Quality, Safety & Experience Committee

Tue 21 January 2025, 09:30 - 12:30

Virtually via Microsoft Teams

Agenda

09:30 - 09:35
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Independent Member/Committee Chair*

09:35 - 09:40
5 min

2. CONSENT AGENDA BUSINESS

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

09:40 - 09:45
5 min

3. COMMITTEE GOVERNANCE ARRANGEMENTS

3.1. Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

3.1 QSEC Action Log 21 January 2025.pdf (5 pages)

3.2. Matters Arising not contained within the Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

09:45 - 09:50
5 min

4. STAFF AND SERVICE USER EXPERIENCE

4.1. Shared Listening & Learning Story

This item was discussed at the In Committee Session

09:50 - 11:20
90 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Thematic Spotlight Presentation - WAST joint investigation framework thematic review

Discussion *Nigel Downes, Assistant Director of Quality & Safety & Lisa Jenkins, Clinical Lead, Serious Incidents &*

Complex Concerns

5.1 WAST Thematic Review QSEC 21 January 2025.pdf (7 pages)

5.2. Report from the Clinical Executives

Discussion *Clinical Executives*

5.2 Clinical Executive Directors Report QSEC 21 January 2025.pdf (17 pages)

5.3. Care Group Highlight Reports

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

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

5.3a Highlight Report from the Children Families Care Group QSEC 21 January 2025.pdf (8 pages)
5.3a Appendix 1 Maternity & Neonatal Metrics December 2024 QSEC 21 January 2025.pdf (14 pages)
5.3b Highlight Report USC QSEC 21 January 2025.pdf (9 pages)
5.3c Planned Care Highlight Report QSEC 21 January 2025.pdf (7 pages)
5.3d MHLD Highlight Report QSC 21 January 2025.pdf (9 pages)
5.3e PCC highlight report QSC 21 January 2025.pdf (11 pages)
5.3f DTPS Highlight Report QSEC 21 January 2025.pdf (16 pages)

5.4. Stroke Services Update

Discussion *Gethin Hughes, Chief Operating Officer*

5.4a Stroke Services Update 21 January 2025.pdf (10 pages)
5.4b Stroke Services Update - Presentation 21 January 2025.pdf (7 pages)

11:20 - 11:35
15 min

6. DELIVERING OUR PLAN

6.1. Quality Dashboard Report

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

6.1a Patient Safety Quality Dashboard Report QSEC 21 January 2025.pdf (13 pages)
6.1b Appendix A-PE report Oct Nov 24 QSEC 21 January 2025 - Final.pdf (9 pages)

11:35 - 12:15
40 min

7. GOVERNANCE, RISK AND ASSURANCE

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

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

7.1 Org RR Cover Report - QSEC Jan 25.docx (7 pages)
7.1b Appendix 1 - Org RR - January 2025 Iteration - QSEC.xlsx (6 pages)

7.2. Mortality Indicators and Mortality Reviews

Discussion *Dom Hurford, Executive Medical Director*

7.2 Mortality Reviews and Mortality Indicators QSEC 21 January 2025.pdf (8 pages)

7.3. Safeguarding Strategy 2024-2027

Discussion *Claire O'Keefe, Head of Safeguarding*

7.3a Safeguarding Strategy Cover Paper QSEC 21 January 2025.pdf (4 pages)
7.3b Safeguarding Strategy 2024-2027 QSEC 21 January 2025.pdf (9 pages)

7.4. Pressure Ulcer Prevalence Audit 2024

Discussion *Susan Reed – Tissue Viability Specialist Nurse*

7.4 Pressure Ulcer prevelance audit 2024 QSEC 21 January 2025.pdf (4 pages)
7.4b CTMUHB 2024 Clinical Prevalence Presentation CONDENSED.pdf (5 pages)

12:15 - 12:20
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the Meeting held on 19 November 2024

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

8.1.1 Unconfirmed Minutes Quality and Safety Committee 19 November 2024.pdf (16 pages)

8.1.2. Unconfirmed In Committee Minutes of the meeting held on 19 November 2024

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

8.1.2 Unconfirmed In Committee Minutes Quality Safety Committee 19 November 2024.pdf (2 pages)

8.1.3. CTM Learning Academy

Decision *Janet Gilbertson, Assistant Director Clinical Education*

8.1.3a CTM Learning Academy QSEC 21 January 2025.pdf (5 pages)
8.1.3b Presentation launch of CTMLA QSEC 21 January 2024.pdf (15 pages)

8.1.4. Estates Policies

Decision *Sally May, Executive Director of Finance*

This item has been deferred to the meeting taking place on 25 March 2025 (to include the Asbestos Management Plan, Water Safety Plan, Medical Gases Policy and Ventilation Policy)

8.2. FOR NOTING

8.2.1. Non-Routine Committee Business (Forward Plan)

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

8.2.1 CTMUHB QSEC Non Routine Bus QSEC 21 January 2025.pdf (3 pages)

8.2.2. Annual Cycle of Business

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

8.2.2 CTMUHB QSEC Cycle of Business 21 January 2025.pdf (4 pages)

8.2.3. Report from the Medicines Safety Group

Information *Dom Hurford, Executive Medical Director*

8.2.3 Report from the Medicines Safety Group QSEC 21 January 2025.pdf (6 pages)

8.2.4. Human Tissue Act (2004) Compliance and Progress Report

Information *Dom Hurford, Executive Medical Director*

8.2.4. HTA compliance Progress Report QSC 21 January 2025.pdf (7 pages)

8.2.5. Joint Commissioning Committee Quality & Patient Safety Committee Chairs Report 4 November 2024

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

8.2.5a QPS Chairs Report QSEC 21 January 2025.pdf (5 pages)
8.2.5b Appendix 1 - Escalation Report QSEC 21 January 2025.pdf (5 pages)

8.2.6. Healthcare Inspectorate Wales Improvement Plan Tracker Report

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

8.2.6a - HIW Tracker Inspection Improvement Plans- QSC Jan 25.docx (8 pages)
8.2.6b Appendix 1 HIW Inspections Tracker QSC Jan 25.xlsx (9 pages)

8.2.7. Cwm Taf Morgannwg University Health Board Infant Feeding Strategy 2025-2030

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

Following the Operational Management Board (OMB) on the 17th January 2025 the cover paper will be updated to reflect the outcome of OMB.

8.2.7a Infant Feeding Strategy 2025-2030 QSEC 21 January 2025.pdf (4 pages)
8.2.7b CTM Infant Feeding Strategy 2025-2030 English QSEC 21 January 2025.pdf (24 pages)

12:20 - 12:25
5 min

9. CLOSE OUT BUSINESS

9.1. Committee Highlight Report to the Board

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

Consider as a Committee the areas of Escalation, Assurance, Advise & Inform

9.2. Meeting Feedback

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

- Is there anything we should do more or less of?
- Have we managed our time and allowed open and balanced discussion?
- Have we considered our values and acted in a way that supports embedding our values across CTM?
- Have we maintained a Strategic Focus?
- Have we received sufficient assurance from a range of sources?
- Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

12:25 - 12:25
0 min

10. Private / Closed Session Business

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

The following item was discussed at the In Committee session held prior to this meeting:

- **Listening & Learning Story**

12:25 - 12:30
5 min

11. Date & Time of the Next Meeting

Information *Carolyn Donoghue, Independent Member/Committee Chair*

Tuesday 25 March 2025 at 9:00am

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Committee Action Log

nmittee
Member

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
16.05.2024	7,1	17	Patient Safety, Quality & Experience Dashboard	Lessons learnt and identified themes from Public Services Ombudsman Reviews to be presented to a future meeting.	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	18-sep-24	Open	**On agenda** November 2024 - This was due be presented to the September Quality & Safety Committee. This will now be presented to the meeting taking place on 21 January 2025 as part of the Quality Dashboard report
23.07.2024	2,1	4	Listening & Learning Story	Review to be undertaken to determine why a decision had been made by the Bed Manager to not move the patient into one of the vacant beds, as opposed to this decision being made by the staff working on the ward.	Unscheduled Care/Planned Care Group Nurse Directors	Executive Director of Nursing/Deputy CEO	18-sep-24	Open	**Proposed for Closure** – Response provided from E James and S'O Brien and shared with G Jones and Committee Members by email on 23 August 2024. Further assurance sought by Committee Members who felt response did not address the concerns raised Further response shared with the Committee Chair and Independent Member by email. Confirmation received that assurance has now been provided
18.09.2024	5.2e	9	Unscheduled Care Group Highlight Report	Discussion to be held outside the meeting in relation to the most appropriate level of detail that could be provided to Committee Members in relation to the risk highlighted within the alert/escalate section and in what forum this should be presented in order to provide the Committee with assurance, for example, In Committee session.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	19-nov-24	Open	**Proposed for Closure** Further discussion held at the In Committee session held on 18 September where is was agreed that further detail would be shared with Members outside the meeting in regards to this matter. Following agreement with the Committee Chair, it was agreed that a further update on the steps taken to address the issues would be included in the January 2025 iteration of the Unscheduled Care Group Highlight report. **On agenda**
18-sep-24	2.1 (CLOSED ITEM)	2	Current position - Health Visiting Services Bridgend	Action plan to be presented to a future meeting of the Committee.	Director of Midwifery	Executive Director of Nursing/Deputy CEO	21-jan-25	Open	**Proposed for Closure** The action plan has been made available for Members to view on request
19.11.2024	5.2b	7	Unscheduled Care Group Highlight Report	Spotlight presentation to be presented to a future meeting in regard to the WAST joint investigation framework thematic review that had recently completed. Presentation to highlight the analysis undertaken and associated recommendations	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	21.01.2025	Open	**On agenda** Has been placed on the agenda for the meeting taking place on 21 January 2025

19.11.2024	5.2d	9	Mental Health & Learning Disabilities Care Group Highlight Report	Consideration to be given to the most appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	21.01.2025	Open	**In progress** Discussions ongoing amongst the Executive Team on the most appropriate way of reporting estates issues
19.11.2024	6,2	12	HMP Parc and Young Persons Unit A Year On	Focussed session to be provided to Board Members on Parc Prison at a future Board Development Session given the number of complexities within the service.	Deputy Chief Operating Officer	Chief Operating Officer	21.01.2025	Open	**Proposed For Closure** Has been added to the forward work plan for Board Development topics
19.11.2024	6,6	14	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24	Discussion to be held with the Corporate Governance Team outside the meeting to confirm future reporting requirements moving forwards.	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	21.01.2025	Open	**Proposed for Closure** The actions referred to within the meeting were actions captured within the review undertaken by Internal Audit on the Welsh Risk Pool. These actions have been captured within the Audit Recommendations Tracker which is regularly being reported to the Audit, Risk & Assurance Committee
19.11.2024	2.1 (CLOSED ITEM)	2	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24	Update on progress against actions to be presented at a future meeting of the Committee.	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	21.01.2025	Open	**Proposed for Closure** The actions referred to within the meeting were actions captured within the review undertaken by Internal Audit on the Welsh Risk Pool. These actions have been captured within the Audit Recommendations Tracker which is regularly being reported to the Audit, Risk & Assurance Committee

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Committee Action Log

nmittee
Member

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
01.11.2021	*7,1*		*Patient Safety, Quality & Experience Dashboard*	*Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors*	*Assistant Director of Quality & Safety*	*Executive Director of Nursing/Deputy CEO*	*01-jan-24*	*Closed*	*Completed* *Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. Completed.* *Spotlight report on Patient Falls presented to the May 22 meeting. Completed.* *Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. Completed.* *Spotlight on Thrombosis to be agreed. – Deputy Nurse Director has suggested that this is closed given that the Committee has received regular reports on Stroke Services.*
24-jan-23	2,1		Listening & Learning Story	Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	jan-24	Closed	Completed An update on Volunteer Services activities is included in the patient experience section of the Quality & Patient Experience Dashboard. The Executive Director for Nursing therefore considers that this action can be closed.
16.05.2024	6,3		Infection, Prevention & Control Strategy	Implementation Plan to be presented to the Quality & Safety Committee on an annual basis for monitoring of progress	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	mai-25	Closed	Completed Added to the Annual Cycle of Business for May 2025
16.05.2024	7,2		Nursing & Midwifery Plan	Periodic updates to be presented to the Committee in relation to progress being made against the Nursing & Midwifery Plan	Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	mai-25	Closed	Completed This item has been included on the forward work programme with next update due May 2025.
23.07.2024	5,1		Report from the Clinical Executives	Cover report to be developed to accompany the AMaT report being presented to future meetings to explain the data being presented	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	19.11.2024	Closed	Completed The AMaT report is no longer going to be included with Clinical Executives Report as data contained within it is being captured within other reports

23.07.2024	5.2b		Unscheduled Care Group Highlight Report	Thematic Review undertaken in relation to identifying the themes and trends around the 15 Nationally Reportable Incidents to be presented to a future meeting Analysis to be undertaken on locally reportable incidents to determine whether numbers would increase or remain the same as the data for nationally reportable incidents	Unscheduled Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	19.11.2024	Closed	Completed An update on this has been included in the Highlight report being presented to the meeting taking place on 19 November 2024
18.09.2024	5,1		Clinical Executives Report	Spotlight Presentation to be presented to a future meeting of the Committee in relation to the work being undertaken to address sexual safety issues within healthcare settings	Deputy Director of Nursing	Executive Director of Nursing/Deputy CEO	19.11.2024	Closed	Completed This item is on the agenda for the meeting taking place on 19 November 2024
18.09.2024	5,1		Clinical Executives Report	Staff Vaccination Audit Plan to be presented to a future meeting of the Committee	Executive Director of Public Health	Executive Director of Public Health	19.11.2024	Closed	Completed An update has been included in the Clinical Executives report which is on the agenda for the 19 November 2024 meeting
18.09.2024	5.2c		Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report	Discussion to be held with the Haematology Service what the alternative plan would look like for addressing Haematology Follow Ups Not Booked position if the request for additional funding was not successful	Care Group Director	Executive Director of Nursing/Deputy CEO	19.11.2024	Closed	Completed Response received and shared with Committee Members by email on 2 October 2024
18.09.2024	6,1		Organisational Risk Register – Risks Assigned to the Quality & Safety Committee	Review to be undertaken of the updates provided against Risks 4906 and 5755 and an update to be provided to P Roseblade outside the meeting.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Boaard Secretary	19.11.2024	Closed	Completed Email response shared with Members by the Director of Corporate Governance on 1 October 2024
18.09.2024	6,3		Update on Dental Services	Confirmation to be provided outside the meeting as to whether the cancellation of non-urgent community dental clinics would increase the waiting time and cause further harm to the children who were waiting	Director of Operations, Planned Care	Chief Operating Officer	19.11.2024	Closed	Completed Response received and shared with N Milligan and Committee Members by email on 1 October 2024
18.09.2024	7,1		Patient Safety, Quality and Experience Dashboard	Confirmation to be provided outside the meeting as to how Duty of Candour was being monitored for Primary Care GP's in relation to incidents	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	19.11.2024	Closed	Completed The monitoring of Primary Care Duty of Candour is included in the Duty of Candour Annual Report which is on the agenda for the 19 November 2024 meeting.
18.09.2024	7,1		Patient Safety, Quality and Experience Dashboard	Duty of Candour process and other compliance pathways to be discussed at a future Board Development session.	Director of Corporate Governance & Board Secretary	Director of Corporate Governance & Board Secretary	19.11.2024	Closed	Completed Topic has been added to the list of topics for scheduling into future Board Development Programme

18.09.2024	9,3		How did we do in this meeting	Consideration to be given to scheduling in an annual development session into all Committee's Annual Cycles of Business where focus could be placed on areas such as the Quality Dashboard, Duty of Candour etc.	Director of Corporate Governance & Board Secretary	Director of Corporate Governance & Board Secretary	19.11.2024	Closed	Completed Director of Corporate Governance & Board Secretary has emailed the Committee Chair with the proposed approach to discuss this further at a Development Session with the full Board, as agreed with the Health Board Chair.
18.09.2024	2.2 CLOSED ITEM		CCTV Cameras – Prince Charles Hospital Mortuary Department	Further assurance to be provided that no abnormal activity or incidents had occurred during the time of the reported issues.	Deputy Medical Director	Executive Medical Director	19.11.2024	Closed	Completed Further assurance provided to Committee Members by email outside the meeting

Agenda Item 5.1	21st January 2025	Quality, Safety & Experience Committee	Thematic Spotlight Presentation - WAST joint investigation framework thematic review

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	
Prepared By:	Lisa Jenkins – Clinical Lead Serious Incidents and Complex Concerns
Presented By:	Nigel Downes – Assistant Director of Quality and Safety Lisa Jenkins – Clinical Lead Serious Incidents and Complex Concerns
Approving Executive Sponsor:	Greg Padmore-Dix, Executive Director Patient Care & Safety/Deputy CEO
Report Purpose	For Discussion For Noting
Engagement undertaken to date:	Thematic Review undertaken

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Patient Experience, Patient Safety, Quality of Care
Related Health and Care Standard	Safe, Effective, Efficient, timely, Equitable
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No – Communication can be undertaken in Welsh and English
Are there any Legal Implications /Impact.	None to date for the Joint Investigation Framework Incidents reported
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Possibly Yes, in relation to the ongoing projects/work required to continually strive to improve our services at point of contact and point of discharge
Link to Strategic Goals	Improving Care

Overview

Ambulance called to attend

Delays in attending scene
SCIF undertaken

75 Incidents reported to CTMUHB

JIF MDT panel review

15 Incidents reported & SBAR investigations undertaken

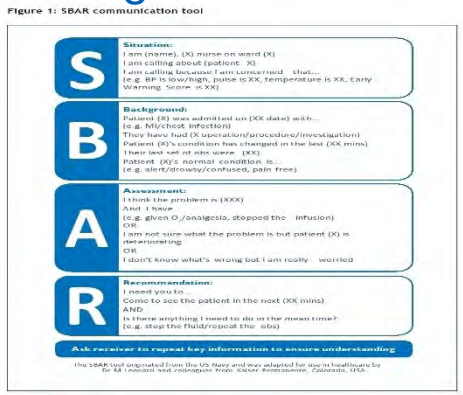


Figure 1: SBAR communication tool

S Situation:
I am (name), (X) nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned that...
(e.g. BP is low/high, pulse is XX, temperature is XX, Early Warning Score is XX)

B Background:
Patient (X) was admitted on (XX date) with...
(e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)'s normal condition is...
(e.g. alert/drowsy/confused, pain free)

A Assessment:
I think the problem is (XXX)
And I have
(e.g. given O2/analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried

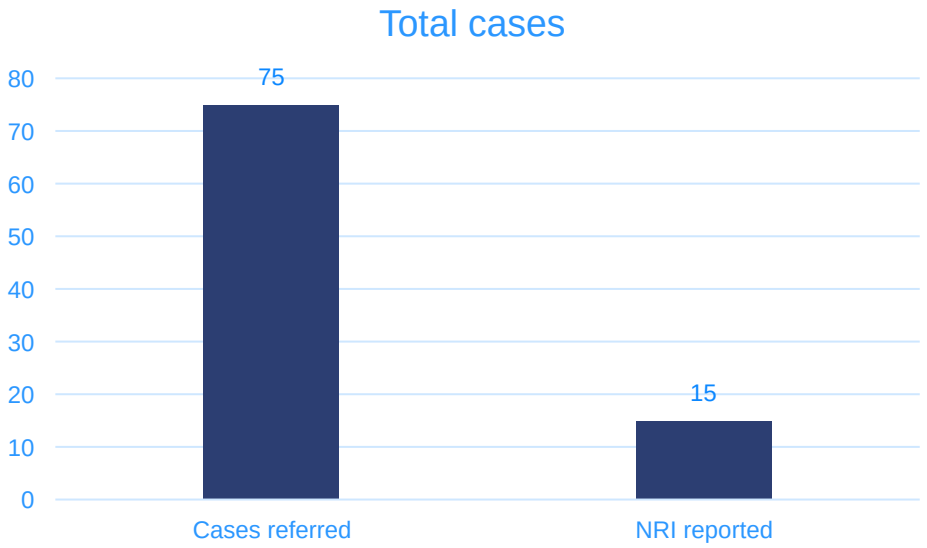
R Recommendation:
I need you to
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the mean time?
(e.g. stop the fluid/repeat the obs)

Ask receiver to repeat key information to ensure understanding

The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA.

Quality, Service Improvement and Redesign Tools. SBAR communication tool – situation, background, assessment, recommendation

Findings

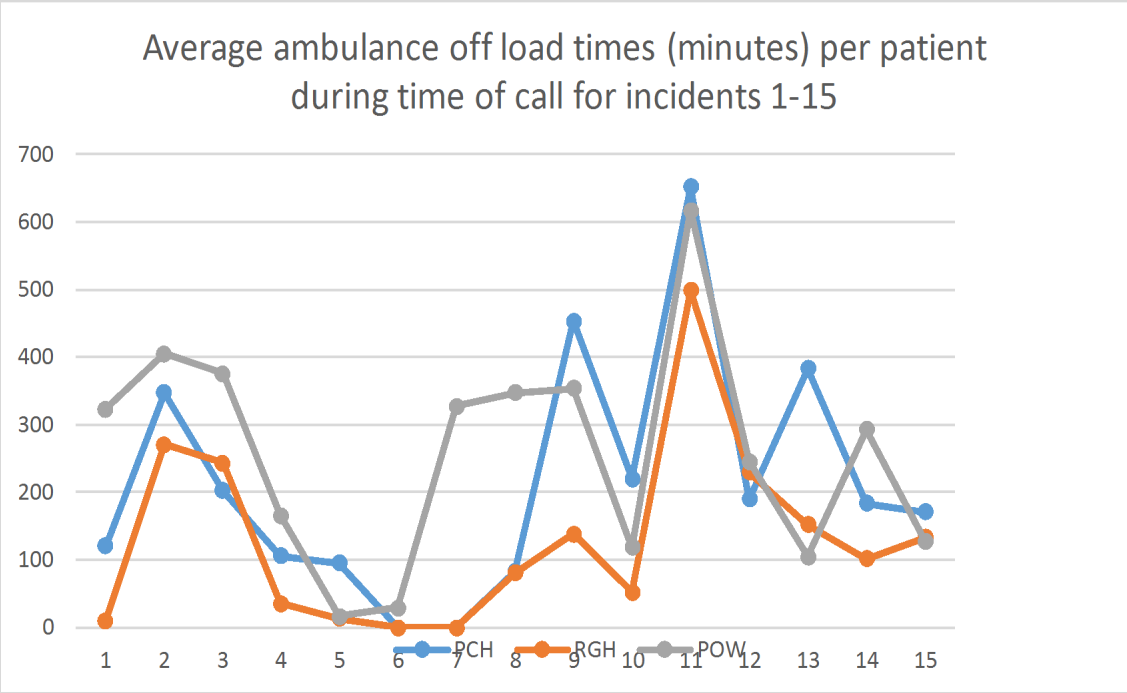


Age of Population and outcome

Age (years)	Number of NRIs	Outcome
90-100	4	2 deaths 2 harm
80-90	5	5 deaths
70-80	3	3 deaths
50-60	2	2 death
40-50	1	1 death

★ Average Patient wait times for an ambulance:
Ranged from 1.5 hours to 22 hours

Findings continued:



Incident	PCH	RGH	POW
1	121	10	323
2	347	271	405
3	202	243	376
4	106	35	166
5	95	13	16
6	unknown	unknown	29
7	unknown	unknown	327
8	83	81	347
9	453	138	354
10	220	52	118
11	652	499	617
12	190	230	245
13	383	152	105
14	184	102	293
15	171	133	128

It can be seen from the chart that all of the Health Board sites were experiencing similar pressures at the time that the 15 NRI incidents were reported.

Average ambulance off-load times at CTM sites in minutes per patient ranged from 10 minutes to 10 hours 52 minutes, however these are average times with longest waits topping 16 hours across the HB sites.

Recommendations

Continue robust collaborative working between Health Board and WAST when reviewing Joint investigation to ensure transparency. While adhering to escalation plans in accordance with Policy and Procedures.

Learning from these reviews to continue to be shared via USC group QSRE to allow for continuous improvement.

Health Board to monitor and record data in relation to Immediate release requests and their ability to meet them when requested.

In order to gain a true picture of the HB status at the time of the incidents information regarding staffing, bed closures, IPC issues (including COVID), patient acuity etc. needs to be readily available.

The Health Board needs to efficiently log activity and patient flow across all of its sites. Previously reporting of patient flow was not uniform over all three sites. This would enable ongoing robust assessments, to mitigate risk and support available actions to relieve the pressures at the ED sites, to allow the release of ambulances to support patients in our communities.

Short and long term plans need to include monitoring and discussions around discharge planning Health and social care provision for patients that are suitably fit for discharge from all Health Board sites.

WAST and the HB to continue to work collaboratively and with relevant service providers on projects and quality improvements, regarding the use of the right services at the right time by all service users.

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Specific Matters for Consideration:

Careful and responsive consideration to discharge planning and early intervention on this. More work and emphasis on care packages and placements for patients requiring extra support in the community or a care home placement. With social care packages not being within the Health Boards gift to assess and improve.
An opportunity to review circumstances where a General practitioner has been involved initially in the patients care pathway and an ambulance has been called. Is it acceptable that a patient is left waiting in a potentially deteriorating condition waiting hours for an ambulance, where ongoing assessments are then via further calls to ambulance control or a welfare call, with no provision for follow up face to face assessments?
Meet with colleagues across other Health Boards in Wales to compare best practice and standards. Collaborative learning from reported incident themes and trends.

Key Risks / Matters for Escalation:

The Health Board has initiated actions to address ongoing issues with patient flow across its sites in adherence with the six goals for urgent and emergency care. In line with Programme for Government commitments to provide effective, high quality and sustainable healthcare focused on prevention, integration, and access, we are committed to the provision of urgent and emergency care services in the right place, first time.
The work being undertaken in CTM is building on its developments in enabling people with urgent or emergency care needs to access the right treatment at the right time, in the right place.
Key risks will remain when the system is overwhelmed from both unexpected and expected sources. But these can be reduced and monitored by assuring effective escalation plans are in place.

Recommendation

The Committee are asked to:

- *Consider whether the Committee can seek assurance from the report that all that can be done with the resources available is being done to mitigate the risks.*

Next Steps

The thematic review of the cases up to 2024 is complete and the USC Nurse Director and Medical Director are committed to continuing the joint investigation framework reviews in collaboration with Patient Safety and WAST colleagues to ensure timely review and identification of ongoing learning and improvements.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
5.2

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	1. Richard Hughes-Deputy Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Therapies and Health Sciences, 4. Philip Daniels-Executive Director Public Gethin Hughes-Chief Operating Officer Health 5. Gethin Hughes-Chief Operating Officer
Cyflwynydd yr Adroddiad / Report Presenter	• Greg Padmore-Dix-Executive Director for Nursing and Midwifery • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • Philip Daniels-Executive Director Public Health • Gethin Hughes-Chief Operating Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	• Greg Padmore-Dix-Executive Director Nursing and Midwifery/Deputy CEO • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • Philip Daniels-Executive Director Public Health • Gethin Hughes-Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AHPs	Allied Health Professionals
DTPS	Diagnostic, Therapies, Pharmacy and Specialties
WAASP	Weight, Appetite, Ability to Eat, Stress Factors and Pressure Ulcers
R&D	Research & Development
RSV	Respiratory Syncytial Virus

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 as highlighted by each of the four Clinical Executive Directors.

- Greg Padmore-Dix Executive Director Nursing, Midwifery & Patient Care/Deputy CEO
- Dom Hurford-Medical Director
- Lauren Edwards-Executive Director of AHPs and Health Science
- Philip Daniels-Executive Director of Public Health

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

In addition, there is an update included with regards to the recently published Ambulance Handover guidelines.

2. Specific Matters for Consideration

3. Clinical Executive Director updates: Nursing & Midwifery

Section 2.1 Specific Matters for Consideration:

2.1.1 Engagement on visiting times in CTMUHB

The Deputy Executive Director of Nursing is leading a significant engagement initiative on visiting times, collaborating closely with the Director of Communications. This comprehensive process, set to conclude by the end of January 2025, aims to standardise visiting practices across the health board's inpatient areas, aligning them with specific care requirements. The workstream will also establish appropriate communication arrangements to inform staff and the public about the agreed model effectively. As part of this thorough engagement process, the team actively seeks input from diverse stakeholders, including staff, patients, and visitors, and incorporates valuable insights from patient advocacy groups such as Llais.

The primary objective of this initiative is to enhance the overall experience for patients and visitors whilst enabling the health board to consider and implement new care initiatives. By standardising visiting times, the health board anticipates improvements in several key areas, including better access for carers, more efficient discharge planning, and enhanced emotional well-being for patients. This holistic approach to visiting times is expected to contribute significantly to the quality of care, fostering a more supportive and inclusive environment for all

involved in the patient's journey. The engagement process reflects the health board's commitment to developing a visiting model that is responsive to its community's needs and aligned with best practices in patient-centred care.

2.1.2 RCN Wales Nurse of the Year Awards

CTMUHB has once again demonstrated its commitment to excellence in nursing care, with notable achievements at the Royal College of Nursing (RCN) Wales Nurse of the Year Awards 2024. The health board's success was highlighted by recognising two outstanding individuals from its Memory Service team. Corrina Cullen, the Memory Service Team Lead, was honoured as a runner-up for the prestigious Registered Nurse-Mental Health Award, showcasing her dedication and expertise in the field of mental health nursing.

Further strengthening CTMUHB's reputation for Quality Care, Sarah Bisp, a primary care support worker in the Memory Service, achieved the Health Care Support Worker Award. Sarah's success is a testament to her exceptional commitment and innovative approach to patient care. Her efforts in establishing a coffee morning in partnership with a local organisation and leading a Cognitive Stimulation Therapy group have significantly improved the lives of patients with dementia. These achievements reflect CTMUHB's ongoing dedication to providing high-quality, compassionate care across various specialities, particularly mental health and support services for older adults.

Challenges

2.1.3 Winter IPC Pressures

The Cwm Taf Morgannwg University Health Board (CTMUHB) in Wales has faced significant challenges in Infection Prevention and Control (IPC) during winter. Influenza A has emerged as the primary Acute Respiratory Infection (ARI) over the past three months, with a marked surge in December causing substantial operational impact across CTM. The situation was further complicated by identifying a small number of cases with dual Flu A and COVID-19 infections requiring prompt isolation. In response to these challenges, CTMUHB reinstated the IPC support cell in late December to provide daily updates on the IPC situation.

CTMUHB implemented a series of measures to address these difficulties to enhance IPC efforts. These included daily evaluations of positive cases by IPC staff, regular meetings between IPC and patient flow teams to review isolation procedures and facilitate safe patient movement, and the reinstatement of universal mask use. The IPC team increased their visibility in clinical areas to support the implementation of required measures, identify challenges, and promote learning. Additionally, IPC leadership maintained a presence at bi-daily Site Escalation meetings and afternoon operational planning sessions. The health board also introduced a daily RAG-rated IPC position for each site to support safe decision-making by patient flow teams, particularly during out-of-hours periods.

2.1.4 Consequences to care delivery and peoples experience

The impact of IPC pressures on patient flow and overcrowding in Emergency Departments (EDs) has been substantial across Prince Charles Hospital (PCH), Royal Glamorgan Hospital (RGH), and Princess of Wales Hospital (POW). These hospitals have experienced significant challenges with long waits in ED chairs and ambulances, reflecting broader issues within the healthcare system. All three EDs realised the need to provide acute care to patients in chairs and trolley spaces for extended periods, requiring additional nursing resources and concerns about care privacy and providing ward-based care in a non-ward environment.

These overcrowding issues have led to potential compromises in ideal infection control standards and increased cross-infection risks, particularly in managing influenza and COVID-19 cases alongside other patients. The situation has been further complicated by delays in patient handovers and insufficient facilities for clinical interventions. CTM critical care services have also been significantly impacted by a significant increase in the demand for level 3 intensive care provision across all three sites. This has required teams to flex their resources across the acute sites dynamically and has been enabled through the leadership of the Lead Nurse and the clinical leadership team within the Planned Care Group.

In response to these challenges at the front door, the hospitals have implemented various mitigation measures. PCH, RGH and POW have fully utilised their 'Safe 2 Start' initiative while also using same-day care units to improve patient flow and reduce admissions. Community teams have responded in the increasing engagement with local authority partners on social care priorities and boarding opportunities within the community hospital setting. Despite these efforts, the hospitals continue to contend with the complex interplay between IPC requirements and the need to manage high patient volumes efficiently, highlighting the ongoing pressures faced by the healthcare system in the region.

Section 3 Medical Directorate

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

This section covers the following achievements:

- Call 4 Concern (Martha's Law) Update
- Diabetes
- Children and Families Care Group Medical Workforce Performance
- Assistant Medical Director for Quality and Safety

3.1 Achievements

Call 4 Concern (Martha's Law) Update

In Wales, Martha's Law is referred to as Call 4 Concern, of which there are 3 parts to it:

Part 1. Structured approach to documenting patient, family and carer concern on a regular basis, to allow escalation based on this parameter through the normal escalation mechanisms

In CTM we will be using the early warning scores process that incorporate patient, family and carer concerns. This is already underway with the changes to Paediatric and Maternity scores/charts.

Part 2. Ability for staff to escalate to an independent team for discussion and review

Part 3. Ability of patient, family and carers to escalate for a second opinion

The second and third parts do rely heavily on an Outreach style response with a phone number that staff, patients, families and carers can call, should they be worried.

With regard to Outreach in our health board we are, on paper, 24/7 on all 3 sites. However, the reality of, sickness, staff shortage cover and occasional gaps means that this is not always available.

At present our Outreach teams are not trained in paediatric nursing, therefore, there is a piece of work to been undertaken with our health board paediatric colleagues. The RADAR and Paediatric leadership teams are working together on this.

We are further ahead than many Heath Boards in Wales and will soon have a robust process to deliver this specific ask.

Diabetes

Aligning different strands all working on Diabetes into one project.

Progress within the range of diabetes areas; podiatry, ophthalmology and maternity. Recently had pan-Health Board meeting to pull all areas of Paediatric Diabetes together into one team. Main issues are overweight services and Type 1 Diabetes.

The Health Board Diabetes Paediatric Lead has been appointed as the new Clinical Director for Paediatrics so this is a positive sign that Diabetes will be a big focus of their work going forwards.

Children and Families Care Group Medical Workforce Performance

The Medical Workforce Productivity Group has taken a new structure over recent months with Care Groups being held to account for their medical workforce productivity.

A huge improvement from the Children and Families Care Group has been evident with job planning, performance and agency spend, showing significant

improvements. Credit must go to Dr Mohamed Elnasharty and his teams for the work undertaken.

Assistant Medical Director for Quality and Safety

After a competitive recruitment process, we are pleased to announce Dr David Deekollu as the new Assistant Medical Director for Quality and Safety. This position has been vacant for a while so having David's experience will be excellent. David starts in February.

2.2 Areas of Focus

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

- Stroke
- Care Group Medical Directors Recruitment
- Hip Fracture Service and Performance
- Mortuary Capacity

Stroke

CTM's stroke provision continues to prove challenging and is an area we continue to focus on tackling.

Care Group Medical Directors Recruitment

Medical Director positions in both the Primary and Community Care and Mental Health and Learning Disabilities Care Group are to become vacant imminently. The recruitment process for these positions is underway. There will be a gap in both areas whilst we look to recruit which the respective teams are aware of.

Hip Fracture Service and Performance

Many steps are being made to address the key performance indicators, all of which need attention. We are putting services in place that will impact positively on the care of Hip Fracture patients.

Mortuary Capacity

There are currently extreme pressures with the Mortuary capacity in CTM. This is due to a mixture of winter illnesses and frailty. We are reminding colleagues to complete certificates of death as a priority and we are working with undertakers to release bodies expeditiously.

Section 4 Executive Director Allied Health Professionals and Health Science

Successes

Successful Appointment to Professional Head of Radiography

In November 2024, CTM successfully developed and recruited to the role of Professional Head of Radiography at CTM. During the organisational change process, colleagues working within Radiology highlight the importance of developing such a role within CTM. In response to this feedback from colleagues and also the needs of the service, this exciting new role was developed in the Health Board to provide strong professional leadership across the operational, strategic and professional elements of the service.

Staff Survey
DTPS had the highest care group response rate in CTM to the 2024 NHS Wales Staff Survey, at 45.8%. Audiology led the way, with 93.9% of the staff completing the staff survey. The valuable information obtained via the survey will be used to inform improvements and developments across the Care Group.

For Awareness

Re-accreditation of Echocardiography Princess of Wales Hospital
The Echocardiography Department in Cardiac Physiology has recently undergone its 10-year British Society of Echocardiography (BSE) inspection for re-accreditation. BSE departmental accreditation is a recognised benchmark of quality and demonstrates that an Echo Department meets quality standards. The accreditation covers processes which include ongoing participation in echo quality, accreditation, training, qualifications, equipment and infrastructure.

The department has applied for the following standards: Echo quality, Transthoracic echo (TTE), Transoesophageal echo (TOE), Stress echo and Training to BSE Proficiency standard.

Following initial feedback, the department is confident that re-accreditation will be confirmed in the New Year.

ALLIED HEALTH PROFESSIONS

Successes

Physiotherapy Community Rehab Redesign
Significant staffing pressures and previous challenges regarding the appropriate use of the physiotherapy community rehabilitation service highlighted opportunities for increased efficiency, to reduce waiting time for patients, and to improve compliance with appropriate quality standards.

A review of service provision led to a deep dive into the caseload and referrals received by the physiotherapy community rehabilitation service. This highlighted duplication across services, confusing referral pathways, and concerns regarding staff experience and retention.

As a result of the review, a band 5 and band 4 from the physiotherapy community service was repurposed into the RCT reablement service for 6 months. This has resulted in an 86% reduction in RTT, 30% reduction in inappropriate referrals, improved compliance with Community Rehabilitation Standards, and a positive shift in PROMs and staff experience.

A Community Physiotherapy and Reablement Pilot poster is available on request for awareness.

Specialist Dietetic Oncology Clinic

Malnutrition has a profound effect on people affected by cancer, therefore timely optimisation of nutrition is essential in improving outcomes that matter to people, treatment options, and quality of life. Traditionally, people with cancer were seen by non-specialist dietitians in general community clinics. This resulted in prolonged waiting times and advice and support from a dietitian who is not a cancer specialist.

A specialist oncology clinic was job planned into an experienced oncology dietitian's working week, with access to the clinic across all regions of CTM. Oncology patients referred into community dietetics were triaged into the specialist oncology clinic. 81% of patients were at moderate to high risk of malnutrition (of which 62% were at high risk), 26% were sarcopenic, and 71% had a significant weight loss of 5% or more.

An improvement in timely access to the service has been seen, with patients now waiting on average 9 days for assessment, compared to 4-6 weeks prior to the specialist oncology clinic, and improved patient experience. In addition, 93% of patients chose telephone consultation, 5% chose a virtual appointment, and 2% chose face to face clinic appointment.

Further work is being undertaken to evaluate the outcomes and the design of the service.

An Oncology Clinic poster detailing the setting up of a specialist dietetic oncology clinic is available on request.

Nutritional Screening

Malnutrition screening is a core component of patient risk assessments on admission to hospital. In line with the national guidelines, the WAASP tool is the nutritional screening tool used to identify if inpatients are at risk of malnutrition.

A CTM-wide audit was undertaken to establish if malnutrition screening was completed in line with nutritional screening standards. The audit found that 65%

of patients had a WAASP tool completed within 24 hours of admission, 85% were repeated weekly, 48% of those with a WAASP >7 were referred to dietetics (WAASP> 7 signifies high risk and referral to dietetics must be made), and 42% of WAASP scores were accurate.

Further work is planned to improve malnutrition risk screening across acute and community hospitals with the development of robust training opportunities. This work will form part of the workplan of the Nutrition and Hydration Steering Group and is being led by the newly appointed Malnutrition Strategic Lead Dietitian.

AHP Advancement

AHPs continue to celebrate the quality of care they provide, with a selection of posters and abstracts being selected for a range of conferences: Macmillan National conference; AHP National conference; and the CTM R&D conference where 2 dietetic posters on “A qualitative service evaluation exploring user experiences of Diabetes Prevention Programmes in Cwm Taf Morgannwg University Health Board” and Establishing an Upper Gastrointestinal Cancer Service won first and second place in the poster competition.

