recognising debriefing as a powerful and essential learning tool. In line with Resuscitation Council UK (RCUK) guidelines, debriefing after a cardiac arrest enables team members to reflect on their experiences, process the event, and identify opportunities for improvement. Due to time constraints, high clinical demands, and limited awareness of its value, debriefing is often overlooked by clinical teams. As such, the Resuscitation Team frequently initiates and leads these sessions, providing expert advice, support, and reassurance to ensure the process is meaningful and effective.

Cold Debriefing

Cold debriefing offers a deeper level of reflection, allowing teams to review events using objective data such as equipment logs, patient notes, and clinical documentation. These sessions are also facilitated by the Resuscitation Team, who bring expertise and support to guide the discussion.

Findings from cold debriefings are used to:

- Inform and enhance resuscitation training
- Guide updates to resuscitation equipment and protocols
- Provide assurance that events are being thoroughly investigated

This information is then fed into the RADAR committee and other relevant groups, ensuring that lessons learned translate into tangible improvements in practice and patient safety.

Collaboration with the Pharmacy Department

Work has been completed in partnership with the Pharmacy Department to standardise and update ‘green drug boxes’ across our Community Hospitals and Clinics. This initiative was crucial to ensuring safe and effective medication administration for patients. Additionally, standardising the emergency drug box and cardiac arrest drug box as part of the Resuscitation trolley/equipment has been completed, in accordance with medicines management compliance

Training Delivery and Compliance

The Resuscitation Service continues to deliver mandatory life support training from Level 1-3 for CTMUHB, Powys HB, and all local GPs and Dentists. Our department is also a leading National provider of Level 4 Advanced Resuscitation Courses for Adults, Paediatrics, New-borns, and Trauma. These courses are offered on an income-generation basis, with both internal and external faculty contributing to their delivery.

Further information and activity and impact data can be found in RADAR annual report

Figure 44

Libraries and Knowledge Management.

Library Usage

There are dedicated Libraries on each of the acute sites operating 24/7 access for our staff and students, to our literature collections; journals and books both electronic and physical and quiet study space with IT access & printing. Our specialist librarians are also available for help and support including literature searching, reference sourcing and critical analysis skills. Our libraries are an important part of our health board activity. The following data visualisations provide the detail of the usage of the library resources over the last 5 academic years and indicate that although there an increased use of online support, footfall within the library spaces is on the upward trajectory, and has surpassed the levels experienced prior the pandemic.

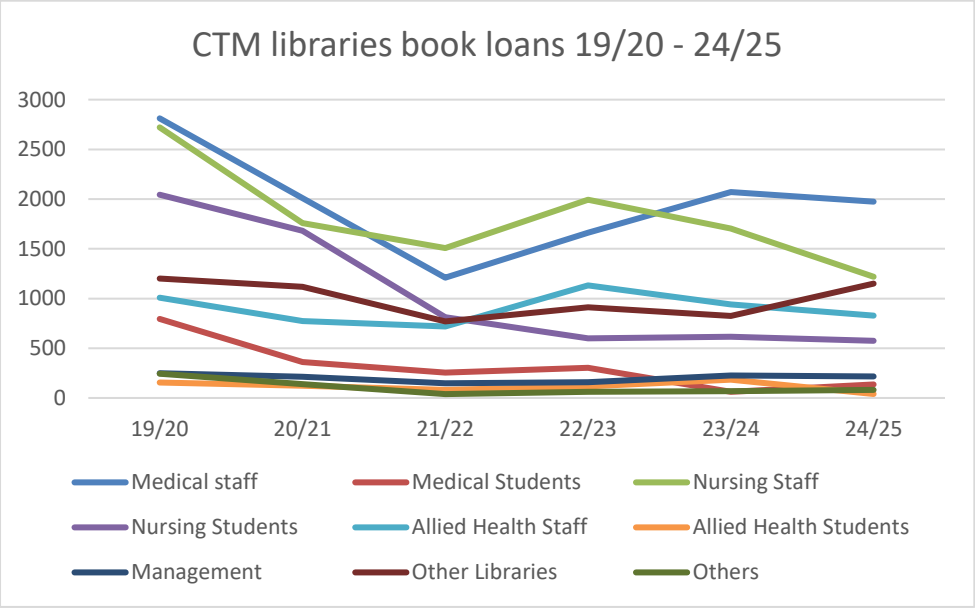


Figure 45

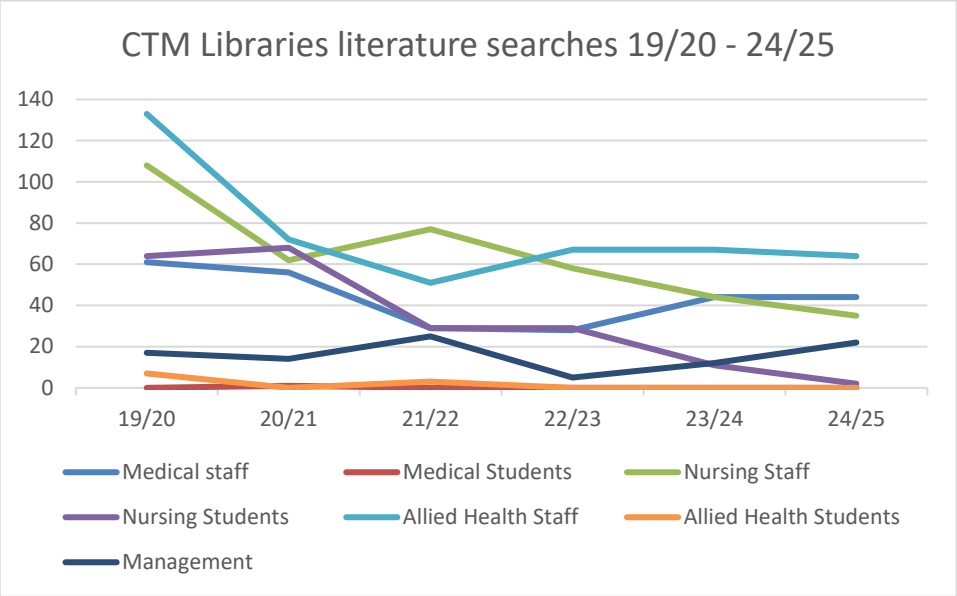


Figure 46

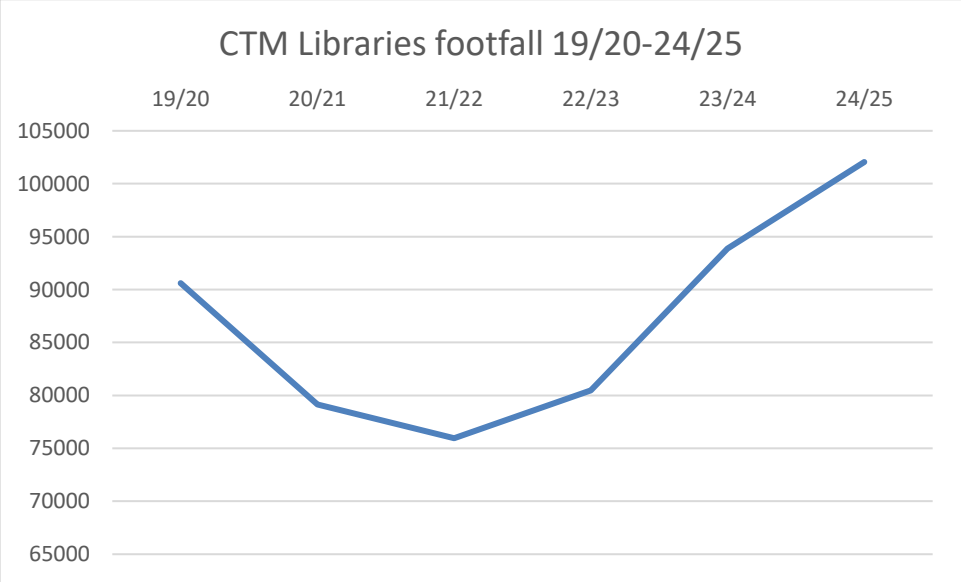


Figure 47

Health Board-wide resources

We have purchased access to Zest, an electronic platform that supports learning through game play for use across the Health Board. The games cover a range of health and management topics from Sepsis, to communication and team building.

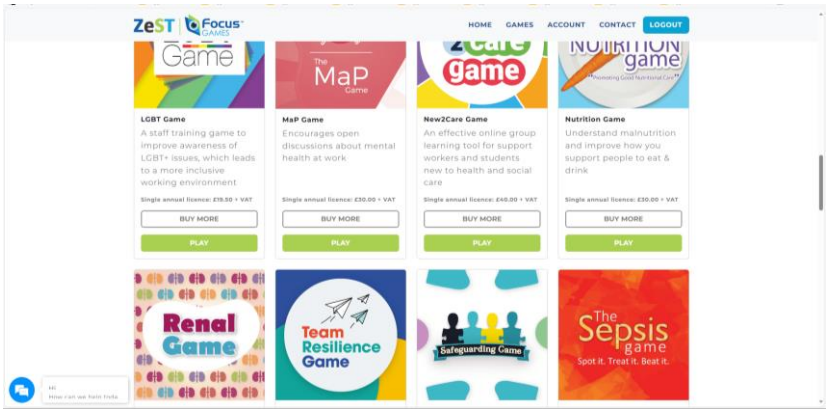


Figure 48

We have also bought access to Dr. Jargon, a game that encourages medical staff to improve communication with patients and families by moving away from medical jargon when explaining issues.

Figure 49

Library Facilities

The Libraries at Princess of Wales and Royal Glamorgan took delivery of new quiet pods at the start of the summer. They can be booked via the libraries and are designed to offer a peaceful and private space for focused work or video calls. The pods provide a comfortable environment with built-in lighting and air conditioning—perfect for short sessions or extended periods of concentration, even during warmer months.

Figure 50

The new Library facilities at PCH have proved very popular and the current building is in a central area and is easily accessible, so this has come as welcome news to staff and users alike.

All the Libraries had stands at the main medical inductions and had excellent levels of engagement with the new staff.