Challenges/Risks

The challenges within the stroke service are being felt across the AHP services, with the relocation of staff initially from the POW site to RGH and more recently from PCH to RGH (Risk ID: 4652). The number of DATIX incidents reported and any themes are being closely monitored. AHPs are actively engaged in the stroke redesign and associated workstreams. Accommodation for staff on the RGH site remains an issue and AHP leads are working with site leads to establish a solution.

AHPs are awaiting a decision on a proposed Speech and Language Therapy and Podiatry clinical administration teams’ relocation from Pontypridd Cottage Hospital. AHPs have put forward several options to facilitate the move cognisant, that any deviation from the planned joint move will impact on the ability to maximise the shared use of this resource.

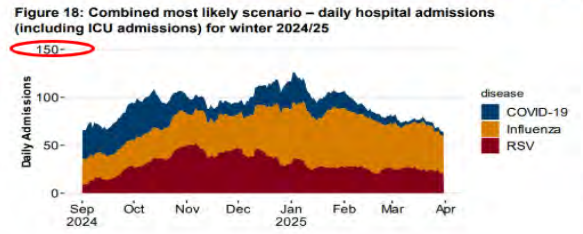
Section 5 Population Health Management (PHM)

Winter Respiratory Season update

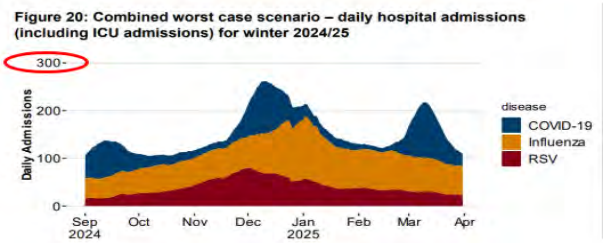
Ahead of the 2024-25 winter season the following models for key respiratory pathogens were developed by Welsh Government to demonstrate possible respiratory scenarios that Wales may encounter. Data sources indicated that the trajectory could be similar to 2023 / 2024 although a worse winter might include waves of Covid, RSV and flu peaking at a similar time as well a difficult flu season.

Overall, we are seeing a higher incidence flu season than last year, RSV is similar to previous years and current rates of Covid-19 are low.

Most likely scenario – similar to last year



Worst case scenario – waves of Covid and a worse flu season

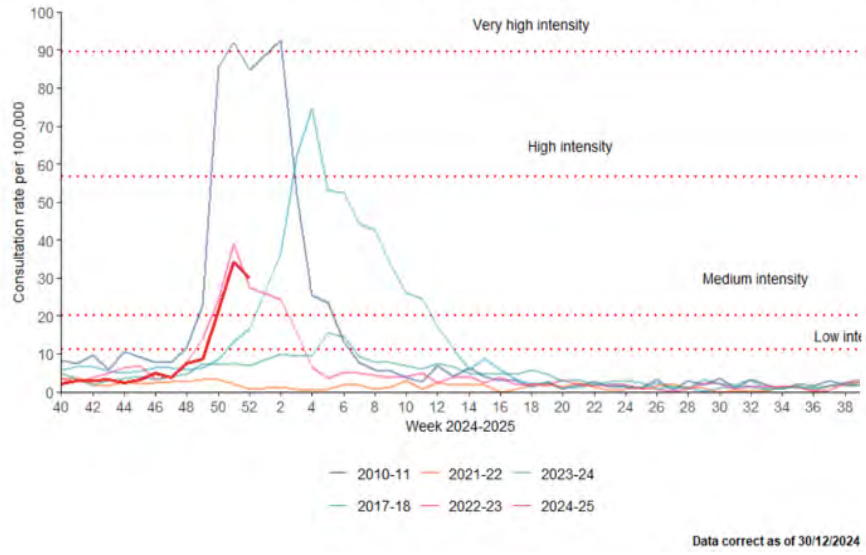


[Winter respiratory framework 2024 to 2025 (WHC/2024/037) | GOV.WALES]

Influenza:

The below graphics are actual influenza rates for CTM plus a short-term forecast for the following fortnight and daily admissions scenarios. Influenza rates have risen steeply since mid-November and remain in 'medium intensity'. Cases appear to be peaking above the most likely scenario (above) and are more similar to the higher 22/23 season. There is potential for further increase and previous years show that a medium/ high intensity trend tends to last a 6-8-week period. The pressures being experienced by hospitals are likely to continue for the next few weeks.

Figure 1.2. Sentinel GP network clinical consultation rate for ILI per 100,000 practice population.



Weekly Acute Respiratory Infection Summary 2024-12-31.pdf https://www.gov.wales/science-evidence-advice-communicable-disease-surveillance-reports

There has been a lower flu vaccination uptake seen in CTM and Wales in all groups than previous years and which is considerably below the 75% target for 31st March 2025.

The table below shows the recorded vaccination uptake to 31st December. It should be noted that some GP practices are highlighting inaccuracies with data reported on IVOR compared to data held on practice systems. It is likely that vaccine uptake is being under reported. These data inaccuracies also risk affecting any development of targeted work programs.

Region	Children 2 to 3 years %	Clinical risk 6m to 64y %	65y and older %
Merthyr Tydfil	27.7	28.1	61.5
Bridgend	39.3	33.3	70.2
Rhondda Cynon Taf	39.4	33.1	66.3
CTM Total	37.7	32.5	67.1
Wales	41.5	33.8	67.9

Regional influenza vaccine uptake measures for CTM (and for Wales) highlight room for improvement, clinical risk groups across all ages remain below the Wales average and targeted interventions are essential to address these disparities. Uptake among children remains low and significant gaps exist for the clinical at risk <65-year-old group and in Merthyr and RCT for older adults. Merthyr Tydfil shows significantly low uptake across all groups, particularly among children (27.7%), although this may be influenced by reporting anomalies.

RSV:
RSV peaked in mid-November, as anticipated in the prediction model, with a peak in cases and admissions in 0-5-year-olds in mid-November and now high numbers in the over 65 age group. Cases in the older group are now declining but remain significantly higher than other age groups, adding to hospital pressures and contributing to CTM having the highest case numbers in Wales. The effect of the vaccination programme for 75- to 80-year-olds introduced in Sept 2024 is not yet demonstrable and as with the other programmes, there is an uptake target of 75% by 31st August 2025

Covid-19
Incidence of Covid-19 continues to decline in all age groups and health boards currently. No significant genomic shift is reported currently and vaccination, for those eligible, remains effective. Uptake in clinical risk groups is notably low across both Covid-19 and flu Vaccination suggesting potential gaps in communication, accessibility and vaccine fatigue amongst the community.

Group	Uptake in CTM	Uptake in Wales
Residents in care home for older adults	68.5%	72.3%
Adults 65+	54.3%	56.2%
6m-64 years in Clinical risk group	20.9%	20.5%
All eligible	40.9%	43.2%

Wales COVID-19 vaccination surveillance weekly report Autumn 2024.pdf

Norovirus:

Norovirus continues to add pressure across the system, 67% of confirmed cases were tested in hospital, source of infection not noted. Most affected age group is the +65-year olds. It is likely that norovirus will continue to contribute to pressures for next few weeks. The last 12-week period is 22.5% higher compared to the same 12-week period in the previous year for Wales.

Mitigations

There is immediate ongoing work to increase vaccine uptake in CTM, as well as longer-term planning to address key inequalities. There have been Health Board discussions with GP practices around their flu vaccination program plans, especially in low uptake practices. As in previous years the Health Board will be undertaking a 'mop up' of the school Fluenz program in January via the Community Vaccination Centres, where all those without a Fluenz vaccine, will be offered an appointment in the January campaign.

First offer vaccinations for Covid-19 is now complete and now 2nd invites are being sent to those who did not take up the initial offer of a vaccine. Invites and vaccinating of the 2nd offers started over the Christmas period and continue through January 2025. There is also an open walk-in policy as well, that has been advertised on our websites and social media channels.

Vaccine reporting and data quality issues have been recognised are being reviewed.

Section 6 WHC Ambulance Patient Handover Guidance

Situation / Background

6.1 On the 29th of October 2024 the Director of Operations, NHS Wales/Health and Social Services Group, Welsh Government wrote to the Health Board to draw attention to a newly published Welsh Health Circular relating to Ambulance Patient Handover Guidance. It has been developed with clinical and operational input and should be read as a second iteration of the original document released in May 2016.

This guidance is intended to set a statement of intent for health boards to deliver when managing the ambulance patient handover process, and to set out key actions for consistent delivery to support optimal outcomes and experience.

In response to the letter the Unscheduled Care Group have revisited their internal processes and reviewed for any further action with an updated action plan in place.

This guidance is intended for executive level staff of health boards, the NHS Wales Joint Commissioning Committee and the Welsh Ambulance Services University NHS Trust. It may also be useful to emergency department and ambulance service clinical and managerial teams when designing local protocols.

6 Matters for Consideration

6.2 The Quality, Safety and Experience Committee are presented with assurance that an action plan has been prepared in response to the above by the Unscheduled Care Group considered by the Chief Operating Officer, as the Operational Management Board Chair Action, January 2025.

6.3 Assurance that the Care Group are taking appropriate action to ensure internal and local processes are aligned to the guidance.

6.4 To ensure that appropriate steps are taken to ensure patient safety is priority and maintained.

6.5 Ambulance patient handovers continue to represent a significant challenge to patient experience and outcomes and the ambulance service's ability to respond quickly to people in the community.

6.6 This is an issue requiring system wide solutions, both in the community and in supporting timely patient flow through emergency departments, the hospital system and back out into the community.

All members of the health board executive team have a responsibility for timely and safe ambulance patient handover, and the communication of this guidance and its content throughout their organisation.

As part of the Oversight and Escalation Framework, Welsh Government continue to assess CTMUHB performance against agreed trajectories, consider the overall quality and safety of services and to undertake deep dives on specific topics. Health boards should proactively raise areas of concern.
CTM participate in monthly meetings with Welsh Government sharing updates and progress against the trajectories.

The letter from the Director of Operations, NHS Wales/Health and Social Services Group, Welsh Government also highlights in conjunction with the NHS Executive, audits will be undertaken of the Health Board compliance with the guidance over the remainder of 2024/2025.

6.7 Key Risks / Matters for Escalation

- Health Board risk progress against the ambulance patient handover trajectories
- Compliance with the national guidance
- Significant challenge to patient experience and outcomes
- Support for timely patient flow through emergency departments, the hospital system and back into the community resulting in the ambulance service's ability to respond quickly to people in the community
- Welsh Government continue to monitor CTMUHB through targeted intervention.

6.8 The Unscheduled Care Group will continue progressing with the actions and noting any changes to the planned actions at Operational Management Board as part of their monthly highlight report.

7. Overarching Key Risks / Matters for Escalation

All challenges identified for this reporting period have been highlighted under each section of the report from each of the four Clinical Executive Directors including an update from the Chief Operating Officer in response to the publication of the WHC Ambulance Patient Handover Guidance.

Assurance is provided that all matters outlined within this report are being addressed through each of the four reporting teams led by the respective Clinical Executive Director and the Chief Operating Officer relating to the WHC Ambulance Patient Handover Guidance.

8. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	Quality of patient care is at the forefront of improvements and decisions made and individual quality impact assessments are completed at the right time by the right team. This report is

		presented for information and noting purposes.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	Quality of patient care is at the forefront of improvements and decisions made and individual quality impact assessments are completed at the right time by the right team. This report is presented for information and noting purposes. If required this report can be made available in Welsh and other languages upon request
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Providing high quality, safe care is vital to the reputation of the health board. This report covers items as a broad update for assurance to the members of the Quality & Safety Committee however, under the directorship and leadership of the four Clinical Executive Directors who hold joint responsibility for this report, there is a collective strive and dedicated commitment to protect the health board's reputation.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

9. Recommendation

9.1 Quality, Safety and Experience Committee members are asked to NOTE the contents of this paper with the updates provided for assurance by the four Clinical Executive Directors.

10. Next Steps

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

Agenda Item
5.3a

Quality, Safety & Experience Committee

Highlight Report from the Children & Families Care Group

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Suzanne Hardacre, Director of Midwifery & CYP Nursing Mohammed Elnasharty, Medical Director Carl Verrecchia, Service Director
Cyflwynydd yr Adroddiad / Report Presenter	Carl Verrecchia Service Director Mohammed Elnasharty, Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CAMHS	Child and Adolescent Mental Health Services
CQC	Care Quality Commission

CTM	Cwm Taf Morgannwg
ED	Emergency Department
EDD	Expected Date of Delivery
GP	General Practitioner
ISH	Integrated Sexual Health
MEWS	Maternity Early Warning Score
MNSSP	Maternity and Neonatal Safety Support Programme
ND	Neuro Development
NEWTT 2	Newborn Early Warning Track and Trigger
PCH	Prince Charles Hospital
PHW	Public Health Wales
PoW	Princess of Wales
PREM	Patient Reported Experience Measures
QSE	Quality, Safety and Experience
SEHS	School Entry Hearing Service
SOGS	Schedule of Growing Skills (Assessments)
TOMS	Theatre Management System (Obstetrics)
WG	Welsh Government
WHC	Welsh Health Circular
'2Wish'	Charitable organisation supporting those affected by sudden and unexpected death of a child or young adult aged 25 or under

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Children and Families Care Group at its meeting on 12th December 2024.

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

2. Purpose of this Meeting

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

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

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice based on local need, to assist in discharging its functions and meeting its responsibilities.

- Provide assurance to the Children and Families Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

Alert / Escalate	• Maternity / Neonatal Temporary closure continues. Air Handling Unit and Electrical work now complete. Roof repair work on schedule for completion early 2025. Communication to staff shared December 2024. Women and birthing people with expected date of delivery (EDD) for February contacted January 2025. Reopening plans in place (including education, training and roster management). • Health Visiting and Oversight Board fully implemented within the Care Group. Recovery and Improvement plan in place following Industrial Action (available to members on request). Improving position noted against Schedule of Growing Skills assessments (SOGS) at Oversight and Improvement Board on 18th December 2024. Interim senior nurse in place, out to advert in January for substantive position. • Paediatric bed pressures at the Royal Glamorgan Hospital (RGH) due to critical incident at Princess of Wales (PoW). Work underway within Children's Assessment Centre to support Paediatric Assessment Unit.
Advise	• School Entry Hearing Service (SEHS) – Cwm Taf Morgannwg (CTM) remains in breach of their responsibility to implement direction from Welsh Government (WG) to handover the governance arrangements of the programme to audiology services. • Unfunded continuing care packages within Community Children's Nursing. Care Group seeking permanent solution, mitigation in place. • Infant Feeding Strategy (2025-2030) developed for approval by Committee 21.1.25 (separate agenda item). • Challenges with delivery of vaccines to schools and other settings. Escalation and discussion with Head of Facilities taking place.

	• Teams redeployed to improve Fluenz uptake position for nursery children in Rhondda Cynon Taff. Thanks extended to corporate nursing colleagues for support. • New Clinical Director for Children and Young People appointed, to commence February 2025. • Environmental issues within Royal Glamorgan Hospital (Risk Register score 15) in relation to hysteroscopy procedure provision. Business case submitted for procurement of air handling unit. • Report received on air exchanges at Tirion Freestanding Birth Centre at the Royal Glamorgan Hospital. Work commenced with Health and Safety colleagues, Infection Prevention and Control and Estates to ensure mitigation in place and minimise risk. • Annual Patient Reported Experience Measures (PREM) report received at Care Group QSE on 12th December. Benchmarked against Care Quality Commission (CQC) framework. Improvement plans and thematic analysis underway. CTM perform higher in 19 of those areas where comparable. There is an improved position between our data for 2022 and 2023 in 52 of the areas.
Assure	• School Nursing service improvement meetings in place in partnership with trade union colleagues. Band 6 job description reviewed. • Two day Neurodevelopment (ND) national workshop took place November 2024 attended by Care Group colleagues. Pilot planned for early 2025 to review process / models to support growing demand. Weekly meetings with Welsh Government taking place to ensure reporting. Joint CAMHS / ND clinics working well with positive outcomes reported • Workshop with Therapies colleagues held to develop a model for childhood obesity services with regular engagement across the Care Group. • Increased number of pressure areas noted within maternity during November. Learning sessions & monitoring in place. • Maternity and neonatal colleagues attended a national community of practice event for the introduction of a Maternity Early Warning Score (MEWS) and Neonatal Early Warning Track and Trigger tool (NEWTT2). Call for Concern

	also being introduced early 2025. Implementation plans in place, plans also include Emergency Department, Gynaecology and Paediatric colleagues. (Welsh Health Circular (WHC/2024/ 035) 17th September 2024. • Update received in Care Group QSE meeting from Lead Nurse for Safeguarding, notably positive progress against training rates. Thanks extended to the Corporate Safeguarding team for their support. • Annual Tirion Freestanding Birth Centre report received at Care Group QSE 12th December 2024. Consultant midwife currently benchmarking CTM position against national Maternity Unit Network standards. Self-assessment being submitted to Maternity and Neonatal Network by 31st January 2025. • Quality improvement plan including Equality, Diversity and Inclusion work underway. Presentation prepared and available on request. • Risk Update:

ID	Title	Rating (current)
5905	Unfunded continuing care packages / unfilled packages	20
5922	Staffing and Capacity (PCH Maternity / Obs)	16
5763	Lack of special school nurses / unfunded service level agreement	16

• Risk ID 5755 Removed as works to replace air handling unit and improve electrical infrastructure at Princess of Wales Hospital Bridgend complete.

(Children & Families Senior Management Team reviewing the risks above for escalation to the Organisational Risk Register)

Inform	• Weekend 111 triage rota being piloted by paediatric consultant colleagues with the aim of reducing 111 referrals to Emergency Department (ED) and GP Out of Hours service. Initial feedback positive, monitoring in place within the Care Group. • Welsh Government guidance issued April 2024 for implementation of Healthy Child Wales Programme Phase 2. National work-streams in place with project extended for further six months. Local implementation plan in place across CTM.

- Data capture concerns ongoing with maternity transfers from Aneurin Bevan University Health Board (ABUHB) due to ABUHB having a paperless system. Care pathways in place with appropriate mitigation while a digital maternity system is sought (as part of Maternity and Neonatal Safety Support Programme MNSSP).
- Digital booking system introduced for induction of labour and elective caesarean sections.
- Digital inclusion project introduced across maternity services for women and birthing people experiencing digital exclusion or poverty.
- Mobile clinics within Integrated Sexual Health (ISH) for vulnerable client groups being progressed.
- Theatre management system (TOMS) into Prince Charles Hospital (PCH) obstetric theatres.
- Aquanatal classes introduced within Bridgend with positive uptake from women and pregnant people.
- Funding received from Public Health Wales (PHW) for introduction of electronic results system for Integrated Sexual Health (ISH).
- Good attendance at CTM and '2Wish' Hope After Loss event on 6th December from the Care Group teams. Corporate bereavement team facilitated a children's grief cycle in support of national children's grief awareness week.
- Several posters and oral presentations received at CTM Research and Development Conference 26th November 2024 from Care Group colleagues. Health Visitor awarded a prize for best oral presentation following her research with gypsy and traveller communities exploring breastfeeding uptake rates.
- Well-being event for Maternity and Neonatal Colleagues planned for 14th February 2025.
- Ward visit from Patient Experience Teams have received excellent feedback from children, young people and parents

	• Funding agreed for a feasibility study exploring the development of an integrated health and social care respite facility for children with complex needs
Appendices	• Appendix 1 – Maternity and Neonatal Metrics.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: • Creating Health • Inspiring People • Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: • Growing Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below: • Culture and Valuing People • Leadership • Learning, Improving and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: • Timely • Effective • Efficient • Equitable

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

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

Maternity Metrics

27th December 2024

Metrics by Exception

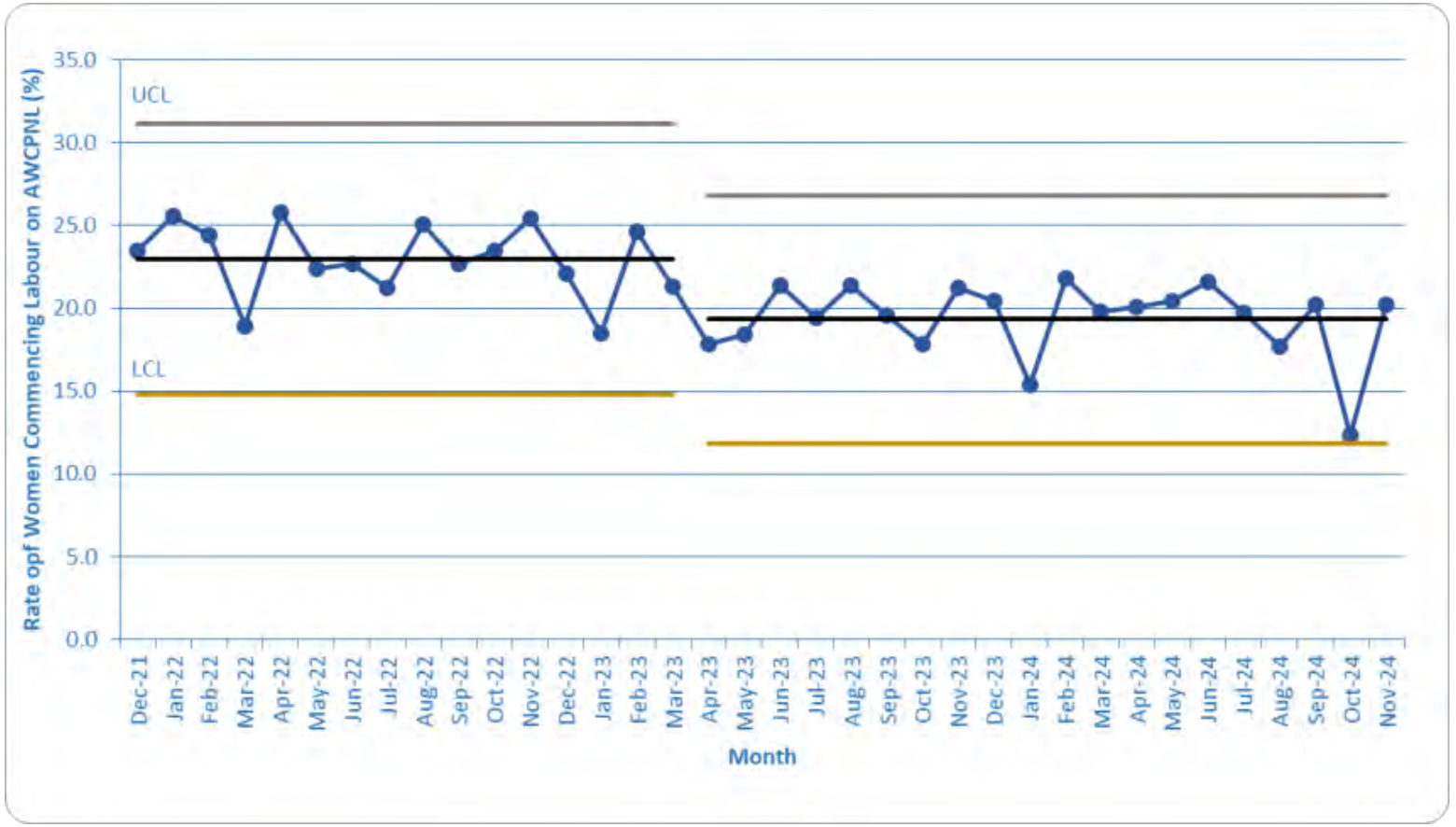
The data shown on the following slides are for December 2021 – November 2024 unless otherwise stated.

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

Metrics are reported by exception only in this presentation.

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

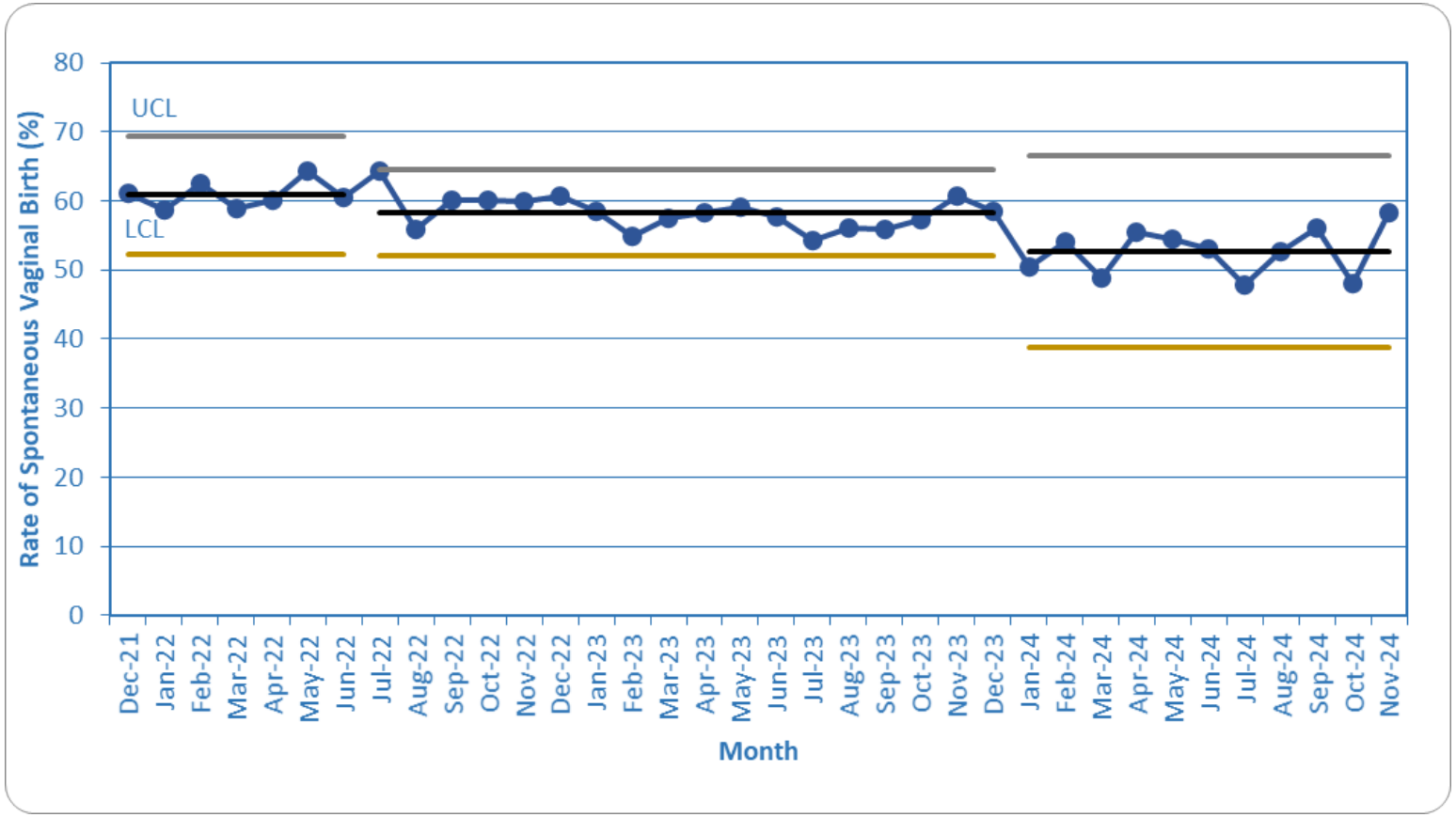
Rate of Women Commencing Labour on the NLP



The median rate has decreased from **23%** to **19%** as of April 2023.

In November 2024, the rate was **20%**.

Rate of Spontaneous Vaginal Birth

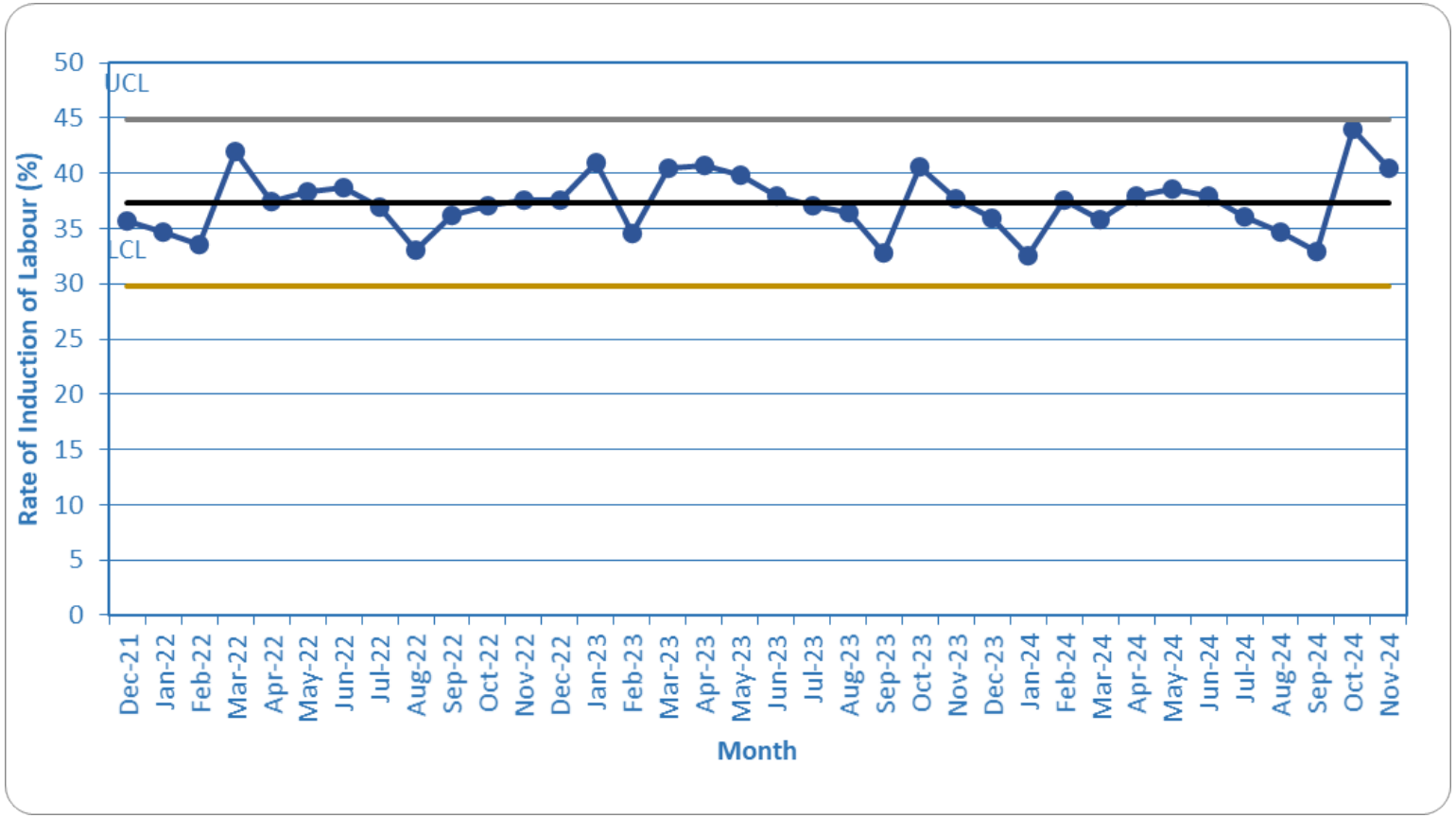


The median rate has decreased from **61%** to **58%** as of July 2022.

There was a further decrease in January 2024 to the current median of **52%**.

In November 2024, the rate was **58%.**

Rate of Induction of Labour

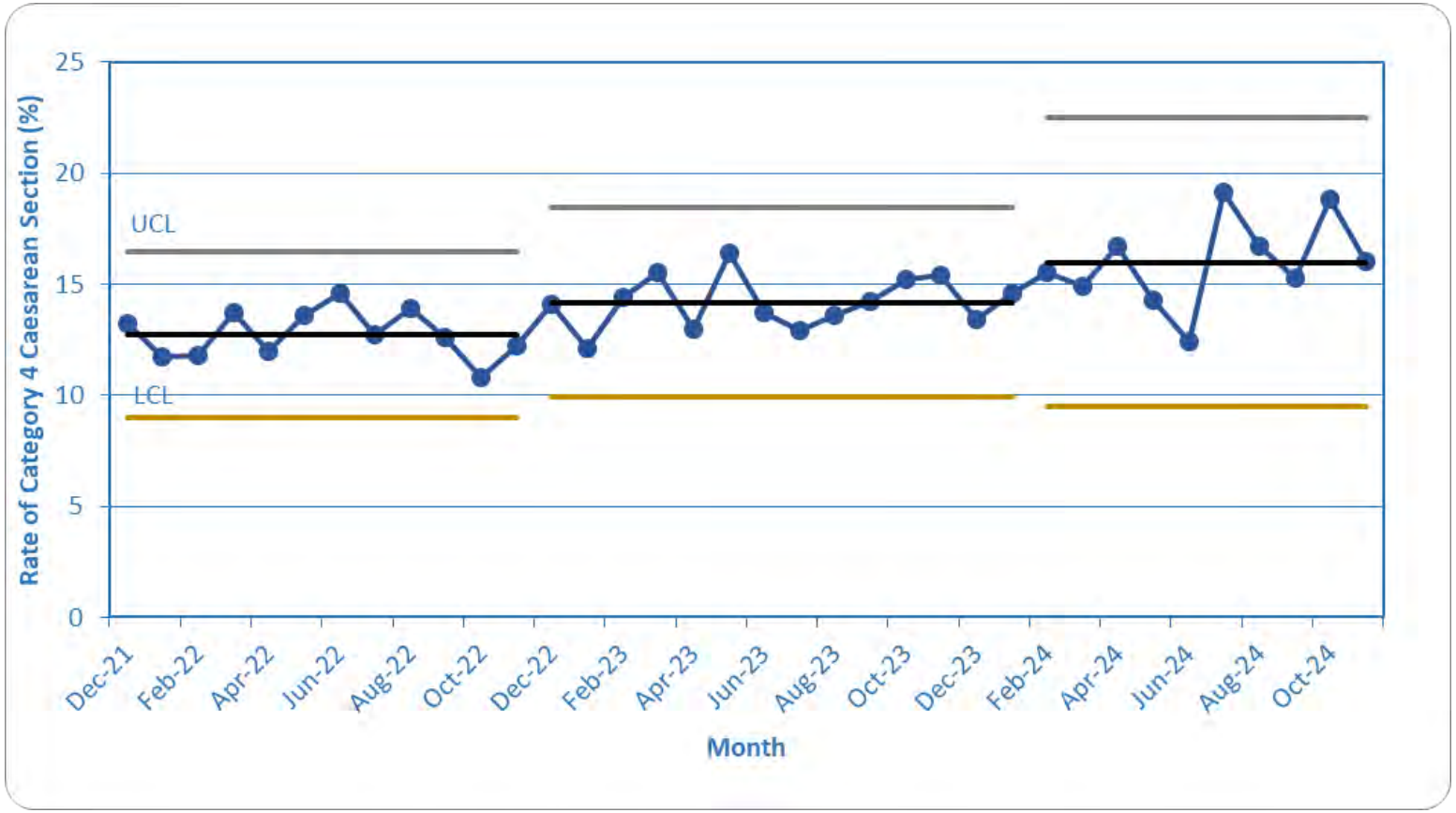


The median rate has remained stable at **37%**.

In October 2024, the rate was **44%,** which reached the upper control limit.

In November 2024, the rate was **41%**.

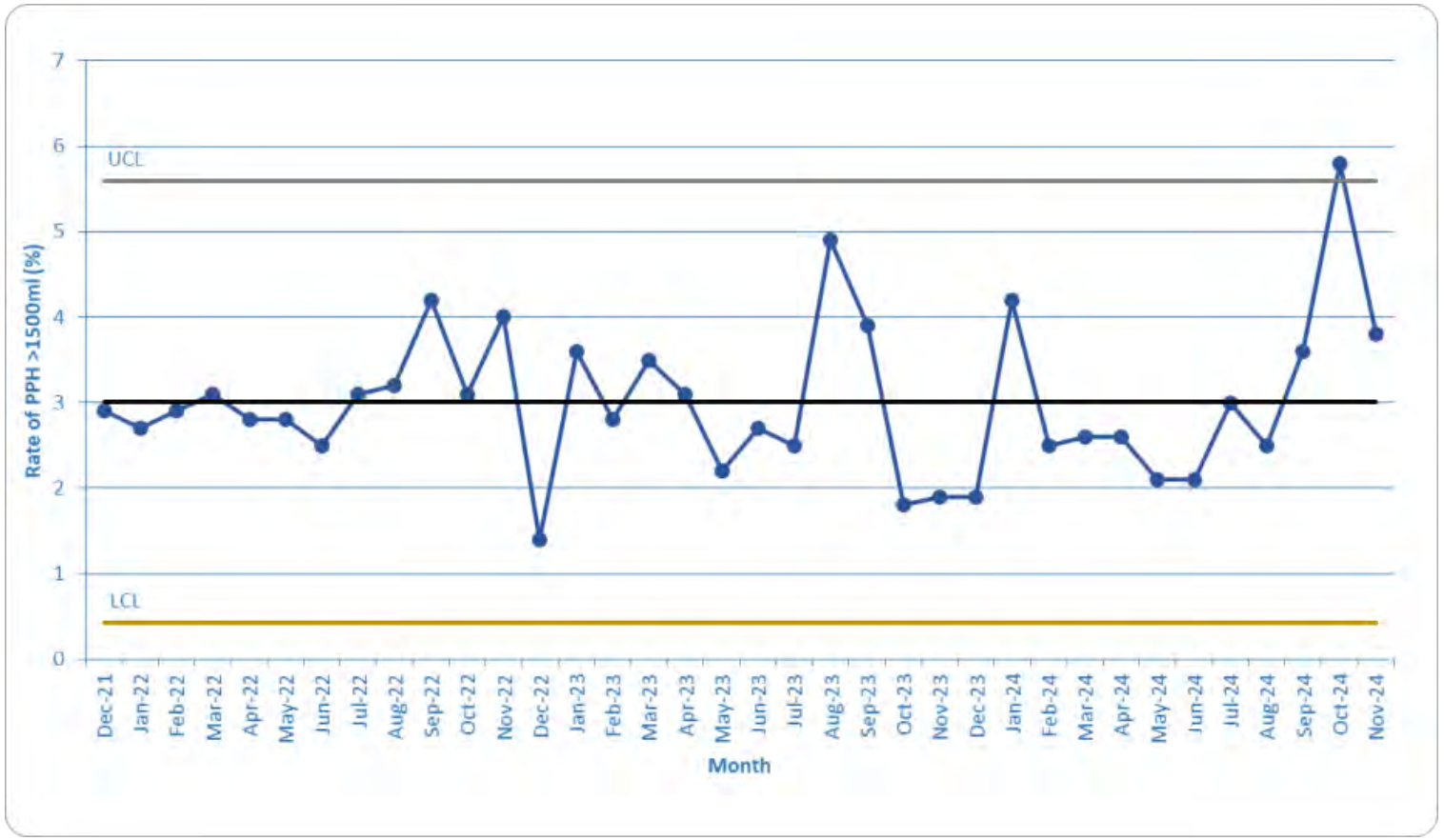
Planned (Category 4) Caesarean Births



The median rate increased from **13%** to **14%** in January 2023, with a further increase to **15.8%** in February 2024.

In November 2024, the rate was **16%.**

Postpartum Haemorrhage ≥1500ml (Major Obstetric Haemorrhage)



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

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

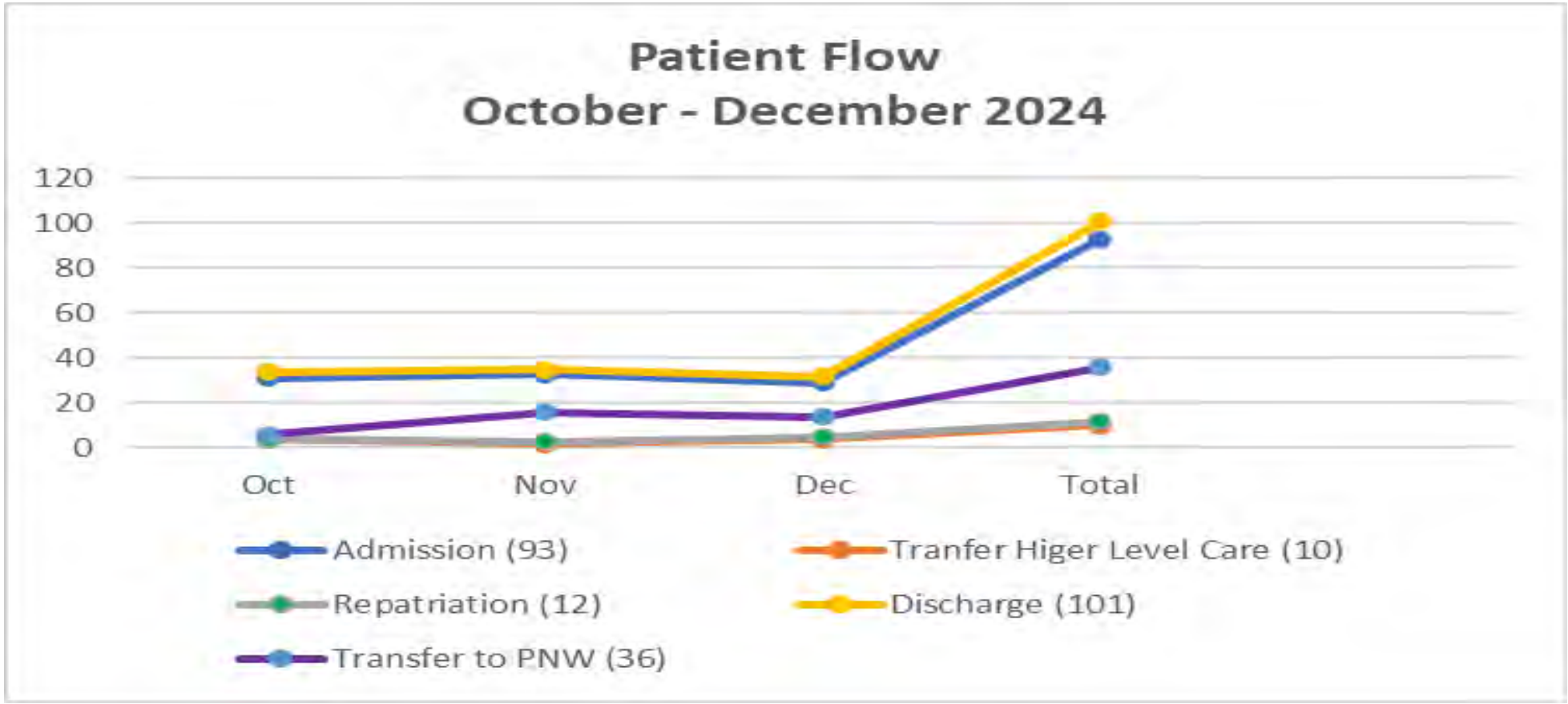
In November 2024, the rate was **3.8%**.

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

Neonatal Metrics

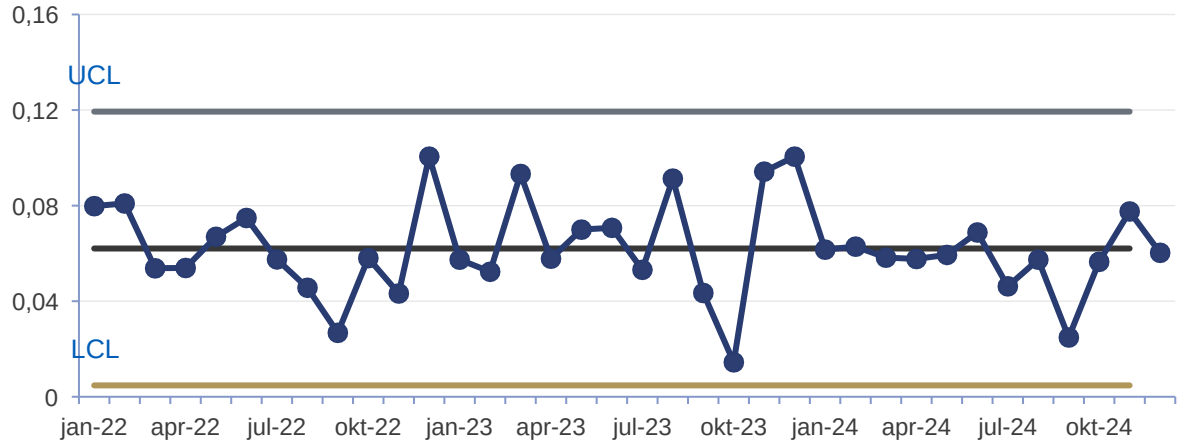
December 2024

Patient Flow

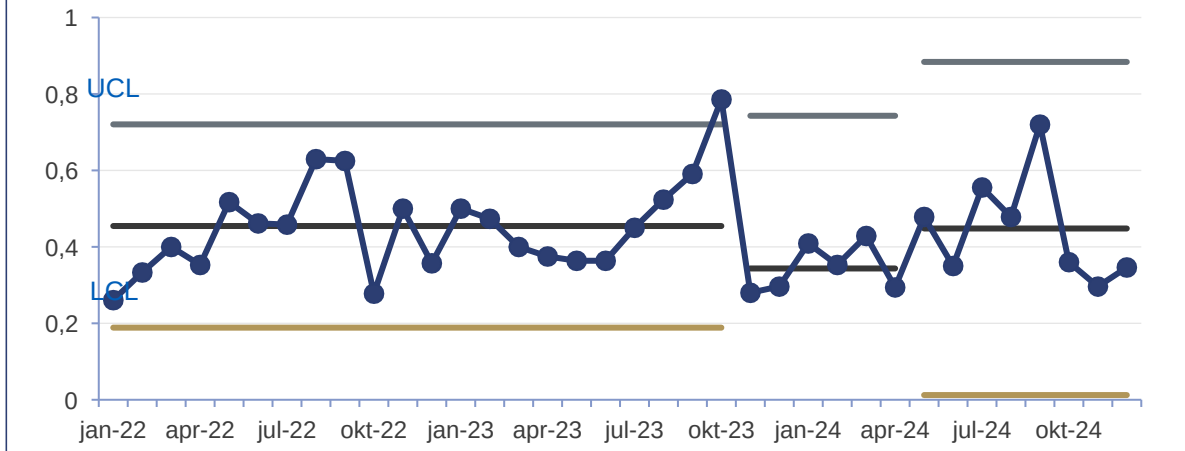


Admission By Categories- Term/Preterm

PCH NNU- **Term** Admissions- *(Jan 2022-Dec 2024)*



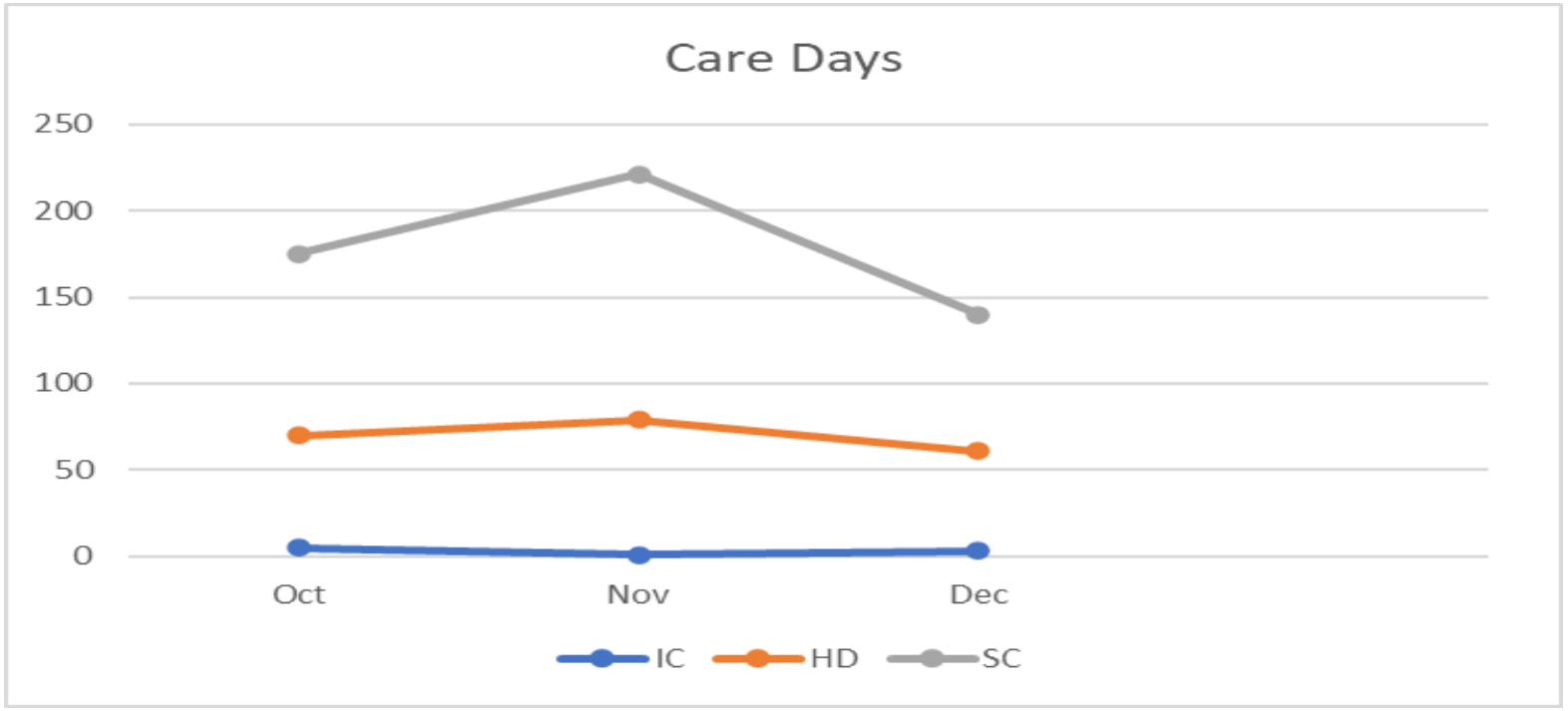
PCH NNU- **Preterm** Admissions *(Jan 2022- Dec 2024)*



- Rate has remained stable median 6.1%
- National target 5%
- Each term admission reviewed in Perinatal MDT setting. Maternity governance team now collate quarterly themes and trends for wider sharing and mitigation of future re-admission.

- Pre term admissions consistently account for the majority of admissions to the NNU at PCH.
- Data includes babies born in PCH (excludes repatriations)
- PeriPrem data continues to be collated and monitored.
- Exception reportable births to be reviewed in the same structure as ATAIN- was the birth in our unit avoidable/unavoidable- themes to be collated and shared.

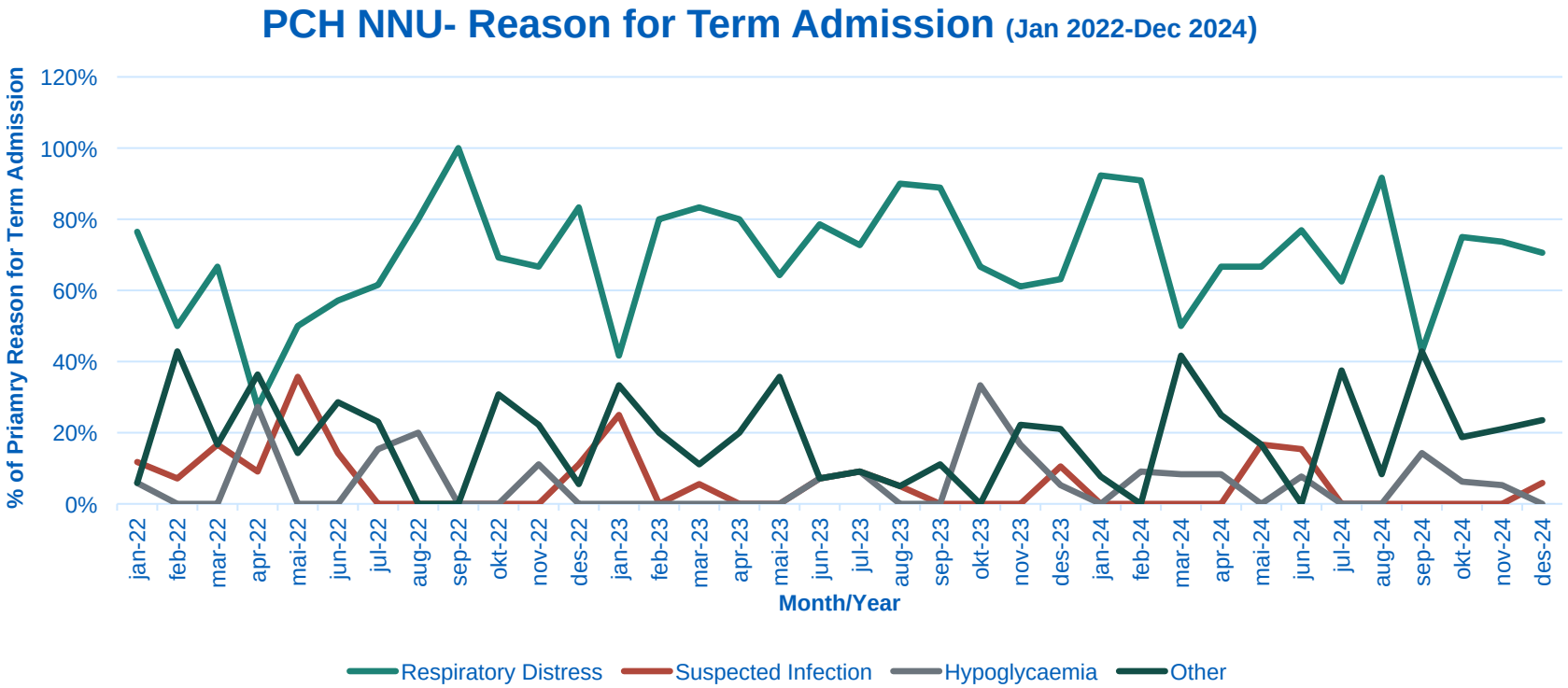
Care Levels



There were a total of 755 care days between October – December 2024

IC care days - 9
HD care days - 210
SC care days - 536

Reasons for Term Admissions

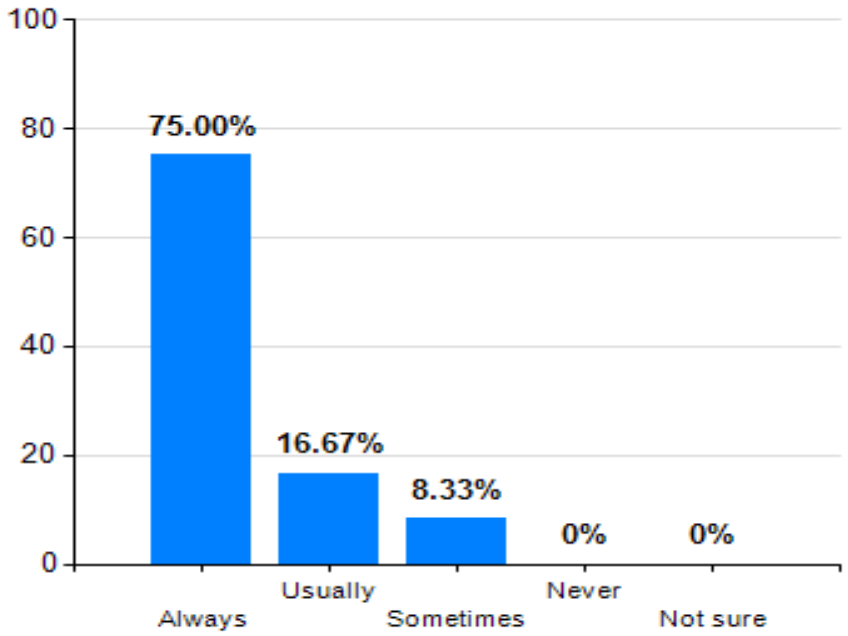


- Respiratory distress consistently accounts for the highest number of term admissions to the NNU.
- ATAIN will now sit on the forward audit plan to monitor rates and action areas of concern.
- Themes from ATAIN reviews collated quarterly for wider sharing.
- Link tertiary centre Neonatal Consultant working on ATAIN- plans to digitalise ATAIN review proforma to allow data extraction and thematic anaylysis.
- There is no direct correlation between the increased caesarean section rates and out comes for term infants.

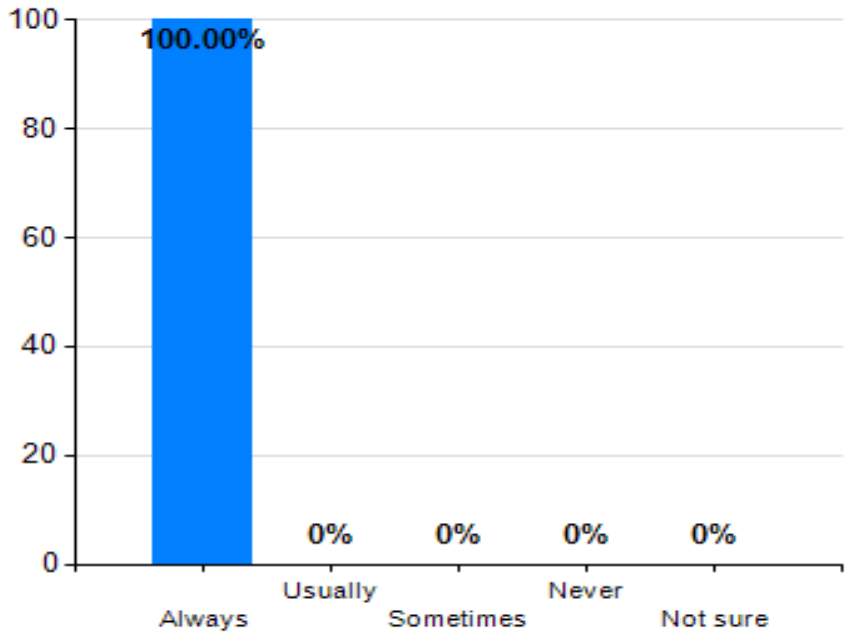
- ‘Other’ reason account for NAS scoring, a place of safety, surgical etc.

PREM data Oct – Dec 2024

Information about unit facilities



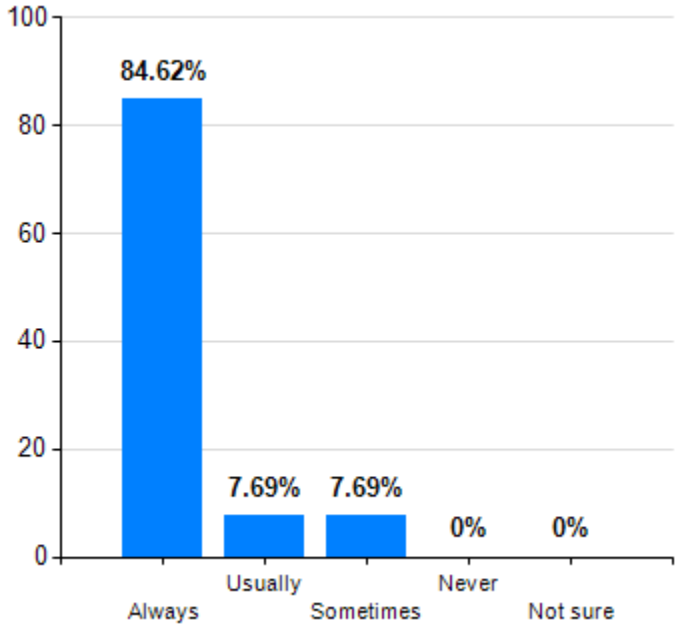
Fully informed about babies care



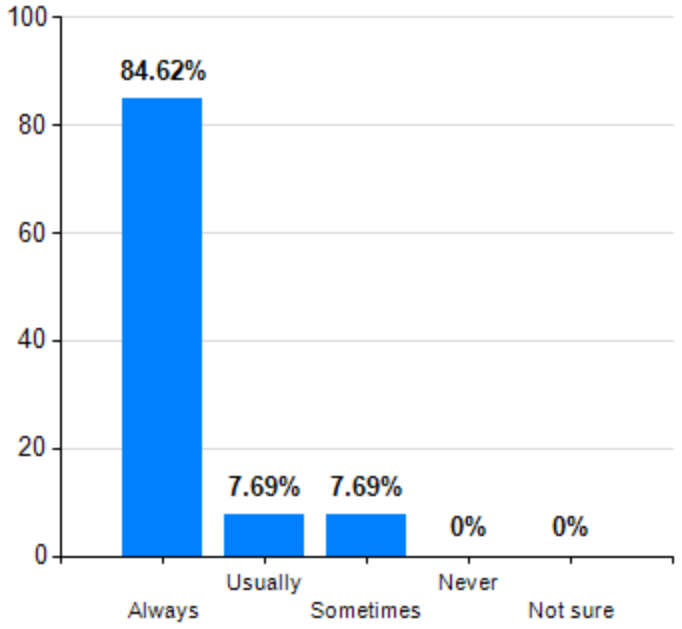
13 responses between Oct – Dec. Parents are being offered the use of ipads to complete the survey on discharge. SMS has also been introduced to improve the response rate

PREM data Oct – Dec 2024

Feels treated with dignity and respect



Feels able to stay with your baby overnight



Agenda Item
5.3b

Quality, Safety & Experience Committee

Highlight Report from the Unscheduled Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma James, Unscheduled Care Nurse Director Owen Weeks/ Robin Martin, Unscheduled care Medical Director & Victoria Healey, Head Of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter	Emma James, Unscheduled Care Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Care Group Quality & Safety Committee	17/12/2024	NOTED

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
ABUHB	Aneurin Bevan Health Board
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
Q&S	Quality & Safety
HIW	Health Inspectorate Wales
USC	Unscheduled Care Group
ED	Emergency Department
AMaT	Audit Management and Tracking System
IPC	Infection prevention control
UHW	University of Wales Hospital

ANTT	Aseptic non touch technique
AMU	Acute Medical Unit
ANP	Advanced Nursing Practitioner
COTE	Care of the Elderly
ACE	Acute care of the elderly unit
MRI	Magnetic resonance imaging
OCP	Operational Change Policy

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 17th December 2024.

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

2. Purpose of this Meeting

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

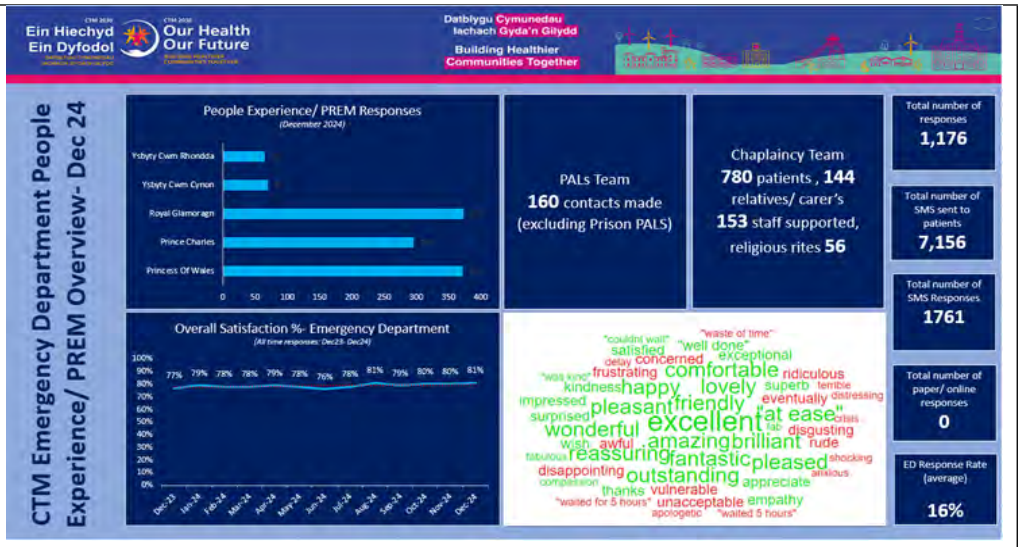
2.2 The Committee is requested to NOTE the report

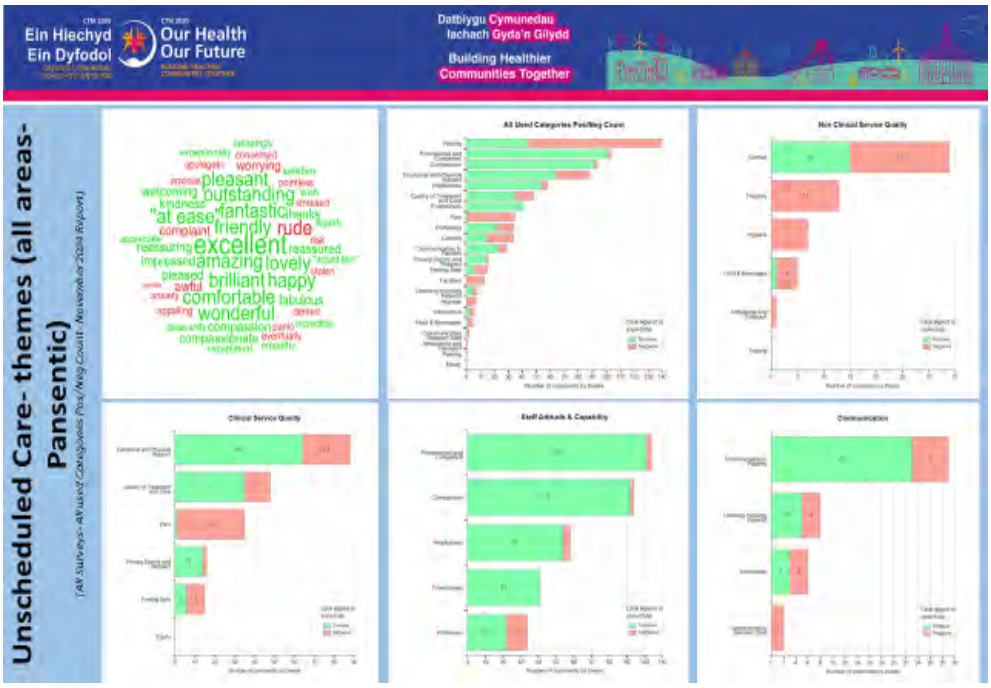
3. Highlight Report

Alert / Escalate	The ability to deliver Senior Stroke Clinical Leadership across 2 Sites (PCH and RGH) has been very difficult for some months but has diminished rapidly over the last few weeks. This has contributed to unsustainable demand upon the remaining consultant workforce (employed and locum) that must be addressed for safety reasons. We have worked closely with stroke and other clinical teams to explore opportunities for utilising the workforce in different ways to improve capacity and also explored cross-health board support with neighbouring health boards. Cardiff consultants have been very helpful where they can, however this is limited, so to maintain a safe service that can continue to save lives and reduce the effects of stroke for as many patients as possible, we must make immediate, local changes to the way in which services are provided. To maintain a safe and effective acute Stroke Service for our patients and communities, immediate urgent plans are being developed to move onto a single site. A decision has been made to temporarily centralise all Stroke services at the Royal Glamorgan Hospital. This decision was enacted following an optional appraisal where if the service was to move to PCH site this would displace 422 patients from CTM to other organisations whereas this move

	displaces 251 allowing us to continue to provide specialist stroke services to a greater proportion of our patients. Moving the PCH Acute Stroke Ward to RGH Ward 19 which will provide 22 Stroke beds as well as the 27 Stroke beds on Ward 20. (Total of 49 beds). It will also allow for the creation of a dedicated Therapy space on Ward 19 to enhance the Therapy Service provided for inpatients on both stroke areas. A project team with dedicated work streams are in place developing plans and clinical pathways and undertaking the actions required at pace to achieve the move to RGH on the 8th January 2025. This includes the involvement of key stakeholders including workforce, staff side, Llais, WAST and other health boards, in particular Powys, to ensure clarity on patient flow implications for Powys i.e. which patients will go to RGH and which to ABUHB. We also have ongoing workforce and wellbeing support available to our teams while we support them with this necessary yet difficult transition to ensure we have the right staff with the right skills and attributes caring for our stroke patients.
Advise	Following the critical incident in POW in October 2024 and the movement of multiple clinical areas and clinical pathways the USC Senior Leadership Team continue to work through any risks or issues as they arise to ensure quality and patient safety remain paramount during this ongoing episode of service disruption. Complaints have been transferred to a central quality governance team within the organisation since February 2023. This has ensured that we maintain equity, consistency and strengthen resilience. USC compliance with the 30 day target has remained in November 2024 at 88%.Currently there are 13 open complaints and 3 over the 30 day compliance. This is a decrease from 18 to 13 open complaints since the last report. The USC leadership team have provided a commitment to support, improve trajectories and have developed a mechanism to escalate when clinicians and nurses are unable to achieve 30 day compliance. This has been closely monitored by the USC Senior Leadership Team which has resulted in a significant improvement. During December's QSRE meeting analysis of concerns and incidents are being triangulated. Ensuring that there is targeted intervention when any themes or trends have been identified. This is enabling proactive learning and improvement where required.

	AMaT A high- level report has been produced to give an oversight of the outstanding actions on AMaT allowing the Directors to drill down specific areas. Available on request is the compliance for all areas within the USC care group to highlight areas which require improvement. Following review of the AMaT actions for USC by the corporate team and a re-fresh of the outstanding actions, these are now discussed as part of each acute sites Safe to Start morning meeting. On review common themes included Fluid Balance completion and Infection, prevention and control issues. In response to this Senior Nurses undertook further training with the relevant areas with support from the IP&C teams on 28th November 2024. 93 members of staff were in attendance. This has supported an improving trajectory in subsequent audits. There are no outstanding AMaT actions for the PCH Acute Site as of the 30th November 2024 - there is a rigorous approach to daily assurance checks by either the HoN or Lead Nurse. For RGH and POWH as part of their ward assurance the Lead and Senior Nurses are reviewing AMaT at a minimum of once a week to ensure compliance with the audits and action plans. Support and education has been put in place for ward managers to utilise existing systems to raise estates work as large amount of actions pertaining to estates issues. Fluid balance compliance has improved, weekly audits continue and bespoke training by the outreach team is being completed. A standardised 1:1 template for ward managers up to Heads of Nursing, AMaT audits are a standing agenda item.
Assure	The Emergency Department (ED) national PREM survey continues to have excellent service user engagement, with the patient experience team providing a monthly report via CIVICA. This patient feedback is reviewed by the department leads and actions are undertaken accordingly with positive and constructive feedback shared. We continue to have the best engagement with this survey pan wales which allows us to develop themes and key work streams and to share 'you said, we did' feedback with service users. This is being developed into a patient digital information board including details on how we have responded to patient feedback and any positive improvements being made, seasonal public health information and redirection information. This will be shown across all 3 Emergency Departments with generic and site specific information being included.





Triangulation of the feedback on pain scoring above undertaken by the senior nurse for ED with over 75% compliance on the patient safety checklist for pain scoring and pain relief with further improvement work ongoing.

Following the successful implementation of the Strategic Transformation of Acute Medicine Programme (STAMP) at PCH, similar methodology has been followed at RGH in order to provide a consistent approach to Acute Medicine Units (AMU) across all of our sites. This approach to protecting the Same Day Emergency Care (SDEC) area and ensuring allocation of beds to the AMU first in order to maintain <72hr length of stay has allowed us to close SDEC as

an overnight surge area since 6th December. Throughout this transformation project the site based clinical and nursing teams have been empowered and given the autonomy to drive this change ensuring patients get to the right place, first time with the right clinical team supporting their care. We have received positive feedback from staff and patients during this programme of work. Following the success of STAMP at PCH and RGH planning will now start for roll out in POW in February.

PCH nursing and medical team have continued their focus on patient wellbeing initiatives on Ward 3 Frailty with afternoon tea's being arranged for patients and their families. This experience was well received by patients and also received multiple compliments from relatives.

The Ward Accreditation programme is ongoing with a further two USC wards Ward 2 RGH (previously Ward 18 POW) and Ward 5 RGH have both achieved Bronze level of accreditation and will have their recognition for this shared later this month.

Inform

Stroke Quality Improvement Measures - September 2024		PCH	POW	YCR	CTM
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours	Total admissions	47	20	N/A	67
	No. of patients within 4	9	2		11
	% Compliance	**19.1%**	**10.0%**		**16.4%**
% of thrombolysed stroke patients with a door to needle time of <= 45 mins	Total thrombolysed	4	2	N/A	6
	No of patients within 45	0	0		0
	% Compliance	**0.0%**	**0.0%**		**0.0%**
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Number diagnosed	48	22	N/A	70
	No. of patients within 1	24	12		36
	% Compliance	**50.0%**	**54.5%**		**51.4%**
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	48	22	N/A	70
	No. of patients within	29	15		44
	% Compliance	**60.4%**	**68.2%**		**62.9%**
% of patients who are assessed by one of OT, PT, SALT within 24 hours	Total admissions	48	22	N/A	70
	No. of patients within	39	19		58
	% Compliance	**81.3%**	**86.4%**		**82.9%**
% of applicable patients discharged with ESD/Community Therapy MDT (rolling 3 months)	Applicable Patients	101	70	12	183
	No. of patients with	39	12	2	53
	% Compliance	**38.6%**	**17.1%**	**16.7%**	**29.0%**

- During September, 16.4% (11 out of 67) of stroke patients were admitted directly to an acute stroke unit (ASU) within 4 hours. There have been significant IPC constraints across all three sites which has impacted on patients being able to be transferred to an ASU within 4 hours. The overall number of confirmed strokes for September was lower than previous months which will also impact on % of patients being transferred within the timeframe.

During August 64% of patients presented to hospital outside of core hours, with a further 7 patients self-presenting to RGH.

- Six eligible patients were thrombolysed, however none of these patients' received treatment within the 45 minutes window. Main factor to not achieving this KPI was that patients presented outside of stroke service hours. 51% of patients self-presented to CTM sites which also impacts performance due to no pre-alert going out.
- 51.4% of patients (36 out of 70) had a CT scan within an hour. Our performance has been impacted by the significant amount of patient's self-presenting to hospital in September, as well as 64% of patients presenting outside of stroke service hours. This will have an adverse impact on timely treatment as there is no specialist stroke care during unsocial hours to advocate timely treatment for confirmed and suspected stroke patients.

62.9% (44 out of 70) of stroke patients treated in September were seen by a specialist stroke physician within 24 hours of arrival at the hospital. Some of the reasons for the 26 patients not having a specialist stroke review within 24 hours are patients presented at the weekend when there is no specialist service. Further restrictions for achieving this was due to patients self-presenting to RGH, as well as patients presenting with atypical stroke symptoms

What actions are we taking to improve our service?

- Due to the fragility of the consultant workforce an urgent service change has been agreed to allow PCH stroke service to move to RGH from Wednesday 8th January

- A further locum is due to start on Monday 6th January at RGH, this will bring the consultant workforce up to two substantive and two locums to mitigate sickness, vacancies and maternity leave

- Service re-design meetings set up with key stakeholders to progress with expanding rehab capacity at YCR and to scope out options regarding new RGH pathway model in line with the current workforce available

- ACP workforce and SSNAP co-ordinator proposal has been submitted and awaiting Care Group feedback to support expanding the workforce to enable 7-day stroke provision at RGH site. Currently unable to identify investment funding due to challenging in year position.

- The impact of Brainomix AI software (reporting for CTs and CT angiograms) continues to be monitored. Review of 6-month data shows 119 CTAs completed, which is a significant increase

	compared to previously. Data is taken through the Stroke Operational and Programme Board to review in high level detail. • CT perfusion can now be undertaken at PCH and RGH. POW has had the software installed and training where possible is underway. The full impact will not be seen for CT perfusion until workforce is expanded to support the new pathways. Review of data shows with the use of CTP, there could potentially be an 80% increase for thrombolysis which the current workforce could not manage.
Appendix	Nil

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: Inspiring People Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below: Culture
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below: Safe Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	Yes - Reuse
	If more than one applies please list below:

Environmental /Sustainability Impact (5Rs)	

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

5. Recommendation

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

Agenda Item
5.3c

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
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	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
SWTN	South Wales Trauma Network
GIRFT	Getting It Right First Time
OPA	Outpatient Appointment
MDT	Multi-Disciplinary Team

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 16th December 2024.

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

2.1 Purpose of this Meeting

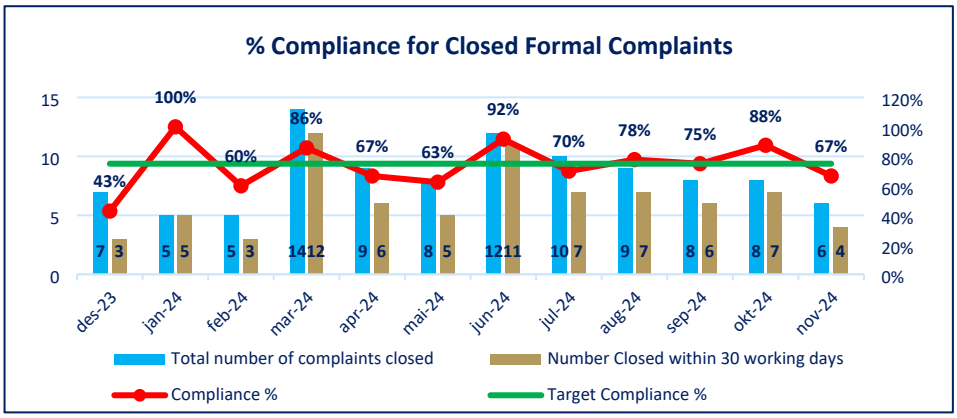
The purpose of the Planned Care/Surgery Quality, Safety, Risk & Experience Group (QSRE) is to provide assurance to the Care Group and the Health Board's Quality, Safety & Experience Committee on the provision of safe and high quality patient care and experience to the population we serve

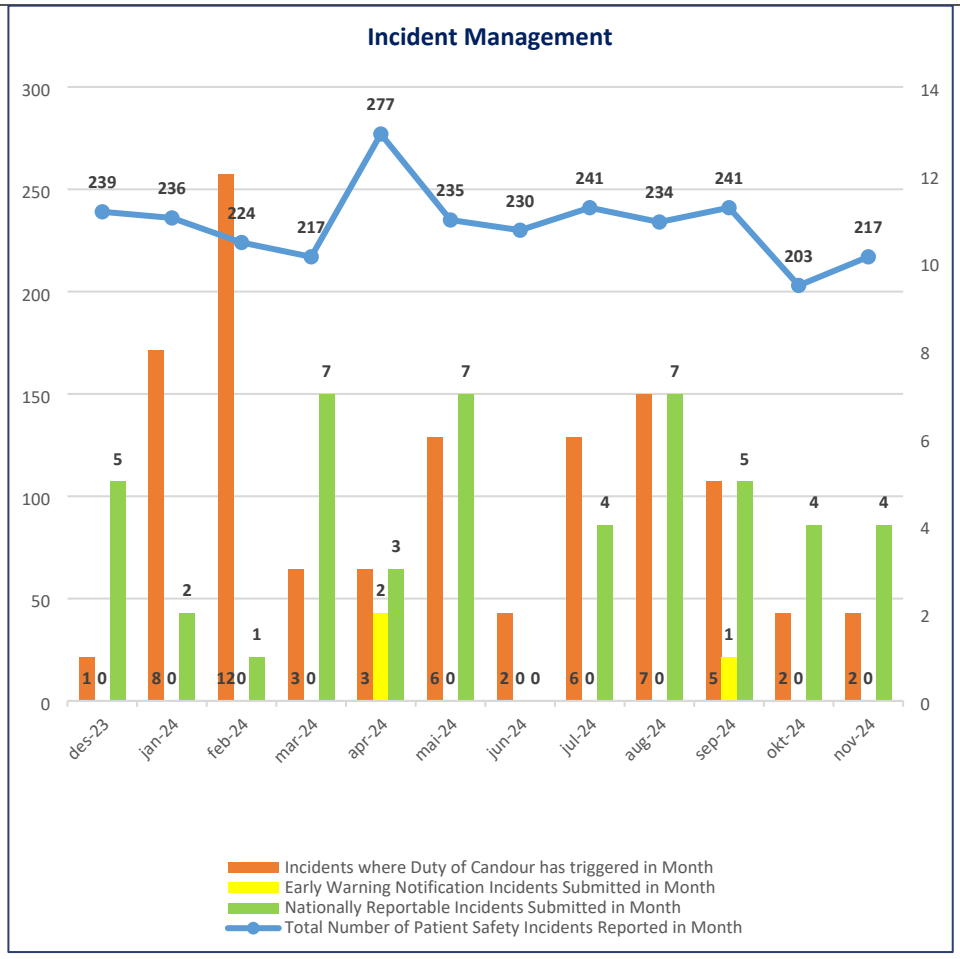
2.2 The Planned Care/Surgery QSRE Group will:

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

3.0 Highlight Report

Alert / Escalate	Impact of Critical Incident in POW on planned surgery Inability to recommence elective orthopaedic surgery & glaucoma surgery in CTM Mitigation • Scoping of additional capacity within RGH • Additional modular theatres within CTMUHB from April 25 • Focusing on recovery planning in relation to location of service delivery, and clinical models. • Instillation of SURGICUBE plans within the POW Ophthalmology Unit being finalised • Scoping of regional outsourcing and capacity commenced.