Figure 51 Library stands at the medical induction August 24

Refs:

1. *A Healthier Wales: https://gov.wales/sites/default/files/publications/2019-04/in-brief-a-healthier-wales-our-plan-for-health-and-social-care.pdf. Accessed 10.10.2019*
2. HEIW IMTP 2025-28 Final
3. https://ctmuhb.nhs.wales/about-us/governance-assurance/annual-reports-annual-accounts-annual-plans/reports1/ctmuhb-annual-report-and-accounts/ctmuhb/ctmuhb-ar-amp-accts-2024-2025-approved-26625-us-incl-disc-pdf/
4. heiw.nhs.wales/files/enhanced-advanced-and-consultant-framework/

Appendix 1:

		August 24	July 25
RED RISK High Risk	Unscheduled Care	2	1
	Planned Care	3	2
	Mental Health	0	1
	Woman & Child Health	0	1
	All Care Groups	0	0
	GP	0	0
ORANGE RISK Medium Risk	Unscheduled Care	2	1
	Planned Care	4	4
	Mental Health	1	0
	Woman & Child Health	2	1
	All Care Groups	1	3
	GP	4	3
YELLOW RISK Low Risk	Unscheduled Care	2	1
	Planned Care	4	3
	Mental Health	0	0
	Woman & Child Health	1	0
	All Care Groups	0	0
	GP	0	3
	TOTAL	26	24

	August 24	July 25	Score rating movement
HIGH RISK	TP256 Emergency Medicine- PCH	TP256 Emergency Medicine- PCH	↔
	TP487 Surgery – PCH	TP487 Surgery – PCH	↔
	TP544 General Internal Medicine – PCH		↓
	TP078 Ophthalmology –RGH		↓
	TP160 General Surgery – RGH	TP160 General Surgery – RGH	↔
		TP361 Psychiatry – All	↑
		TP840 Obs & Gynae - POWH	↑
MEDIUM RISK	TP590 General Surgery –POWH	TP590 General Surgery –POWH	↔
	TP361 Psychiatry – All		↑
	TP589 GP Llynfi Surgery		REMOVED
	TP593 GP Parc Canol Surgery	TP593 GP Parc Canol Surgery	
	TP610 GP- Western Vale		↔
	TP800 Organisational Change – All	TP800 Organisational Change – All	↓
	TP545 GP – Pontcae	TP545 GP – Pontcae	↔
	TP581 General Internal Medicine - RGH		↔
	TP834 Anaesthetics - RGH		REMOVED
	TP840 Obs & Gynae - POWH		
	TP842 T & O – RGH		REMOVED
	TP837 – Anaesthetics - PCH		
	TP838 – Emergency Medicine - POWH		↑
	TP839 – Obs & Gynae – PCH		↓
	TP836 – Cardiology – RGH		↓

		TP544 General Internal Medicine – PCH TP837 Critical Incident – All TP906 Cardiology – POW TP908 Paediatrics – PCH TP078 Ophthalmology –RGH TP807 General Practice – Eryl Surgery TP862 Hospital at night – ALL TP905 Acute Internal Medicine - RGH	↓ REMOVED REMOVED ↓ NEW NEW NEW ↓ NEW NEW NEW
LOW RISK	TP531 Diabetes and Endo – POWH TP316 T & O - PCH TP483 Paediatrics – POW TP484 General Internal Medicine – POWH TP575 Intensive Care Medicine - POWH TP523 Otolaryngolog – RGH	TP316 T & O - PCH TP610 GP- Western Vale TP837 Anaesthetics - PCH TP838 Emergency Medicine – POWH TP842 T & O – RGH TP879 GP Bron y Garn TP880 GP Oak Tree	REMOVED ↔ REMOVED REMOVED REMOVED REMOVED REMOVED ↓ ↓ ↓ ↓ NEW NEW

Appendix 2

Widening Access Timetable 2024-25

Month	School year	WAM topic *(Facilitators)*	School year	Medical school Application Timetable
September		Contact Head teachers / schools *(Widening access team)*	13	Sit UCAT Exam
October	13 13	The medical Interview & Mock interviews including MMI *(Clinical fellows +/- medical staff)*	13 13	Sit UCAT Exam UCAS application closes
November	12 12	**Students:** Studying at a University Finance – course costs / SFW Routes to medicine and entry requirements *(Ideally F2F; TEAMS vis schools also possible; Clinical Fellow & WA lead)* Application for Medical Work Observation sent to Schools in CTM Catchment *(Widening access team)*	13 13	Sit BMAT Exam Attend Interviews
December	12 12	**Students:** Studying at a University Finance – course costs / SFW Routes to medicine and entry requirements *(Ideally F2F; TEAMS vis schools also possible Clinical Fellow & WA lead)*	13	Attend Interviews
January	12	**Parents evening:** Why go to University; Medical school information; Careers advice; Selecting a medical school; Application process; Admissions process; Key dates; Preparing for University *(Face to Face; WA lead & Clinical fellow)* Primary school sessions *(Year 3 SSC)*	13	Attend Interviews
February	11	**Teachers/career advisers:** A career in medicine: Career options Include info on subject choices and grades UG v PG courses *(F2F or TEAMS; WA Lead & Clinical fellows)* Primary school sessions *(Year 3 SSC)* Year 10 Clinical skills and simulation event *(Clinical fellows KHAC)*	13	Attend Interviews
March	5&6	Year 10 Clinical skills and simulation event *(Clinical fellows KHAC)*	13	Attend Interviews
April	5&6 12	Application for Medical Work Observation closes and shortlisting done. *(Widening access team)*	13	Attend Interviews
May	5&6 12	Primary school sessions *(Year 4 SSC)* UCAT training & UCAT mock (Bank questions / online material) *(Clinical fellows)*	13	Confirm University choices

June	5&6 12	Primary school sessions ***(Year 4 SSC)*** WOBS induction ***(Widening access team)***		
July	12 12	WOBS virtual sessions ***(Widening access team)*** WOBS in hospital week ***(Widening access team)***	12	Sit UCAT exam
August			12 12	Sit UCAT exam Start writing statement

Agenda Item
8.2.6

Quality, Safety & Experience Committee

Bi-Annual Report CTM Radiation Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon Donovan Professional Head of Radiography
Cyflwynydd yr Adroddiad / Report Presenter	Lauren Edwards, Executive Director of AHPs and Health Science
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
EPs	Employers Procedures
HIW	Healthcare Inspectorate Wales
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
LPA	Laser protection advisor

MEG	Medical Exposure Group
MPE	Medical Physics Expert
NRW	Natural Resources Wales
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RPA	Radiation Protection Advisor
RPSC	Radiation Protection Service, Cardiff
RPS	Radiation Protection Supervisors
RSC	Radiation Safety Committee
RPG	Radiation Protection Group
DTPS	Diagnostics, Therapies, Pharmacies and Specialties

1. Purpose

1.1 This report has been prepared to provide the Committee with details of the key matters considered by the Radiation Safety Committee (RSC) at its meeting on 24th October 2025. Minutes are available on request.

1.2 Key highlights from the meeting are reported in section 5.

1.3 The Committee is requested to **NOTE** the report.

2. Specific Matters for Consideration

2.1 CTMUHB RSC is scheduled to meet twice yearly, with meetings held in April and October 2025. The next meeting is scheduled for April 2026.

2.2 In 2025, a new radiology management structure has been developed and implemented, with a Professional Head of Radiography and a Radiology Quality Manager now in post, providing both subject matter expertise and consistency of approach for the RSC meetings.

2.3 Following April's meeting of the RSC, a proposal was made to change the format of the meeting to enable better assurance and avoid duplication. The proposal to change the format of the meeting was taken through internal governance structures for approval.

2.4 The meeting on 24th October 2025 was the first RSC to be held in the new format of Radiation Protection Group (RPG) and Medical Exposure Group (MEG). RPG and MEG provided an Alert, Advise & Assure format. The new format brought the reports together for each modality in CTMUHB and avoided duplication. It enabled colleagues to attend the group that is most appropriate to them, or both if required. A required attendance list will be distributed ahead of the next RSC. This meeting will continue to report into the Quality, Safety & Experience Committee.

3. Highlight Report

Alert / Escalate	• RSC made aware of a staff member who is using the mini-C arm, a form of imaging equipment, in POW theatre without the correct entitlement to use the equipment. RSC agreed that this practice was to cease with immediate effect until the correct entitlement is issued. A notification letter to cease use was sent on the 24th of October 2025, with members of the RSC agreeing to meet to ensure the correct entitlement is issued. • Ongoing temperature issues in Nuclear Medicine (NM) in POW are causing a spike in humidity that is affecting Quality Assurance and Image Quality. Issue escalated to both DTPS Directorate Manager and Estates services on 27th October, highlighting that this work needs to be completed by Dec 2025 – prior to NM centralisation in POW. • Highlighted again that there is no Laser Protection Advisor cover in POW. Chair to discuss with Planned Care Directorate Manager to progress a solution. Risk to be updated on the risk register. • Dermatology UV update document required. CTMUHB did have a Service Level Agreement (SLA) with C&V but this has not been renewed. Chair to escalate to care group directors to progress a solution. Risk to be added to corporate risk register after discussion with MPE.
Advise	• Mini C Arm, a form of imaging equipment, in PCH has been out of action for 2 years. Repairs not possible at present so decommissioned. There is a demand for the mini c arm now theatre capacity has increased again after the closure of the vanguard, therefore it will be fixed or replaced. • Update on CTM readiness for Medical Device Regulation changes to be shared at Operational Management Board on 29th October 2025. • As a security improvement measure, the sealed source storage box for radio isotope needs replacing in POW NM to improve security. Superintendent Radiographer is addressing. • POW needs to directly order Iodine 123 for Nuclear Medicine examinations as currently an outlier in South Wales. Nuclear Medicine Superintendent Radiographer is reviewing 2 suppliers and comparing pricing. Reviews of NRW permit revision and Standard Operating Procedures (SOPs) for ordering and delivery are being drafted. • Community Dental service has advised they are behind on the screening of thyroid shields and will work on rectifying as soon as possible as annual screening is recommended for safe practice for staff. • Requirement to purchase metal detectors for Magnetic Resource Imaging (MRI) Parc Prison patients following an

	incident whereby a prisoner concealed a razor blade on their person. This was a near miss and a safety alert. Head of Radiography to meet with Parc Prison manager to ensure patients and staff are protected. • As a result of a missed intra orbital foreign body on a prescreening questionnaire for a patient in RGH, the MRI safety expert is providing revised screening documentation on an all-Wales basis to reduce future occurrences. • There is a new taxonomy policy now on Datix. All staff will be required to Datix all near misses or (Good catches), as this is now an IR(ME) R requirement. Quality manager will work with staff groups to educate as to how report- and will work with Datix team. • DEXA RPS RGH Audit needs completing as currently outstanding. Velindre Physics Team are aware and planning to rectify as soon as possible recognising that delays have occurred due to a number of vacancies within the Team. • No MPE (Velindre) service Lead for RGH/PCH since MPE resignation in August 2025 and no suitable candidates at present. On site audits delayed due to lack of capacity in the team. Interim MPE will advise of recruitment progress and confirm when audits are complete. Consideration for one SLA with a single physics provider to cover all sites in CTMUHB would enable equity of physics provision in CTMUHB. Commissioning work ongoing. • Duty Holders Audit in RGH and PCH are outstanding. The Velindre physics team have agreed to carry these out imminently. • Highlighted that PoW Theatre Employers Procedures require updating. Lead Medical Physics Expert to meet with Theatre team to implement an action plan to allow the procedures to be updated.
Assure	• Radiographers from RGH and PCH have attended Radiation Protection Supervisor (RPS) training. • A POW radiographer will undertake RPS training for NM in November. • The Community Dental Team are now engaged and attended the RSC meeting. • The Dental Team are reviewing EPs and entitlement documentation with Velindre Physics Team. • The updated Classified Workers document was presented and accepted for approval in the meeting. • The Administration of Radioactive Substances Advisory Committee (ARSAC) practitioner license has been modified for one consultant radiologist to include RGH and POW. License has been approved (AA-11733)

	• An US Governance Group is being established. DTPS care group director is leading on this and will be formalising TOR. Dates to be agreed to meet. • MRI RGH plans in progress to start works to reduce entry points to MR Controlled Access Area, as detailed in physics risk assessment. SON and Fire Build applications have been completed and approved. Architect and contractors appointed. • Revised NM permit in POW to accommodate increased waste in readiness for when NM service centralises. Limits have been calculated to future proof the service. RPA will complete the application and send to NRW once Purchase Order is raised. Process takes 3 months to process in readiness for centralisation of service. Fee to be approved by Radiology Directorate manager. • There is a new taxonomy policy now on Datix. All staff will be required to Datix all near misses or (Good catches), as this is now an IR(ME)R requirement. Quality manager will work with staff groups to educate as to how report- and will work with Datix team • Head of Radiography to seek a point of contact in CTMUHB to oversee the monitoring of Radon risks to enable assurance to HSE. • Dental Team working with physics on employers' procedures and entitlement documentation. • No schedule for rehearsal of contingency plans for radiation incidences – all sites. The Quality manager will implement as soon as possible to minimise risk.
Inform	• HIW inspection PCH Radiology general department 20th -21st May went well. The immediate action issued around diagnostic reference levels (DRLs) in CT has been addressed. An action plan was issued, and the Head of Radiography and Quality Manager and team have been working to complete the actions in a timely manner. The action plan included entitlement of external referrers to refer into CTMUHB. This is now complete, for all other health boards in Wales. All other health boards in Wales are looking to adopt the same approach following discussion in all Wales Radiography Professional Head Group and Quality Forum so we may receive a similar letter. An internet page is underway for sharing of the CTMUHB Radiology employers' procedures. The only outstanding actions are concerned with lack of staffing out of hours.