	Cancer Harm Review incident reviews • Focused work is ongoing to close the historical 104 and 146 day plus harm reviews. • Additional support required from operational teams to review the complex cases.
Advise	<u>Complaints Management (Nov 2024)</u>  Planned Care in PCH and PoW response rate 100% for the past two months. PCH with only 1 formal complaint in December and zero in POW. Trends/themes Identified • Communication and attitude includes all members of the MDT • Clinical issues • Pain assessments • NEWS calculation and Fluid Balance Chart completion and monitoring



8 x NRI's <u>reported</u> to NHS Wales Exec during Oct & Nov 2024:

- 1 x death following unwitnessed fall (PCH/General Surgery – 64243))
- 1 x death following delay in clinical assessment (RGH/ACCTTO – 62561)
- 4 x avoidable pressure damage (2 x PCH/ACCTTO 2 x POW/General Surgery)
- 2 x Ophthalmology – FUNBs (Glaucoma)

CURRENT TOTAL NRI's Open for Planned Care = 25 (decrease of 11 since last QSRE)
8 x Avoidable PUs identified at Assurance Panel remain open
6 x General Surgery / 2 x ACCTTO : 4 x POW / 3 x RGH / 1 PCH

Assure	• Surgical Co-ordinator pilot has been trialed across the surgical floor, ED and ITU in PCH. Plan to introduce in RGH. • Treatment Escalation Plans (TEPs) to be piloted on ward 6 in PCH on the back of concerns highlighted in Rapid Reviews. • "Sip til Send" initiative-commenced on Day Surgery in PCH. Ward Accreditation • Wards 5, 6, 7, 8 in PCH received Bronze accreditation • Ward 10 in RGH received Bronze accreditation Breast Service • USC One stop appointments within 3 weeks continues to be maintained above 95% compliance. • 52 week RTT Target for breast 1st OPA met at end of November, & all stages of 104 weeks to on target to be cleared by end December 2024.
Inform	• Endoscopy are piloting VR Googleminds – a Virtual Reality Programme to provide training in the department. Ongoing discussions with finance to discuss the funding of this Programme permanently. Surgical Pre-Assessment pan CTM • All Wales endorsement of CTM Health Screening Questionnaire (HSQ), go live date Dec 2024 • Excellent collaboration work by CTM Pre-Assessment Teams to standardise pathways and processes to meet GIRFT standards. Llantrisant Health Park (LHP) • Clinical review of the most recent and more detailed drawings for the site. Space, Location and adjacencies' scrutinised • LHP joint school workstream in development looking at best practice, improving efficiency and productivity with MDT involvement. • Building on early regional discussions, broad agreement to develop a virtual solution. Example of best practice being taken from across the UK. • Nursing generic and orthopaedic clinical competencies completed Good news Ward Manager on Ward 7 in PCH has received a SWTN GREATix for the ward delivering extremely high levels of care to a number of complex repatriations.

Appendices	Nil

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 *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Choose an item. 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	Yes: ☐	No: ☒

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

3. Recommendation

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

Agenda Item
5.3d

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lloyd Griffiths, Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AMAT	Audit Management and Tracking system
CMHT	Community Mental Health Team
C+V	Cardiff and Value University Health Board
HCSW	Healthcare Support Worker
HIW	Health Inspectorate Wales
HMC	His Majesty's Coroner
HMP	His Majesty's Prison
HoN	Head of Nursing
ICTM	Cwm Taf Morgannwg Improvement Team
IPC	Infection Prevention and Control
LA	Local Authority
MHA	Mental Health Act
MH	Mental Health
MHLD	Mental Health and Learning Disability
MHU	Mental Health Unit
MOJ	Ministry of Justice
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
PICU	Psychiatric Intensive Care Unit
POW	Princess of Wales Hospital
QSRE	Quality Safety Risk and Experience Meeting
RAG	Red, Amber, Green
RC	Responsible Clinician
RCRP	Right Care Right Person
RGH	Royal Glamorgan Hospital
SBUHB	Swansea Bay University Health Board
SRU	Supported Recovery Unit
SWP	South Wales Police

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 QSRE meeting on 04/12/2024.

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.

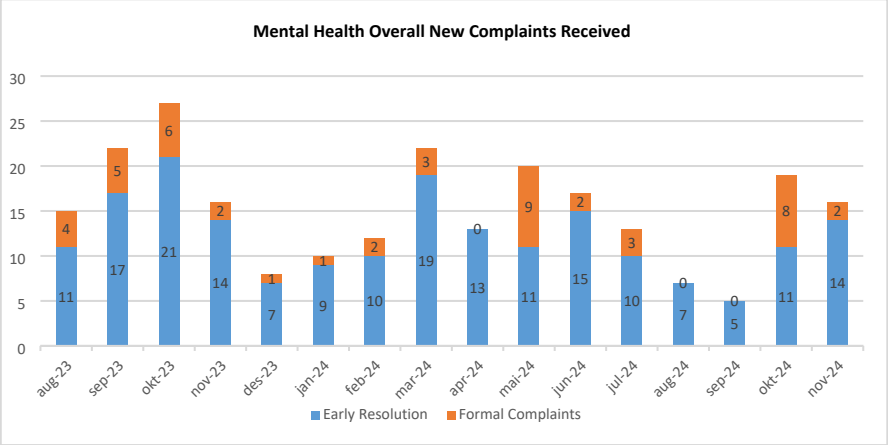
2.2 The MHLD Care Group QSRE Board will:

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

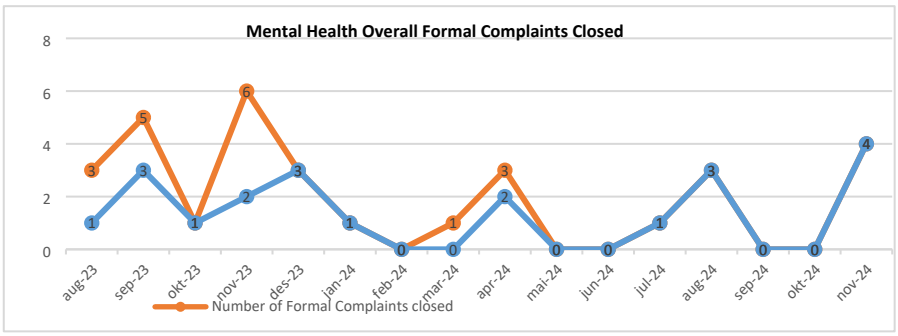
3. Key Risks / Matters for Escalation

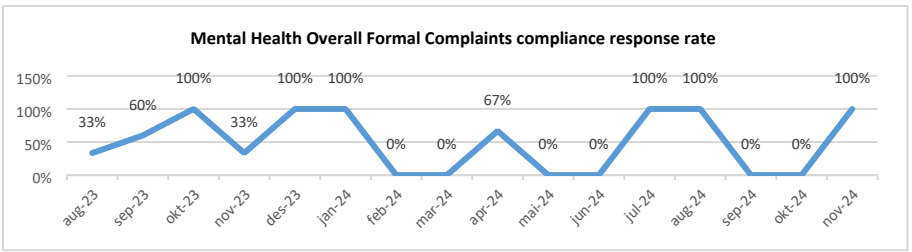
Alert / Escalate	• Medical staffing remains fragile across the whole of Adult MH services. There is a significant shortfall in medical staffing across the Care Group's Rehabilitation wards, Outreach and Recovery Teams and all 6 CMHT's. This is having a significant impact on MHA tribunals and the Health Board's statutory obligations for restricted patients in relation to RC cover. In recent weeks the MOJ has twice asked for assurance. The clinical teams are working with patients, families and advocates to minimise the impact on patients. The Adult Directorate is exploring all options to release Consultant capacity to minimise the impact for the current shortages.

	• The implementation of Phase 3 + 4 of RCRP which relate to the transportation of patients and patients who are detained under S136 of the MHA has been delayed until March 2025. At present there is no agreed alternative approach to the transportation of patients who currently require police support. The Care Group continues to engage with SWP stakeholder events and is working with C+V UHB and SBUHB to develop a regional response.
Advise	• The HoN has been working with the Business Intelligence Manager in the Patient Care and Safety team on the development of a Quality Dashboard. This has been delayed due to data migration issues in Datix Cymru which has been escalated in previous reports to committee. There has now been agreement and it is anticipated that the required changes will be in place by the end of January 2025. • A new Consultant Psychiatrist has been appointed at HMP Parc and will take up post in January. This will have a very positive impact on both services. HMP Parc has also employed another CPN which will help with the pressures they face regarding high caseloads. • A Community Mental Health Improvement group is under development to oversee, guide, and support initiatives aimed at improving community mental health services. This is in response to the outcome of the service review and consultation with community staff and the LA's to identify improvement areas. • In November 2024, Ward 14 and PICU were subject to an unannounced 3 day HIW inspection. It is pleasing to report that the feedback was largely positive with the impact of the Inpatient Improvement Board recognised. There was no Immediate Assurance required although a number of estates and environmental issues were highlighted. The reviewing team were assured that these were already known to the Care Group and plans are in place to address.
Assure	• The number of complaints received by the Care group during this reporting period was consistent with the mean (18 per month over the last 2 years). The number of formal complaints received in October was 8 (compared to a mean of 4), on investigation there was no apparent reason for the increase with the 8 split evenly across the directorates and all related to well-known themes. In November the number returned to below the mean.



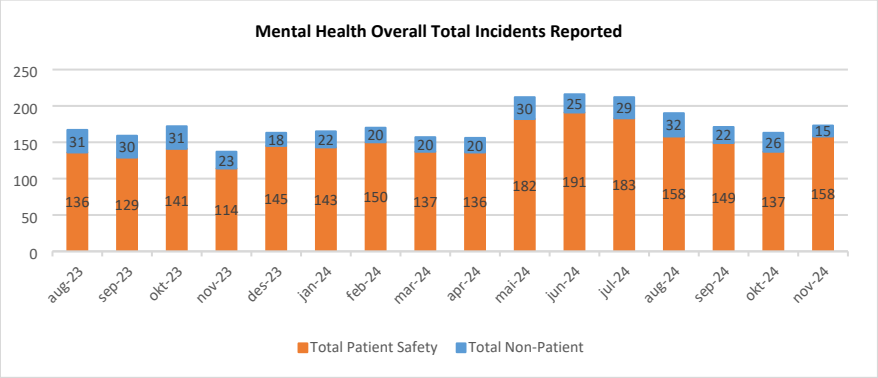
Complaint closure compliance in the Care Group was 0% in October and 100% in November, however, the low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.





At the end of November there were 6 open formal complaints (up from 3 at the end of September, this is due to the 8 received in October but still with a 2-year mean of 7).

- The Datix incidents reported this period, 163 in October and 173 in November are consistent with the 2-year mean of 195, areas of high acuity during this period are Ty Llidiard and PICU POW.



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

  There was 1 new NRI reported during this period.

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

Project	No. audits	Current compliance	Improvement	Overdue actions
Health & Safety	2	G 100.0%	▲	3
Health and Care Standards	2	G 97.5%	▲	0
Infection Control	14	G 100.0%	▶	0
Medicines Management	2	G 96.6%	▶	1
Patient Safety	17	A 85.4%	▶	21

There are 21 overdue actions in the Patient Safety category, up from 42 in the last reporting period. Of these 21, 15 are RAG rated green with 5 RAG rated as amber, these relate to IPC estates issues. 1 action is rated as Red which relates to an out of use bedroom in SRU which has been highlighted in previous papers, capital works are progressing. Performance against these audits is monitored in the individual directorate's QSRE meetings.

- The Care Group reviews the HIW inspection reports of other MHLD services in Wales and where there is applicable learning self-assessments are completed and monitored through the Care Group QSRE. This enables the Care Group to identify themes and trends from HIW in readiness for when HIW visit CTM services.

- The Care Group has implemented a programme of Quality Assurance Reviews, initially focussing on inpatient areas they will eventually include all MHLD services. The aim of the

	reviews is to prepare staff for future HIW inspections as well as providing assurance to the Care Group. Action plans are developed in response to these quality assurance reviews which are monitored in directorate QSRE meetings and referenced in highlight reports to the Care Group QSRE. The Care Group is working with corporate nursing colleagues to ensure that these reviews are in line with the Ward Accreditation programme. The reviews have been well received by staff who have found the process supportive and informative. Ward 14 had a Care Group Quality Assurance Review shortly before the recent HIW unannounced inspection and the ward manager felt the internal review was good preparation for the HIW visit.
Inform	• At the recent RCN Nurse of the Year Awards a HCSW from the OPMHS Memory Service in Merthyr won the HCSW Category in recognition for her work setting up and running of Cognitive Stimulation (CST) groups. A Nursing Team Lead in Bridgend OPMHS Memory Service was runner up in the MH Nurse of the Year Category for her work introducing Clinical Nurse Specialists and CST Groups. • The Lead Nurse for Adult Community MH delivered an overview of lessons learnt from recent attendance at HMC inquests to CTM wide “Listening and Learning” event. The session focussed on the positive impact of high quality, evidence based learning statements. The session was positively received and ICTM colleagues are keen to potentially develop the learning further. • 60 HCSW’s across two adult inpatients sites are scheduled to undertake Trauma Informed Practice training based on the Wales Trauma Framework for HCSW’s, this practice increases awareness for staff to provide additional understanding, and confidence in supporting patients who have experienced trauma.
Appendices	None

4. Assessment

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

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

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	POSITIVE/NEUTRAL NEGATIVE 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

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

Agenda Item
5.3e

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lucie Williams, Nurse Director, Primary Care & Communities
Cyflwynydd yr Adroddiad / Report Presenter	Lucie Williams, Nurse Director, Primary Care & Communities
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms

ACT	Acute Clinical Team
CNS	Clincal Nurse Specialist
CTM	Cwm Taf Morgannwg
CVC	Community Vaccination Centre
DIC	Death's in Custody
DHCW	Digital Health and Care Wales
DN	District Nurses
ED	Emergency Department
GMS	General Medical Services

HB	Health Board
HCQ	Hydroxchloroquine
HMPPS	HM Prison and Probation services
IPC	Infection Prevention Control
MDT	Multidisciplinary Team
NRI	Nationally Reportable Incident
OD	Organisational Development
OOH	Out of Hours
PCH	Prince Charles Hospital
PDR	Personal Development Record
POWH	Princess of Wales Hospital
QI	Quality Improvement
RSV	Respiratory syncytial virus
SLA	Service Level Agreement
UCAF	Unified Contract Assurance Framework
WG	Welsh Government
WGOS	Welsh General Ophthalmic Services

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience Primary Care and Communities Care Group at its meeting on the 4th December 2024.

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

2. Purpose of this Meeting

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

2.2 The Primary Community Care Group QSRE Board will:

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

Highlight Report

Alert / Escalate	Salaried Dental Services following the incident with the roof at POWH, adhoc lists that were scheduled for the end of October have been pulled. As a result of the paeds ward in RGH being converted to an adult ward, the two weekly regular lists the service had have also been pulled until further notice. Adhoc lists in PCH are still going ahead with one taking place on 24th October and one due to take place on 21st November. However, PCH is now at 100% list utilisation so it is unlikely that the service will access any more lists. This will have a significant impact on waiting times. A paper has been drafted to look at alternative options to manage this service/list.
Advise	Lymphoedema Service – Operational Lead continues to address these referral breaches, the waiting list remains at a high, however, positive progress is being made to address these issues, including: • Workforce & OD led programme being progressed with team in a bid to reduce absence rates • Plans in place to extend clinics into evenings and weekends to increase capacity of service • Additional clinic room now in use in Maesteg hospital, doubling the clinical capacity of the Bridgend service • Plans to increase administrative capacity • Cleansing of waiting list to ensure patients' priority is being reviewed and appointment is still required • Data dashboard being produced to inform future improvements An action plan is in place and a plan to scope and remodel the service is in place. Outpatients Maesteg Nursing staffing deficits continue resulting in cancellation of clinics. Plan agreed for service to move over to planned care to achieve streamlining of all outpatient services and stability of staffing. Delay in confirmation date for move is resulting in ongoing cancellations and negative impact on the service delivery. Optometry • WGOS 4 –HCQ – it has been agreed this is the next WGOS pathway to be developed across the Health Board under the new contract. This will see patients screened in optometry practices to monitor toxicity levels to avoid permanent loss of sight when taking HCQ medication. Funding has been awarded for 2 years to identify patients on lists that are suitable to be managed in primary care. There is currently no screening of these patients in CTM, 1000 identified. Task and

Finish groups are being established to monitor progress across secondary and primary care.

- An expression of interest exercise being undertaken to provide optometry services in Prison SLA – there needs to be value for money and a review of sessions required to ensure an appropriate level of service is required.

District Nursing the service is undertaking a significant piece of work in relation to safeguarding.

District Nursing activity All Wales Civica due to difficulties in obtaining accurate data for all Health Boards in Wales, the team have a group in place and links to CTM informatics team to build a Business Intelligence dashboard.

District Nursing and Specialist Nursing services Community Nursing specification work ongoing across the services to align to WG model. Monthly reporting on the specification continues and work is continuing to improve weekend working to reach 80% by March 2025.

Wound Clinic wound care pilot implemented for homeless patients, which will be provided on a clinical bus in the community.

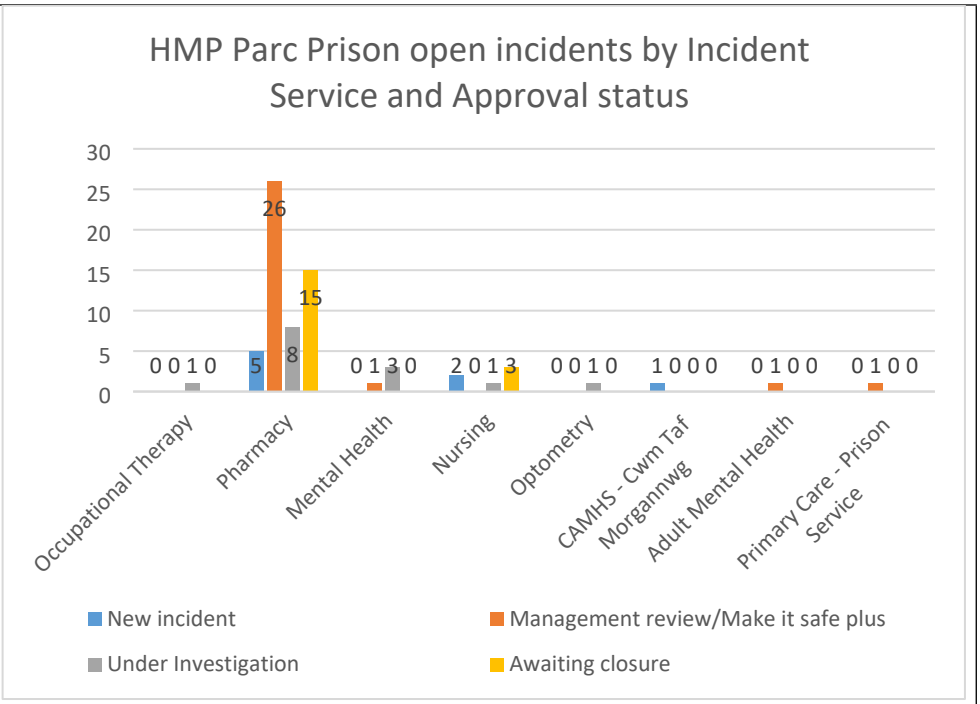
Wound Clinic Senior Nurse to professionally lead wound clinic model review and improvement work. Working group in place to review pathways.

Primary Care the withdrawal of Audit+ was initially implemented in NHS Wales on the 1st October 2007. It is General Medical Services (GS) funded (DHCW managed) system procured specifically to support General Medical Practices in the delivery of clinical care, undertaking clinical audit and quality improvement (QI) activities, improving data quality and supplying data for solutions, and looking at the National Data Resource to replace some Audit+ functionalities.

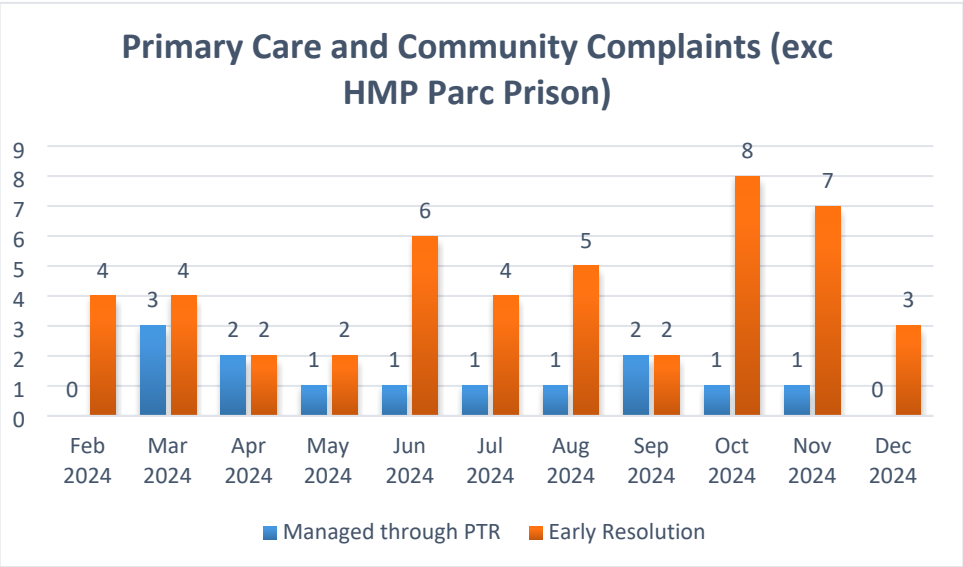
A supplier briefing session has resulted in further conversations with a small number of suppliers where DHCW are awaiting clarification on some elements.

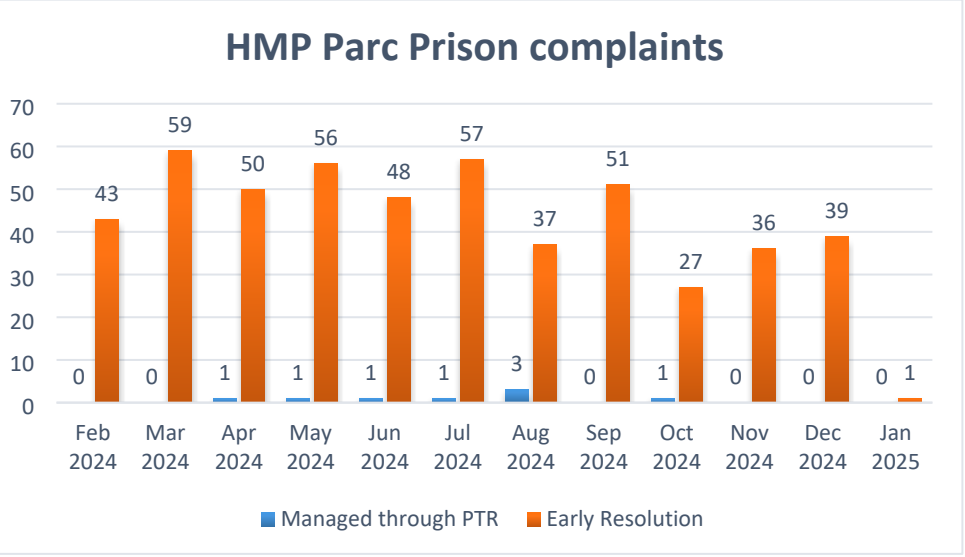
Primary Care sustainability of General Practice and recruitment of GPs into CTM. Sustainability Workshop undertaken on 20th November 2024. Experience has demonstrated that early conversations with practices can avoid contracts being resigned

	and disruption to services offered to patients. Scoring outcomes may well look relatively healthy but the situation is fluid and can change rapidly. The workshop identified that even where a practice has looked relatively stable from a medium/long term sustainability perspective, a crisis can have a significant detrimental impact. The GMS team are now reviewing their action plans regularly and continue to build upon the strong working relationships already established with individual practices. Parc Prison • Directorate Manager engaging in discussions with the Clinical Director for ED, POWH regarding the possibility of developing a bespoke training programme to enable prison healthcare staff to treat more prisoners on site and reduce the need to transfer to an emergency department. • Staffing Model: as part of the HSCNA and in response to the DIC action plans, a review of the current staffing model is underway to review the nursing and pharmacy staffing model provided at the prison. • Integrated Services: plans to develop a coordinated care model that integrates mental health, neurodiversity and substance misuse programs to provide holistic treatment for prisoners. A review of how secondary care services are provided within the prison is underway to understand the use of remote clinics and assess potential for further in-reach services. • Continuous Improvement Plans: Healthcare outcomes and processes to identify opportunities are regularly evaluated for further enhancements and ensure compliance with health care standards. The pharmacy team recently underwent a process of working with iCTM to review current practices and to identify possible changes that will improve the staff experience whilst reducing errors and incidents as part of the medication hatch review.
Assure	Incident Management <u>Parc Prison</u>


HMP Parc Prison open incidents by Incident Service and Approval status
30
25
20
15
10
5
0
0 0 1 0
5
26
8
15
0 1 3 0
2 0 1 3
0 0 1 0
1 0 0 0
0 1 0 0
0 1 0 0
Occupational Therapy
Pharmacy
Mental Health
Nursing
Optometry
CAMHS - Cwm Taf Morgannwg
Adult Mental Health
Primary Care - Prison Service
New incident
Management review/Make it safe plus
Under Investigation
Awaiting closure

Concerns


Primary Care and Community Complaints (exc HMP Parc Prison)
9
8
7
6
5
4
3
2
1
0
0
4
3
4
2
2
1
2
1
6
1
4
1
5
2
2
1
8
1
7
0
3
Feb 2024
Mar 2024
Apr 2024
May 2024
Jun 2024
Jul 2024
Aug 2024
Sep 2024
Oct 2024
Nov 2024
Dec 2024
Managed through PTR
Early Resolution



AMAT

Audit	Frequency	Compliance						Current	Improvement
POINT REVIEW: Fire Safety Management Audit	M	97.8%	97.6%	96.2%	97.4%	98.2%	98.2%	100.0%	
POINT REVIEW: Presentation (uniform) audit	M	98.7%	98.9%	98.9%	99.2%	99.4%	99.3%	100.0%	
EXTERNAL AUDIT (04): IPC & Environmental Audit (V2)	Q	N/A	N/A	N/A	N/A	Nil	Nil		N/A
POINT REVIEW: Glucose Monitoring Audit	M	100.0%	96.0%	92.3%	100.0%	94.7%	100.0%	100.0%	
POINT REVIEW: Infection Prevention & Control audit, & Environmental Audit (V2)	M	97.1%	96.5%	96.8%	96.8%	97.9%	97.6%	97.6%	
POINT REVIEW: Wristband audit (V2)	M	94.8%	99.2%	97.3%	96.0%	95.9%	98.6%	100.0%	

District Nursing transcribing of medication is now embedded in practice and following review the new process has been approved.

Primary Care GMS Unified Contract Assurance Framework (UCAF) has been established and Desk Top Reviews for all Practices have been undertaken by 31.12.2024. The desktop reviews will result in some practices being selected for either:

a) A “Full Governance Visit” which will be an in depth whole day visit undertaken by a multi-disciplinary team to include a Clinical Director (GP) and Medicines Management covering all 12 Quality Standards or
b) A “Focused Visit” which will be undertaken by a team pertinent to one of more Quality Standards.

	Parc Prison Infection Prevention & Control actions are required regarding a recent visit from IPC colleagues - the infection control report will necessitate a collaborative effort, as the environment is not solely under the management of the healthcare.
Inform	ACT Patient feedback forms implemented. Currently there has been some uptake for completion, with overall very positive feedback. CRT (Pharmacy) medication charts have now been rolled out across Bridgend following a successful implementation in the East cluster, enabling care staff to administer medication to individuals in their own homes. A second project involving the use of medication dispensers to support people to remain independent is approaching the closing and evaluation stage following successful recruitment of individuals. The project will be evaluated by Swansea University. Parc Prison have been successful in recruiting to numerous vacancies and now have only 3wte RN vacancies. This increase in our workforce will enable us to reduce our reliance on agency and provide continuity of staff to the population. Parc Prison A Health and Social Care Needs Assessment has been undertaken, which better understands the health needs of the resident population in Parc and to assess the extent to which the current need and demand for health and social care in the prison establishment were being met. An action plan for improvement has been created and will be worked through collaboratively with G4S. Parc Prison improvement work continues: • Offer and uptake of testing for Hepatitis C continues. The healthcare Team undertook 285 tests on weekend of 16/17 November 2024. • Palliative Care MDT initiated to support those patients with palliative diagnosis. MDT will continue to run monthly and educational sessions for the team provided by the CNS team. • Admissions team for healthcare established to implement a more efficient and comprehensive system. Work being undertaken to streamline the admission and screening services in alignment with the All-Wales approach, several key initiatives are being explored. These initiatives aim to enhance

	efficiency, improve patient experience and ensure consistent standards across healthcare services in Wales. • The sexual health service has recruited a new Band 7 nurse who will dedicate one day each week to providing sexual health services to patients, in collaboration with a consultant to enhance screening and treatment pathways. CHC & FNC there have been breaches identified with retrospective claims. These patient cases have been allocated and are being worked through in line with policy. Care Homes there are currently no CTM nursing homes in escalating concern or increased enhanced monitoring. Hazards Health Protection Service are in the final planning stages of the Mpox vaccination for the OOH on-call rota. Vaccination (in hours and OOH) will at present be on site at Dewi Sant Health Park. Hazards Health Protection Service The Maternal RSV programme is now embedded and the CVC's are successfully seeing daily (small) numbers of pregnant ladies coming through for vaccination. District Nursing have implemented a compliance tracker for all team leaders to monitor mandatory training and PDR's. Areas of improvement identified. Optometry as part of the new contract, practices are obliged to complete an Annual Return to demonstrate they are meeting quality standards in practice. The deadline for completion 31/01/25 where HBs will need to review the submitted information to deem practices compliant and make associated payment.
Appendices	Nil to add.

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below: Ageing well Dying Well Growing Well
Dolen i Hwyluswyr Ansawdd *(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): 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)* /	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

4. Recommendation

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

Agenda Item
5.3f

Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Dr Sally Bolt, DTPS Care Group Medical Director/Consultant Radiologist
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

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

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 16th December 2024.

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

2. Purpose of this Meeting

2.1 The purpose of the Care Group 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 and 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>Radiology</u> • Corporate Risk 5590 – Notified in November 2024. Supply of Technetium may be stopped for a period of 4 weeks, potentially up to 10 weeks, due to supply issues. This will affect the urgent suspected cancer (USC) patients being scanned, having the most impact on breast surgery. This is a national issue. Mag Trace can be used as an alternative but is more costly and felt to be inferior by the operating surgeons. This is further compounded by an urgent medical device correction letter stating that the gamma camera at RGH cannot be used due to a safety issue. All cases are now being scanned at POW whilst options are worked through • Limited access to MRI pacemaker service. The service has recently commenced but is only available to scan USC patients due to capacity and funding constraints. The service is only currently available on the PCH site which inhibits access for patients. <u>Pathology</u> • LIMS 2.0: The overarching risk in relation to meeting the project timelines has already been escalated to the organisational risk register. The project timeframe is tight and there are significant concerns regarding the resource required to deliver this project safely within expected timeframes. The user acceptance testing (UAT) phase has been throughout September and October, where Health Boards across Wales have had to commit resource to complete UAT. Due to the significant number of defects and failure to meet specified functionality requirements, the UAT phase has now been extended to January 2025. This is a significant burden on Pathology staff, as additional staff time and effort has been required to re-test functionality once the fixes have been put in place – there are instances where defects are still detected with a need for a third (and on occasion more) round of testing. The extension of UAT phase and the resource required to complete this will impact other projects that had been planned around the anticipated completion of UAT by the end of November. All Pathology departments have risks recorded in relation to staff resource. The extension of UAT phase and associated resource burden is exacerbating these risks in terms of managing competing priorities, staff morale and wellbeing. A presentation articulating the issues, risks and current mitigations will be presented at Operational Management Board in January 2025. • Clinical Haematology: A risk was escalated in September regarding no new patient (NP) capacity due to sickness and

annual leave, primarily at RGH. A locum consultant was employed to pick up the NP capacity until the substantive consultant returned from absence. This temporarily resolved the issue. Unfortunately, the locum consultant contract has ended and they are leaving to take up another position and the substantive consultant will not be returning. The reduced consultant capacity at RGH has meant that there is once again no capacity to take on new patients. An advert for a locum/fixed-term consultant is in progress.

The POW decant further impacted NP capacity in PCH as staff have had to reduce their NP clinics to support the increased day unit work. There has been agreement for a locum to support the increased patient capacity at the PCH HaDU, allowing the substantive team to pick back up full NP clinics. The service is extremely fragile and any reduction in staff capacity will have the potential to impact patient care.

- Impact of MES Reform on Mortuary Services: New regulations came into force on September 9th, whereby all non-coronial deaths will now be independently scrutinised by the Medical Examiner Service. This has resulted in some administrative changes to the death certification process, leading to increase length of stay for the deceased. This has already impacted on capacity at the RGH site, where we have had to transfer to other body stores to create sufficient capacity. This introduces risks around HTA compliance.

- Due to seasonal increases in death rate and significant delays in death certification, we are currently tracking above our Winter 2022 capacity where we breached capacity. As a result, the Mortuary capacity risk has now been increased to high. To manage capacity, the deceased are currently being transferred between storage locations within the Health Board, and a temporary 'pop up' mortuary storage facility is being utilised. Delays in death certification has a significant impact on flow through the mortuary, and more importantly a detrimental effect on bereaved families who wish to make arrangements for their loved ones. Several complaints have been received in relation to this. Delay in death certification is significantly impacting the Mortuary capacity risk, and support is required to promote prompt death certification throughout the Health Board. Executive Medical Director has supported the Care Group with targeted messaging to individual teams.

	<u>Healthcare Science</u> <u>Backlog for Medical Illustration</u> ▪ WG funding for three posts ends March 2025. Alternative funding is actively being sought. ▪ Demand is consistently exceeding available capacity. This is impacting on patient care due to increased waiting times for referrers to receive images. ▪ Currently, urgent work is being prioritised through a triage process undertaken by the Head of Service. ▪ Options to reduce waits include funded overtime, outsourcing, and review of referral criteria compliance. ▪ A review of referral compliance is being undertaken to inform long-term solutions to sustain the service. <u>All disciplines – impact of movement of patients in relation to POW roof issues</u> • Emerging issue around patient pathway in YGT and expectation of particularly pharmacy. Meeting request with clinical leadership in USC to clarify pathway. • There has been a 115% rise in the number of patient safety incidents reported in AHPs for November. The mean number of patient safety incidents for AHPs is normally around 13 per month, in November this rose to 28. Changes to patient acuity across sites has led to demand exceeding capacity for some smaller fragile professions, such as Speech and Language Therapy. Risk management in place in original location has needed review and redesign, mostly in relation to pathway management and inadequate staffing. The trend is dropping back down to normal with new processes and pathways in place.
Advise	<u>Allied Health Professions</u> • Continued delay in the funding for AHP neonatal workforce being allocated to AHP budget is resulting in continued resource gap in meeting BAPM standards, as the service is not staffed to meet the clinical needs of neonates. This is being proposed as one of the investment priorities for the IMTP. <u>Clinical Engineering - Management of Beds</u> • Regular meetings are being held to discuss issues around increased demand and future risks of decreased supplies due to stock age within the Bed Management Service. • Regular meetings are being held between CTM and the external provider to ensure maintenance processes are being followed and escalated as previously agreed. This will ensure that any maintenance work undertaken is proportionate to the age and condition of the bed stock.

- Options are being considered for the additionality needed to replace bed systems that will become defunct in early 2025.
- A three-year Bed Management Strategy is to be developed to demonstrate long term options for providing this service along with the impacts of proposed changes. Cognisant of staff capacity, it is recognised that the development of the strategy will need additional support. This support has been agreed in principle and further work is being undertaken to develop the scope and timeline for this work.

Radiology

- CT mobile in situ from 02/10/24 for 12 weeks to reduce CT waiting times and alleviate pressure on the DGHs. Since operationalising, the overall waiting list has reduced from 3469 patients awaiting a scan, with 1447 patients breaching over 8 weeks to 1547 patients awaiting a CT scan, with 71 patients breaching over 8 weeks. The current changes in patient pathways due to the site issues at POW require the movement of activity from RGH. Some of this can be done in POW, but due to increased staffing demands in RGH, we are needing to transfer some scanning from RGH to LHP.
- Capacity issues have been identified out of hours (OOH) for CT/X-Ray, with the current staffing model not meeting demand and changes to patient presentations, which require PAT sliding in the main. Additional funding is required for staffing resource in order to maintain a safe and resilient service OOHs. A paper has been submitted outlining the requirements. In the meantime, we are using overtime to bolster the shifts which are most affected, particularly with changes to patient movement due to the POW site issues. The out of hours model will be reviewed following approval of this paper.

Pathology

- POW decant update: At the start of the decant, a number of issues were highlighted in terms of Pathology service provision. Concerns were raised around the potential additional workload for Pathology, as Pathology services at POW are currently provided by Swansea Bay under SLA. Workload is currently being monitored, and there is now a better understanding of the impact of the POW decant on Pathology services and actions taken to minimise impact to patient safety:

- POCT Training: Provision of point of care testing (POCT) equipment and training has been previously delivered by SBUHB. However, the relocation of nursing staff from POW to RGH created a training challenge for CTM, as the POCT

equipment used at RGH deferred from that at POW. To address this, the CTM POCT team developed a comprehensive training plan totalling 78 training sessions ensuring 119 relocated nurses were trained by mid–December. This was a well-coordinated response by a small team of specialised staff, made possible through the support of two fixed term posts dedicated to training and service support. However, these posts funded by transition funding are set to end in March 2025, raising concerns about future training strategy and service continuity.

- Mortuary: Additional pressure on Mortuary capacity due to the POW decant, specifically at the RGH site, this is in addition to service pressure already introduced by the new MES (Medical Examiner Service) legislation. The mortuary capacity risk is being escalated.
- Clinical Haematology: The Haematology Day Unit (HaDU) at RGH was collapsed to support the POW decant. Concerns have been raised around patients that are refusing to travel for treatment. Complaints have been received from patients finding it difficult to travel. Incidents have been reported in relation to there being no trained Clinical Haematology nurses at the RGH site to administer chemotherapy. At present, the Haematology nurses are travelling to RGH when chemotherapy administration is required and options are being explored to secure space at RGH to deliver some treatments.
- Blood Transfusion: Concern around transfusion training compliance in nurses that have been relocated from POW. Additional training sessions have been arranged. The transfusion team are looking to increase the capacity of existing training sessions to accommodate this additional training requirement. This model has been implemented as a quick resolution and is not sustainable for the future training strategy, which will include full repatriation of POW Pathology services.

- Biochemistry: Incident trend identified relating to incorrect storage of samples (fridge vs freezer) leading to increased number of sample rejections. This issue is compounded by staff shortages, particularly within the band 7 leadership team, which has been highlighted as a high-risk issue on the pathology risk register. The reduced staffing capacity is impacting the management of a significant workload and the effective delivery of training.

  To mitigate these challenges, the Biochemistry team is actively recruiting for a new band 7 post and reviewing shift arrangements through the health roster to improve supervision within specimen reception. Additionally, the

Quality team is preparing a presentation for specimen reception staff to emphasise the importance of correct sample handing and its impact on patient care. This presentation will be delivered by the end of January, and incident trends will be monitored to evaluate the effectiveness of these actions.

- Virology freezer failure: The walk-in freezer storing approximately 45,000 patient samples failed, resulting in the samples thawing out. These are samples that have already been processed by the laboratory; they are stored in the event of any additional requesting being required. Alternative storage was identified in the Public Health Wales IP5 facility in Newport. However, by this point the samples had been thawed for several days. Quotes for immediate freezer repair are approximately £4000, with an additional cost of £6-7k to include a backup system for redundancy to avoid a recurrence of this incident in the future. There is internal learning around prompt escalation in the event of a fridge/freezer failure. The samples are now being stored at the correct temperature in IP5. If any additional testing is required a comment will be added to the report to treat results with caution as sample storage was compromised. Out of the 45,000 samples it is estimated that only around 0.3% will require further testing.