	• Cone Beam CT unit will be installed in PCH Summer 2026 • Fluoroscopy interventional Room 4 in RGH will be replaced before April 2026
Appendices	N/A

4. Recommendations

4.1 Quality, Safety and Experience Committee are asked to **NOTE** the report.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
8.2.7

Quality, Safety & Experience Committee

Antimicrobial Stewardship Report – October 2025

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Avril Tucker, Principal Pharmacist for AMS
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dr Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Gentamicin audit across all DGH	May 2025	Audit, evaluation, action plans completed. Teaching sessions scheduled to cascade results, feedback and learnings.
Antimicrobial Guardian Awards	9th June 2025	3 entries for CTM AMS team, 2 entries related to CTM specific work, 1 entry came second with a high commended honour: UTI Friday- managing rUTI in Primary Care
Antimicrobial Stewardship Group Meeting	19th June 2025	Cancelled due to not being quorate.

(TOR agreed and action log generated, appendix 1 – available on request)		
Antimicrobial Stewardship Group Meeting	4th September 2025	Reviewed strategy and plan for reviewing/updating antimicrobial guidelines
AMS Agenda Item at Medical Directors Meeting	9th October 2025	MD away day utilised to share key commitments for all specialties from AMS Group Meeting. Discussed importance of medical representation being at the meetings following unsuccessful June meeting.

Acronyms / Glossary of Terms	
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
RCT	Rhondda Cynon Taf
AMS	Antimicrobial Stewardship
NPI	National Prescribing Indicator
NAP	National Action Plan
AMR	Antimicrobial Resistance
DDD	Defined Daily Dosing
rUTI	Recurrent urinary tract infection

1. Situation /Background

Antimicrobials are critical to maintaining public health in the fight against infection. Through systemic over and inappropriate use of antimicrobials worldwide development of antimicrobial resistance (AMR) poses a significant risk if action is not taken to prevent further development of antimicrobial resistant microbes.

The UK government in response to the threat of AMR has developed a 20-year vision for antimicrobial resistance, setting goals to be delivered via a series of 5-year national action plans (NAP).

Building from the May report which introduced the NAP targets, this report focuses on updating our position on the previously referenced targets in 'Optimising the use of antimicrobials'. The targets set by the Welsh Health Circular, which come from the UK NAP are:

Target 4a contains improvement goal 11a (primary care) highlighted in figure 1 and 11b (secondary care): by 2029, aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.

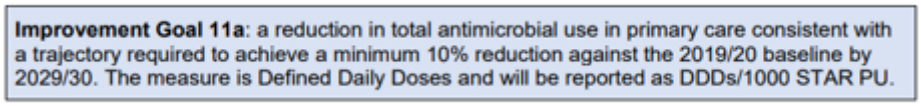


Figure 1: *Exert from the Welsh Health Circular issued by Welsh Government in response to publication of the second NAP*

Target 4b contains improvement goal 12a (primary care) and 12b (secondary care): by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system.

Access antibiotics are those with a narrow spectrum of activity, fewer side effects, lower costs, and importantly lower resistance potential[1].

To support delivery of these targets in Wales the All Wales Medicine Strategy Group have developed a series of National Prescribing Indicators (NPIs) which align to the NAP goals:

- Total antimicrobial prescribing
- 4C antimicrobials
- Course duration for respiratory tract antibiotics

[1] UK Access, Watch, Reserve, and Other classification for antibiotics (UK-AWaRe antibiotic classification) - GOV.UK

2. Specific Matters for Consideration

a. Primary Care

From a Primary Care perspective CTMUHB is no longer the highest prescribers of antimicrobials in the UK or in Wales when measured in DDDs/1000 STAR-PU, as illustrated in figure 2 (light blue line is no longer the highest based on the most recent data towards the right of the graph).

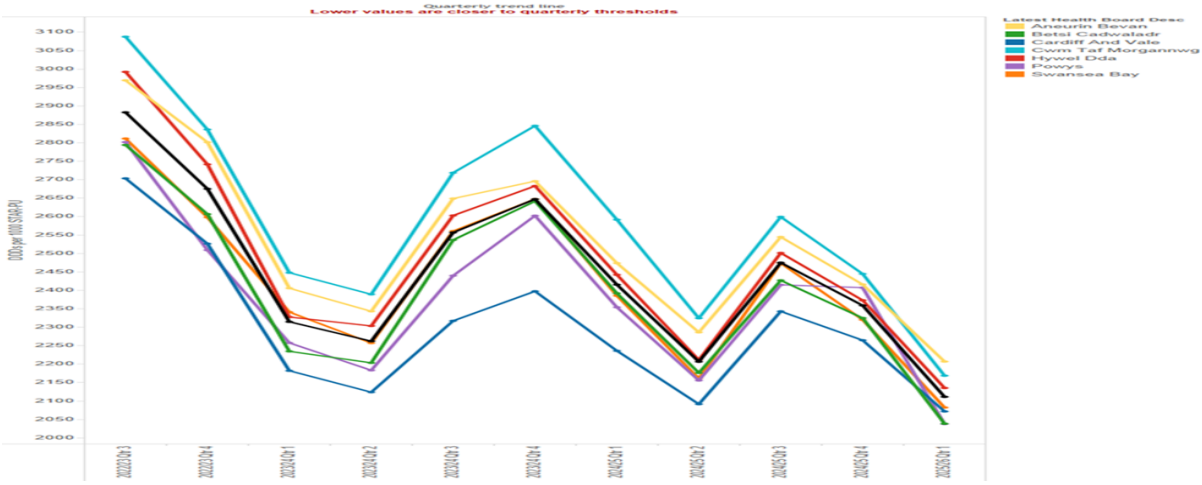


Figure 2: *Comparison of All-Wales anti-microbial prescribing rates in primary care*

Figure 3 below demonstrates the continuing challenging landscape with high levels of antimicrobial prescribing across Wales. It is worth highlighting CTMUHB is one of the only LHBs to achieve a volume of antimicrobials below the target rate. This highlights the significant progress that has been made across primary care over the last 12 months aligned with the new NPIs linked to the NAP targets.

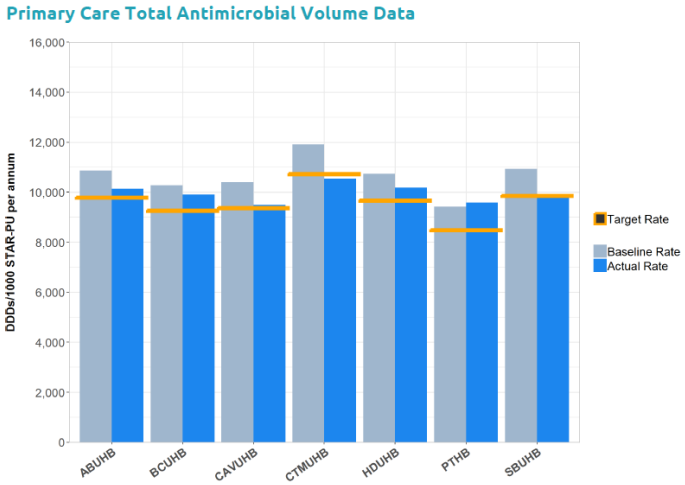


Figure 3: *Comparison of All-Wales antimicrobial prescribing rate reductions in primary care*

b. Secondary Care

From a secondary care perspective, both metrics are showing significant progress over a relatively short time frame. Figure 4 below, demonstrates the positive changes being made in secondary care with a visible reduction in total antimicrobial usage when measured in DDDs. This has now plateaued but remains one of the lowest of all the Welsh health boards. In addition, figure 5 highlights CTM as the only LHB in Wales delivering an actual prescribing rate of antimicrobials below the target rate.

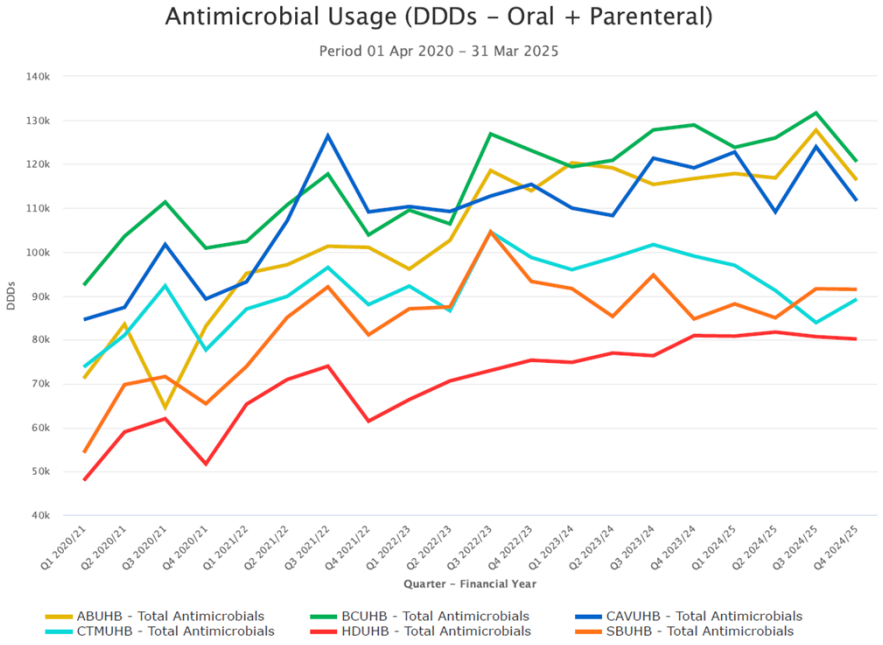


Figure 4: *Comparison of All-Wales anti-microbial prescribing rates in secondary care*

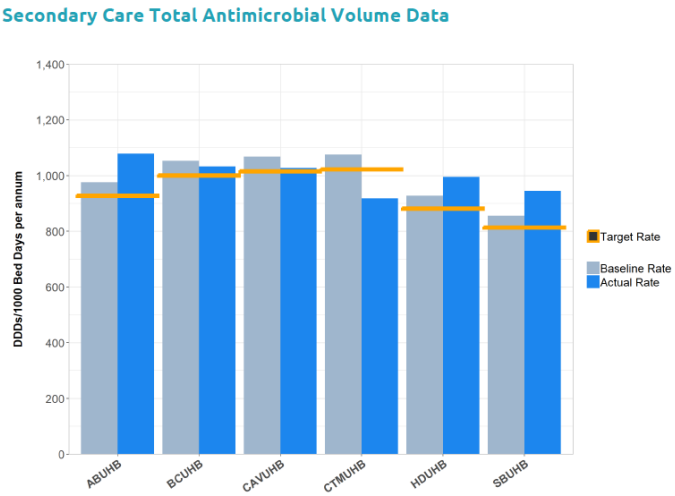


Figure 5: *Comparison of All-Wales antimicrobial prescribing rate reductions in secondary care, measured in DDDs/1000 bed days*

c. **NAP Target 4a Progress**

Improvement Goal 11a Primary Care: 10% reduction in total antimicrobial usage by 2029/30.

By the end of 2023/24 CTMUHB in Primary Care delivered an overall **11.6% reduction** in consumption against the target (baseline 2019/20) as measured in DDD /1000 STAR-PUs. CTM is **currently achieving** this target, the only Welsh health board to do so.

Improvement Goals 11b Secondary Care: 5% reduction in total antimicrobial usage by 2029/30.