<u>Healthcare Science</u>
<u>Datix Risks</u>

- Currently there is no DTPS access to Health Science risks through Datix, as this has not been set up following the move on April 1st and risks remain with former care group's owners.
- The consequence of this is there is no generation of monthly risk reports to update DTPS QSRE and, where needed, onwards escalation.
- A meeting was held with Patient Care & Safety Team on 16th October 2024 to describe what Health Science Services needed for their risks to be moved and aligned to DTPS structure, to discuss the complexity of this work, and the options for moving the Health Science risks to DTPS.
- A follow up meeting took place on the 21st November to progress the movement of Health Sciences into DTPS Datix structure so that new risks are recorded into the correct governance structure and that plans are developed to move legacy risk into DTPS structure.
- Heads of Service are identifying the sub-structures needed to progress this work.

<u>Medicines Management</u>

- The automated dispensing cabinet in the Emergency Cupboard in PCH needs to be moved due to damage in its current

	location. Colleagues are working to resolve this issue and identify a new suitable location DATIX completed. Interim process in place. Escalated for repair and move. • Issue identified where electronic Discharge Advice Letters (eDALs) are being suspended for patients transferred from POW to stroke ward in RGH. RCA identified that issue arises when medical records merge two different PAS numbers for patients. Escalated to I.T. Teams to resolve. PAS merger planned for May 2025; interim solution will be required before then. • Incident reported from care home involving suspected diversion of controlled drugs (no further detail appropriate as under police investigation). Review of controlled drugs management practices conducted by the Medicines Management team, and all recommendations have been actioned by care home management. This has highlighted a risk and opportunity in lack of medicines management input into Care Homes across CTM. Initial scoping exercise around learning from the incident and potential for cost savings being investigated; working with Primary Care to develop.
Assure	<u>Radiology</u> • The NOUS waiting list continues to show a reduction in patients awaiting a scan with a current total waiting list of 2791. Currently, 182 patients are breaching over 8 weeks. • The MR waiting list has stabilised since the mobile MR solution ceased, with 33 patients breaching over 8 weeks within the current wait of 1899 patients awaiting a scan. • The CT waiting list over 8 weeks is now down to 41 patients and the mobile CT scanner has been decommissioned from LHP site on 31st December 2024. <u>Medicines Management</u> CD audits: Target= 100% Current figures for completion of CD audits are: • <u>PCH</u>: 100% [Previous Quarter 100%] • <u>POW</u>: 67% [Previous Quarter 98%] N.B. this is 67% of remaining wards in POW • <u>RGH</u>: 100% [Previous Quarter 71%] • <u>YCR:</u> 100% • <u>YCC</u>: 80% • Deterioration in POW from previous quarter. This is potentially due to the situation with the roof in POW and movement of pharmacy staff, with teams prioritising direct patient care over regular auditing. An expectation has been conveyed that this will be rectified in subsequent months.

	• Following centralisation of dispensing services at YCR/YCC, there were some issues with delays in receiving stock. A weekly meeting has now been instituted to ensure issues are identified and worked through by on-site (YCR/YCC) and centralised (acute site) teams. <u>AHPs</u> • Improving quality of care in Podiatry: MSK Podiatry have updated their on-line self-referral form to ensure that the service users are seen by the right person at the right time in their clinical presentation. The system now signposts to self-management approaches and advice on when a podiatry referral is needed, avoiding unnecessary attendance to Primary Care. <u>Pathology</u> • Microbiology: A risk has been previously highlighted in relation to Microbiology staff resource and impact on continued service provision. To mitigate this risk, arrangements have been made to outsource the Virology work to PHW, commencing on 25th November. Staff previously covering the Virology service have now been moved to support the rest of the Microbiology service. Approval has also been granted for a locum biomedical scientist and 2 fixed term biomedical scientist to further stabilise the service.
Inform	<u>NHS Wales Staff Survey</u> • DTPS had the highest care group response rate to the 2024 NHS Wales Staff Survey, at 45.8%. • The responses were driven by work within Therapies AHP services, who held engagement sessions with over 500 staff, providing an opportunity to listen to their views following the themes identified from the previous survey. This resulted in AHPs having a 140% increase in response rate to the survey this year. • Audiology led the way, with 93.9% of the staff completing the staff survey. <u>AHPs</u> • A collaboration between CTMUHB and CAVUHB physiotherapy delivered two workshops aimed to help MSK physiotherapists tackle complexity and uncertainty. The rising complexity of modern healthcare increases decisional uncertainty for clinicians, fuelling stress and burnout. This in turn reduces engagement and productivity. The post-course evaluation showed a significant improvement in confidence to manage

uncertainty, so this approach will be further embedded across the service.

<u>Pathology</u>

New Policies:

- Clinical Haematology – Patient Initiated Follow Up (PIFU) for patients with low risk Monoclonal Gammopathy of Undetermined Significance (MGUS): introduced to give patients more control over their care, free up much needed capacity to see patients when they most need to be seen, and reduce the number of appointments that do not add clinical benefit for patients.
- Point of Care Testing Policy – applies to all users of POCT devices across the Health Board, including in general practice, care homes, screening venues and patients' homes. The policy defines the governance framework and principles to ensure the safe implementation and delivery of POCT services.

- Improved Notification of POCT Incidents: Majority of incidents relating to POCT devices are reported by users, with the responsible service being the clinical area that holds the POCT device. As a result, the POCT team were not being notified of POCT incidents, and therefore no ability to analyse trends or support departments with investigation. The POCT team have worked with the CTM Datix Team to put a system in place that now ensure the POCT team are notified of incidents. These incidents are already starting to filter through and the correct incident reporting mechanism is being included in POCT training for users.

- Paperless Reporting Workshop: The Pathology department plans to introduce paperless reporting. This is being driven by the LIMS 2.0 implementation and supports the CTM goal of becoming a greener organisation, increases administrative capacity, and eliminates the risk of paper reports being lost in transit. All Pathology results are transmitted electronically, but it has become apparent that there is still a reliance on paper reports in some areas.

  A workshop was held at the start of December with broad representation, including those that solely use electronic reporting and those that still rely on paper reports. The workshop helped understand some of the concerns around paperless reporting, and how we can ensure that a paperless system is introduced safely by using a staggered approach.

  There is concern around the fact that Swansea Bay Pathology services will be switching off paper reporting in January 2025.

Following director level discussion, assurance has been given that POW will not be turned off and paper reports will continue to be sent to clinical teams.

Radiology

- Patient story presented by radiology from the Snowdrop Centre:
  - 30 year old female presenting with breast lump
  - CTMUHB are the Best performing Health Board in Wales for breast services by a considerable margin – 78.7%

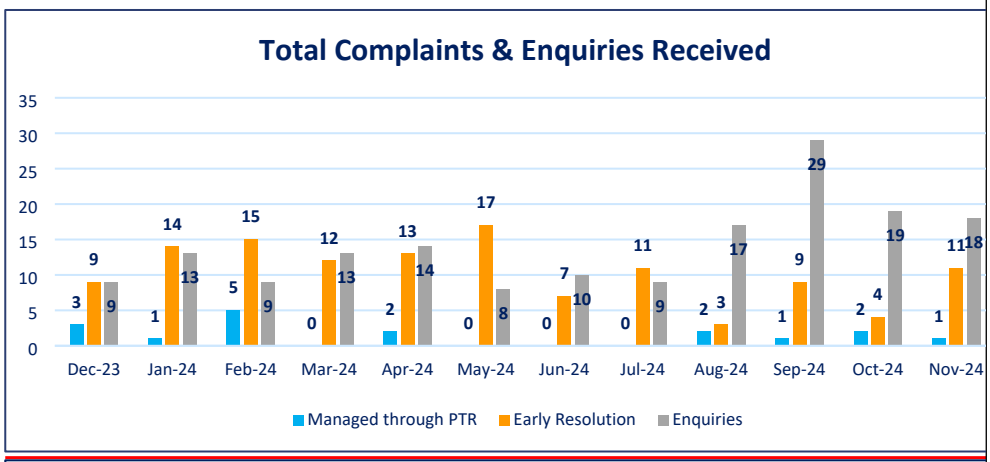
Medicines Management

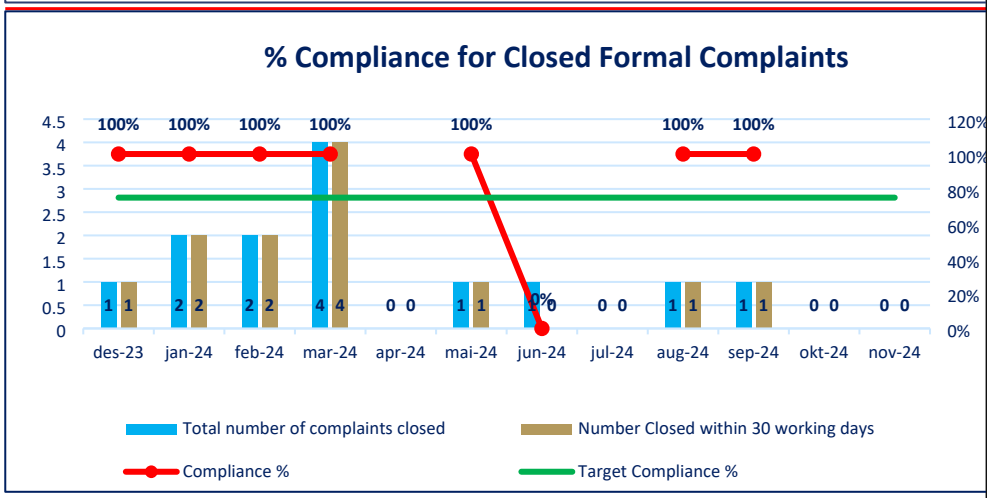
- Medicines Management Teams in POW and RGH took part in the MedsSafetyWeek. Interactions with over 130 individuals (staff and members of the public) to discuss Medicines Safety and Yellow Card Reporting. A member of the 'Men's Shed' community initiative requested a medicines safety talk for his 'shed'. This presents a good example of CTM working with the local community to reduce harm from medication
- Homecare: Haematology Service is very time critical and relies heavily on technician support. Evaluation of previous invest to save proposal underway with a view to further extension of this in 2025-26.
- General Practice DPIA and Data Sharing Agreements with General Practice: Medicines Management team are standardising DPIAs and Data Sharing Agreements with Practices. Draft CTM-wide DPIA and Data Sharing Agreements have been developed and submitted for discussion and launch with Head of GMS
- HMP Parc SOP review- 2-year review due December 2024 for all SOPs due to Parc transfer date in December 2022. Plan in place for review: CD SOPs will need to be prioritised due to HO licence.

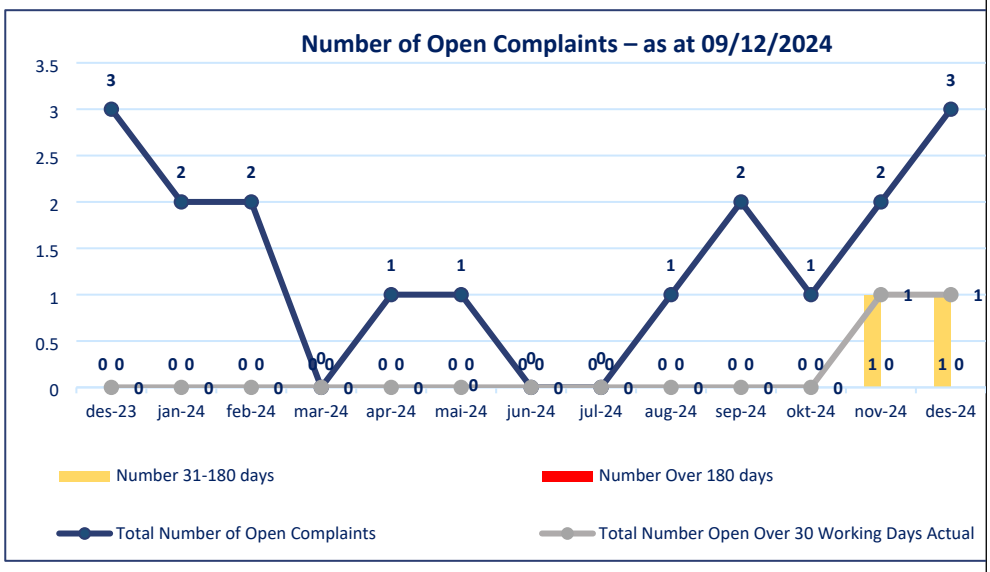
Pathology

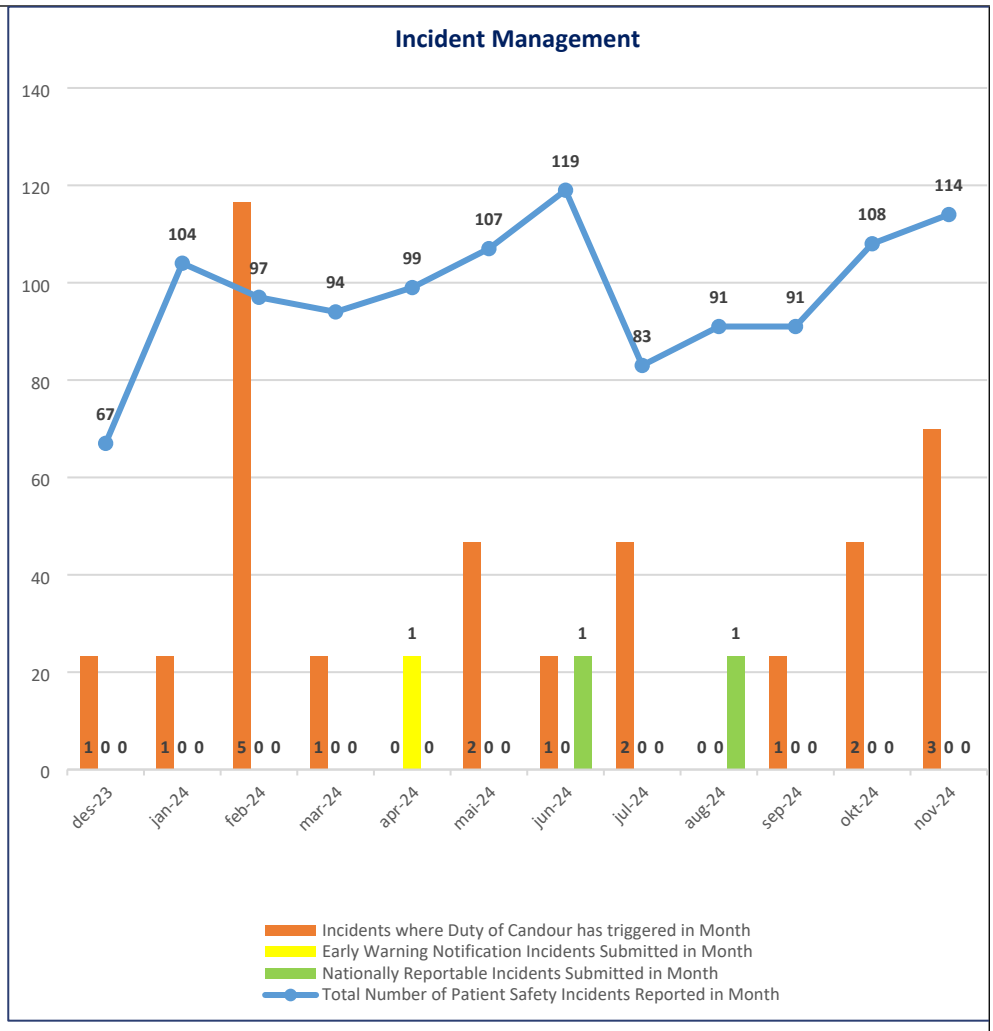
- HTA Update: The HTA will now carry out unannounced inspections as opposed to being organised every 2 years. A guidance document has been developed for Mortuary staff, so they are aware of what to do and who to contact upon the arrival of a HTA inspector.

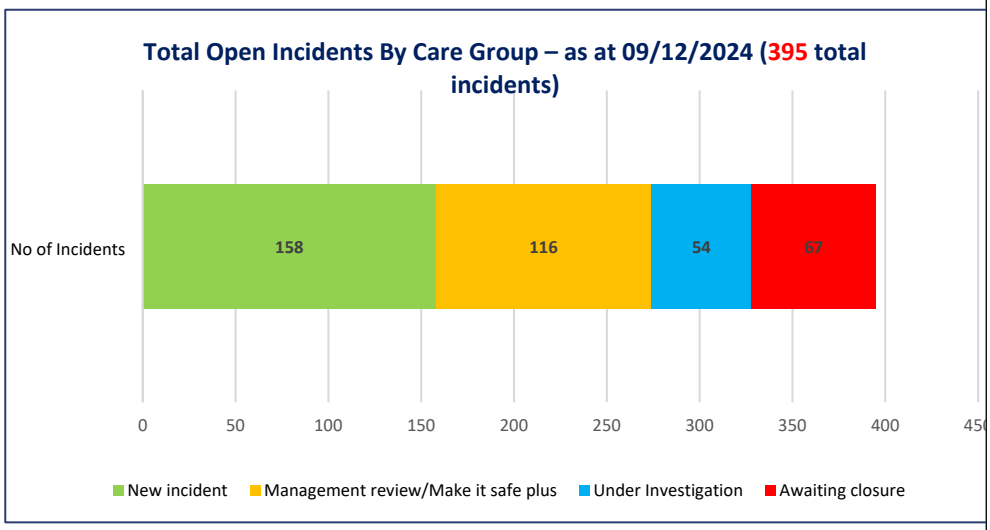
DTPS Complaints Received and Compliance











Appendices	Nil

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 *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
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
5.4

Quality, Safety & Experience Committee

Stroke Services Update

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sian Bingham, Head of Operational Planning USC/PC&C Jade Rees, Directorate Manager for Integrated Medicine
Cyflwynydd yr Adroddiad / Report Presenter	Sarah Follows, Service Director, Unscheduled Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Recognising that the changes to Stroke were an emergency service change, there was limited opportunity for significant engagement. However, in addition to a range of internal discussions, there were discussions, with Llais, our Trade Union partners as well as other Health Boards	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POWH	Princess of Wales Hospital
SB	Swansea Bay
UHW	University Hospital Wales
ACP	Advanced Care Practitioner
WTE	Whole Time Equivalent

1. Situation

1.1 The ability to deliver Senior Stroke Clinical Leadership across 2 Sites (PCH and RGH) has diminished rapidly over the last 2 weeks due to long-term sickness within the stroke workforce. This has contributed to unsustainable demand upon the remaining consultant workforce (substantive and locum) that must be addressed to continue providing a safe service to patients experiencing a stroke.

1.2 We have worked closely with stroke and other clinical teams to explore opportunities for utilising the workforce in different ways to improve capacity and also explored cross-Health Board support with neighbouring Health Boards. However, to maintain a safe service that can continue to save lives and reduce the effects of stroke for as many patients as possible, we must make immediate temporary, local changes to the way in which services are provided.

As such, to maintain a safe and effective acute Stroke Service for our patients and communities, immediate urgent plans are being developed to move onto a single site. Following an options appraisal (Appendix 1) a decision was made to centralise all Stroke services at the Royal Glamorgan Hospital.

1.3 A project team and workstreams are in place developing plans and pathways and undertaking the actions required at pace to achieve the move of the Stroke Service from PCH to RGH on the 8 January 2025.

2. Background

2.1 Due to the roofing issues at the Princess of Wales hospital in Bridgend and the resulting necessity to decant some wards and services to alternative locations, emergency stroke services were moved from POWH into the RGH in Llantrisant in the Autumn 2024.

2.2 This move took place against a backdrop of existing, severe specialist medical workforce challenges within the stroke services across POW and PCH that have made it extremely problematic to provide a resilient, safe and sustainable service to the population of CTM. The main underlying issue has been the difficulty in recruiting to vacant Stroke Consultant positions on a substantive and also locum basis.

2.3 There are currently 4.0 WTE substantive stroke consultant positions and 4.8 WTE CNS positions across CTM, broken down as follow:

<u>PCH</u>

- 2 WTE substantive consultants in post (x1 on maternity leave)

- 1 WTE consultant Vacancy
- 2 WTE Clinical Nurse Specialists

Mitigations/escalations:

- 1 WTE fixed term locum consultant who was due to start in November has not yet been cleared for pre-employment checks

RGH

- 2 WTE substantive consultants in post (x1 on long-term sick leave)
- 2.8 WTE Clinical Nurse Specialists

Mitigation/escalations:

- 1 WTE agency locum consultant to cover long-term sickness (contract extended until April 2025)
- A second WTE agency locum is due to start on Monday 6 January 2025

2.4 Currently the Stroke consultants within CTM cover Stroke services on two acute sites (RGH and PCH) including the provision of Stroke outpatient and TIA Clinics. The RGH consultants and CNS team have also providing TIA and stroke outpatient clinics on the POW site.

2.5 The consultants provide a 1:6, seven-day stroke on-call advice service. However, due to vacancies/sickness within the consultant workforce the ratio for the on-call rota is currently 1:3 due to constraints within the workforce.

2.6 The Stroke consultants at RGH also have a GIM on call commitment on a 1:21 rota on the POW site, comprising of weekday evening and full weekend day cover resident cover with non-resident overnight cover.

2.7 The Acute Stroke service across CTM has become increasingly fragile over recent weeks and this was brought to a head during December when one of the 3 remaining substantive consultants was required to go on long-term sick with immediate effect. This left just one substantive and one locum consultant working at RGH.

2.8 PCH is also at significant risk with just one substantive consultant.

2.9 A decision was made prior to Christmas to suspend some of the TIA and outpatient Stroke clinics until a safe service could be provided.

3. Proposal

3.1 Following an options appraisal (Appendix 1) a decision was made to urgently centralise all Stroke services at the Royal Glamorgan Hospital. One

of the main findings was that locating the Service at PCH would displace 422 patients out of CTM to SB and UHW. Choosing RGH displaces 251.

3.2 This proposal will entail:

- Moving the PCH Acute Stroke Ward to RGH Ward 19 which will provide up to 22 Stroke beds as well as the 27 Stroke beds on Ward 20. (Up to 49 beds).
- Creating a dedicated Therapy space on Ward 19 to enhance the inpatient Therapy Service provided for patients.
- Reprovision of TIA clinics.
- Continuing to progress plans to enhance Community Rehabilitation beds at YCR increasing from 8 to 27.
- Self-presenting patients with suspected Stroke symptoms (FAST+ve) to continue to be directed to their nearest Hospital as per national pathways.
- All EDs (PCH, POW and RGH) administrating time critical treatment for patients that present with suspected stroke symptoms. All patients with a confirmed diagnosis of Stroke requiring an Acute intervention will then be conveyed to the RGH for admission onto a Stroke inpatient ward.
- Patients identified as suspected Stroke by WAST will continue to be conveyed to the nearest Acute Stroke Unit as per the pathway.
- There will be no change to the access to community rehabilitation beds due to the centralisation onto the RGH site.

To achieve this immediate and urgent temporary change:

- Workstreams established focusing on i. Communication and Pathway development ii. Workforce iii. Estates and Physical environment.
- Data provided to inform the demand and potential impact on flows. This will however need to be monitored over the coming months.
- Communications' colleagues are working to ensure that accurate and timely information is provided to our communities, workforce, patients and partners.
- Internal moves at RGH have been undertaken to enable the relocation of Stroke onto the Site.
- Identification of administrative space and storage.
- Workforce planning, engagement and arrangements to facilitate the urgent change of delivery.
- Community provision is being maximised/prioritised for patients that are clinically optimised for discharge at RGH.
- Plans are being developed for the Therapy component of the Community Plans.
- Discussions are on-going with WAST colleagues re pathways of suspected Stroke patients.
- Discussions are underway to agree plan to mitigate the high demand/lost capacity for beds across the RGH site.

- Arrangements to transfer remaining Stroke patients from PCH to RGH on 8 January 2025 are being progressed.
- High level Senior discussions have taken place with neighbouring Health Boards and with the Regional Partnership re changes to flow.
- Engagement has taken place with Llais under their emergency changes protocol.
- WAST pathway to convey query strokes to nearest Acute Stroke Unit is in place to ensure the best outcomes possible for Stroke patients.
- Data will be monitored to analyse impact and regular discussions will be on-going with neighbouring Health Boards.

3.3 Following the move to RGH as the single site, work will continue beyond the 8 January 2025 to enhance and develop the pathways further. This will also include monitoring the data on demand and flows as well as performance. This analysis and the forecast for successful Consultant recruitment will be key in informing the future delivery model for Stroke patients across CTM.

4. Risks

4.1 An increase in sickness of either nursing and/or medical staffing or locums leaving would have a significant impact on the viability of a safe and effective Acute Stroke service. Mitigations:

- Discussions have taken place to explore options with Cardiff and Vale UHB,
- Stroke Locums continue to be sought alongside continued advertising for substantive appointments.
- Well-being services are engaged with teams.

4.2 The demand levels to transfer self-presenting patients with a confirmed Stroke diagnosis from PCH and POW to the Stroke Unit at RGH in a timely manner could significantly increase demand on WAST and availability of a Stroke bed at RGH. Mitigations:

- additional WAST vehicles will be procured by the Health Board to ensure a dedicated service to RGH and also from RGH to a Community bed.
- There will be a requirement for a minimum of 2 Stroke beds to be ring-fenced on the Stroke Unit at all times.
- Increased Community beds at YCR.

4.3 The increased flow of patients across a number of specialties and recent changes in flow across CTM could overwhelm the RGH. Mitigations:

- Exploration of urgent options to mitigate the loss of bed capacity underway.

4.4 Delays in confirmation of the Therapy workforce and funding/recruitment to provide the rehabilitation element for the expansion of beds at D4 YCR

could impact flow of patients across the system in relation to the opening of the additional beds. Mitigations:

- Immediate proposal in development by the Therapies Service
- Funding/Recruitment
- Stroke governance arrangements to monitor and support the development of deliverable plans and progress a longer-term Community model for Stroke.

4.5 Neighbouring Health Boards and Trusts in England may experience a higher demand in WAST conveyed query Stroke patients where there is a change to the nearest Acute Stroke Unit Site. Mitigations:

- High level discussions have taken place with neighbouring Health Boards.
- Change of flows will be contained as will only impact WAST query Stroke patients and not self-presenters.

4.6 Due to limited consultant workforce there was a decision to cancel TIA and stroke clinics, this remains a significant risk for patients waiting an appointment. Mitigations:

- Plans in place to move all outpatients' clinics to RGH for both PCH and POW local patients to support consultant efficiencies
- Further locum due to start on Monday 6th January
- Review if acute medical teams will support with additional clinics (WLIs) to reduce long waits / TIA backlog

5. Assessment

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

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	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	Yes (Include further detail below)	
	There could be reputational damage for CTM should the service have to collapse due to the fragile consultant workforce	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	Due to gaps within the medical workforce, there will be an impact on financial budgets due to the reliance on locum support	

6. Recommendation

6.1 To NOTE the urgent change of service model for Stroke across CTM and the progress being made to plan and ensure the provision of safe, resilient and effective Stroke services.

7. Next Steps

7.1 To continue to progress the planning and implementation of the urgent change to centralise the CTM Stroke Service on the RGH Site through the Stroke Operational Governance arrangements.

7.2 To continue to monitor the levels of demand for Acute Stroke and Rehabilitation beds and provision for future plans.

7.3 To continue to seek opportunities to stabilise the Stroke Consultant Workforce.

7.4 To progress the Therapy plan/recruitment to enable the opening of the additional Stroke beds on D4 YCR.

7.5 To consider the optimum Stroke Service for CTM informed by the data, performance and workforce position and forecast that develops over the coming months.

Appendix 1

Option 1

Collapse and centralise service onto RGH site

Risks

- Staff engagement to move from PCH to RGH site, particularly the ward nursing team
- Increased levels of sickness
- Risk to managing to demand through one site with only 3 WTE consultants
- Increased travel times for patients presenting with stroke symptoms
- Risk of managing self-presenters at PCH emergency department
- Capacity for TIA / stroke outpatient clinics to prevent physicians from working across site
- Unclear on impact to Powys patients

Enablers

- Move ward 10 PCH to ward 19 RGH
- De-escalate ward 1 RGH to allow ward 19 to move into, currently planned care capacity
- Sufficient TIA / stroke outpatient capacity to stop cross site working
- Potential stroke support from Neurology consultant at RGH
- WAST input to pathway changes

Benefits

- Enables consultant to cross cover during leave periods
- Likely to support future recruitment to consultant workforce due to site location
- Reduced risk of stroke service fully collapsing
- More ANP/CNS resource on one footprint to support front door stroke patients
- Will enable the required therapy space to be created if ward 19 is allocated to stroke services (potentially reducing LOS for patients)

Option 2

Collapse and centralise service onto PCH site

Risks

- Emergency department at PCH would not be able to support demand of all stroke patients for CTM
- Smaller bed base on ward 10 compared to RGH ward 20/ward 19 proposal
- PCH has an overall smaller bed based in comparison to RGH site
- Unlikely to support future recruitment to consultant workforce

- Staff engagement to move from RGH to PCH – taking into account staff at RGH have only just moved from POW site
- Capacity for TIA / stroke outpatient clinics to prevent physicians from working across site
- Increased travel times for patients presenting with stroke symptoms
- No ward identified to create a 'step down' area for acute stroke patients / stroke mimics

Option 3

Do nothing and provide a reduced service at PCH with 1 WTE consultant

- Severe risk of service collapse
- Cannot maintain a service with only 1.0 WTE consultant and no prospective cover on one site (PCH)
- High risk to patient safety and outcomes
- Severe risk of staff burnout creating further significant staffing issues

Recommendation

Option 1 – to centralise stroke services onto RGH site on Wednesday 8th January 2025, if all enablers are able to be met prior to move.

5.4b	21 January 2025	Quality, Safety & Experience Committee	Stroke Services Update - Urgent change to Acute Stroke Services

FOI Status:	Open
If closed please indicate reason:	Not applicable
Prepared By:	Sian Bingham/Jade Rees
Presented By:	Sarah Follows, Service Director Unscheduled Care
Approving Executive Sponsor:	Gethin Hughes, Chief Operating Officer
Report Purpose	For Noting
Engagement undertaken to date:	Workforce/Neighbouring Health Boards/WAST/Llais/Patients and Families on the ward.

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	The emergency change of service has been necessary to achieve safe levels of care.
Related Health and Care Standard	
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No (Explain why) – Emergency Measures.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes – expenditure on Locums and other workforce gaps to ensure safety and effective care.
Link to Strategic Goals	Please Select: Improving Care

Situation / Background

- The ability to deliver Senior Stroke Clinical Leadership across 2 Sites (PCH and RGH) diminished rapidly during the end of December 2024 due to long-term sickness within the stroke workforce.
- Background: existing severe specialist medical workforce challenges and emergency re-location of the Stroke Service from POW to RGH due to the critical incident.
- Result: an unsustainable demand upon the remaining consultant workforce (substantive and locum) to maintain a safe and effective acute Stroke Service for our patients and communities.
- Options appraisal undertaken for an immediate solution to maintain services with decision to centralise all Stroke services at the Royal Glamorgan Hospital.
- Data modelling undertaken to support the planning and decision making. Data suggested that locating the Service at PCH would displace 422 patients out of CTM to Swansea Bay and University Hospital Wales. Choosing RGH displaces 251.
- A project team and workstreams are in place developing plans and pathways and undertaking the actions required at pace to achieve the move of the Stroke Service from PCH to RGH on the 8 January 2025.

Proposal

Urgent centralisation of all Stroke services at the Royal Glamorgan Hospital.

This proposal will entail:

- Moving the PCH Acute Stroke Ward to RGH Ward 19 which will provide up to 22 Stroke beds as well as the 27 Stroke beds on Ward 20. (Up to 49 beds).
- Creating a dedicated Therapy space on Ward 19 to enhance the inpatient Therapy Service provided for patients.
- Reprovision of TIA clinic service.
- Continuing to progress plans to enhance Community Rehabilitation beds at YCR increasing from 8 to 27.
- Self-presenting patients with suspected Stroke symptoms (FAST+ve) to continue to be directed to their nearest Hospital as per national pathways.
- All EDs (PCH, POW and RGH) administrating time critical treatment for patients that present with suspected stroke symptoms. All patients with a confirmed diagnosis of Stroke requiring an Acute intervention will then be conveyed to the RGH for admission onto a Stroke inpatient ward.
- Patients identified as suspected Stroke by WAST will continue to be conveyed to the nearest Acute Stroke Unit as per the pathway.
- No change to the access to community rehabilitation beds due to the centralisation onto the RGH site.

Planning and Implementation

- Workstreams established to focus on i. Communication and Clinical Pathway development ii. Workforce iii. Estates and Physical environment.
- Data provided to inform the demand and potential impact on flows. This will be monitored over the coming months.
- Communications' colleagues working to ensure accurate and timely information is provided to our communities, workforce, patients and partners.
- Internal moves at RGH undertaken to enable the relocation of Stroke onto the Site.
- Identification of administrative space and storage.
- Workforce planning, engagement and arrangements to facilitate the urgent change of delivery.
- Community provision being maximised/prioritised for patients that are clinically optimised for discharge at RGH.
- Plans are being developed for the Therapy component of the Community Plans.
- Discussions are on-going with WAST colleagues re pathways of suspected Stroke patients.
- Discussions are underway to agree plan to mitigate the high demand/lost capacity for beds across the RGH site.
- Arrangements to transfer remaining Stroke patients from PCH to RGH on 8th January are in train.
- High level Senior discussions have taken place with neighbouring Health Boards and with the Regional Partnership re changes to flow.
- Engagement has taken place with Llais under their emergency changes protocol.
- WAST pathway to convey query strokes to nearest Acute Stroke Unit is in place to ensure the best outcomes possible for Stroke patients.
- Data will be monitored to analyse impact and regular discussions will be on-going with neighbouring Health Boards.

work will continue beyond the 8th January to enhance and develop the pathways further and to monitor the data on demand, flows, performance and patient experience. This analysis and the forecast for successful Consultant recruitment will be key in informing the future delivery model for Stroke patients across CTM.

Risks

1. An increase in sickness of either nursing and/or medical staffing or locums leaving would have a significant impact on the viability of a safe and effective Acute Stroke service. Mitigations:

- Discussions have taken place to explore options with Cardiff and Vale UHB,
- Stroke Locums continue to be sought alongside continued advertising for substantive appointments.
- Well-being services are engaged with teams.

2. The demand levels to transfer self-presenting patients with a confirmed Stroke diagnosis from PCH and POW to the Stroke Unit at RGH in a timely manner could significantly increase demand on WAST and availability of a Stroke bed at RGH. Mitigations:

- additional WAST vehicles will be procured by the Health Board to ensure a dedicated service to RGH and also from RGH to a Community bed.
- There will be a requirement for a minimum of 2 Stroke beds to be ring-fenced on the Stroke Unit at all times.
- Increased Community beds at YCR.

3. The increased flow of patients across a number of specialties and recent changes in flow across CTM could overwhelm the RGH. Mitigations:

- Exploration of urgent options to mitigate the loss of bed capacity underway.

4. Delays in confirmation of the Therapy workforce and funding/recruitment to provide the rehabilitation element for the expansion of beds at D4 YCR could impact flow of patients across the system in relation to the opening of the additional beds. Mitigations:

- Immediate proposal in development by the Therapies Service
- Funding/Recruitment
- Stroke governance arrangements to monitor and support the development of deliverable plans and progress a longer-term Community model for Stroke.

5.Neighbouring Health Boards and Trusts in England may experience a higher demand in WAST conveyed query Stroke patients where there is a change to the nearest Acute Stroke Unit Site. Mitigations:

- High level discussions have taken place with neighbouring Health Boards.
- Change of flows will be contained as will only impact WAST query Stroke patients and not self-presenters.

6. Due to limited consultant workforce there was a decision to cancel TIA and stroke clinics, this remains a significant risk for patients waiting an appointment. Mitigations:

- Plans in place to move all outpatients' clinics to RGH for both PCH and POW local patients to support consultant efficiencies
- Further locum due to start on Monday 6th January
- Review if acute medical teams will support with additional clinics (WLIs) to reduce long waits / TIA backlog

Next Steps

- To continue to progress the planning and implementation of the urgent change to single site the CTM Stroke Service on the RGH Site through the Stroke Operational Governance arrangements.
- To continue to monitor the levels of demand for Acute Stroke and Rehabilitation beds and provision for future plans.
- To continue to seek opportunities to stabilise the Stroke Consultant Workforce.
- To progress the Therapy plan/recruitment to enable the opening of the additional Stroke beds on D4 YCR.
- To consider the optimum Stroke Service for CTM informed by the data, performance and workforce position and forecast that develops over the coming months.

Recommendation:	The Committee are asked to: To note the urgent change of service model for Stroke across CTM and the progress being made to plan and ensure the provision of safe, resilient and effective Stroke services.

Agenda Item
6.1

Quality, Safety & Experience Committee

Patient Safety & Quality Dashboard

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Discussions with key individuals in corporate services and within directorates and localities	Various dates	

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

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.11.24 to 31.12.24 taken from systems on 07.01.25, unless otherwise specified.

Key areas to note in this reporting period are:

- Number of Complaints managed via PTR (formal) has fallen
- Compliance with the 30 working day target for responding to complaints over the period is 79% (Welsh Government target above 75%)
- The Nationally Reportable Incidents submitted remains relatively consistent

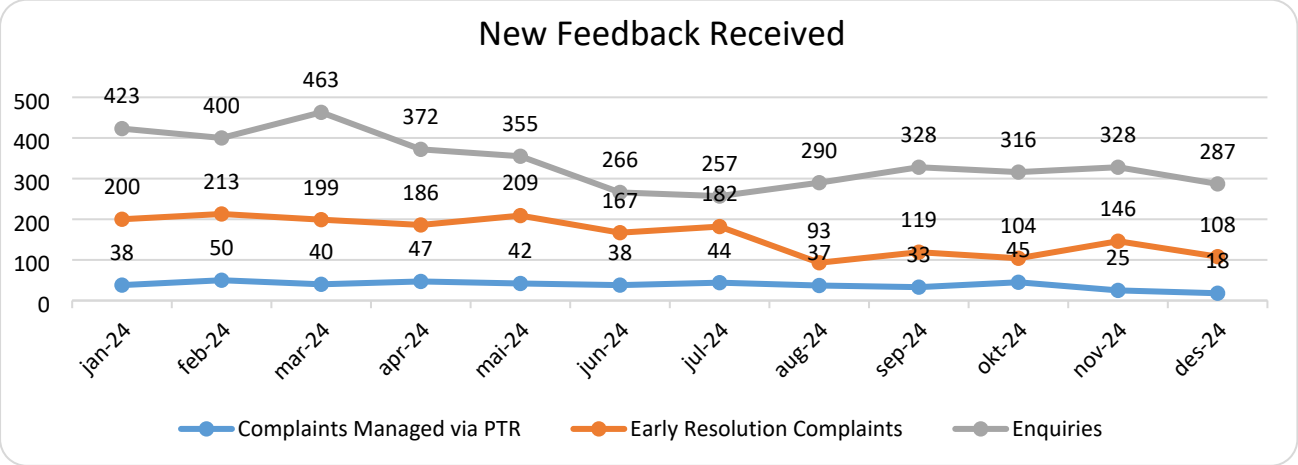
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

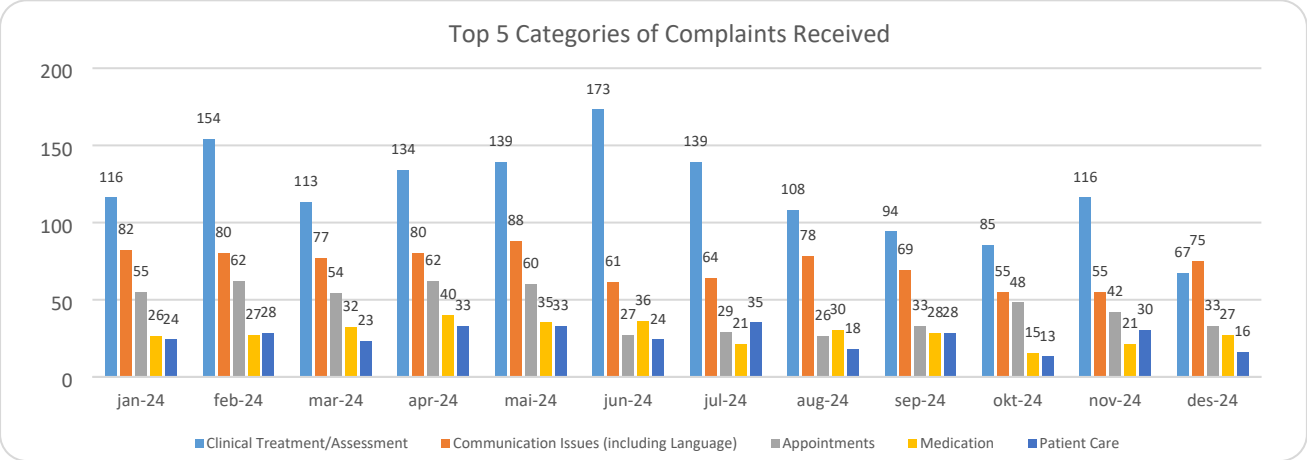
Complaints

<u>New Complaints Received</u>

Between the 01.11.24 and 31.12.24 the Health Board received a total of 297 complaints. Of these, 43 were categorised as formal and managed under the Putting Things Right Regulations (PTR). The number of formal complaints has dropped over the past two months. The number of early resolution complaints increased in November 2024 but dropped back down in December 2024, continuing to decrease since August 2024. The number of enquiries continued to rise through to November 2024 but dropped down in December 2024.

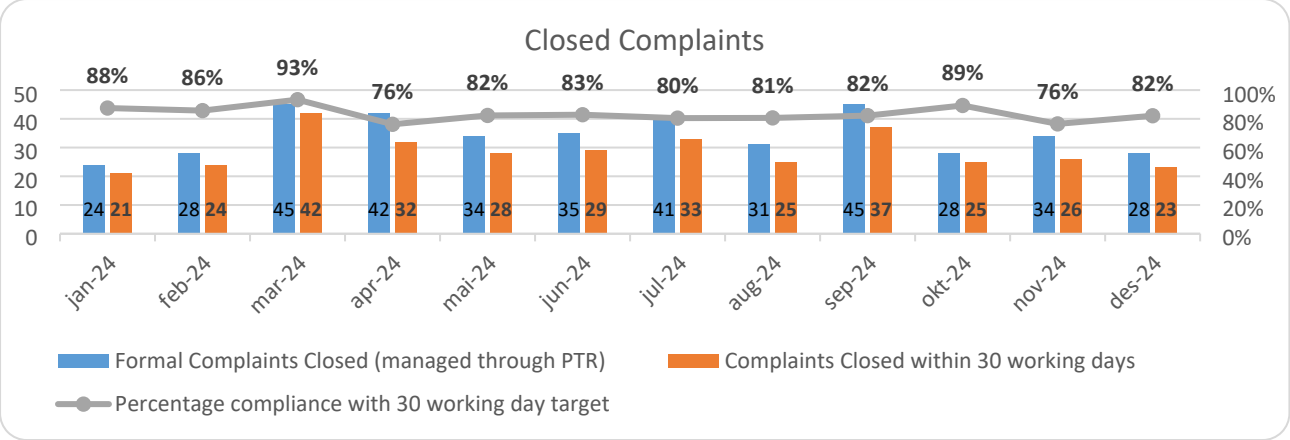


For <u>all feedback (Complaints and Enquiries)</u> received in November and December 2024, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (183), Communication Issues (130) and Appointments (75).



Closed Complaints

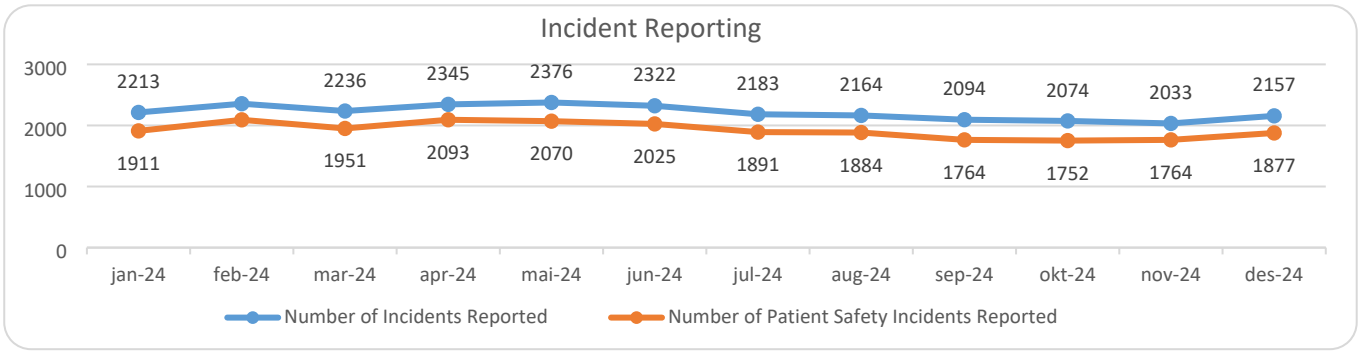
Within the period of 01.11.24 to 31.12.24, the Health Board closed a total of 62 formal complaints (managed through PTR). Compliance has remained over the national target of 75% during the two month period. As at 06.01.25, the Health Board had 47 open formal complaints. Of these, 23 complaints were open over 30 working days. Daily complaints huddles are fully embedded to ensure open cases are reviewed and robust escalation is undertaken.



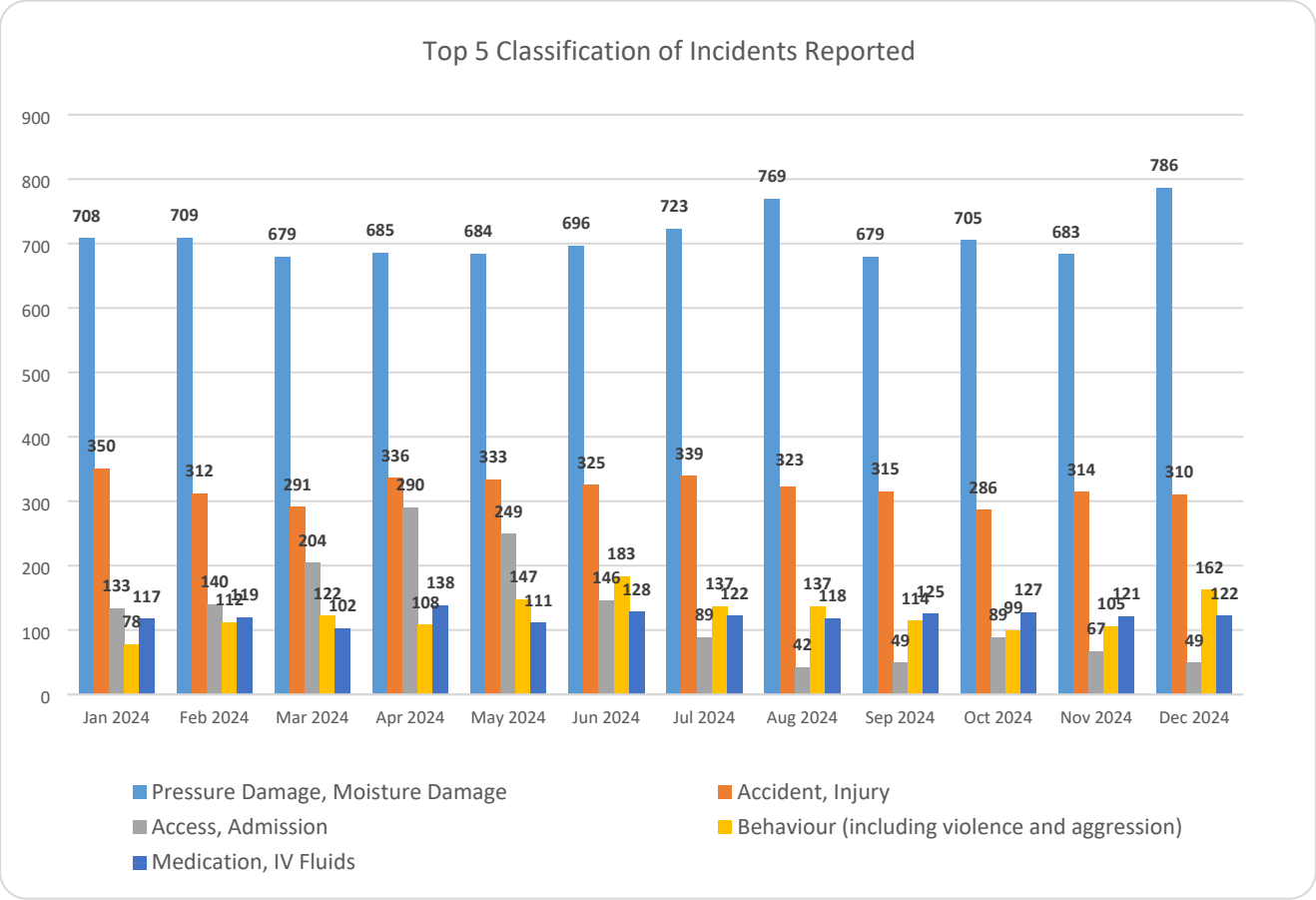
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 3641 incidents were reported between 01.11.24 to 31.12.24, this represents an increase of 125 when compared with the previous 2 months (3,516).



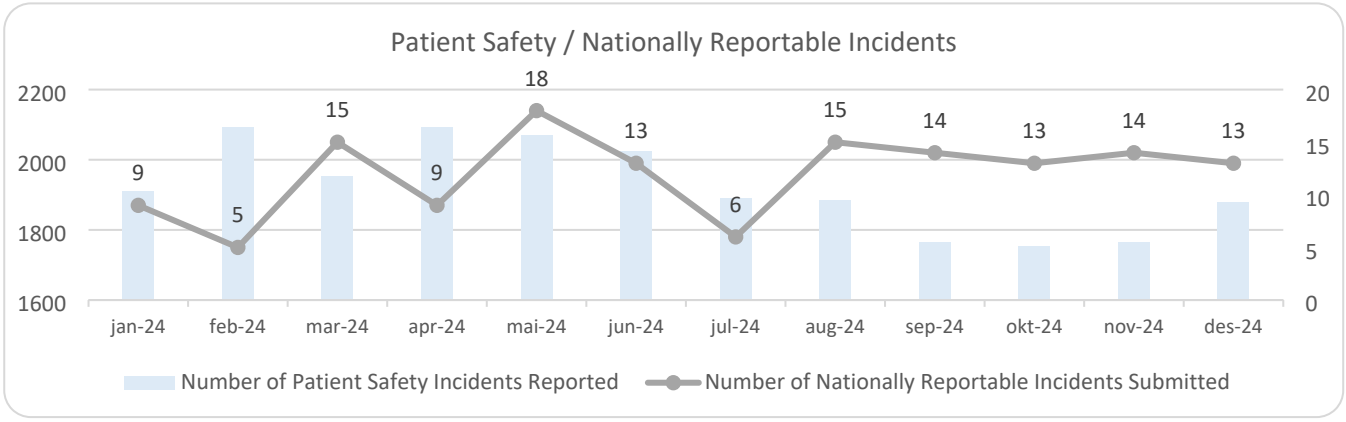
The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 12,705 incidents reported, 86% (10,932) were reported as the patient affected.



The top 3 types of incidents reported for November and December 2024, linked to a patient affected incident are: Pressure Damage /Moisture Lesion (1469), Accident, Injury (624) and Behaviour (including violence and aggression) (267). This represents a change in the top 3 classifications of incidents as Medication, IV Fluids has been replaced by Behaviour (including violence and aggression) during this time period.

Nationally Reportable Incidents

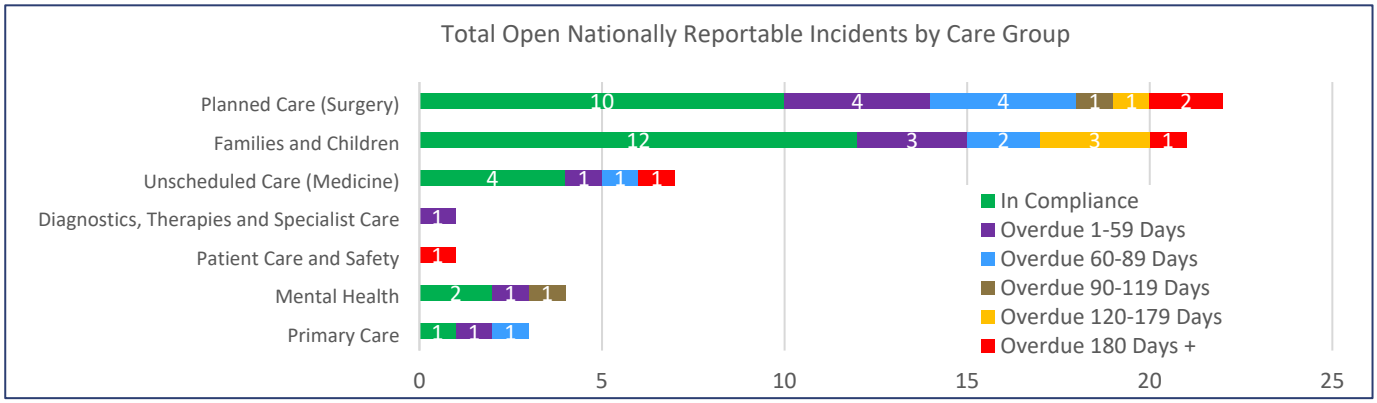
Between 01.11.24 to 31.12.24, 27 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive. The significant decrease in the number of incidents reported during July 2024 can be linked to the transition to the NRI Reporting Portal which resulted in some delays in the submission process. These incidents were subsequently reported in August 2024. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

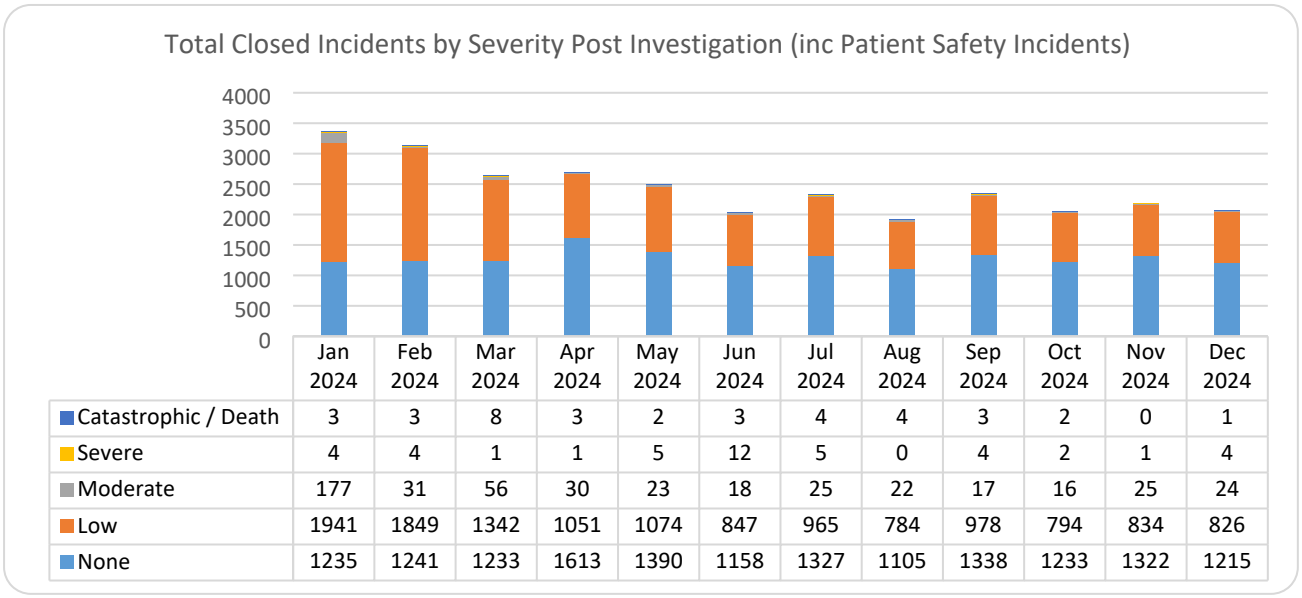
Classification	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Total
Access, Admission	2	0	2	1	2	0	0	3	2	0	0	0	12
Accident, Injury	0	1	0	0	0	0	0	0	0	1	0	1	3
Assessment, Investigation, Diagnosis	0	0	2	0	1	2	0	2	2	1	0	0	10
Behaviour (including violence and aggression)	0	0	0	1	0	0	0	0	0	0	1	0	2
Communication	0	0	0	0	0	0	0	0	0	0	1	0	1
Equipment, Devices	0	0	0	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	0	0	0	1	0	2	1	1	3	0	0	2	10
Infrastructure (including staffing, facilities, environmen	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity adverse occurrence	2	1	2	4	2	3	0	2	1	3	2	2	24
Medication, IV Fluids	0	0	0	0	0	0	0	1	0	0	0	0	1
Monitoring, Observations	0	0	0	0	0	0	0	1	1	0	0	0	2
Patient/service user death	1	0	2	0	1	2	1	0	0	0	2	0	9
Pressure Damage, Moisture Damage	3	3	5	1	4	3	4	3	3	8	6	7	50
Safeguarding	0	0	1	0	0	0	0	0	0	0	0	0	1
Transfer, Discharge	1	0	0	0	1	0	0	0	1	0	0	0	3
Treatment, Procedure	0	0	1	1	7	1	0	2	1	0	2	1	16
Total	9	5	15	9	18	13	6	15	14	13	14	13	144

As at the 07.01.25, the Health Board currently has 59 open Nationally Reportable Incidents, of which 30 are overdue the timescale for completion. A trajectory plan is in place to ensure investigations are concluded and an outcome provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

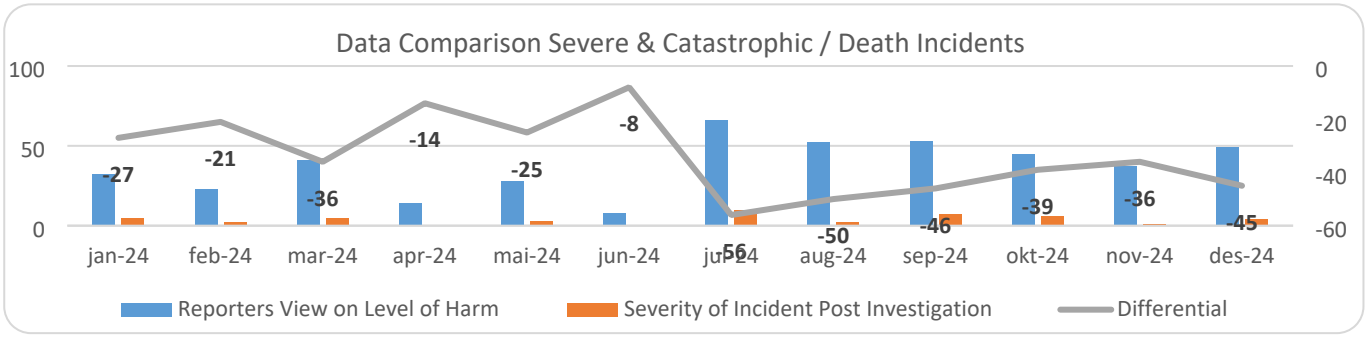
Between the 01.11.24 to 31.12.24 a total of 3559 patient safety incidents were closed. Of the 3559 patient safety incidents closed, 5 were closed with severity post investigation of severe harm (4) or catastrophic/ death (1). The 12 month trend is reflected in the table below. The 1 incident closed with a severity post investigation of catastrophic / death was classified as Assessment, Investigation, Diagnosis.



	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Catastrophic / Death	3	3	8	3	2	3	4	4	3	2	0	1
Severe	4	4	1	1	5	12	5	0	4	2	1	4
Moderate	177	31	56	30	23	18	25	22	17	16	25	24
Low	1941	1849	1342	1051	1074	847	965	784	978	794	834	826
None	1235	1241	1233	1613	1390	1158	1327	1105	1338	1233	1322	1215

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

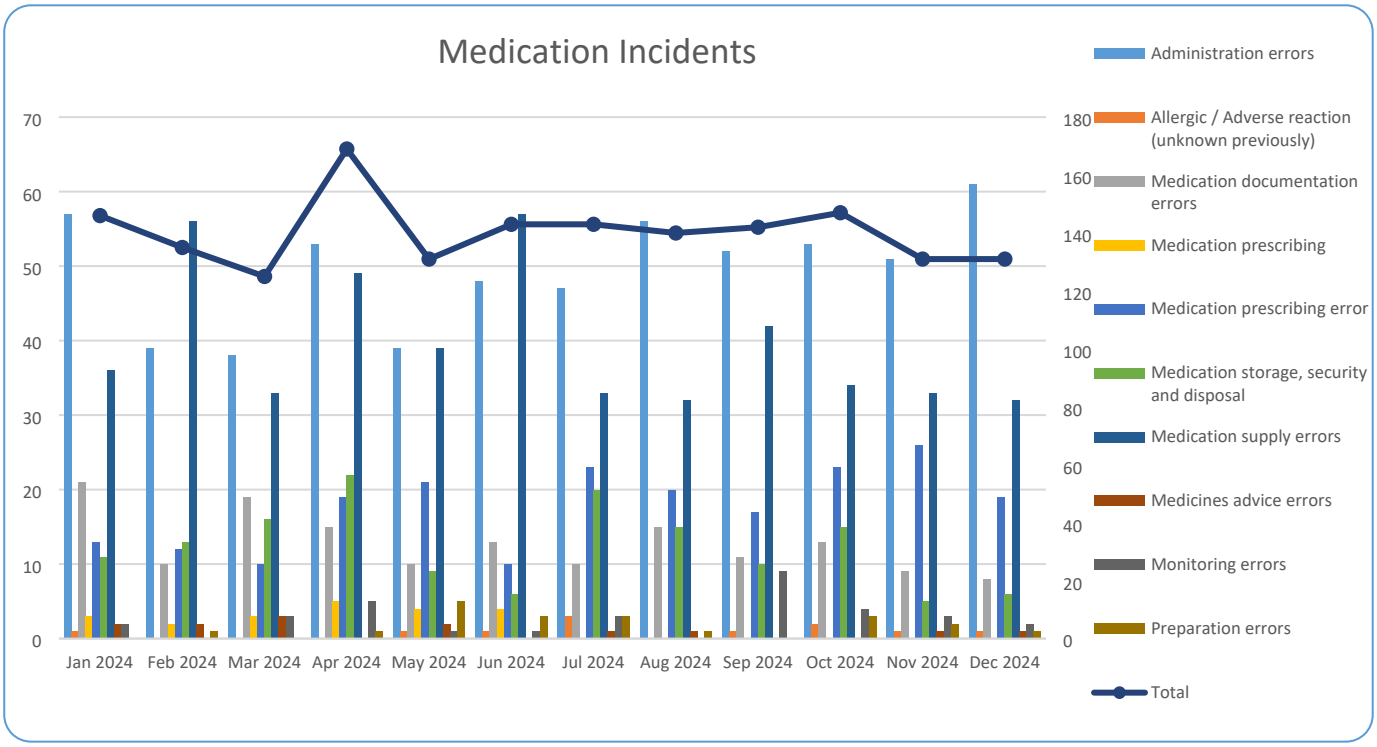
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

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

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

A total of 262 medication incidents were reported as occurring between 01.11.24 to 31.12.24. This is a decrease of 27 when compared with the previous 2 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (112), supply errors (65), and medication prescribing errors (45).

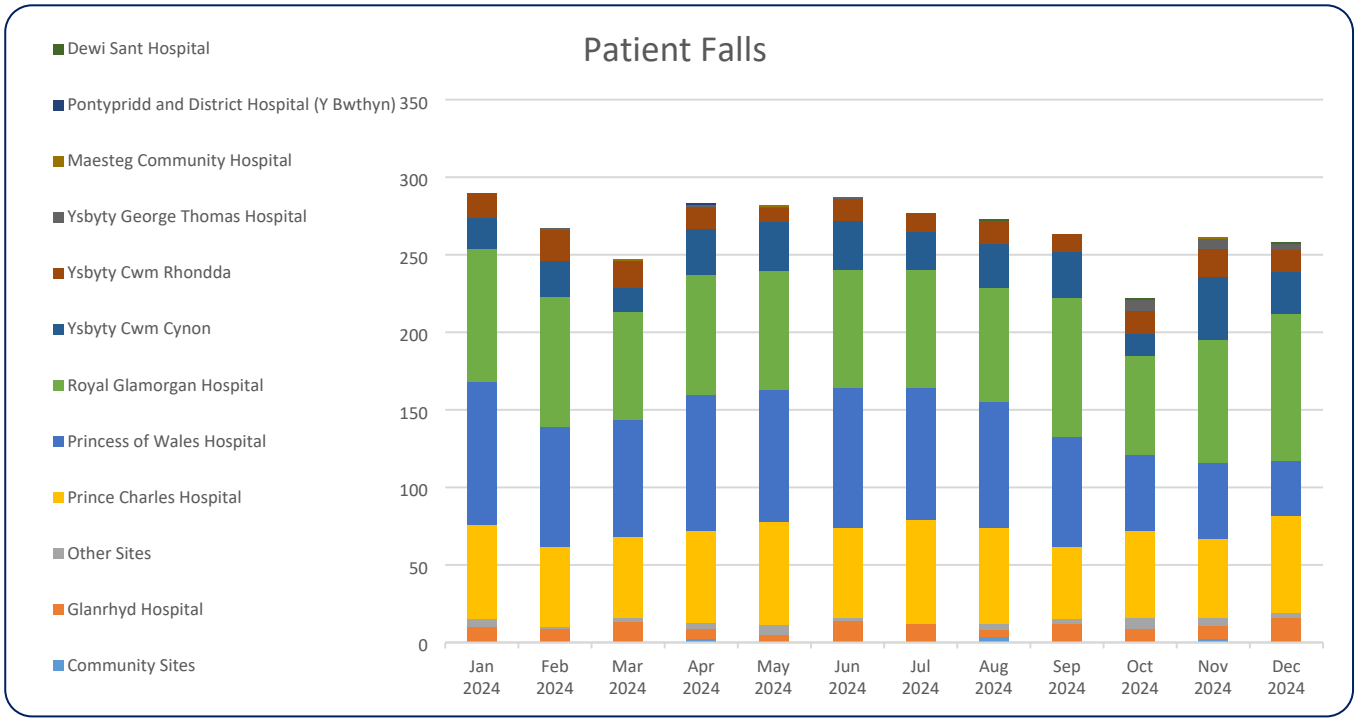


87% of the medication incidents were reported as resulting in no (106) or low (123) harm, with the remaining reported as resulting in moderate harm (30) and severe (3) harm. No incidents were reported as resulting in catastrophic harm/death. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 519 falls, where the person affected was a patient, were reported during November and December 2024. This represents a slight increase of 33 compared with the previous two months.

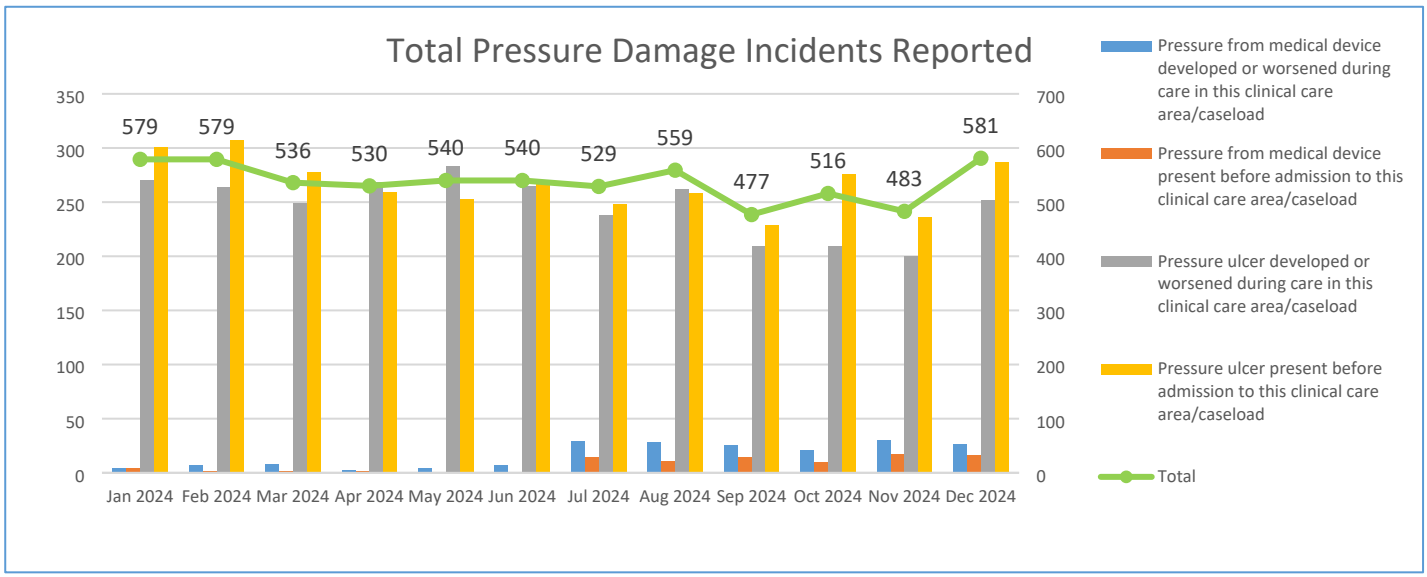
Of the falls incidents within the time period, 94% were reported as no (167) or low (323) harm. The remaining incidents were reported as moderate (26) and severe (3) harm. No incidents relating to patient falls were reported as resulting in death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



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

2.3.3 Pressure Damage

Between the 01.11.24 and 31.12.24, a total of 1064 pressure damage incidents were reported, of which 508 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (556) were reported as being present before admission to this clinical care area/caseload.



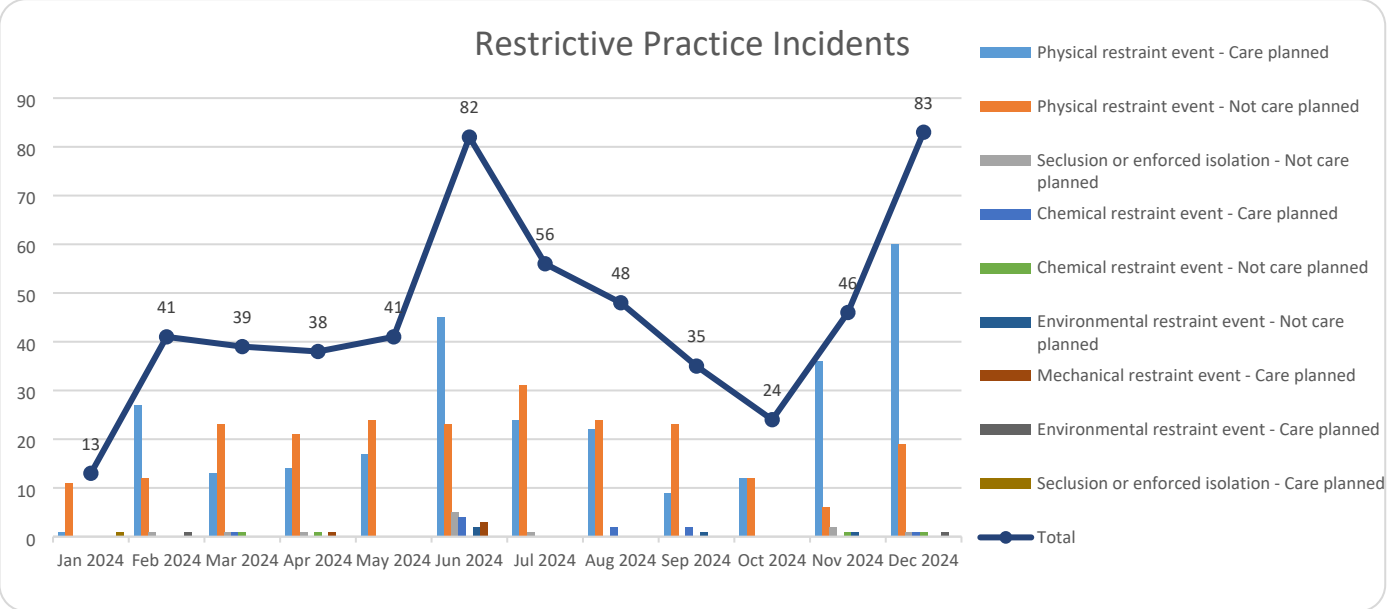
Of the 508, identified as developing or worsening during current caseload, 257 were identified as occurring within the community, which is a slight increase compared to the previous two month period.

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

2.3.4 Mental Health Metrics

Restrictive Practices

Between 01.11.24 and 31.12.24, a total of 129 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 70 incidents when compared to the previous two months.

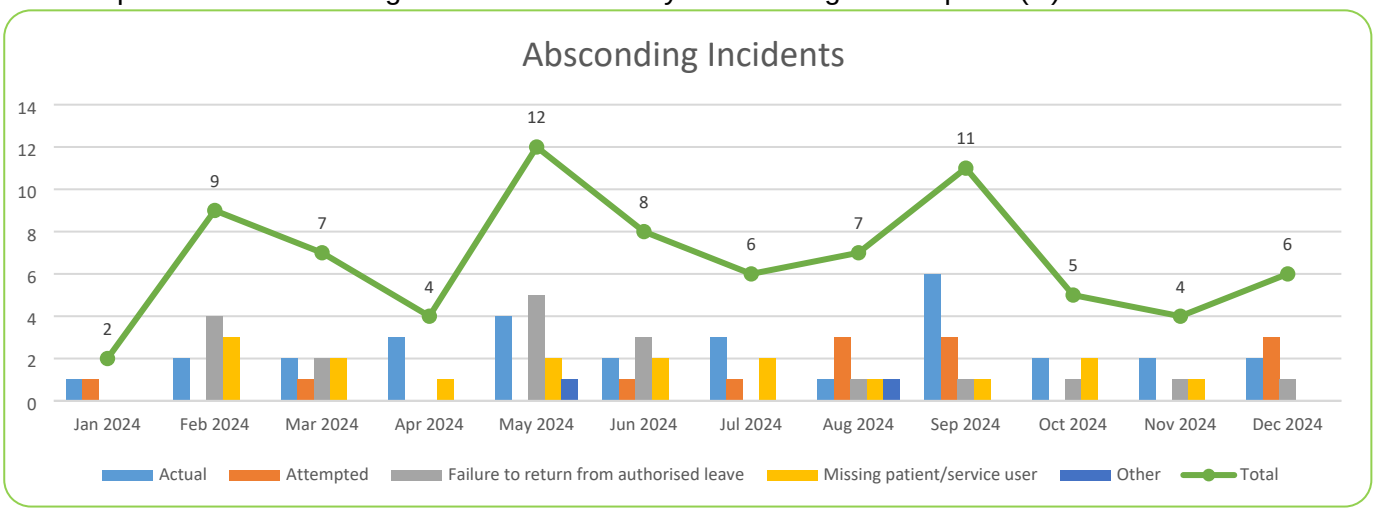


Of the 129 incidents, 31 were reported as not care planned (not included in the care and treatment plan for the patient) and 98 were reported as care planned (included in the care and treatment plan for the patient). The 3 highest number of incidents were reported as occurring on the Enfys Ward, Princess of Wales Hospital (83), Seren Unit, Royal Glamorgan Hospital (12) and Coity Clinic, Princess of Wales Hospital (7). It should be noted that the 83 Incidents on Enfys ward relate to 3 patients.

Absconding incidents

During November and December 2024, a total of 10 Absconding incidents were reported, a decrease of 6 when compared with the previous 2-month period. 4 were recorded as Actual absconding, with the remaining recorded as Attempted absconding (3), Failure to return from

authorised leave (2), and Missing patient/service user (1). The highest number of incidents were reported as occurring in Ward 22 at Royal Glamorgan Hospital (4).



3. Key Risks / Matters for Escalation

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

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:

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

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

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

5. Recommendation

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

6. Next Steps

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

Agenda Item
6.1 Appendix A

Quality, Safety & Experience Committee

People's Experience Activity Report October- November 2024

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PROMS	Patient reported outcome measures
PREMS	Patient reported experience measures.
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
PALS	Patient Advice & Liaison Service
ED	Emergency Department
CNS	Clinical Nurse Specialist
QSRE	Quality Safety Risk & Experience

1. Situation /Background

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

2. Specific Matters for Consideration

2.1 Population Engagement Events

Date	Event	Staff Member
15th October	Llais Event – Aberfan & Merthyr Vale Community Centre	Member of PALS & Unpaid Carer's Lead.
18th October	CTM 2030 Leaders Group Meeting – Merthyr Tydfil	Jenny Oliver, Head of People's Experience.
22nd October	Ysbyty Cwm Cynon People's Experience Roadshow	People's Experience Team and third sector stakeholders.

NHS Wales People's Experience Framework and Toolkit

Conversations are ongoing at senior meetings to highlight the ask behind the Framework and the need to ensure there is a process in place to support implementation across the whole of Cwm Taf Morgannwg UHB (CTMUHB) at care group and corporate levels.

Release date for the above Framework and Guidance has yet to be confirmed by Welsh Assembly/NHS Executive.

Ongoing projects

Lost Property Pilot
The type of container to be used has been agreed and there is work ongoing to look at the costs now associated with this to facilitate a pilot project in Theatres and ED areas across CTMUHB.

Strategic Engagement with Third Sector
Xmas campaign – Gift of Kindness has been signed off and was launched in November 2024.

CTMUHB Strategic Engagement Forum has made progress and now has a draft engagement calendar in place for discussion in the next meeting in January 2025. Representation from groups with sensory loss are also

attending to highlight when engaging with services for the Forum to look to build into any future engagement/planning events across CTMUHB.

Patient Satisfaction Feedback

Following approval by Welsh Government and NHS Executive the Health Board has recreated the new All Wales Patient Experience Survey within the Patient feedback system they are currently utilising. This survey will also be the baseline utilised for all feedback across the services with the ability to add further questions pertinent to specialities as needed.

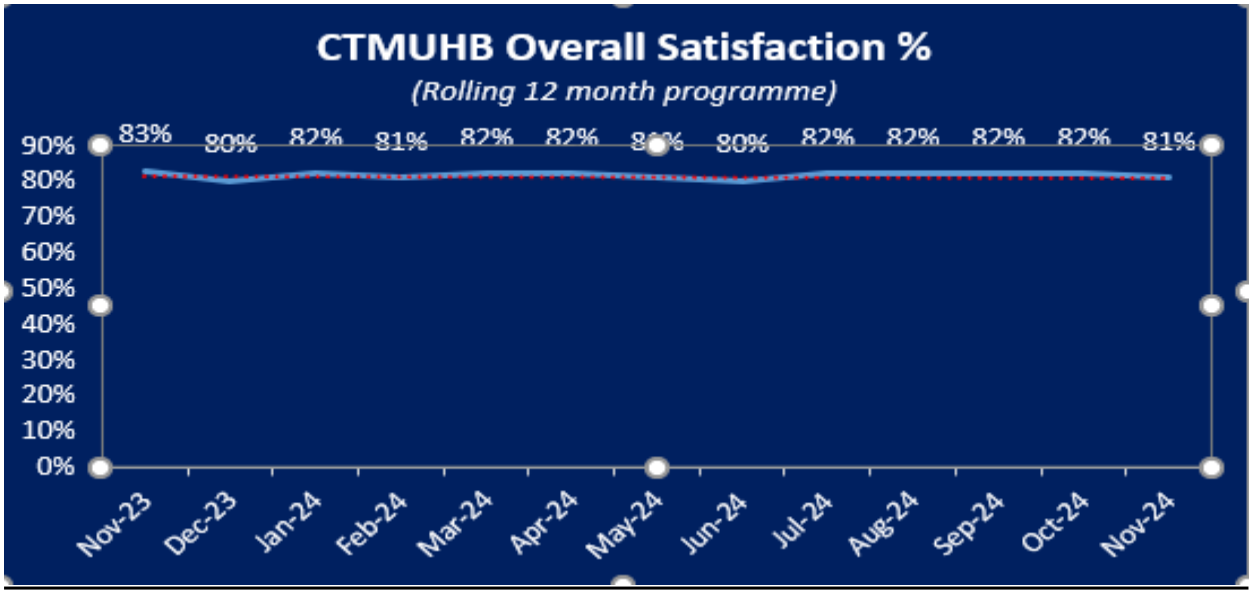
- Value Base Health Care Team are progressing the implementation of PROMS across the Health Board. A number of discussions have been undertaken by the team to manage the implementation in a phased approach and to ensure the alignment of patient feedback (PREMS) in line with this as well.
- The team are launching the "Digital Health Assessment App" in January 2025 which will provide further feedback around symptom specific specialties, physical health and quality of life between appointments from service users.