By the end of 2023/24 CTMUHB in Secondary Care (acute hospital inpatient usage only) delivered an overall **14.6% reduction** in consumption against the target (baseline 2019/20) as measured in DDDs/1000 Occupied Bed Days. CTM is **currently achieving** this target, the only Welsh health board to do so.

- Royal Glamorgan – 31.8% reduction
- Prince Charles – 0.8% increase
- Princess of Wales – 9.3% reduction

d. **NAP Target 4b Progress**

Improvement Goals 12a Primary Care: 70% of total antibiotic use from the Access category**.**

Please note - Primary Care (PC) comprises all prescribing by GP in hours (GPIH), GP out of hours (GPOOH), Independent Prescribers, and the Common Ailments Service (Sore Throat and UTI schemes) dispensed in the community.

By the end of 2023/24 CTMUHB in Primary Care delivered **65.7%** antimicrobial usage from Access Category as measured in DDDs. This is a reduction from 67.0% previously reported. We are **currently NOT achieving** this target and plans are in place to address this. No Welsh LHB is currently achieving this target.

Plans include presentations to all GPs at Protected Time for Learning Events over the summer. Penicillin allergy delabelling clinics have been established in RGH and are expanding to PCH and POW which will improve patient prescribing in access categories.

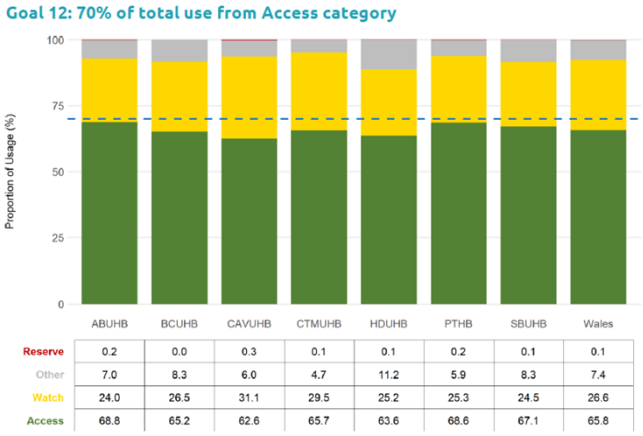


Figure 6: *Comparison of All-Wales antimicrobial access category prescribing rate in primary care. Dotted line represents the target.*

Improvement Goals 12b Secondary Care: 70% of total antibiotic use from the Access category.

By the end of 2023/24 CTMUHB in Secondary Care delivered **70.5%** antimicrobial usage from Access category as measured in DDDs. We are **currently achieving** this target.

For individual hospitals, the proportions were:

- Royal Glamorgan – 67.4%
- Prince Charles – 71.6%
- Princess of Wales – 73.7%

POW and PCH are **currently achieving** the 70% access target. An action plan is in place to further this work and target RGH.

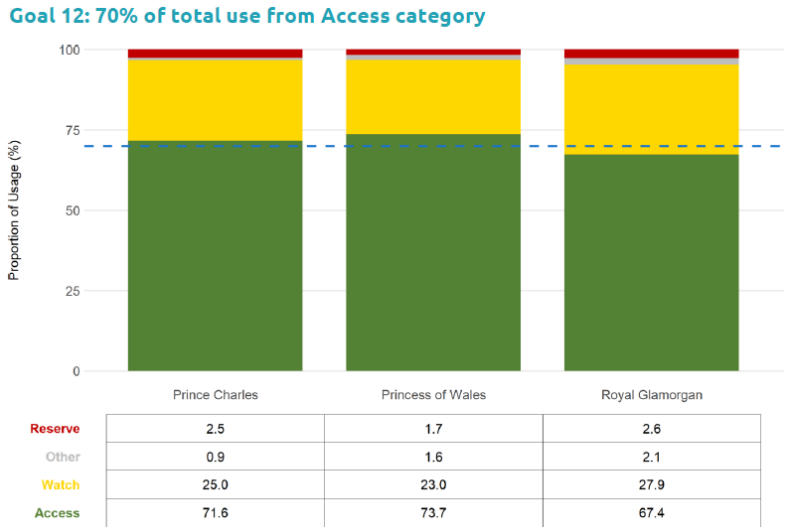


Figure 7: *Comparison of each CTM hospital site's antimicrobial access category prescribing rate in secondary care. Dotted line represents the target.*

3. Key Risks / Matters for Escalation

The Antimicrobial Stewardship Group was established in September 2024 and meet quarterly. Any actions that arise from the group are forwarded, as appropriate, to the leads of each care group and then cascaded where needed. The membership of the group is reviewed regularly, and a document was sent to the Medical Director's Meeting in October to discuss ongoing engagement with the antimicrobial stewardship agenda. Antimicrobial use crosses all care groups so all sectors are key stakeholders.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Sustaining our Future
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Growing well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below: Data to knowledge Learning, improvement & research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below:

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

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

5. Recommendation

The committee is asked to **NOTE** the progress made to date.

6. Next Steps

The CTM AMR strategy has been established with direct correlation to the National Action Plan (NAP).

A robust action plan has been generated to support the outputs of the Antimicrobial Audit completed in Secondary Care at the end of 2024 and progress will be monitored at each appropriate Antimicrobial Stewardship Meeting.

Review of the National Prescribing Indicator data indicates progress in key Antimicrobial areas and further work is planned to take place across this new financial year with particular focus on Primary Care Prescribing.

Agenda Item
8.2.8

Quality, Safety & Experience Committee

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

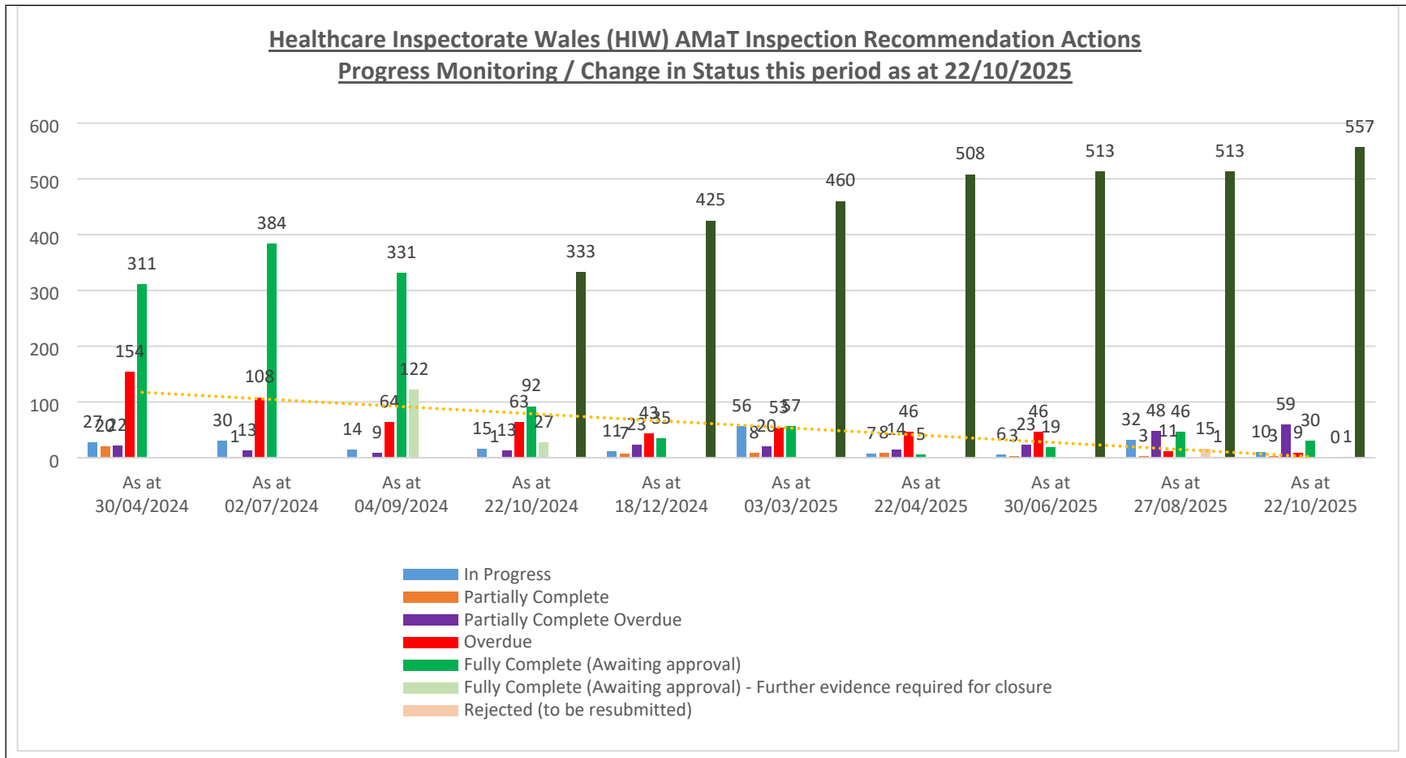
Dyddiad y Cyfarfod / Date of Meeting	18 November 2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown- Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes - Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes - Executive Nurse Director

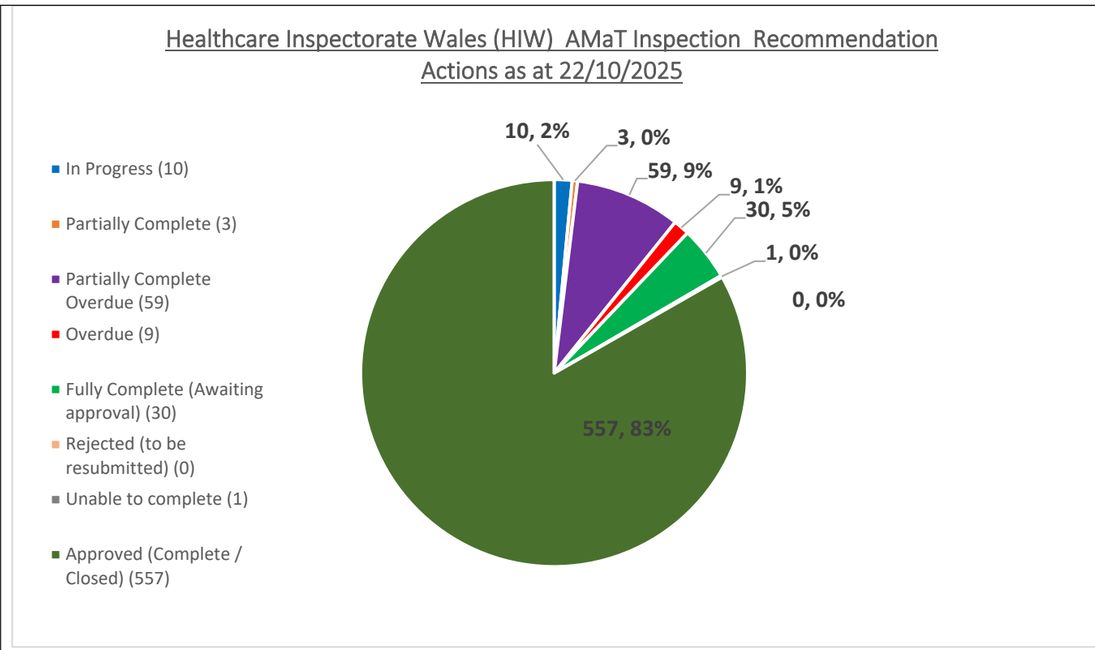
Pwrpas yr Adroddiad / Report Purpose	For Noting