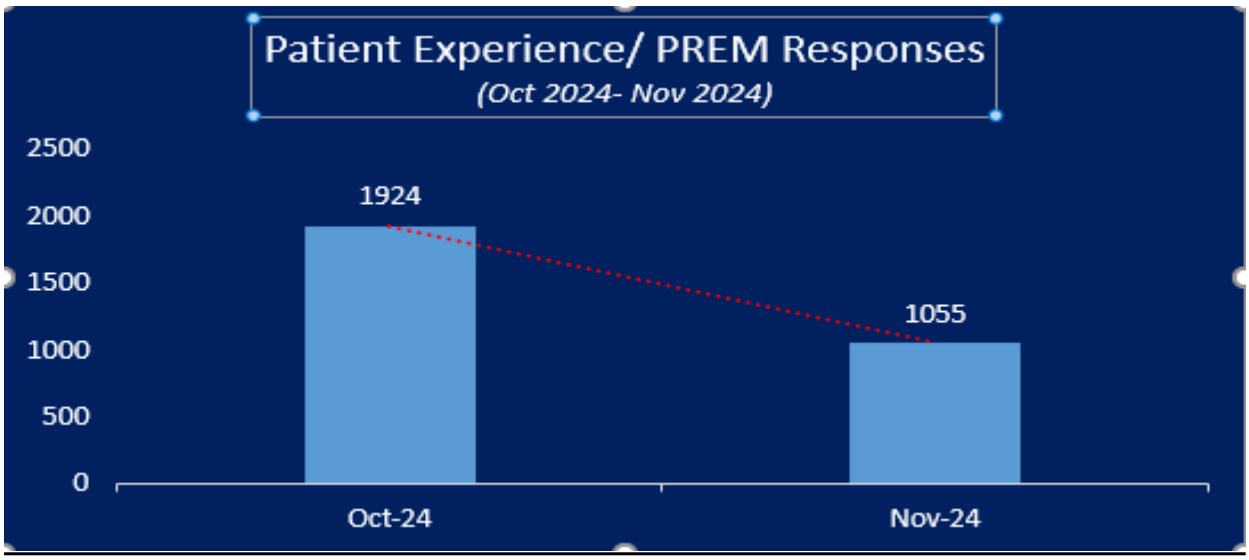
Feedback aligned to Service Improvement

The People's Experience team are continuously exploring ways to engage with the community to ensure that the services we provide are meeting the needs of our community and to also highlight the services provided by third sector stakeholders that compliment services in different areas.

The Patient Experience team together with third sector colleagues undertook a showcase event to exhibit the services on offer in Ysbyty Cwm Cynon on 22nd October.

Overview of feedback responses for CTMU HB





Chaplaincy

Spiritual/holistic care remains a priority, particularly ways to evaluate how we support our patients/families/unpaid carers and staff on their health journeys within CTMUHB.

Number of People supported Significant Spiritual and Pastoral Care	
Patients	1002
Relatives/carer's	295
Staff	488

- The team have provided 22 hours training to staff across CTMUHB on the ethos of spiritual care.
- The team supported Baby Loss Awareness week across CTMUHB and on Prince Charles Hospital acute site approximately 60 families joined us in the Butterfly Garden, and staff from all the disciplines working with baby loss were represented. A total of 100 tea-lights were distributed that night and lit in the garden.
- Twenty-three services were held during this period with a total of 510 people attending. This also includes the three remembrance services that were held on every site.

Bereavement

The Bereavement Lead continues to work to ensure the HB is measuring itself against all the indicators within the All-Wales Bereavement Strategy and our communities are supported when they lose a loved one.

- Supported two new interim Bereavement Midwives in their posts to develop the service provided.
- Delivered Pregnancy Loss Register (PLR) training to 30 staff members in Bridgend Clinic following the moving of the gynaecology services and new staff needing training.
- Attended the Impact and Engagement awards in University of South Wales where the team were shortlisted for the work undertaken through Hydra and the healthcare support worker training programmes
- Created a working group for bereavement and the Race Equality Network to establish what is important and if the Health Board is doing all it can to engage with our communities.

Volunteers

Volunteer Manager continues to explore avenues to increase volunteers across CTMUHB and how they can support our staff to improve patient experience.

- Volunteer information session held in November 2024, with 31 people attending, the numbers of people attending are increasing year on year.
- Local orientations arranged which took place at maternity ward and ward 3 PCH. Ward 3 is a newly identified ward requesting the support of volunteers. Local orientation was extremely positive and staff, including CNS in older persons, who were very excited to have volunteers to support with one to one and group activity sessions.
- The People's Experience Team is reviewing different methods to leverage the expertise and extensive knowledge our volunteers contribute to CTMUHB beyond their volunteering roles.

Armed Forces/Veterans

Work with armed forces family is progressing across CTMUHB. Connections internal/external to the Health Board are being forged to look at the different areas that need to be strengthened to raise awareness of the Armed Forces Covenant and CTMUHB as an employer.

- Work completed and points of contact agreed to support CTMUHB Armed Forces Referral process now in place and being progressed within Primary Care.
- Discussions are being held with Local Authorities to look at holding wellbeing events across CTMUHB following feedback from armed forces/veterans through the working forums surrounding the availability and understanding of services available to support them.
- Plans to present at Primary Care Practise Manager Group in March 25 to highlight Armed Forces Covenant and NHS Veterans Wales Services.

PALS (Patient Advice Liaison Service)

The team work proactively across the sites to support patients/families/unpaid carers to resolve issues before reaching a complaint level.

Number of PALS contacts	Merthyr	Bridgend	Rhondda
	110	139	85

Top three themes
Communication
Clinical treatment
Patient care

- As the teams have embedded, work to explore further representation in different forums is underway and staff members have been aligned to Care Groups and QSRE forums to forge stronger links and look to develop the 'you said, we did' formats.
- PALS teams have supported the gathering of feedback to support ward moves across the HB.
- Work is underway to look at engagement opportunities with the public for 2025.
- Supported information session – PCH Skills Day to highlight the service and how it works with Carers Lead.

Unpaid Carers

The aim of the carers lead is to raise awareness of unpaid carers, the role they undertake and how this can be supported when the person they care for accesses secondary health services to ensure both are supported within this.

- Attended the Falls Prevention Steering Group to raise awareness of carers in this setting.
- Attended Carers Sharing Event in Bettws to listen to the carers voice.
- Attended a meeting to discuss new RCT Citizens Advice carers service.
- Supported a carer to create a patient story around the difficulties they face accessing secondary care services.
- Discussions held with Head of Employee Engagement and Involvement to look at identifying and supporting staff carers.

3. Key Risks / Matters for Escalation

3.1 A member of the PALS team (RGH) is continuing to support the central concerns team due to staffing issues at present.

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

Impact Assessment		
Ansawdd *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:

	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	Yes (Include further detail below)	
	Person centred care and the involvement of stakeholders within this process is imperative to ensure the services we provide are reflective of our communities and the resources within CTMUHB to support this. If not in place these can pose a reputational risk.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

Members of the Quality, Safety and Experience Committee are asked to NOTE this report.

6. Next Steps

The People's Experience Team will continue to work with internal and external stakeholders to ensure that the voice of our communities is heard within service development and improvement.

Agenda Item
7.1

Quality, Safety & Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	22 January 2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	November / December 2024	RISKS REVIEWED
Operational Management Board	November / December 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	Via email 10 January 2025	MANAGEMENT SIGN OFF RECEIVED

Acronyms / Glossary of Terms	

1. Situation /Background

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

2. Specific Matters for Consideration

Risk Review

2.1 Care Groups and Central leads are continuing to review and update their assigned risks considering feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews. This will be a continuous improvement area that Members will hopefully note will evolve and improve over the next 12 months.

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

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

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

2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 3 January 2025. Where review dates have passed, and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

2.6 The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of risks and therefore as noted in Appendix 1 there are three risks that have not been reviewed this period, however, the Care Group Senior Management Team have confirmed that they will endeavour to ensure a review is captured in the next iteration.

2.7 The risks on the Organisational Risk Register have been reassigned to align with the new Committee Structure implemented in January 2025.

Training

2.8 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.

2.9 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

2.10 To date 765 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. In addition to this number training has also been provided to the Joint Commissioning Committee Senior Leadership Team during this period and their feedback is captured in the evaluations at 2.1.4.

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

2.12 101 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 4.78 out of a maximum score of 5.

2.13 100% of the 101 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.

2.14 99% of the 101 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

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

- *Easy to follow and enough information to have a clear understanding of the risk escalation process and how to appropriately document risks.*
- *I am new to Risk. I found the session very interesting and informative. The presenter was a great speaker and gave good explanations and examples to follow.*
- *"I'm new to NHS so this session was invaluable*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Nil as reported to the Organisational Risk Register in January 2025.

3.2 CHANGES TO RISKS

Risk Score Increased

Nil as reported to the Organisational Risk Register in January 2025.

Risk Score Decreased

Medical Directorate

- Datix Risk 4080 - Failure to recruit sufficient medical and dental staff. Risk score reduced from a 15 to a 12 in December 2024. The rationale for de-scalation from the Organisational Risk Register is that the risk is being managed through the Care Group Structure and scrutinised through the Medical Workforce Productivity Programme (MWPP) via relevant workforce and medical leaders. Core spend has increased. Agency usage has reduced but this has been offset against bank spend. The overall position remains above the previous 12 months and the risk will continue to be monitored through MWPP.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

There were no risks escalated to the Organisational Risk Register that were closed this period.

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

3.5 EMERGING RISKS

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

Risk assessments are underway in terms of the sustainability of pathology services and the delivery of a digital cellular pathology solution for the Health Board. Once the assessments are complete, they will be considered for escalation to the Organisational Risk Register as appropriate. Update as at January 2025 from the Service Director of the DTPS Care Group is that risk is being considered ahead of

the next meeting of the Operational Management Board with the Chief Operating Officer. If once considered it is approved for escalation it will feature on a future Organisational Risk Register report.

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

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee	Current score	Scoring Trajectory *(since the last report received by the Board)*
1a	Sufficient capacity to meet elective demand Click Here for Risk1a	Improving Care IMPROVING CARE	Chief Operating Officer	Quality, Safety & Experience Committee Operational Delivery Committee	20 (C4xL5)	No change this period. ⟷
1b	Sufficient capacity to meet emergency demand Click Here for Risk1b	Improving Care IMPROVING CARE	Chief Operating Officer	Quality, Safety & Experience Committee Operational Delivery Committee	20 (C4xL5)	No change this period. ⟷
2.	Ability to deliver improvements which transform care and enhance outcomes Click Here for Risk 2	Improving Care IMPROVING CARE	Executive Dir. Of Nursing, Midwifery / Executive Medical Director	Quality, Safety & Experience Committee Strategic Development Committee	16 (C4xL4)	No change this period. ⟷

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	A Resilient Wales
	If more than one applies please list below:

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	5932	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Assistant Director of Planning - (Capital and Estates), Strategic and Operational Planning	Sustaining Our Future	Environmental / Estate / Infrastructure	Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.	If: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof area at the POWH. Then: there is a risk of collapse of the roof coverings which could result in the roof coverings falling through the roof void into occupied clinical/non clinical areas and externally from the edges of Phase 1. This risk increases in adverse weather with additional loading on the roof. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations being considered under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport Workforce Digital Facilities Patient Safety Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update January 2025: Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor has been appointed. Welsh Government funding £26.524m was approved Friday 8th November, contractor started the roof replacement programme on Monday 11th November. Phase 1 has prioritised Maternity and Special Care Baby Unit, on target to hand over to the clinical service on Monday 13th January. Contractors and any staff that need to be in any of the first floor areas must wear hard hats and hi-vis vests. Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025.	Operational Delivery Committee Quality, Safety & Experience Committee Health, Safety & Fire Sub Committee	20	C5xL4	10 (C5xL2)	↔	23.09.2024	06.01.2025	28.02.2025
4	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.	**Elective/ Planned Care -** • Critical incident declared at Princess of Wales on 9th October 2024 due to the roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity • There has been continuous planning on clinical pathways and diversion of emergency intakes, which again has impacted on the capacity and resilience across the full CTMUHB system. • There has been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTMUHB acute and community. • There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. • Planning continues on recovery phase following critical incident with the impact not yet quantified. • The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. • The large-scale capital programme at Prince Charles Hospital will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. • The current Fire enforcement notice at Princess of Wales hospital will be completed as part of the Critical incident response and reduce the number of operating theatres until early summer 2025. Plans are ongoing for the temporary location of the theatres. • Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. • Regional working continues and the positive and negative impact of this will be continuously reviewed. **Unscheduled Care** - Critical incident declared at Princess of Wales on 9th October 2024. Roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity • There has been continuous planning on clinical pathways and diversion of emergency intakes that again has impacted on the capacity and resilience across the full CTMUHB system. • There has been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTMUHB acute and community. • There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. • Planning continues on recovery phase following critical incident with the impact not yet quantified. • There has been some improvement against trajectories for emergency demand. Specifically in total reduction of lost ambulance hours. • There remains a high number of clinically optimised patients in core capacity that is impacting on patient flow. • The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. • Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. The conversion from locum to substantive and establishing COVID un-commissioned capacity remains a priority.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 C4 x L3	↔	13.7.2023	29.08.2024	31.12.2024
5	5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	If: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update November 2024 - Work ongoing to work through short term contract offer with aim to finalise and gain approval. This service would deliver assessment and first line treatment for urgent cases. Meeting with a provider 6th November. Also to be discussed at next primary care commissioning meeting so updated comms can go out to GPs Update January 2025 - December 24 Update - Work continues to source alternative service offer. Key updates include - the provider is likely to start triaging the first batch of 40 ref's Jan/Feb. Draft agreement been produced. Referral process established with referral management team. Still need to confirm how urgent referrals seen by provider that convert to follow up.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	4 (C4xL1)	↔	08.07.2024	24.12.2024	31.01.2025
6	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update November 2024 Risk reviewed by SMT, stroke services options appraisal has been submitted to Executive Leadership Group. The Stroke consultants within CTM cover Stroke services on two acute sites (POWH and PCH). They also provide a 1:6, seven-day stroke on-call advice service. However, due to vacancies and maternity leave within the consultant workforce the ratio for the on-call rota is currently 1:3 to mitigate gaps. There are currently 4.0 WTE stroke consultants and 4.8 WTE CNS in post across CTM, broken down as follow: • PCH – 2.0 WTE consultants with 1.0 WTE vacancy • PCH - 2 WTE Clinical Nurse Specialist • POWH – 2.0 WTE consultants with an additional 0.6 WTE agency locum Consultant • POWH - 2.8 WTE Clinical Nurse Specialist The Stroke consultants at POWH also have a GIM on call commitment on a 1:21 rota, comprising of weekday evening and full weekend day cover resident cover with non-resident overnight cover. The service becomes increasingly more fragile from September 2024 when one consultant at PCH will be commencing maternity leave for a 12-month period, from July they will also be coming off the on-call rota. This will leave just 3 substantive consultants undertaking a 1:6 rota with a 50% less workforce, as well as leaving just one consultant at PCH from September which will significantly impact being to deliver a safe and sustainable stroke service at PCH. In order to try and mitigate this, a locum Consultant started at PCH on Tuesday 27th August to cover maternity leave, with a second fixed term locum due to start at the end of October, this will allow adequate time for the care group to work through more sustainable options. Update January 2025 - The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of this risk, however, they will endeavour to ensure a review is captured in the next iteration. In terms of the urgent, temporary change to Stroke Services, stroke patients from Prince Charles Hospital were successfully transferred to the Royal Glamorgan Hospital (RGH) on the 8 January 2025, along with all the stroke specialist clinicians. This ward is now located to the stroke ward that was relocated to RGH from Princess of Wales Hospital and both wards have access to a shared rehabilitation space. Work is ongoing with internal and external stakeholders to monitor the impact of the move and explore any further opportunities to	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4 x L3)	↔	11.05.2021	05.11.2024	31.12.2024
7	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	**IF**: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. **THEN** patients will not receive the necessary imaging **RESULTING IN** delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Update November 2024 - 07/11/24 Further shortage of Technescan HDP until 11/11/24 impacting Isotope provision, particularly bone scans. The Reactor in Poland restarted 31/10/24. Confirmation received that the usual levels of supply will reinstated by 11/11/24. No change to risk score. Update January 2025 - 16.12.24 update - ongoing nationally . No change to risk score.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	16.12.2024	20.01.2025
8	5276	Director of Digital	Central Support Function - Digital and 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 November 2024: UAT has been extended and resulting in a 2 month delay to go live, however the end date of December 2025 is non-negotiable. Activity to understand the consequences of the delay such as dependencies on other projects such as ePMA are being investigated. Update January 2025: Progressing with User Acceptance Testing 2 in January, everything currently still on target for December 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	20.12.2024	28.02.2025
9	4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update July 2024 - risk ongoing, mitigation continues to be : ongoing increased scrutiny of pathways, focused work with urology, Gynae and colorectal, enhanced monitoring with Velindre Cancer Centre. Update November 2024 - Performance is improving, however, CTM are still not meeting the set Trajectory so the risk remains. Update January 2025 - Whilst not achieving SCP target there is a sustained improvement in cancer performance and backlog position.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	24.12.2024	31.01.2025
10	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update April 2024 Previous high risk areas of the injection/macular clinic and the diabetic retinopathy service are now in a much better position with significant delays mostly eliminated. They remain vulnerable and work is ongoing to try and make them more robust and sustainable. CTMUH B did not have a substantive glaucoma consultant from 2017 to 2023. The glaucoma service is top of the list of services to fix but in the process of fixing it, we are going to come across many, many cases of avoidable vision loss. Aside from the human cost of avoidable blindness, there is a large financial and reputational risk to the HB. The glaucoma service is currently at score of 25 on risk matrix - catastrophic consequences (blindness in high volume of patients) (5) x almost certain to occur (5). This needs to be the highest priority area in ophthalmology for the HB. Cataracts and eye casualty are ongoing problem areas but are less urgent clinically than the risks outlined below. Major risks in ophthalmology at present 1) Glaucoma – glaucoma causes irreversible vision loss due to damage to the optic nerve. a. high volumes of long waiting patients. Many not seen for several years. Increasing Sis with severe harm as long-waiters finally being seen b. Large numbers of stage 4 glaucoma patients awaiting surgery, some for > 1 year. This is the highest risk glaucoma population. Patients are generally listed for surgery when medical treatment does not work – these patients are at high risk of vision loss with such long delays. Mitigating factors – we have 2 substantive glaucoma consultants, 1 locum consultant. Community glaucoma scheme and WGOS4 will allow some low risk patients to be monitored in the community Immediate actions: meeting next week to formulate plan for stage 4 patients Need decision on funding for diagnostic hub to increase capacity in glaucoma service 2) Medical retina a. Long delay for new appt. Few dedicated medical retina appointments. 3) Inappropriate discharge by outsourcing company in April 2019. a. ~3000 patients discharged after notes review by outsource company in April 2019. b. Was noted that many of these patients had sight-threatening disease and should not have been discharged. Some patients with ocular cancer received a discharge letter. c. Sample of 350 records reviewed in 2021- ~50% were appropriate discharge. 22% not appropriate. 23% uncertain. d. Initial plan was to review all notes of all discharged patients to ascertain if discharge was safe – this work still outstanding Update August 2024 - risk ongoing, no new updates in addition to those reported in April 2024, to be reviewed in September 2024. Update January 2025 - December 2024 - 95% of macular patients are meeting their target date currently.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4 x L5	12 C4 x L3	↔	01.04.2014	24.12.2024	31.01.2025

	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
11	5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	**If** there is insufficient capacity within the adult weight management service to meet the demand **Then** patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. **Resulting in** missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening of diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update August 2024 - Current mitigations remain in place: Pathway redesign and Demand and Capacity (D&C) oversight- Pathway redesign: 74% of level 3 patients identified as suitable for group education, this group delivery model is in progress, which has resulted in an 50% increase in annual capacity compared to the original service model of 1: 1 MDT treatment. Despite this efficiency demand exceeds capacity. D&C: Real time validation of waiting lists ensures appropriate signposting according to service specification, alongside implementation of partial booking. Referral rates continue at approx. 100/mth with service capacity of 40/mth. A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3. Update January 2025 - update from 28.10.24: Risk reviewed, no change to score. Given there is unlikely to be additional funding available to support the business case for expansion of current service, discussions are underway with planning, DTPS and public health colleagues as to the best way to proceed. The non-finance dependant mitigating actions remain in place: patients are offered the lowest intervention required in line with the Healthy Weight Healthy Wales pathways; signposting to 'waiting well' support; maximising digital opportunities for efficiencies within pathways and maintaining communication with patients to manage expectations; implementation of group interventions to maximise service capacity. CTM UHB is one of a number of Health Boards across Wales facing these challenges and national collaboration via the Executive Directors of Allied Health Professions and Health Science peer group has been strengthened to enable collective action and sharing of best practice.	Quality, Safety & Experience Committee Operational Delivery Committee Strategic Development Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	03.01.2025	28.02.2025
13	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update November 2024. The USC SMT reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an SOP relating to fit2sit. We continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Quality statement baseline assessment has been completed, part of this work, will result in the development of an overcrowding score which should help reduce the risk of harm with overcrowding in the emergency department. 1. Currently developing a standardised approach to our huddle capture and reporting. 2. Proof of concept has been completed with engagement from operational and clinical stakeholders. 3. Move to development of software project. 4. This will support a consistent approach to recording and reporting escalation levels across all our acute sites. 5. USC Dashboard which provides daily and ongoing trend data for performance metrics I Emergency Care. 6. Developing data intelligence Emergency department acuity levels, including risk stratification and also clinical frailty score for all attendances in each of our Emergency Departments. 7. CTM IMTP describes development of a predictive data model to enhance current systems (we already have predicted attendance) This remains an ongoing risk for all 3 sites and is reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With sustained high level of escalation, risk rating to remain at 20. C4, likely hood 5. Update January 2025 - The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of this risk, however, they will endeavour to ensure a review is captured in the next iteration.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	05.11.2024	31.12.2024
14	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 January 2025 30/12/2024 Update - A monthly list has now been secured for Paeds in Prince Charles Hospital (released by Max Fax) and approximately 6 patients can be seen on each list. This will be used to prioritise any Cat 1/urgent treatment that comes in during the month as well as rebooking patients who had a cancelled GA as a result of the issues in Princess Of Wales Hospital. On average over a 12-month period, there are 29 children accepted per month for treatment under GA, as a result of only have one list per month, the waiting list is going to increase significantly. Currently, there are 707 children waiting for GA assessment/treatment under GA with a longest wait of approximately 183 weeks. Due to the service having significantly reduced access to theatre lists, private treatment via alternative providers is being explored. A QIA will need to be completed where appropriate when considering alternative providers.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	9 C3xL3	↔	20.04.2023	30.12.2024	21.02.2025
15	5961	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Estates Directorate	Sustaining Our Future	Environmental / Estate / Infrastructure	Remedial roof works to resolve the water ingress at POWH.	If: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof areas at the POWH Then: water ingress will continue to be a problem. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations to vacate 1st floor wards & depts. of Phase 1 being managed under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. Decant plan agreed 15th Oct. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport, Workforce, Digital, Facilities, Patient Safety, Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update January 2025: Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor has been appointed. Welsh Government funding £26.524m was approved Friday 8th November, contractor started the roof replacement programme on Monday 11th November. Phase 1 has prioritised Maternity and Special Care Baby Unit, on target to hand over to the clinical service on Monday 13th January. Contractors and any staff that need to be in any of the first floor areas must wear hard hats and hi-vis vests. Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	8 (C4xL2)	⇔	21.10.2024	06.01.2025	28.02.2025
17	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.	Update as at January 2025 Project Initiation Document drafted to capture the activity needed to support the review of the Non Clinical Written Control Documents process. This will include but is not exhaustive of the following areas: Explore available options to automate the process including a filing portal and automatic prompting. Explore if the process for the policy on policies for Non Clinical written control documents could be simplified. Review the policy library linked to the SharePoint site Produce a baseline position as to the status of all non clinical written control documents Timeframe - December 2025. Risk escalated as likelihood of increased due to the capacity constraints impacting the teams ability to undertake the mitigating actions required.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	⇔	26.10.2021	12.12.2024	28.02.2025
18	5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	CCTV System Failure in Prince Charles Hospital	**IF:** Major CCTV security management platform (SMP) headend and camera outage at PCH. Unable to live view live data images at the security control centre. NVR recording function is not available to record data images. The outage is also linked with the PCH site refurbishment scheme. The Capital Major Projects team advise that the new (SMP) headend server is not part of the PCH scheme as there is no funding for it. **THEN:** As a consequence this presents a site security with very limited site surveillance available to identify site incidents and provide evidence of criminal activity and crime. **RESULTING IN:** The ground floor, first floor and external site areas require the roll out of (124) new CCTV cameras as part of the PCH refurbishment scheme and the existing old (SMP) headend server does not have the functionality and capacity to accept these additional cameras therefore the contractor TD are unable to roll out the new cameras on site until a new SMP is installed. Risks to the PCH site, patients and staff safety risk. Site risk of theft, property damage and personal injury/assault.	Incident meeting held by Facilities with Digital ICT, Estates, the system contractor and Capital Major Projects team who are managing the PCH site Major project scheme to review the faults and aim to resolve the issue.	Update October 2024 added in red to August update - The Estate CCTV system contractor attended site and identified the root cause of the system failure and restored the PCH security management system headend and power to the majority of existing site cameras. The outcome and recommendation from the system contractor, Capital Major Projects team and TD s is that there is further CCTV system replacement and upgrade of hardware and software work to be undertaken. The existing Security Management Platform (SMP) which is the headend control system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced, the GF/FF contractor will also be unable to fully install the (124) new site GF/FF scheme CCTV cameras and a 'moderate' risk of future system failure remains until this work is completed. A specification and estimate of cost of a new (SMP) headend has been completed and funding has been approved. Waiting for a contractor to be allocated the work and an installation date to install the SMP system. Following a recent tender process a supplier has been awarded the contract and the work to install the security management platform(headend) is due to commence in November 2024. Security Systems Risk Assessments A rolling programme of security vulnerability risk assessments is being undertaken out at a number of sites that include the suitability, compliance and provision of current CCTV and control of access systems and where systems may require replacing and upgrading or where site system provision is inadequate. Where there is a requirement for replacement/upgrade or additional systems further work is then required with support from Estates and Digital Services to complete the system technical specifications before a statement of need is provided to the Operational Capital Group for replacement or new works and security hardware/software scheme funding. Update January 2025 - It is anticipated that the work to install the new Headend will not take place until January 2025. The review date for this risk has been amended to 31/01.25 so that the action to mitigate the risk can be updated as soon as work commences.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	C3xL4 12	↔	31.01.2024	16.12.2024	31.01.2025
19	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. As of March 2024, the update from DHCW is that they working on delivering the open architecture to support sharing documents and diagnostic results. Update November 2024 - - DHCW have confirmed they are anticipate the work will be undertaken in March next year to resolve this issue. CTM have reiterated the specific issues that need resolving. Risk remains the same until DHCW complete this work. Update January 2025 - No change to progress or risk score. Next review scheduled for 31.3.2025. CTM leads continue to follow up and raise at relevant stakeholder meetings.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	30.12.2024	31.03.2025
20	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care	**If** there is no dietetic service to POW critical care... **Then** this will impact on the safe and effective provision of nutrition and hydration to critically ill patients... **Resulting in** poorer nutrition provision and increased rated of malnutrition, which in turn lead to increased risk of infection, dependency on mechanical ventilation, poorer patient outcomes, increased length of stay and longer rehabilitation and recovery times following critical care. In addition to increased health utilisation costs, inequity of service provision across CTM critical care units, and non compliance with national standards and guidance as highlighted in critical care peer	At present there is no dietetic provision to POW critical care unit due to lack of specialist critical care dietitian on the POW site and lack of funding. Therefore the nutritional needs of critical care patients on the POW site are managed by the critical care Multi Disciplinary Team.	Update October 2024 - The Planned Care - Care Group is currently undertaking a full gap analysis of the ITU service in line with the national ITU standards (GPIC) and will update the risk. No significant incidents of harm have been identified within the service due to the current dietetic position, but that this will be kept under review. Update January 2025 - Update from 21.11.24 - Risk reviewed following Princess of Wales Hospital critical incident, and remains unchanged at 16. Awaiting planned care group workforce gap analysis.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	19.12.2023	03.01.2025	28.02.2025

	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
21	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	The impact of "Right Care Right Person" (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 January 2025 - Risk reviewed no change RCRP Health Board Regional Position meetings with SBUHB and CAVUHB implemented Phases 3+4 implementation delayed until 10/03/25 - correspondence available from South Wales Police. RCRP is MHLD Care Group top investment priority in 2025/26 IMTP.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	07.01.2025	31.03.2025
22	5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	Update October 2024: Meeting between DTPS, public health, planning, children and families care groups and growing well strategy leads on 17/10/24. Agreed model of care for CYP WMS and priority areas are level 1 and level 3 for business case. Agreed to develop a phased approach over 3 years. Next steps are wider engagement with care groups and refining the current business case to reflect decisions within the meeting. Business case to be developed for early Q4. Update January 2025 - The risk has had a change in risk handler and a detailed review is scheduled for the 8 January 2025. Further update will be provided in the next iteration once the new handler has had time to review the risk.	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	03.1.2025	28.02.2025
23	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively	**If:** The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2024: Over the summer, all Redress cases have been reviewed by the senior staff member allocated overtime; with priorities identified for each case. The Legal Services team is currently depleted of staff, by 4 Claims Investigation Officers and 2 Legal Administrative Staff, which is due to sickness levels and members of staff leaving the organisation. This is having an effect on the workload of the Legal Services team. Staff members are being managed and supported appropriately through the Managing Attendance at Work Policy. The recruitment process of staff is also underway and the team are/have temporarily recruited agency staff to address the issues identified above, relating to management of legal cases. The agency staff recruited/to be recruited are: • 2 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of February 2025; • 2 legal agency (solicitors) are being recruited, to cover the immediate gap in case management of Redress and Inquest cases. It is anticipated they will commence in November 2024 – for an initial period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety. It is proposed that both Datix ID 4907 & 4908 are amalgamated as one for the next ARC meeting as both the risks relate to Legal Services/Concerns and are of the same nature of risk. Update January 2025 - A full and robust review of both risks 4907 & 4908 will be undertaken in readiness for the next iteration of the risk register. No change to current risk score of 16.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	09.01.2025	28.02.2025
24	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WKP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2024; The Legal Services team is currently depleted of staff, by 4 Claims Investigation Officers and 2 Legal Administrative Staff, which is due to sickness levels and members of staff leaving the organisation. This is having an effect on the workload of the Legal Services team. Staff members are being managed and supported appropriately through the Managing Attendance at Work Policy. The recruitment process of staff is also underway and the team are/have temporarily recruited agency staff to address the issues identified above, relating to management of legal cases. The agency staff recruited/to be recruited are: • 2 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of February 2025; • 2 legal agency (solicitors) are being recruited, to cover the immediate gap in the management of legal cases. It is anticipated they will commence in November 2024 – for an initial period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety. It is proposed that both Datix ID 4907 & 4908 are amalgamated as one for the next ARC meeting as both the risks relate to Legal Services/Concerns and are of the same nature of risk. Update January 2025 - A full and robust review of both risks 4907 & 4908 will be undertaken in readiness for the next iteration of the risk register. No change to current risk score of 16.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	09.01.2025	28.02.2025
30	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update January 2025: Following the identification of risks with the hospital roof in Princess Of Wales Hospital, the first floor of the hospital has had to be vacated to allow the remedial roofing works to take place. As a result, this has emptied the Theatre template and will therefore make the current FEN invalid. Discussions with South Wales Fire & Rescue Service have led to them withdrawing the Fire Enforcement Works in this area due to the area now being unoccupied and the ongoing programme of work to satisfy the issues in the FEN. The Fire Service will continue to monitor the Health Board's progress with these works to ensure the Main Theatres are fully fire safety compliant prior to the Health Board taking back occupancy of this area.	Quality, Safety & Experience Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	06.01.2025	31.03.2025
33	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	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 October 2024 - risk reviewed, no change A business case has been put together with another Health Board o bring a single patient record system into the Care Group. The business case has been approved and Welsh Government have agreed funding. A programme board will oversee the implementation. Update January 2025 - Risk reviewed, no change, see uploaded Decembers newsletter for progress which is available upon request from Datix.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	07.01.2025	31.03.2025
34	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update March 2024 - Still Awaiting a feasibility review on Mental Health inpatient space that will support the mitigation for this risk. Care Group Director engaging with the Capital Team on progressing this at present. No change to risk score at this stage. Update October 2024 - Risk Reviewed no change. Risk will be transferred to new MHLD Service Director when the post holder commences in late November. Update January 2025 - Risk Reviewed no change at this stage.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	07.01.2025	31.03.2025
35	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 January 2025 - This risk is due for review on 31st Jan 2025. Following the Health Board allocation letters, there has been an increase to the Health Protection (HP) funding allocation from Welsh Government, however, the impact of this will need to be evaluated against the current gap and the HP strategic plan.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	03.01.2025	28.02.2025

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
4080	Executive Medical Director Executive Director of People	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	Update January 2025 - Risk de-escalated. The risk is being managed through the Care Group Structure and scrutinised through the Medical Workforce Productivity Programme (MWPP) via relevant workforce and medical leaders. Core spend has increased. Agency usage has reduced but this has been offset against bank spend. The overall position remains above the previous 12 months and the risk will continue to be monitored through MWPP.Consequence risk lowered as contigencies are in place through agency agreements if low staffing situation does become unmanageable.	Quality, Safety & Experience Committee Operational Delivery Committee	**12** Risk descreased from a 15 to a 12	8	Update January 2025 - Risk de-escalated. The risk is being managed through the Care Group Structure and scrutinised through the Medical Workforce Productivity Programme (MWPP) via relevant workforce and medical leaders. Core spend has increased. Agency usage has reduced but this has been offset against bank spend. The overall position remains above the previous 12 months and the risk will continue to be monitored through MWPP.

	A	B	C	D	E	F	G	H	I	J	K
1	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
2	No risks proposed for closure from the Organisational Risk Register this period.										

Agenda Item
7.2

Quality, Safety & Experience Committee

MORTALITY INDICATORS AND MORTALITY REVIEWS

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
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)	Click or tap to enter a date.	

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

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 23rd December 2024), since the introduction of the Datix Mortality Review Module on 1st April 2022 the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Under Investigation/ Action Required	Closed
CTMUHB	3420	94 (3%)	57 (2%)	3269 (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.

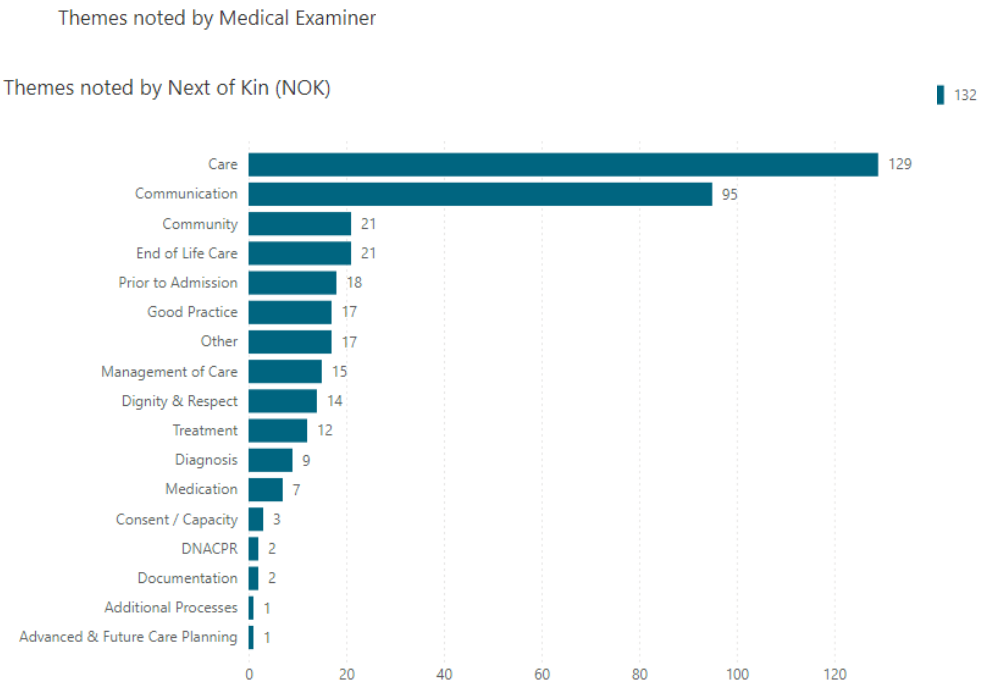
The tables below show the number of cases identified for HMR since 2022-23 (as of 23rd December 2024), the number where the review has been completed and the percentage completed within 28 days of screening panel.

	Number of HMR	Number Complete	Completed <28 days of Screening
2022-23	616	615 (99%)	11%
2023-24	373	371 (99%)	84%
2024-25	234	207 (88%)	82%

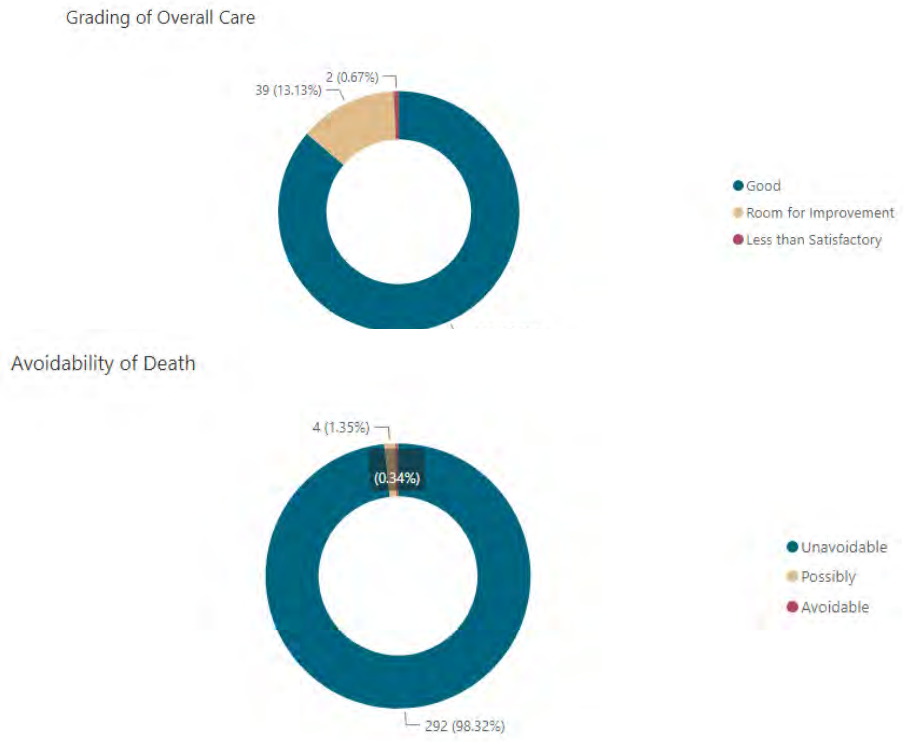
1.5 Stage 3 Mortality Review panel continues to be held on a monthly basis via Teams. There are currently 18 cases either waiting to be reviewed or in progress.

1.6 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.

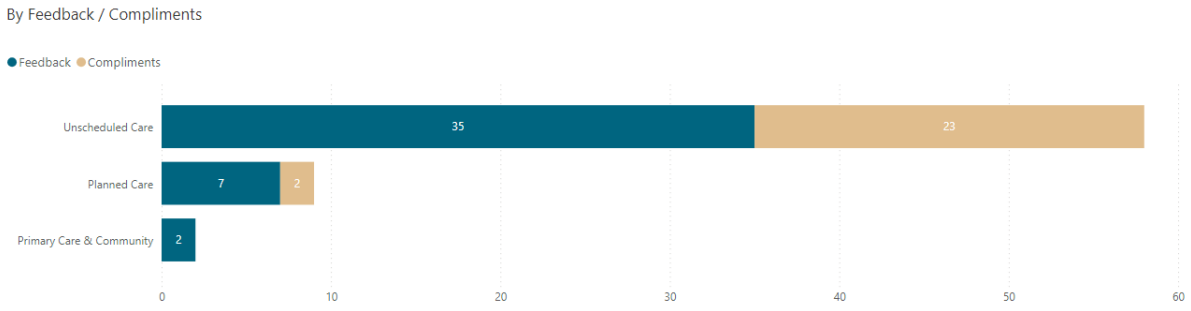
The following charts have been taken from the MR Dashboard. It is important to note the dashboard is still at an early development stage and the data is yet to be fully tested. Due to IT issues we are currently unable to add data for deaths in A&E and Primary care. This is being investigated.