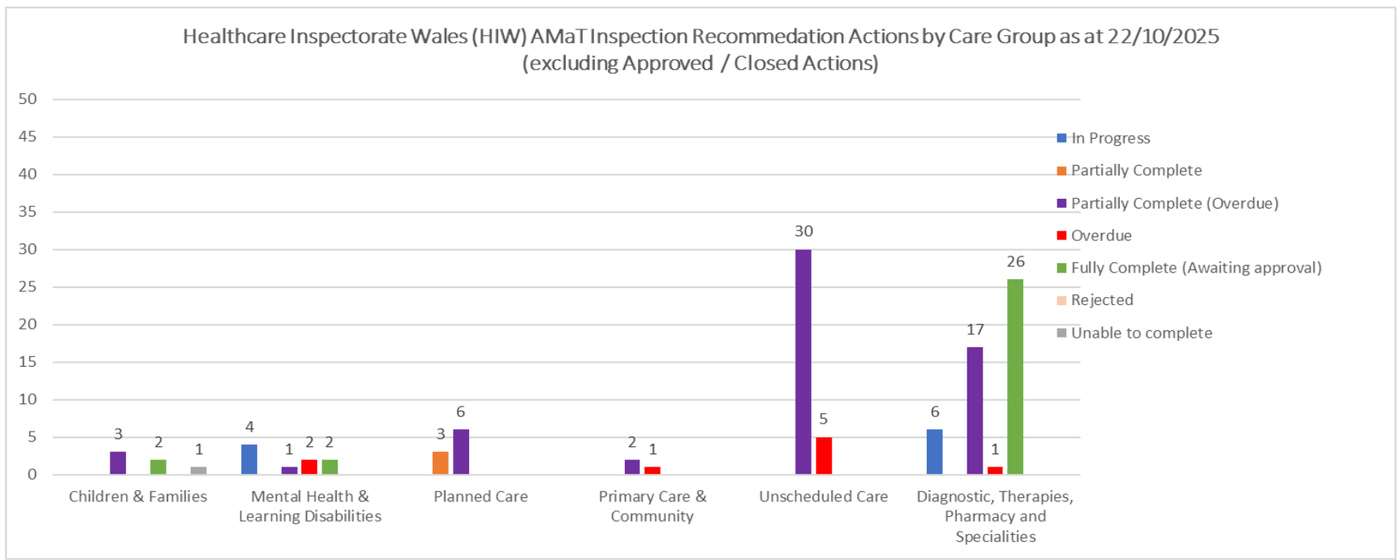
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	3 November 2025	

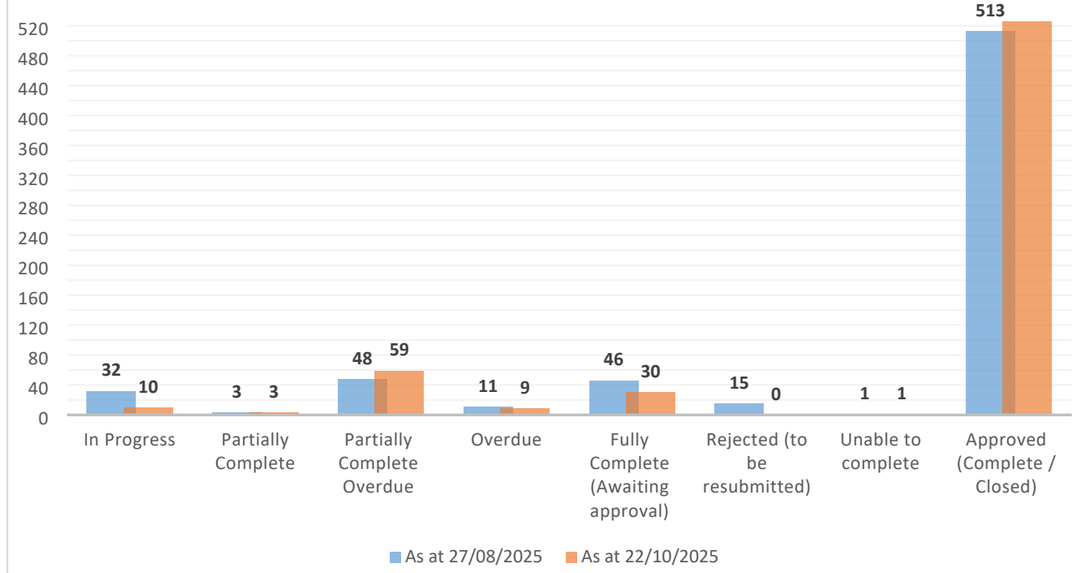
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking

Compliance Dashboard









1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker (Appendix 1) of the accepted Improvement Plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 27th August to 22nd October 2025.

1.2 This report has captured a sporadic pattern of improvement in the updates recorded with good engagement across some care groups to close down long-standing actions, however further input from some Care Groups is required to continue to update and close actions that are overdue.

2. Specific Matters for Consideration

2.1 As mentioned in previous reports, HIW inspection activity is captured via the AMaT system and therefore continues to be live. Therefore, Members will note some changes and progress on the actions which remain as open as they transition to closed/completed actions throughout this and future reports.

2.2 The Quality Assurance and Compliance team continue to work with system developers and other Health Boards in Wales to improve the tracking and management system in terms of the inspection module. The team are also liaising with other NHS England trusts to share good practice and any work arounds for the system. The team continue to raise new queries and requests in order to improve upon the effectiveness of compliance requirements within the inspection module.

2.3 Care Groups are responsible for providing regular updates on the improvement plans within their care group portfolios in order that the tracker can remain live and up to date ensuring all actions are completed in a timely manner. Reminders are sent out in advance via AMaT of reporting deadlines to encourage and request further updates from Care Groups. Further engagement continues with Executive Nurse Directors in order to gain momentum in the regular updating of actions by Care Groups.

2.4 Following on from the last report the Quality and Assurance team were able to increase engagement across some Care Groups which has shown an improved response rate in some inspection actions. The Quality and Assurance Team will continue to focus a targeted approach to those Care Groups who are less consistent in providing updates.

2.5 A breakdown of the status position with regards to all actions up to the 22nd October 2025 is detailed below. Please note that this also includes actions that were reported on in the July report but were not presented or discussed at the July meeting of the Committee.

- A total of **669 actions** are reported with a further breakdown of the stages towards compliance reported in *table 1* located in the dashboard at the beginning of this report.

- **2** Inspections were 'fully complete, approved and closed' with a further **30** actions 'fully complete and awaiting approval'.

3. New Inspections / Actions

- There were **0** new Improvement Plans and **0** actions added for this period.

3.1 Please note that Death in Custody reports and data are no longer included in this data as they are outside the scope of this process and have other monitoring and reporting arrangements in place.

4. Key Risks / Matters for Escalation

4.1 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. As described previously, where updates have not been received more than twice this has been flagged on the tracker. Care Groups are reminded that the system is a live system and will store any input until the data is collected. Therefore, regular and consistent updates are encouraged throughout each period to ensure updates are captured for each report.

4.2 The Head of Quality Assurance and Compliance and Assistant Director of Governance and Risk continue to actively offer support to Care Groups via targeted sessions at the appropriate forums, with the aim of improving both the regularity of updates and also the quality of updates provided. There has been some engagement in this activity and the team would encourage further engagement from Care Groups to work through overdue and partially complete actions.

4.3 Ongoing AMaT system developments and requests are continuing in order to deliver a system and process that is required for improved quality assurance and compliance. The system continues to necessitate a manual element in reporting and analysing of data for the purpose of the inspections module.

4.4 Due to strict reporting deadlines, any updates to actions received after the prescribed deadline for submission are noted by the Quality and Assurance Team and will be included as part of the next report.

5. Assessment

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

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

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

6. Recommendation

5.1 The Quality, Safety & Experience Committee are asked to **NOTE** the contents of this report and the activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.

7. Next Steps

6.1 The Head of Quality Assurance and Compliance will continue to work with Care Group Leads in order to provide assurance of the Health Board's engagement and compliance with HIW recommendations and Improvement Plans.

6.2 The Executive Director of Nursing will introduce HIW measures as part of the weekly Executive Nursing and Midwifery Senior Leadership Meeting for oversight whilst teams work on compliance.

HIW Inspection Recommendations Tracker
Leads as at 20/10/2025

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	22	22	**Planned Care** Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	2	2	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	17	18	**Mental Health & Learning Disabilities** Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07/03/2023	39	180	**Mental Health & Learning Disabilities** Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	2	2	**Unscheduled Care** Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	7	7	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	50	50	**Unscheduled Care** Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	31	36	**Unscheduled Care** Deborah Matthews, Nurse Director

HIW Inspection Recommendations Tracker
Leads as at 20/10/2025

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	09/01/2024	2	27	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	14	36	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13.11.2024	27	46	**Mental Health & Learning Disabilities** Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	27.01.2025	13	14	**Mental Health & Learning Disabilities** Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2025/261	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	20.05.2025	4	8	**Diagnostic, Therapies, Pharmacy and Specialities** Carl Verrecchia, Service Director
Healthcare Inspectorate Wales (HIW)/2025/264	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20.05.2025	24	59	**Diagnostic, Therapies, Pharmacy and Specialities** Carl Verrecchia, Service Director

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.
Rejected (To be resubmitted)	This Inspection action was submitted as Fully complete (Awaiting Approval) however more narrative is required to satify closure of the action and to provide assurance it has been completed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.
Unable to Complete	This action is unable to be completed.

HIW Inspections Recommendation Actions Tracker as at 20/10/2025
(for Quality, Safety and Experience Committee 18/11/2025)

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current 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.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	31.12.2025	Partially complete	October 2025 Update (14.10.25) - Roll out of open eyes is planned for March 2026 for all ophthalmic services across Wales. August 2025 Update (21/8/25) - Regional digital eye care board meeting 19/8/25. Awaiting confirmation from digital team re configuration completeness and next step of UAT. Clinical risk log needs to be completed via digital service. Funding needs to be approved post Jan 27. Local implementation meeting to be established.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD8/1	The implementation of Open Eyes will provide optometrists with access to patient information that will promote, simplify and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024	31.12.2025	Partially complete	October 2025 Update (14.10.25)- Awaiting confirmation from digital team regarding roll out of open eyes planned for March 2026. August 2025 Update (21/8/25) - Regional digital eye care board meeting 19/8/25. Awaiting confirmation from digital team re configuration completeness and next step of UAT. Clinical risk log needs to be completed via digital service. Funding needs to be approved post Jan 27. Local implementation meeting to be established.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Healthcare Inspectorate Wales (HIW)/2017/141/MD10/1	Documents and resource related to FUNB patients are shared between the business Informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PIFU Patients with appointments cancelled	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update (14.10.25) - Awaiting confirmation of health board strategy to manage the backlog of patients - PIFU and SOS pathways being agreed and implemented in accordance with CIN recommendations. these pathways will be applied retrospectively to FUNB list MM & CR August 2025 Update (21/8/25) - Health Board strategy being developed to manage patients backlog. PIFU and SOS pathways being agreed and implemented in accordance with CIN recommendations. these pathways will be applied retrospectively to FUNB list KJ 21/8/25
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Healthcare Inspectorate Wales (HIW)/2017/141/MD12/1	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A Significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	October 2025 Update (14.10.25) - Health Board strategy being developed to address and manage backlog. PIFU and SOS being implemented via CIN recommendations. These pathways will be applied retrospectively to FUNB list CR & MM 14.10.25 August 2025 Update (21/8/25) - Health Board strategy being developed to address and manage backlog. PIFU and SOS being implemented via CIN recommendations. These pathways will be applied retrospectively to FUNB list 21/8/25 KJ
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	Healthcare Inspectorate Wales (HIW)/2017/141/MD13/1	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update (14.10.25) - Health Board strategy being developed to address backlog of FUNB patients. Meetings in diary to complete all outstanding NRI's. PIFU and SOS pathways to be implemented in accordance with CIN recommendations. These will be applied retrospectively to FUNB list cr & mm 14.10.25 August 2025 Update (21/8/25) - Health Board strategy being developed to address backlog of FUNB patients. Meetings in diary to complete all outstanding NRI's. PIFU and SOS pathways to be implemented in accordance with CIN recommendations. These will be applied retrospectively to FUNB list (KJ 21/8/25)
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HIW)/2017/141/MD15/1	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CARRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete	October 2025 (14/10/25) - New optometry lead appointed who is reviewing this and in discussions with HEIW. Re placements this year qualifies for 0.5 WTE band 4. Working through with HEIW finance - waiting for confirmation of admin support for post - CR & MM 14.10.25 August 2025 Update (27/8/2025) - Recruitment unsuccessful. New optometry lead appointed who is reviewing this and in discussions with HEIW. Re placements this year qualifies for 0.5 WTE band 4. Working through with HEIW finance (KJ)
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/141/MD17/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update (27/8/25) - as of today we are still waiting WG decision re further advice / shared learning (KJ)
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	October 2025 Update (14.10.25) - No further updates to provide CR & MM 14.10.25 August 2025 Update (21/8/25) - Head of optometry appointed into and commenced 5th Aug 25 (KJ) 21/8/25
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HIW)/2017/141/MD21/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	October 2025 Update (14.10.25) - Business case submitted to make the current 3 part-time temporary optometrists substantive. CR & MM 14.10.25 August 2025 Update (21/8/25) - Head of optometry appointed and in post from 5th Aug 25 (KJ 21//8/25) Glaucoma 8a post on TRAC
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HIW)/2020/139/MD2/1	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care and Community	01.10.2020	01.10.2020	Overdue	August, October 2025 Update - No update against this recommendation action has been received on these occasions. June 2025 update - Email sent from head of Nursing to Assistant Director of Transformation requesting an update on the outstanding action. No response received currently.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MD3/1	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete (Overdue)	October 2025 Update - Unfortunate delay in this being signed off, will be brought back to November QSE for sign off. August 2025 Update - physical health monitoring meeting is being held in September, following this evidence will be presented at QSR in October meeting with a view to being sign off.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Healthcare Inspectorate Wales (HIW)/2022/131/MD1/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Unable to complete	August 2025 Update - this action is unable to be completed - this matter has been escalated to the Exec colleagues and was raised on the recent HIW inspection Aug 2025.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MD18/1	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2025 Update - It has been agreed by Head of Nursing (MHLD) and the Executive Director of AHPs and Health Science on 7th October that this action is now completed due to being at the procurement stage. The recommendation has therefore been achieved. August 2025 Update - The matrix is still in place and working effectively as the risk mitigation for the retrieval and sharing of patient information throughout MH in CTMUHB. MH Single Clinical Record - evaluation is now ¾ complete. Reference site visits to meet with other HBs who are using the digital systems has taken place with good information obtained. Financial scoring to take place by the end of August with total scoring known by middle Sept (indicative). Procurement anticipated to be complete by end of September 2025 (Indicative) Supplier will be known in Autumn 2025.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/2	Mental health policies will follow the agreed organisational process for ratification. All NH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 in date and approved 13 Expired 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" (recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Fully complete (Awaiting approval)	October 2025 Update - Head of Nursing (MHLD) and the Executive Director of AHPs and Health Science on 7th October that this action is now completed we have 66 polices in date. The recommendation has therefore been achieved. August 2025 Update - To note updates have been added from February to July 25 , current position is as follows In date – 55 Under review -5 Awaiting ratification – 4 (for OMB Sept)
Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales (HIW)/2023/134/MD2/1	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance:- ED •Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. •An 8a Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. •A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCSWs Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ILS and PILS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	October 2025 Update - Clinical decisions Unit (CDU) is now called Acute Medical Unit (AMU) - Basic Life Support (BLS) - 82% Intermediate Life Support (ILS) Registered Nurses 46% awaiting further course dates to be released Emergency Department - Basic Life Support (BLS) 81% Intermediate Life Support (ILS) 69% Advanced Life Support (ALS) 45% (Band 7 and Band 6) Emergency Paediatric Life Support (EPLS) -60% Advanced Paediatric Life Support (APLS) -29% (Band 7) awaiting further course dates to be released August 2025 update - Following targeted intervention the BLS for AMU has increased to 72% and ED compliance has increased to 74% ED Compliance for ILS has increased to 65%
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken . To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October 2025 - No update against this recommendation action has been received on these occasions. October 2024 Update - Discussion with Head of Healthcare within HMP Parc, chaser email sent to GP contractors to request update on process with implementation of recommendation.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MD7/1	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include- flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October 2025 - No update against this recommendation action has been received on these occasions. August 2024 Update - Ongoing with Pharmacy lead and GP in HMP parc.
Healthcare Inspectorate Wales (HIW)/2023/155S	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155S/MD5/1	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily Safe2Start meeting which provides assurance around site based escalation, staffing, patient safety and clinical priorities. The meeting allows the identification of clinical priorities, including stroke patients, and time frames for movement to appropriate inpatient beds. All patient flow constraints are discussed and risk is shared across the acute inpatient wards and community sites in order to balance risk within the Emergency Department. This remains an action-focused meeting, with clear ownership and delivery prior to the afternoon meeting. As part of this work, under the 6 Goals national programme, the Safe2Start template has been revised to include SAFER, Red2Green and both internal and external delay metrics. There was a delay in launching the new template due to access required into SAFECARE to display nurse staffing levels, this is being worked through by informatics colleagues with the new template expected to be completed and implemented by November 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Optimise, a programme of work under the national 6goals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Unscheduled Care	01.11.2023	01.11.2023	Partially complete (Overdue)	October 2025 Update (14th October 2025) - actions described in the overview are complete and embedded across the HB. August 2025 Update - The overarching Action Plan has supported this work whereby the below is embedded and the Senior Stroke Team undertake a formal patient review daily identifying who does not require ongoing care within the Stroke Unit and that includes discharge and transfer out internally across the HB and neighbouring HB's (formally discussed on the national call at 11:00 daily. The detail is communicated robustly to the Flow Team daily and updated accordingly to ensure Stroke capacity available.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales (HIW)/2023/155/MD6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - CTM wide review of stroke pathway ongoing including all workforce requirements. The need for dedicated pharmacy support will be included in this service review.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD8/1	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cymru. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS Exec colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our speciality demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - The Stroke Unit for CTM has been relocated to the RGH since January 2025 and this work is ongoing due to the change of service. The review to date has identified that the demand for CTM is supported more efficiently from the RGH. There is ongoing regional stroke work where this is currently being worked through.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	Healthcare Inspectorate Wales (HIW)/2023/155/MD9/1	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - the introduction of SDEC, STAMP, Surgical and Trauma Assessment Units that has supported the concerns identified. These are now established at RGH but review of surgical, medical and trauma pathways will be reviewed post critical incident to confirm whether these units are fully formalised.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD10/1	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within work stream 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams having direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon Safe2Start site based meeting. This piece of work is Optimise and focuses of value added care. This work is ongoing and is large scale transformation with a detailed project plan and times lines for implementation that are monitored via 6goals Board.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - SAFER, Red2Green and right patient, right time now embedded in daily practice and implemented across wards. Lead Nurse for Optimise in post to support patient flows across the Health Board.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Healthcare Inspectorate Wales (HIW)/2023/155/MD11/1	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD12/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - E-triage not currently in place in CTM. OCP now complete. Awaiting update from Service Manager, Emergency & Acute Medicine to confirm FAST training programme for clerical staff.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Healthcare Inspectorate Wales (HIW)/2023/155/MD13/1	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Stroke Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and query arriving at our emergency departments. In addition, we are currently reviewing our nurse specialist provision in order to create capacity to better support the early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - collaborative work with WAST continues, specifically following temporary consolidation of inpatient stroke services at Royal Glamorgan Hospital. WAST colleagues included in Stroke Programme Board / Stroke Operational Group. CNS workforce included within the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD14/1	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 update - This action remains ongoing. Stroke inpatient services currently centralised at Royal Glamorgan Hospital. Stroke Service Redesign programme reviewing the full stroke pathway, including community / rehabilitation provision with bed modelling and workforce review to ensure that flow through the pathway is not blocked.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented '*why not*' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Awaiting update from Clinical Director, Emergency Medicine re internal ED mitigations. Triage times and numbers of patients awaiting triage are noted on 3x daily HB conference calls. E-triage not currently implemented in any Health Board Emergency Departments.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Review of stroke clinical workforce is included in the Stroke Service Redesign programme. Stroke services currently centralised at Royal Glamorgan Hospital with clinical teams combined to support one Acute Stroke Unit. New stroke consultant recently appointed and will start January 2026. CNS workforce also centralised at Royal Glamorgan Hospital to support emergency presentations and ward patients. The 3 CTM Emergency Departments continue to provide emergency stroke care. Stroke teaching is included in induction programmes for ED resident doctors.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 - Stroke Services currently centralised at the Royal Glamorgan Hospital. CNS Stroke Workforce currently centralised too. CNS workforce being reviewed as part of the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - remains ongoing with digital team as per August 24 update.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HIW)/2023/155/MD19/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - awaiting update from Clinical Director, Emergency Medicine
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - awaiting update from Clinical Director, Emergency Medicine.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD22/1	The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Time to CT Scan KPI is now 20 minutes. Performance against this KPI is reported via Stroke Operational Group to Stroke Performance Board. Current improvement programme in progress to identify any delays to scan and process map patient journey to CT scan with involvement of all key stakeholders.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD25/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Thrombolysis guideline has been updated nationally to 30 minutes (following CT scan within 20 minutes). Performance against this target is monitored monthly and reported via Stroke Operational Group to Stroke Programme Board. Current improvement work reviewing this key metric with all key stakeholders engaged.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Work continues to improve 4 hour performance. Stroke inpatient services are currently centralised at Royal Glamorgan Hospital and improvement work ongoing to support improvement in 4 hour performance with process mapping and key stakeholder involvement. Dedicated ambulance transfer vehicle commissioned for clinical transfers from PCH / POW to RGH to support transfer for emergency patients to Royal Glamorgan Hospital. 4 hour performance measured and reported at Stroke Operational Board and Stroke Programme Board. 4 hour performance included within Stroke Service Redesign programme as KPI for acute patient pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Inpatient stroke services currently centralised at Royal Glamorgan Hospital. Agreement that confirmed strokes only will be admitted to the Acute Stroke Unit to prevent medical outliers occupying stroke capacity. Daily aim to ensure ringfenced stroke bed to support flow and stroke pathway. Stroke demand on all three sites discussed at Safe to Start meetings twice daily and at HB conference calls. Ring fenced beds and ASU capacity continues to form part of the out of hours and weekend planning cycle of the HB.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD31/1	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Following the temporary relocation of stroke services the therapy workforce has been reviewed and an investment proposal has been submitted as part of the IMTP process, the outcome of which is awaiting. This is linked to recommendation 38 regarding the need for funded 7 day service.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - due to critical incident and urgent service move, Stroke Services now currently centralised at Royal Glamorgan Hospital. There is currently no psychology support for stroke patients across the Health Board. The lack of psychology support is noted on the corporate risk register (risk ID 4632). 0.6 wte Neuropsychology post currently advertised. This will support stroke services. The need for psychology support will be included in the workforce review as part of the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - CTM UHB continues to offer a 5 day clinical model. The Health Board aim is to provide a 7 day clinical model to support patient outcome and experience. Workforce requirements to support this are being identified as part of the Stroke Service Redesign programme and will require investment as the current workforce is unable to support 7 day working.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Inpatient acute stroke services currently centralised at Royal Glamorgan Hospital. Dedicated therapy bay established within the Acute Stroke Unit for use by all therapists. Community hospital provision - 8 funded stroke specific rehabilitation beds at Ysbyty Cwm Rhondda (ability within current workforce to flex up to 14 patients if required). Stroke Service Redesign programme reviewing workforce model and optimum patient pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the D2RA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 - No update against this recommendation action has been received on this occasion. August 2025 Update - awaiting update from Primary & Community Care Group DM
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - awaiting update from Primary & Community DM
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD41/1	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - awaiting update from Primary & Community DM

HIW Inspections Recommendation Actions Tracker as at 20/10/2025
(for Quality, Safety and Experience Committee 18/11/2025)

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD42/1	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD44/1	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update - Patient discharge manually updated on whiteboards by ward staff. Currently no progress with 'push report' functionality.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	Overdue	October 2025 Update - capital work is still ongoing and PCH major construction works are continuing. Welsh Government funding continues to be explored, which will facilitate improved patient clinical areas allowing for improved patient and staff experience. June 2025 update - capital work is still ongoing and PCH major construction works are continuing. Welsh Government funding continues to be explored, which will facilitate improved patient clinical areas allowing for improved patient and staff experience.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/6	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2025 -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 has been implemented. This reinforces that patient flow is a team approach across the site. The plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area are ongoing. Capital environmental works remain ongoing across the site. June 2025 Update - 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 has been implemented. This reinforces that patient flow is a team approach across the site. The plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area are ongoing. Capital environmental works remain ongoing across the site.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/7	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	Overdue	October 2025 Update - no change to action -part of ongoing capital plans. We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety. June 2025 Update - part of ongoing capital plans - We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DoLS (CDU) training.	Healthcare Inspectorate Wales (HIW)/2023/167/MD29/1	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug'23 fire training for staff is as follows:- ED-RN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2025 Update - ED Fire Training Compliance Registered Nurses - Department Training - RNs 94% and HCSWs 90% Classroom Training - RNs 90% and HCSWs 88% CDU (now AMU) Fire Training Compliance - RNs 100% and HCSWs 100% July 2025 Update - ED Fire Training Compliance Registered Nurses - 75.6% Health Care Support Workers -69.0% CDU (now AMU) Fire Training Compliance Registered - Registered Nurses - 92% Health Care Support Workers - 96%
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD30/1	Monthly mandatory training study days and reports now include V & A, DoLs, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration-action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2025 Update - Violence and aggression training compliance AMU - (Module A ESR) - RN - 100% HCSW - 100%, Module B Classroom - RN 16% Has -10% Awaiting training dates from Violence and Aggression Training Teams Violence and aggression training compliance ED RN - 75% HCSW - 84%% MCA training compliance AMU RN - 59% HCSW - 87% Awaiting training dates from Training Teams MCA training compliance ED - RN - 48% HCSW - 80% Safeguarding training compliance AMU (Adult) - RNs -100% HCSWs -96% (children) RN -100% HCSWs - 89% Safeguarding training compliance ED (Adult) - RNs - 80% HCSWs -92 % (children) RN - 94% HCSWs - 89% July 2025 Update - Violence and aggression training compliance CDU (now named AMU) Registered Nurses - 9.0% Health care Support Workers - 0.0% Awaiting training dates from Violence and Aggression Training Teams Violence and aggression training compliance ED Registered Nurses - 75% Health Care Support workers - 76% MCA training compliance AMU Registered Nurses - 57% Health Care Support Workers - 92.5% MCA training compliance ED - Registered Nurses -57% Health Care Support workers - 92.5% Safeguarding training compliance AMU (Adult) Registered Nurses 52.7% Health Care Support Workers 100% (Children) Registered Nurses 96% Health Care Support Workers 93% Safeguarding training compliance ED (Adult) Registered Nurses 77% Health Care Support Workers 77% (Children) Registered Nurses 91% Health Care Support Workers 85%
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/7	g)Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024	01.02.2024	Fully complete (Awaiting approval)	September 2025 verbal Update - Recently recruited a Birthrate plus midwife to commission a review of midwifery acuity and workforce requirements. Expecting a draft report in Autumn.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/10	j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Fully complete (Awaiting approval)	September 2025 verbal Update - Through Streamlining events we have successfully recruited our commissioned streamlining places. Attracted students from Cardiff University as well as Swansea University. Another Cohort of midwives due to qualify in March 2026 and we are fully engaged in recruiting via Streamlining.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	June, August, October 2025 Update - No update against this recommendation action has been received on these occasions. March 2025 Update - Meetings planned to revisit this work for PCH and PoW in March 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits of attracting staff to CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	June, August, October 2025 Update - No update against this recommendation action has been received on these occasions. March 2025 Update - Mat-Neo services in PoW has now re-opened - Will revisit this work , contact made with recruitment to meet in April 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	June, August, October 2025 Update - No update against this recommendation action has been received on these occasions. March 2025 - There have been challenges with attendance in Safe to Start meetings during the PoW temp closure due to the acuity and timing of the sessions which clash with handover and essential safety briefings in maternity. this will be revisited in a meeting arranged for 25th 2025, Senior on-call midwifery managers attend daily and weekend site escalation meetings.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	5. The health board must develop a policy in line with best practice guidelines that ensures the safety, privacy, dignity and rights of patients can be maintained throughout the mixed gender wards as well as keeping patients of the same gender safe in dormitories.	Healthcare Inspectorate Wales (HIW)/2024/235/MD5/2	The Health Board has developed a Single Sex accommodation policy. The draft version is currently going through the Health Board's ratification process.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Overdue	October 2025 Update - continue to be working towards the completion date of 31st October , being presented at OMB next month. August 2025 - revised date for completion is now 31st October 2025.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	7. The health board must develop a policy to provide guidance to staff regarding patients' use of electronic equipment, mobile phone devices and access to the internet.	Healthcare Inspectorate Wales (HIW)/2024/235/MD7/1	There is an all Wales Social Media Policy and a Health Board policy that supports use of mobile phones within hospital settings. Both policies are out of date. A request has been made to update the Health Boards policy.	Mental Health & Learning Disabilities	30.06.2025	30.06.2025	Overdue	October 2025 - continuing to be working towards completion date 31st October.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	9. The health board must ensure that a mental health pharmacist is allocated to the ward to support staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD9/1	Pharmacy provision to form part of the wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. The mitigation includes; Ysbyty Cwm Cynon pharmacy teams screen medication charts and supply medication to the wards and the Principle Pharmacist for Mental Health supports the ward on an ad hoc basic with reviewing medication incidences.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	August, October 2025 Update - No update against this recommendation action has been received on these occasions. June 25 - Pharmacy provision to form part of the wider strategic programme on Older Adult inpatient redesign work. estimated 31/12/25
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	11. The health board must ensure that a dietician is allocated to the ward to support staff and meet the needs of the patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD11/1	Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. Mitigation includes; all patients have a risk assessment which determines the level of risk. There is a scoring mechanism in place from 0-7+ based on nutritional risk. If the score is 7+ then the patient requires referral to Dietetic service. In this scenario the Advanced Nurse Practitioner (ANP) or Doctor also prescribe supplements, advise on diet plan and nursing staff would complete weekly weights.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	August, October 2025 Update - No update against this recommendation action has been received on these occasions. June 25 Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. Estimated 31/12/25
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	12. The health board must ensure that policies are reviewed to ensure they are current.	Healthcare Inspectorate Wales (HIW)/2025/241/MD12/1	The policies identified within the inspection that were; Mental Health policies • Management of violence and behaviours that challenge, no review date (this has been completed) Corporate / Health Board policies • Health and safety policy, review date August 2024 • Consent to examination or treatment, review May 2024 • Policy for safe support and supervision of patients, review date October 2018 • PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents, however, at appropriate intervals there will be engagement with the Assistant Medical Director Quality & Clinical Effectiveness, who leads on Clinical Written Control Documents to ensure consistency and flow. Project Objectives: 1. To establish a baseline compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. 4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents. To review the "Policy on Policies" and develop a simplified document supported with clear process maps.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	August, October 2025 Update - No update against this recommendation action has been received on these occasions. June 25 The policies identified within the inspection that were; Mental Health policies •Management of violence and behaviours that challenge, no review date (this has been completed) Corporate / Health Board policies •Health and safety policy, review date August 2024 •Consent to examination or treatment, review May 2024 •Policy for safe support and supervision of patients, review date October 2018 •PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents estimated 31/12/25
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	13. The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HIW)/2025/241/MD13/1	It has been agreed that a priority for the Older Adult Mental Health Directorate is to complete a pan CTM inpatient redesign review which will scope a widespread multi-disciplinary establishment review.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	August, October 2025 Update - No update against this recommendation action has been received on these occasions. June 2025 Update - Estimated completion 31/12/25

HIW Inspections Recommendation Actions Tracker as at 20/10/2025
(for Quality, Safety and Experience Committee 18/11/2025)

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/3	CTM DRL group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRLs. The DRL group will feed into CTM image optimisation team and radiation safety committee.	Diagnostic, Therapies, Pharmacy and Specialities	05.06.2025	05.06.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update (20/08/2025) - Meeting scheduled for 22/7/2025 cancelled. Date of next meeting to be held in September (Date TBC)
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	1. The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Healthcare Inspectorate Wales (HIW)/2025/264/MD1/2	Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Partially complete (Overdue)	October 2025 Update - To be ratified in Radiation Safety Committee Friday October 24th.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	1. The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Healthcare Inspectorate Wales (HIW)/2025/264/MD1/3	All amended EPs will be shared and acknowledgement of changes required and recorded. Amended EPs will be added to CTMUHB SharePoint.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	October 2025 Update - Will be added to SharePoint following ratification of document at Radiation Safety Committee 24th October.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	2. The employer must ensure that training and competency is evidenced prior to duty holder entitlement.	Healthcare Inspectorate Wales (HIW)/2025/264/MD2/1	Review existing practitioner and operator duty holders training and competency evidence. Ensure that practitioner and operator training and competency prior to entitlement is assessed for specific tasks e.g. Cardiologists practitioner training to justify imaging in theatre. Duty holder competency will be assessed by ongoing referral form audit i.e. accurate completion of request form; signature, adequate clinical information, date.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	October 2025 Update - Documentation ready for sign off, awaiting training records as evidence.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	3. The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	Healthcare Inspectorate Wales (HIW)/2025/264/MD3/2	Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Partially complete (Overdue)	October 2025 Update - To be ratified in Radiation Safety Committee Friday October 24th.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	3. The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	Healthcare Inspectorate Wales (HIW)/2025/264/MD3/3	All amended EPs will be shared and acknowledgement of changes required and recorded. Amended EPs will be added to CTMUHB SharePoint.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	October 2025 Update - To be added to SharePoint following ratification at Radiation Safety Committee 24th October.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/1	PACs team to generate a list of individual external referrers with GMC numbers. Scoping work to commence internally and nationally re: practicable ways to issue entitlement to external referrers.	Diagnostic, Therapies, Pharmacy and Specialities	11.08.2025	11.08.2025	Fully complete (Awaiting approval)	October 2025 Update - Change of strategy - CEOs in other health boards entitled by CEO.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/2	CTMHUB employer's procedures will be available via the intranet to employers/referrers outside CTMUHB.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Partially complete (Overdue)	October 2025 Update - PowerPoint sent to Web development for Radiology site to be added to CTMUHB internet page. Documents will then be added.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/3	Entitlement will be issued to external referrers in other health boards via email to indicate their duty holder roles and responsibilities, information on how to access referral guidelines, and how to make/amend/ cancel a referral.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Partially complete (Overdue)	October 2025 Update - Documentation to be ratified October 24th in radiation safety committee.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/4	CTMUHB is leading a benchmarking exercise to understand the approaches in place across Wales. Discussion and escalation at national groups, with a view to developing an agreed All Wales approach.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Fully complete (Awaiting approval)	October 2025 Update - Discussed at All Wales Quality forum and Professional head group.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/5	Entitlement of external referrers will be an agenda item at the following groups: The All-Wales Imaging Quality Forum	Diagnostic, Therapies, Pharmacy and Specialities	03.09.2025	03.09.2025	Fully complete (Awaiting approval)	October 2025 Update - Discussed in September 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/6	Entitlement of external referrers will be an agenda item at the following groups: Radiography Professional Heads Group	Diagnostic, Therapies, Pharmacy and Specialities	13.08.2025	13.08.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	6. The employer must ensure that the non-medical referrers who were clinically evaluating are appropriately entitled and that the entitlement is supported by relevant training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD6/2	Scope of practice for clinical evaluation and entitlement by Radiology CD will be sent to existing NMRs on receipt of evidence of training and competency. Policy for NMRs will be updated to include entitlement for clinical evaluation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	October 2025 Update - Scope of practice sent. NMR policy to be updated.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/2	Retrospective audit of CT forms justified by a Radiographer to ensure exposures have been justified appropriately.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Partially complete (Overdue)	October 2025 Update - Discussion required as to audit approach.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/3	To be discussed at CT modality user group meeting, pan-CTM to clarify justification or authorisation process for Radiographers.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	October 2025 Update - CTMUHB CT user group to meet November 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/4	If authorisation as an operator is agreed, guidelines will be issued by an individually named practitioner.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	In progress	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	8. The employer must ensure that individuals outside radiology performing practitioner and operator tasks are appropriately entitled. The entitlement should be underpinned with the appropriate training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD8/1	Review duty holder entitlement outside of Radiology. Identify any gaps and entitle, where appropriate, following confirmation of training and competency.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	October 2025 Update - Documentation complete, awaiting evidence of training before entitlement sign off.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	12. The employer must ensure that: • All AMaT forms are completed fully to support robust audit • The clinical audit schedule includes the list of all scheduled audits, timeframes and frequency of audit and the individuals responsible for performing the audit and ensuring findings are actioned.	Healthcare Inspectorate Wales (HIW)/2025/264/MD12/1	Meet with clinical audit team, and radiology audit leads to ensure that all audits are registered on AMaT, and all documentation is complete. Ensure clinical audit schedule is updated to include timeframes, frequency of audit and responsible person for carrying out audit.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	In progress	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/1	Review of observational and referral form compliance audit.	Diagnostic, Therapies, Pharmacy and Specialities	31.05.2025	31.05.2025	Fully complete (Awaiting approval)	October 2025 Update - Compliance targets have been set at 100%, action plans have been developed and a TEAMs channel created. Audit frequency has been changed from annual to bimonthly. Clinical evaluation audit outside Radiology has been added to IRMER audit schedule, and first one completed September 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/2	Target for compliance set to 100%.	Diagnostic, Therapies, Pharmacy and Specialities	14.07.2025	14.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Compliance targets have been set at 100%, action plans have been developed and a TEAMs channel created. Audit frequency has been changed from annual to bimonthly. Clinical evaluation audit outside Radiology has been added to IRMER audit schedule, and first one completed September 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/3	Observation and referral form audit will be added to AMaT system to ensure action plans in place, robust analysis and re-audit in an appropriate time frame.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	In progress	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/4	Clinical evaluation audit outside Radiology to be added to IR(ME)R schedule i.e., evidence of clinical evaluation documented within patient notes.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	October 2025 Update - Completed September 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/5	Audit frequency changed from annual to every 2 months. Reaudit of areas that fall below 100% will take place as required.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Fully complete (Awaiting approval)	October 2025 - Compliance targets have been set at 100%, action plans have been developed and a TEAMs channel created. Audit frequency has been changed from annual to bimonthly. Clinical evaluation audit outside Radiology has been added to IRMER audit schedule, and first one completed September 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	15. The employer must review the gaps in the QC records and the inconsistencies in baselines between the policy and manufacturer recommendations.	Healthcare Inspectorate Wales (HIW)/2025/264/MD15/2	Meeting with MPEs to review baselines and manufacturer recommendations. Will review policy and amend.	Diagnostic, Therapies, Pharmacy and Specialities	29.07.2025	29.07.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	16. The employer must ensure that the process to ensure that training records and the review of entitlement are checked at suitable intervals and evidenced appropriately.	Healthcare Inspectorate Wales (HIW)/2025/264/MD16/1	All training records and entitlement will be reviewed at personal development reviews. All staff that perform PDR's will be reminded.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Partially complete (Overdue)	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	17. The employer must ensure clinical evaluations performed by individuals outside radiology are audited on a regular basis.	Healthcare Inspectorate Wales (HIW)/2025/264/MD17/1	Audit of orthopaedic follow up referrals to be implemented. IR(ME)R audit schedule updated to include frequency.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	October 2025 Update - Audit completed September 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	18. The employer must ensure that staff are reminded of the intellectual task of justification and exposure and how this differs to authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD18/1	CPD session to be delivered on changes to employers procedures to include the difference between justification and authorisation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Overdue	October 2025 Update - To be scheduled.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&CQS – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/1	Putting things right leaflets will be available in Welsh.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Fully complete (Awaiting approval)	October 2025 Update - Welsh version sent to site leads.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&CQS – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/2	Patient experience champions have been appointed on each site to support gathering of feedback.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Each site as an appointed patient experience champion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&CQS – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/3	Feedback Friday to be implemented i.e., staff will actively ask patients to give feedback. Once feedback has been gathered 'you said, we did' board will be displayed.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Partially complete (Overdue)	October 2025 Update - Champions appointed - further engagement with front of house staff required.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20. The department must continue to highlight the business case to the employer and ensure that a decision is made in a timely manner.	Healthcare Inspectorate Wales (HIW)/2025/264/MD20/1	A case has been submitted for additional radiography staff that supports the future workforce model and demand as part of the IMTP investment priorities for 2025-26 across the sites. This will continue to remain the priority for Radiology. To date, no source of funding has been identified. Additional staff have been rostered out of hours at RGH temporarily while services from POW are temporarily relocated.	Diagnostic, Therapies, Pharmacy and Specialities	30.04.2026	30.04.2026	In progress	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	21. The health board is to inform HIW of the actions taken to increase this percentage compliance.	Healthcare Inspectorate Wales (HIW)/2025/264/MD21/1	Action plan developed to support timely appraisals. Dates are pre-planned. There is a process for escalation should the expected date not be met.	Diagnostic, Therapies, Pharmacy and Specialities	31.12.2025	31.12.2025	In progress	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	21. The health board is to inform HIW of the actions taken to increase this percentage compliance.	Healthcare Inspectorate Wales (HIW)/2025/264/MD21/2	Plan to have documented 1:1 interim meeting every three months to support staff with ongoing objectives and wellbeing.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	October 2025 Update - Plans is place as part on annual PDR process - 3 monthly check ins to follow up.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	21. The health board is to inform HIW of the actions taken to increase this percentage compliance.	Healthcare Inspectorate Wales (HIW)/2025/264/MD21/3	Quarterly modality/staff user groups re-established to support peer discussion around performance and development.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - First meetings have taken place to re-establish user groups - minutes available.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/1	There are processes in place to address the negative responses and concerns, including staffing. There are already reports of staff confirming that morale in the department is much improved during staff survey face to face discussions. Regular band 7 meetings and information sharing with the 8a site superintendent is contributing to staff feeling more positive. CTMUHB has appointed a Professional Head of Radiography in 2025 who has oversight of each Radiology department and is leading this work. A review of staffing and activity and demand is also underway on all sites to ensure equity and safe working practices.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Fully complete (Awaiting approval)	October 2025 - Staff survey roadshows allowing staff to speak up. Band 7 and 8 meetings established. Professional Head in post staffing reviewed.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/2	Staff training In CT have been assigned a mentor and the health board are supporting CT staff to attend external CT training courses to further enhance skills.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Mentors in place- one member of staff signed off, next trainee has started training. External CT course added by staff October 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/3	Radiology has a newly appointed Quality manager in the team who is actively working with the national QSI improvement partner There is investment from the health board to promote and support this work.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Quality Manager in post. Access to QSI hub has been procured.

HIW Inspections Recommendation Actions Tracker as at 20/10/2025
(for Quality, Safety and Experience Committee 18/11/2025)

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/4	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Re-establishment of modality user groups – promote team communication.	Diagnostic, Therapies, Pharmacy and Specialities	30.06.2025	30.06.2025	Fully complete (Awaiting approval)	October 2025 Update - Quarterly modality user groups re-established.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/5	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Leadership team development (AFFINA questionnaire and development days)	Diagnostic, Therapies, Pharmacy and Specialities	30.07.2025	30.07.2025	Fully complete (Awaiting approval)	October 2025 Update - AFFINA questionnaire complete - staff have met to share ideas. Site specific feedback given to site leads to share with modality leads.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/6	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Staff Newsletter	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Quarterly staff newsletter established.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/7	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Pilot of patient safety huddles: share staffing levels, equipment issues, site concerns – opportunity for staff to voice concerns and feel involved and valued.	Diagnostic, Therapies, Pharmacy and Specialities	30.06.2025	30.06.2025	Fully complete (Awaiting approval)	October 2025 Update - Patient/staff safety huddles established on all sites.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/8	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Patient experience champions on all sites established.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	October 2025 Update - Patient experience champions named on all sites
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/9	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Wellbeing champions to be established.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Partially complete (Overdue)	October 2025 Update - Scoped well being champion role - staff to be appointed.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/10	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Radiology staff survey roadshow days at all sites. To discuss staff survey themes and listen to areas of concern and ideas for improvement.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Roadshows on all sites complete. Staff survey 'you said we did together' posters displayed on all sites.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/11	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Preceptorship programme to be developed for Band 7 team leaders.	Diagnostic, Therapies, Pharmacy and Specialities	31.12.2025	31.12.2025	In progress	October 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/12	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Head of Radiography to meet monthly with the Site 8a Superintendents. Communication to be cascaded down to the teams and staff to escalate concerns and suggestions up.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Band 8a and Band 7 meeting established on all sites.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/13	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Senior managers have developed a weekly roster across all sites to improve visibility.	Diagnostic, Therapies, Pharmacy and Specialities	31.05.2025	31.05.2025	Fully complete (Awaiting approval)	October 2025 Update - Senior managers rotate across CTMUHB to improve visibility - weekly roster available.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	23. The health board must ensure that all staff receive duty of candour training.	Healthcare Inspectorate Wales (HIW)/2025/264/MD23/1	Source appropriate duty of candour training for staff i.e., e-learning	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	October 2025 Update - ESR training available and will be discussed at PDR.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	24. The health board is to inform HIW of the actions they will take to ensure all patients have equal and fair access to the right health care at the right time, without fear of discrimination.	Healthcare Inspectorate Wales (HIW)/2025/264/MD24/1	All patients will be treated fairly and in turn in CTMUHB – staff are trained to recognise patients' individual needs and to be always responsive. Staff meetings and PDRs will provide opportunities to remind staff to be alert and sensitive to each service users' needs when they are visiting this service.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - Mandatory training regarding individual patient characteristics will be promoted via the staff newsletter and PDRS.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	24. The health board is to inform HIW of the actions they will take to ensure all patients have equal and fair access to the right health care at the right time, without fear of discrimination.	Healthcare Inspectorate Wales (HIW)/2025/264/MD24/2	The Health board is actively looking at innovative ways to ensure all patients can access the right healthcare at the right time regardless of any protected characteristic. We will ensure all staff complete mandatory training modules by assigning a module of the month.	Diagnostic, Therapies, Pharmacy and Specialities	30.06.2025	30.06.2025	Fully complete (Awaiting approval)	October 2025 Update - Mandatory training regarding individual patient characteristics will be promoted via the staff newsletter and PDRS.