1.7 Current CTMUHB Mortality data shows that there is room for improvement in care in around 14% of deaths. Data also shows that 1.7% of all hospital deaths have a degree of suspected avoidability due to problems in healthcare



1.8 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

1.9 The Health Board needs an oversight Mortality Board that oversees and receives assurance that processes are in place to learn from all deaths.

The first meeting took place on 16th December 2024 and was chaired by the Medical Director. Future membership will include 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 will meet quarterly, and will oversee;

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

Initial actions required with timescales:

- SOP and TOR for Care Group Screening Process – End of January 2025. This has highlighted the need for increased clinician involvement in the MR process, to participate in and lead on, within each care Group.
- Governance meeting template for Specialties – End of January 2025
- Share with Care Groups for their plans to adopt in Feb
- March agreement to proceed with new process

Ongoing Development

1.10 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 trial phase as a development build, but there are ongoing issues with coding of causes of death, that is delaying completion of this work.

Baseline Population Numbers

1.11 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

1.12 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.

1.13 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.

3.2 Increasing workload for the teams involved will need to be monitored and may require alternative strategies.

3.3 Ongoing work in progress to improve clinical engagement via clinical governance day workshops and communications to all doctors.

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 report.

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
6.4 Continued development of CTMUHB Whole Mortality Database
6.5 Full implementation of Mortality Review Board

Agenda Item
7.3

Quality, Safety & Experience Committee

Safeguarding Strategy 2024-2027

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire O'Keefe – Head of Safeguarding
Cyflwynydd yr Adroddiad / Report Presenter	Claire O'Keefe – Head of Safeguarding
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
Safeguarding Executive Group	31/10/2024	Approved

Acronyms / Glossary of Terms	
CTMSB	Cwm Taf Morgannwg Safeguarding Board

1. Situation /Background

1.1 Cwm Taf Morgannwg University Health Board is committed to safeguarding all who work and access services. The Safeguarding Strategy sets out a strategic approach for CTMUHB to ensure a whole-organisational approach to strengthen the arrangements for safeguarding across the health board over the next three years.

2. Specific Matters for Consideration

2.1 This Safeguarding Strategy has been developed in line with the Cwm Taf Morgannwg Safeguarding Board strategic plan 2023-2026, National Safeguarding Service work plan and feedback from care groups, safeguarding practitioners and identified learning from reviews.

2.2 The Safeguarding Strategy seeks to foster a proactive safeguarding culture within our organisation, supported by robust digital integration, staff training, and multi-agency collaboration. Our mission is to empower all CTMUHB staff, equipping them with the knowledge and resources necessary to identify risks, respond appropriately, and ensure the highest standards of care and protection. Our strategic priorities include enhancing digital solutions for integrated care, fostering a reporting culture, and safeguarding training, all aimed at ensuring effective and timely interventions.

2.3 The strategy's rollout will be overseen by the corporate safeguarding team in partnership with care groups across our Health Board, steered by the Executive Director of Nursing. Through collaborative efforts, aim to embed safeguarding measures within every facet of our service delivery, providing a structured approach to continuous improvement and transparent reporting through the Quality, Safety & Experience Committee.

3. Key Risks / Matters for Escalation

3.1 To ensure that our strategic objectives and priority areas are actionable and achievable, in addition a detailed work plan that outlines key deliverables, outcome measures, and timescales will be developed. This work plan will be integrated into the annual reporting cycle, providing a structured approach to monitoring and achieving safeguarding goals.

3.2 The Safeguarding Executive Group will be responsible for overseeing the delivery of the work plan, regularly reviewing progress against the defined milestones. They will report directly to the Quality, Safety & Experience Committee, (a committee of the Health Board), to ensure transparency, accountability, and continuous improvement. This approach will enable CTMUHB to maintain a clear focus on safeguarding priorities, measure

progress effectively, and adjust strategies as needed to respond to emerging challenges and opportunities.

3.3 This document has been shared with all key stakeholders and partner agencies for comment.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below:
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))*	Safe
	This document sets out how it will achieve CTMUHB priorities using all domains of quality.
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 strategic strategy report detailing a three year plan.

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 strategic strategy report detailing a three year plan.
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 Committee members are asked to note and Endorse for Board Approval the Safeguarding strategy for 2024-2027.

6. Next Steps

6.1 To disseminate the strategy across all services of Cwm Taf Morgannwg University Health Board.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Safeguarding Strategy

2024 - 2027

Our Vision

To be a trusted, safe organisation where all children, young people and adults at risk of harm, abuse or neglect are safeguarded by staff who feel empowered, valued and supported. Working collaboratively and innovatively with our patients and their families to ensure the best support and outcome is achieved. Cwm Taf Morgannwg University Health Board firmly believes that a whole organisational approach is required to safeguard and promote the welfare of children, young people and adults at risk using health board services.

Version
v1.04 - OCTOBER 2024

Created by
Claire O'Keefe

Review by
Quarter 2 / 2026

Introduction

Safeguarding is a fundamental responsibility in healthcare, essential for protecting vulnerable individuals from harm, abuse, and neglect. This strategy outlines our comprehensive approach to safeguarding, demonstrating our unwavering commitment to the safety and well-being of patients, staff, and the wider community. It provides a framework for identifying risks, responding to concerns, and promoting a culture of vigilance and responsibility throughout our organisation. By implementing this strategy, we aim to create a safe, supportive environment where all individuals receive the highest standard of care and protection. This document sets out clear guidelines, protocols, and responsibilities, ensuring that everyone involved in healthcare delivery understands their role in safeguarding and is equipped with the knowledge and tools to fulfil this crucial duty effectively.

Safeguarding in Wales is a legal framework provided by the Social Services and Well-being (Wales) Act 2014, the Children's Act 1989, and the Welsh Government statutory guidance on safeguarding under the 2014 Act. The Wales Safeguarding Procedures details the essential roles and responsibilities for practitioners to ensure they safeguard children and adults who are at risk of abuse and neglect.

Executive Summary

The Cwm Taf Morgannwg University Health Board (CTMUHB) aims to create a safe and inclusive environment by collaborating with partners to protect those at risk of harm, abuse, or neglect. The strategy focuses on evidence-based practices, digital integration for better care, and a strong safeguarding culture. Key priorities include staff training, prevention, and fostering a culture where concerns can be reported safely. The strategy will be guided by the Executive Director of Nursing and the Safeguarding Operational Board, with a focus on adapting to new challenges through transparent governance and collaboration.

VISION

To create a safe, inclusive environment by collaborating with internal and external partners to protect those at risk of harm, abuse, or neglect. We aim to balance individuals' rights with the Health Board's duty of care, ensuring safety and well-being for patients, staff, and the wider community.

MISSION STATEMENT

To implement evidence-based safeguarding practices across all levels of the organisation, promoting a culture of vigilance and continuous improvement. We are committed to preventing harm through timely interventions, digital integration, and creating an environment where concerns can be reported confidentially.

The Service	The CTMUHB Safeguarding Strategy 2024-2027 focuses on enhancing safeguarding through digital integration, embedding a robust safeguarding culture, and providing expert training to staff.
The Financial Status	Current resources are allocated towards implementing digital solutions and training. The goal is to maintain sustainable funding to support safeguarding activities and ensure continuous improvement.
Future Plans	Enhance digital solutions for integrated care, embed a robust culture of safeguarding, and adapt to emerging challenges in safeguarding through continuous learning and collaboration.

Our Priorities

2024/25: Providing Access to Expert Safeguarding Advice, Supervision, and Learning.

We recognise the critical importance of safeguarding expertise in ensuring the safety and protection of individuals across our services. To this end, we are dedicated to providing a wide range of safeguarding expertise within our teams, enabling all CTMUHB staff to access professional advice, supervision, and ongoing training as needed. This access to expert practitioners will empower our workforce to make informed safeguarding decisions, ensuring swift and appropriate responses to concerns. Furthermore, we are committed to promoting a culture of learning by providing facilitated feedback from complaints, reviews and incidents. By learning from incidents, we will continuously improve our services, creating a confident and resilient workforce capable of protecting communities from abuse, neglect, and exploitation.

2025/26: Embedding a Robust Safeguarding Culture to Prevent Abuse and Harassment.

Promoting an inclusive environment where every staff member and community member feels safe and empowered to report abuse, harassment, or any form of discrimination—whether based on gender, sex, religious beliefs, or cultural differences—confidentially and without fear of retaliation. We are committed to fostering a proactive culture that promotes open dialogue and supports individuals who are disadvantaged or marginalised. Our safeguarding framework will be underpinned by preventative measures against Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV), ensuring that we are vigilant to any evolving threats within our communities.

2026/27: Enhancing Digital Solutions for Holistic and Inclusive Safeguarding Across NHS Wales.

In collaboration with NHS Wales and partner agencies, we will drive the development of cutting-edge digital solutions aimed at creating a unified single care record. This integration will facilitate secure, efficient information sharing and enable early identification of safeguarding issues, ensuring swift, appropriate interventions.

Our focus on digital integration will allow us to provide comprehensive, holistic support to both children and adults, addressing their diverse care needs. The systems we implement will continually evolve, ensuring resilience to emerging threats and enabling us to enhance the protection and support of vulnerable populations.

Implementation

3 YEAR STRATEGY

The strategy will be implemented by the corporate safeguarding team in collaboration with Cwm Taf Morgannwg University Health Board care groups, led by the Executive Director of Nursing. The Safeguarding team will co-ordinate delivery plans in order to implement the strategy.

Members of the Safeguarding Operational Board, Executive Group, Care Group, Quality Safety Risk Experience and Quality and Safety Committee should ensure that actions to achieve this strategy are fully embedded within the Care Groups' delivery plans.

Safeguarding and Executive Group members will act as a conduit for information, so that improvement plans can be linked via Safeguarding to the annual Safeguarding Maturity Matrix. The Executive Director of Nursing will continue to have direct access to the Medical Director and / or Executive Lead if matters require immediate escalation and attention.

Multi-Agency Public Protection Arrangements	PREVENT / CONTEST	Female Genital Mutilation	Mental Capacity Act / Deprivation of Liberty Safeguards	Violence Prevention
Exploitation	Modern Slavery	Sexual Safety	Children Looked After	Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV)

Delivery of Strategy

	Role	Responsibilities
SAFE	Ensure there is a high quality, highly reliable and safe systems that avoid preventable harm.	• Work collaboratively with partner agencies to identify best practice, share information and work in partnership. • We will support our staff to exercise 'professional curiosity', promoting a culture of safety where there are safeguarding concerns. • Initiating appropriate and decisive action where abuse or neglect has taken place while in a healthcare setting. • Ensure employee wellbeing is a priority in the management of safeguarding. • Ensure staff will feel psychologically safe to raise concerns and try out new ideas and approaches.
Timely	We will ensure a safe and competent workforce through access to high quality advice, training and supervision.	• Ensure robust learning takes place across the whole organisation. • Implementing and monitoring improvements from learning identified through incidents, reviews, concerns and feedback. • Ensure CTMUHB have access to safeguarding policies and procedures and are confident in their 'Duty to Report; safeguarding concerns. • We will promote a culture of safety where safeguarding concerns can be raised across all areas of the trust. • To deliver robust safeguarding arrangements and appropriate, timely and effective use of procedures to protect those who are most at risk.
Effective	We will demonstrate our accountability through transparent governance arrangements.	• Work collaboratively with partner agencies to identify best practice, share information and work in partnership to safeguard children and adults. • We will always work in partnership with patients, their families and other agencies to safeguard people at risk of harm. • We will learn from local, regional and national reviews to embed best practice standards. • Focus on developing evidence based approaches to safeguarding practice that balances the rights and choices of individuals.
Efficient	We will work in partnership with our statutory partners to improve outcomes for people at risk of abuse or neglect.	• CTMUHB will contribute to the development and implementation of regional safeguarding Policies. • In collaboration with the Regional Safeguarding Board and partner agencies, identify themes and trends to inform early intervention and preventative strategies. • The Health Board will provide robust leadership for safeguarding at every level and across the organisation. • Demonstrate that we are a 'learning organisation' which is informed by the best practice and learning from safeguarding reviews with the ethos of a 'Just Culture'.
Equitable	We will be open and honest when safeguarding concerns have arisen and take the time to explain those concerns clearly.	• We will involve patients in how we respond to their safeguarding concerns. • Training and education; the Safeguarding team to ensure provision of training for all new and existing staff. • All Health Board staff have a responsibility to adhere to Safeguarding policies and procedures. • We will ensure information is provided to individuals in their fist language to enable them to fully engage in processes.
Person Centred	To ensure the voice of children and adults are used to shape and improve services that safeguard them.	• Work alongside carers and young carers, to ensure they receive the support they need to experience good health and wellbeing. • We will ensure our staff have the confidence to routinely ask our service users if they feel safe, if anyone is harming them, and if they need our help. • We will always listen to the voices of children and adults at risk and always seek their views ensuring that any barriers to communication are addressed. • We will involve patients in how we respond to their safeguarding concerns. • We will ask for feedback and learn and improve from patient and staff safeguarding experiences. • Linking safeguarding to spiritual care.

The social services and well being (Wales) act 2014 core principles for protecting children and adults at risk

These core principles work together to create a person centred approach that respect individuals' autonomy while ensuring the safety and well-being of vulnerable children and adults.

VOICE AND CONTROL

Putting an individual and their needs at the centre of their care and support.

PREVENTION AND EARLY INTERVENTION

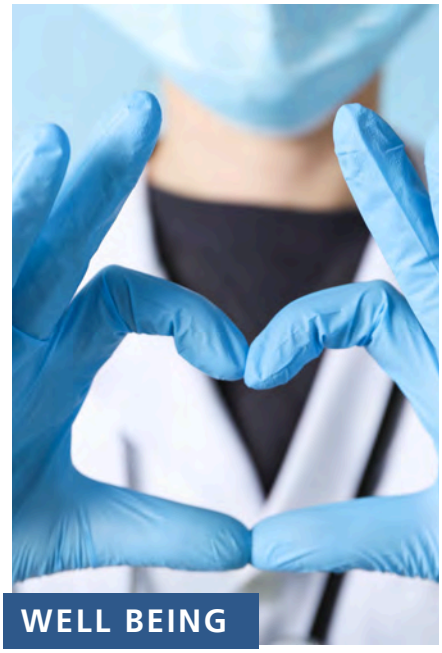
Emphasises taking proactive measures to identify and mitigate potential risks before harm occurs.

MULTI AGENCY

Strong partnership working between all agencies and organisations to improve the well-being of people in need of care and support.

CO-PRODUCTION

People will be more involved in the design and delivery of their support, working with them and their family, friends, and carers.



WELL BEING

Supporting people to achieve well-being in every part of their lives.

Roles and Responsibilities in Safeguarding

CTMUHB is committed to collaborating with the Regional Safeguarding Board and partner organisations to achieve the objectives of its 2023-2026 strategic plan. Our safeguarding priorities focus on both protection and prevention, ensuring the safety of those in need of care and support.

Protection	Safeguarding children and adults at risk from abuse, neglect, or other forms of harm. Responding effectively to safeguarding concerns to ensure a timely intervention.
Prevention	Implementing proactive measures to prevent children and adults from becoming at risk of harm. Promoting a culture of vigilance and early intervention within all services.
Training and Development	Ensuring that all staff have access to evidence-based training that reflects the latest learnings and best practices in safeguarding. Building a competent workforce that can confidently identify and address safeguarding concerns.
Collaborative Working	Fostering partnerships with national organisations and local agencies to enhance the effectiveness of safeguarding efforts. Sharing information and best practices to ensure a cohesive approach to safeguarding across the region.
Governance and Accountability	Demonstrating accountability through transparent governance structures and regular reporting. Embedding safeguarding practices into the culture of the organisation to ensure it is recognised as "everyone's business".

Ensuring Deliverability of Strategic Priorities

WE ARE WORKING TOWARDS A BETTER FUTURE

To ensure that our strategic objectives and priority areas are actionable and achievable, we will develop a detailed work plan that outlines key deliverables, outcome measures, and timescales. This work plan will be integrated into our annual reporting cycle, providing a structured approach to monitoring and achieving our safeguarding goals.

The Safeguarding Executive Group will be responsible for overseeing the delivery of the work plan, regularly reviewing progress against the defined milestones. They will report directly to the Quality and Safety Committee, (a subcommittee of the Health Board), to ensure transparency, accountability, and continuous improvement.

This approach will enable us to maintain a clear focus on our safeguarding priorities, measure progress effectively, and adjust our strategies as needed to respond to emerging challenges and opportunities.

2024

Q1: Refine resources to redesign training and supervision.
Q2: Assess training impact; align competencies.
Q3: Roll out workshops and supervision sessions.
Q4: Review outcomes and plan improvements.

2025

Q1: Evaluate reporting system effectiveness.
Q2: Promote confidential reporting.
Q3: Run awareness campaigns on VAWDASV blueprint workstreams.
Q4: Implement and evaluate protections against sexual harassment and abuse.

2026

Q1: Scope digital requirements with partners.
Q2: Pilot digital solutions in select departments.
Q3: Optimise data sharing.
Q4: Plan full roll-out based on feedback.

2027

Agenda Item
7.4

Quality, Safety & Experience Committee

Pressure Ulcer Prevalence Audit 2024

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Susan Reed – Tissue Viability specialist Nurse
Cyflwynydd yr Adroddiad / Report Presenter	Susan Reed – Tissue Viability specialist Nurse
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
Weekly Quality and Safety Assurance meeting	11/11/2024	Noted
Presented at Senior nurse/Lead Nurse meeting	30/10/2024	Recommendations discussed and actions

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 Pressure ulcers are localised injuries to the skin and underlying tissue caused by prolonged pressure, often over boney areas or heels. They significantly impact patient quality of life and can lead to severe complications such as infections and increased mortality in severe cases.

1.2 As well as the cost to patients there is a considerable financial burden associated with Pressure ulcers. The table below illustrates the approximate costs related to each category of skin damage

Pressure Ulcer Category	Brief description	Cost to heal pressure ulcer
Category 1	Non-blanchable redness of intact skin. Intact skin with non-blanchable erythema of a localised area, usually over a bony prominence	£1,214
Category 2	Partial thickness skin loss or blister. Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough.	£5,241
Category 3	Full thickness skin loss (fat visible). Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscles are not exposed.	£9,041
Category 4	Full thickness tissue loss (muscle/bone visible). Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or Escher may be present. It often includes undermining and tunnelling.	£14,108
Unstageable Ulcer	Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough and/or Escher in the wound bed.	£14,108
Suspected Deep Tissue Ulcer	Purple or maroon localised areas of discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.	£5,241 - £9,041 The cost would be adjusted based on wound care treatment.

1.3 To support the strategic pressure ulcer prevention strategy, a yearly audit is conducted in partnership with Arjo Huntly Clinical Consulting Lead. A pressure ulcer prevention assessment is performed across Cwm Taf Morgannwg University Health Board.

The assessment occurred across all inpatient hospitals, including paediatrics, between June 10 and June 13, 2024. The assessment is conducted by teams of assessors, with each team comprising at least one representative from the healthcare provider to gather patient data and one representative from Arjo to collate and enter the data. Information is gathered through observation of preventative equipment deployed, clinical review of nursing records, and visual inspection of the skin by suitably qualified personnel. The latter two points are undertaken by the wound care nurse or another authorized employee of the healthcare provider to protect patients' rights to confidentiality.

Visual inspection and categorisation (staging) of pressure ulcers are restricted to just one or two of the most experienced clinicians to maintain patient dignity, increase accuracy (particularly for category 1 ulcers), and reduce inter-rater error. No questions are posed directly to patients. For

those patients who refuse a skin inspection, have a non-removable dressing, or are absent from the clinical area at the time of the assessment, the facility is offered the option to use information obtained from the patients' notes or clinical team.

2. Specific Matters for Consideration

2.1 The total number of patients assessed in the audit was 1,337, of which 108 had a pressure ulcer identified.

2.2 Of the 108 patients with a pressure ulcer, these ranged from category 1 to the most severe category of pressure ulcers, suspected deep tissue injury. The severity of skin damage is reported using the International Pressure Ulcer Classification System as outlined in the Pressure Ulcer Prevention and Treatment Clinical Practice Guidelines.

3. Key Risks / Matters for Escalation

3.1 Overall 79% of patients had a risk assessment within 6 hours of admission, and 87% recorded as having a skin assessment within 6 hours of admission.

3.2 Overall 90% of patients reviewed had the appropriate mattress to meet their clinical needs, and 78 % had appropriate seating to meet their needs.

3.3 A review of the availability of slide sheets needs to be undertaken.

3.4 Learning should be shared with areas that have low or no pressure areas ulcers and have achieved 100% assessments within the admission time frames.

4. Assessment

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

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

5. Recommendation

The Committee is asked to NOTE the outcome of annual pressure ulcer prevalence report 2024.

6. Next Steps

- Multi-Professional Pressure Ulcer steering group has been established to maintain oversight of pressure ulcer prevalence and prevention for the Health board, as well as act as a conduit to imbed consistency of best practice.
- There is evidence to suggest there is a large number of patients that attend hospital with existing pressure ulcers. With this in mind the 2025 prevalence audit will take place across the Emergency departments which will help to identify any areas for improvement
- Review process for shared learning and arenas for multi professional learning to ensure wider learning is embedded.

Introduction

To support the strategic pressure ulcer prevention strategy, an annual audit is conducted in collaboration with Arjo Huntly Clinical Consulting. The Tissue Viability (TVN) team reviews patients with pressure ulcers, including visual skin inspections, as part of the assessment across Cwm Taf Morgannwg University Health Board.

Pressure Ulcer Assessment Findings:

- 66 patients identified with pressure ulcers in seating areas.
- 30 patients were bedbound; 36 sitting out,
- 71 patients (5%) recorded with moisture-associated skin damage.
- 8 patients had established pressure ulcers in seating areas.

Key Issues Identified:

- Insufficient availability and use of slide sheets across the Health Board.
- No data collected from the Princess of Wales Maternity Unit.

Actions for Further Investigation:

- Assess caregiver knowledge on risk assessment, repositioning, and transfers.
- Develop an equipment selection guide for early, targeted interventions.
- Ensure availability of suitable equipment to meet patient needs.

- **142 (74%)** patients' skin were inspected
- **50 (26%)** patients' skin were not reviewed for various reasons
- **61 (40%)** pressure ulcers out of the **154** recorded were validated
  - **34** pressure ulcers categorisation had been recorded correctly
  - **27** pressure ulcers were re-categorised
- **3 (4%)** patients were identified with a combination of lesions present
- **3** adult patients and **1** child were found with a darker skin tone
- **51 (27%)** of patients reviewed had diabetes
- **91 (47%)** of patients reviewed were wearing a body containment product

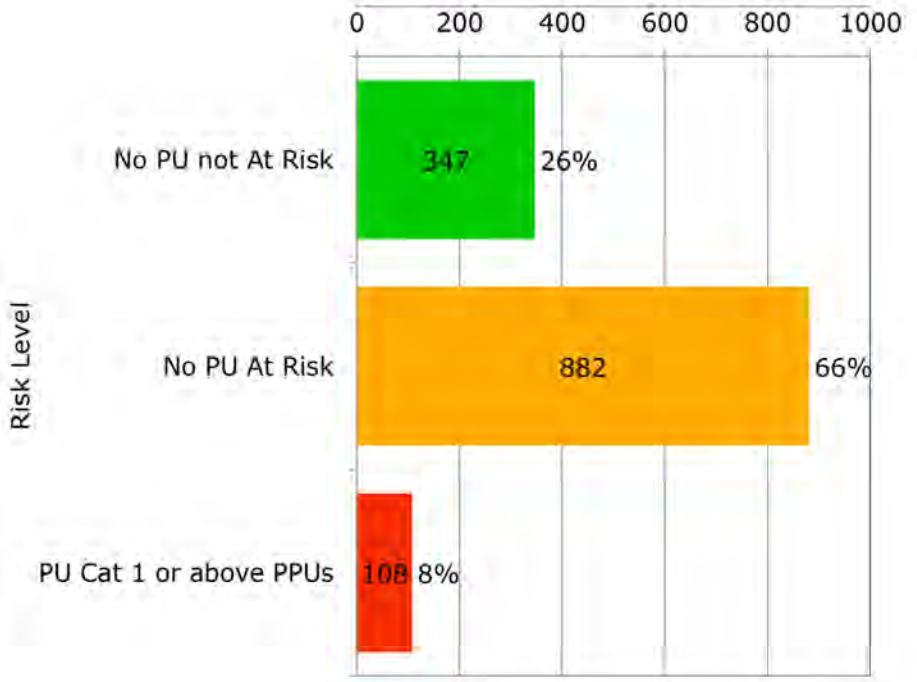
Executive summary

	Community Hospital Sites	Royal Glamorgan Hospital	Prince Charles Hospital	Princess of Wales Hospital	Combined results
Number of patients assessed	243	395	303	396	1337
Total number of patients with pressure ulcers	19	40	24	25	108
The total number of pressure ulcers recorded was	27	60	30	37	154
Overall point prevalence	7.82%	10.13%	7.92%	6.31%	8.08%
Facility acquired pressure ulcers	13	32	8	7	60
Facility acquired prevalence	4.94%	4.81%	2.64%	1.52%	3.37%
Average length of stay in days	88	33	17	37	41

Total number of pressure ulcers recorded **154**
60 (39%) were hospital acquired
126 patients have had a previous pressure ulcer

Quality of preventative care

	Community Hospital Sites	Royal Glamorgan Hospital	Prince Charles Hospital	Princess of Wales Hospital	Combined Results
Risk assessment with 6hrs of admission	217 (89%)	315 (80%)	214 (71%)	307 (78%)	1,053 (79%)
Skin assessment within 6hrs of admission	241 (99%)	340 (86%)	231 (76%)	356 (90%)	1,168 (87%)
Individual prevention care planning At risk+	198 (98%)	218 (76%)	170 (85%)	272 (91%)	858 (87%)
Repositioning care plan At risk+	166 (82%)	232 (81%)	152 (76%)	237 (79%)	787 (79%)
MUST assessment At risk+	178 (88%)	247 (86%)	166 (83%)	263 (88%)	854 (86%)



1,337 patients assessed

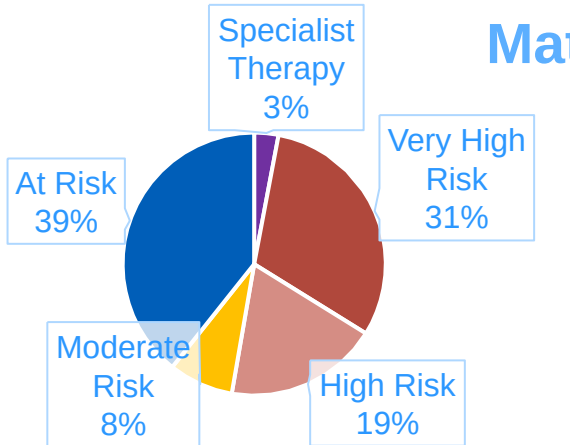
990 (74%) of patients had sufficient risk factors to be vulnerable to developing a pressure ulcer.

Equipment and repositioning overview

Equipment	Community Hospital sites	Royal Glamorgan Hospital	Prince Charles Hospital	Princess of Wales Hospital	Combined Results
Slide sheet availability on site (refers to quantities available)	130	130	98	159	517
Required slide sheets (C,D,E) mobility	212	252	166	280	910
Shortfall	-82	-122	-68	-121	-393
Patients requiring standing lifts (B,C) mobility	113	185	124	184	606

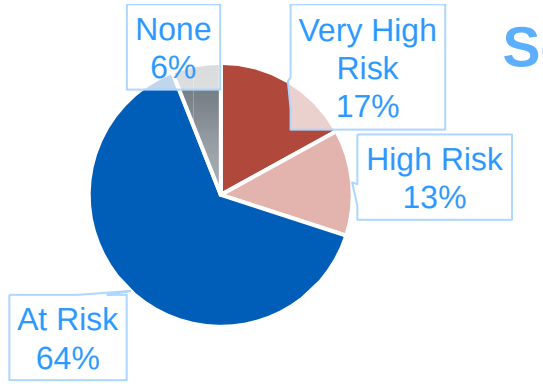
- Royal Glamorgan Hospital has the highest demand for slide sheets.
- The greatest shortfall is observed in Community Hospital sites.

Mattress



15 (1%) of patients were identified as ‘Never assessed for risk’ and on admission.

Seating



Empowering movement towards healthier outcomes

- There's a clear connection between mobility and people's physical and mental well-being
- Through empowering movement, we contribute to improving clinical, operational and financial outcomes
- With the right equipment, skills and environments, we contribute to driving healthier outcomes for everyone involved

Next Steps & Planning 2025

- Accident and Emergency project.
- 2025 Clinical prevalence dates
  - 2nd – 5th June 2025
- To consider for 2025 'Hot spot wards' with 100% skin inspection.
- To consider undertaking one hospital site assessment with a deeper dive of quality of preventative care.

Pressure ulcers are considered **avoidable or 'never events'**

Agenda Item	8.1.1

UNAPPROVED Minutes of the Quality & Safety Committee

Date and Time of Meeting	Tuesday 19th November 2024 at 14:00hrs
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Helen Lentle	Independent Member
	Hayley Proctor	Independent Member
In Attendance	Gethin Hughes	Chief Operating Officer
	Lauren Edwards	Executive Director of Allied Health Professionals and Healthcare Sciences
	Philip Daniels	Executive Director of Public Health (In part)
	Dom Hurford	Executive Medical Director
	Hywel Daniel	Executive Director for People (In part)
	Richard Hughes	Deputy Director of Nursing
	Sallie Davies	Deputy Medical Director
	Suzanne Hardacre	Director of Midwifery
	Leanne Davies	Head of Nursing Primary Care & Community
	Alex Brown	Unscheduled Care - Care Group Medical Director (In part)
	Emma James	Unscheduled Care - Care Group Nurse Director
	Sharon O'Brien	Planned Care - Care Group Nurse Director
	Chris Beadle	Assistant Director of Health, Safety & Fire
	Nigel Downes	Assistant Director of Quality & Safety
	Julie Denley	Deputy Chief Operating Officer – Primary Care, Community, Mental and Learning Disabilities (in part)
	Lloyd Griffiths	Head of Mental Health Nursing
	Sally Bolt	Care Group Medical Director
	Steffan Gwynne	Directorate Manager, Prison Healthcare

	Julie Dickenson	Lead Nurse, Unscheduled Care (In part)
	Kellie Jenkins Forrester	Head of Concerns & Business Intelligence
	Gaynor Jones	RCN Convenor
	Ceri Bear	Llais Cymru Representative
	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business (Secretariat)
Meeting Observers	Filipe Leitao	Head of Nursing for Infection, Prevention & Control

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	The Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	Apologies for Absence
	Apologies for absence had been received from: • Dilys Jouvenat, Independent Member; • Patsy Roseblade, Independent Member; • Greg Dix, Executive Director of Nursing/Deputy Chief Executive; • Mary Self, Mental Health and Learning Disabilities Care Group Clinical Director; • Ana Llewellyn, Mental Health and Learning Disabilities Care Group Nurse Director; • Mohamed Elnasharty, Children and Family Care Group Clinical Director; • David Miller, Primary Care and Community Care Group Clinical Director; • Lucie Williams, Primary Care and Community Care Group Nurse Director;
1.3	Declarations of Interest There were no interests declared.
2.	SHARED LISTENING & LEARNING
2.1	Shared Listening & Learning Story – Care of the Elderly Dare to Dream Music Sessions
	J Dickenson shared the presentation with the Committee which provided an update on the care of the elderly 'dare to dream' music sessions. The Committee Chair extended her thanks to J Dickenson for sharing the positive story which highlighted the beneficial effects of music therapy. Attention was drawn to the learning identified in terms of including the Estates Directorate in planning for such events from the outset to ensure arrangements can be made

	so that the environment is conducive, and the sessions can be used to their full potential.
Resolution	The presentation was NOTED
2.2	Spotlight Presentation – Sexual Safety & Safeguarding Briefing Paper
	R. Hughes presented the report to Members of the Committee which provided an update on Sexual Safety & Safeguarding. H Daniel advised that he had agreed the scope of this report with R Hughes and provided an update in regard to how the people and cultural issues would be addressed and assurance received through the appropriate Board and Committee business. Members noted that in addition to the safeguarding concerns that had been outlined by R Hughes, there had been a number of staff concerns raised and individual cases were currently being investigated. The Committee will be provided with an update on these at the most appropriate time. It was noted that in terms of addressing any cultural issues in the areas concerned an initial piece of work had been undertaken, by site and department and Members noted that the review findings were currently being worked through. H Daniel advised that the findings of this review would be presented to the Executive Leadership Group on the 25 November 2024 to include next steps and that an assurance report on the people and culture aspects would be presented to the In Committee session of the People & Culture Committee taking place on 5 December 2024. G Jones sought assurance that where a perpetrator had been identified appropriate action had been taken. G Jones also sought clarity that procedures and policies were being followed to ensure these issues were being addressed robustly. H Daniel confirmed that where suspension was appropriate this action had been taken and confirmed that processes were being worked through in the normal way, with some cases being accelerated. Members noted that a 'look back' exercise was also being undertaken to determine whether outcomes from previous investigations were appropriate. Members noted that a more detailed update would be presented to the December meeting of the People & Culture Committee. K Palmer welcomed the transparency that had been outlined within the report and expressed concern about the numbers highlighted. K Palmer added that she endorsed the next steps that would be taken and added that it was evident that action was being taken. Furthermore, K Palmer sought clarity as to whether there was anything that needed to be undertaken in relation to communication and messaging of the issues highlighted and how concerns could be reported. R Hughes advised that the data that had been recorded appeared to show that there had been an under-reporting of issues, both within the acute and community settings. R Hughes advised that consideration was therefore being given to how the public health agenda could be utilised in terms of messaging and allowing people to access safe spaces to raise their concerns. C Bear advised that she found the report clear and easy to understand, she sought assurance as to what support was being offered to those individuals who

had been subject to sexual abuse and queried how the Health Board would monitor their health and wellbeing moving forwards. R Hughes confirmed that the appropriate support was being provided to individuals on a case-by-case basis, for example, he commented that where there was police involvement then counselling may be offered. Members noted that in relation to staff, they had access to the Health Board's wellbeing support. R Hughes advised that consideration was being given to the need to understand the multi-faceted routes that individuals were being signposted to and whether the approach being taken was fit for purpose or whether it could be further strengthened.

H Daniel advised that in relation to communication, the Health Board is taking an evidence-based approach as to how the organisation responded to the issues. H Daniel advised that a proposal would be made to the Executive Team in determining how the Health Board acknowledges the concerns that have been raised and the steps being taken to address the issues. He advised that an invite will be extended to staff to participate in conversations held in early 2025 regarding the issues identified. H Daniel referred to the Worker Protection Act and the Health Board's duty to be proactive in this space.

H Daniel advised that in relation to the query raised by C Bear regarding wellbeing, there was a well-structured wellbeing team in place within the Health Board, which was led by a Team of Occupational Psychologists and Psychological Wellbeing Practitioners and added that the cultural work that had initially been undertaken had been led by the Senior Occupational Health Psychologist. Members noted that specialist support was also being provided to individuals, which was dependent on the individual cases.

H Daniel added that the Health Board would need to continue to recognise that there are likely to be cases that would have gone unreported which reiterates the importance of creating a culture where you could speak up safely, with clear guidance as to what response you should expect to receive from the organisation as a result. H Daniel advised that the organisation also needed to be careful as to how it responded to individuals who reported cases of sexual harassment or abuse, and was reviewing the best available evidence to ensure it responds in the most appropriate manner. H Daniel advised that in addition to the People & Culture Committee, the Quality & Safety Committee would continue to be kept update on progress made.

D Hurford advised that it was distressing to hear that this could be happening within the organisation and advised that all clinical groups were vulnerable to this issue and referred to the report received a couple of years previously from the Royal College of Surgeons which highlighted national issues regarding this matter. Members noted that the Speaking up Safely Champion, G Watts, Director of Corporate Governance/Board Secretary would shortly be attending the Local Negotiating Committee to provide an update on Speaking up Safely. D Hurford recognised that as awareness is increased that individuals are encouraged to speak up safely it is likely that more cases of this nature will be identified.

The Committee Chair extended her thanks to R Hughes for presenting what was quite a sobering and reflective report and noted the assurances of the actions being taken to appropriately address the issues identified from the findings, she

	further recognised that due to the wide spanning nature of the issues, consideration should be given to where this is reported to avoid duplication..
Resolution	The presentation was NOTED
3.	**CONSENT AGENDA BUSINESS**
3.1	The Committee Chair 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.
4.	**MATTERS ARISING**
4.1	Action Log
	The Action log was received. The Committee Chair sought confirmation from Members as to whether they were content to close the actions being proposed for closure. K Palmer raised a general question on process and queried whether updates would still be received via the forward work programme on some of the actions being proposed for closure. C Hamblyn confirmed that where there was a specific action to add an item to the forward plan, these items were being added to the forward work programme and would not be lost sight of. Members confirmed they were happy to close the actions being proposed for closure.
Resolution	The Action Log was NOTED
4.2	Matters Arising Not Captured on the Action Log
	There were no matters arising.
5.	**SETTING THE SCENE – SERVICE DELIVERY**
5.1	Report from the Clinical Executives
	R Hughes and Clinical Executive Directors presented the report and highlighted the key areas for Members attention. C Bear made reference to the Haematology Day Unit service being fragile and the move of the Day Unit from Princess of Wales Hospital to the Prince Charles Hospital and sought clarity as to how patients had responded to this move, given the distance to travel between the Princess of Wales Hospital and Prince Charles Hospital, and whether the Health Board had put any arrangements in place to help patients transfer from one site to the other. G Hughes clarified that it was the Haematology Day Unit at Royal Glamorgan Hospital that had moved to Prince Charles Hospital, as opposed to the unit at the Princess of Wales Hospital. G Hughes advised that the unit needed to be converted back into a ward to accommodate patients that had to be moved out from the Princess of Wales Hospital. G Hughes confirmed that all Princess of Wales Hospital patients have their Haematology services delivered via Singleton or Neath Port Talbot Hospitals. In regards to patient feedback, G Hughes advised that some patients had expressed concerns with having to travel to Prince Charles Hospital to access Haematology services, given that some patients were having to attend the Haematology Day unit daily. As a result of this, options were being explored

	in regard to providing some services on the Royal Glamorgan Hospital site for those patients who were unable to travel. Members noted that a purpose-built Haematology Day Unit had now been opened on the Prince Charles Hospital site, and it was positive to see that this unit was being fully utilised. G Hughes advised that the position would continue to be monitored, and feedback would be taken into consideration, with confirmation provided to C Bear that this was a temporary measure whilst works at the Princess of Wales Hospital were being undertaken. The Committee Chair advised that she was pleased to hear about the work being undertaken in relation to falls and that progress and outcomes would be reported to the Improving Care Board, which helped to provide assurance to the Committee that actions were being taken. The Committee Chair made reference to Boarding and advised that whilst it was pleasing to see that improvements had been made, she queried what the impact would be of all the changes that had to be put into place to respond to the critical incident at the Princess of Wales Hospital and queried whether the position would worsen as a result of this. G Hughes advised that at present the Health Board were operating with 75 fewer beds than prior to the critical incident. Members noted that Teams were working hard to avoid boarding and noted that if patients did need to be boarded, these were being de-escalated promptly. G Hughes advised that the balance of risk was important along with ensuring a multi-disciplinary approach was being taken and that focus was being placed on the delivery of the improvement actions. The Committee Chair advised that she felt encouraged by this update.
Resolution	The report was NOTED
5.2	Care Group Highlight Reports
5.2a	Children & Families Care Group Highlight Report
	S Hardacre presented the report and highlighted the matters contained within the alert/escalate section. H Lentle referred to the sickness levels and sought clarity as to whether there were any underlying issues that Members needed to be made aware of. S Hardacre advised that whilst there was a mixture of reasons associated with sickness levels, there had been significant sickness within the staff group who had been affected by the closure of the Maternity and Neonatal Unit at the Princess of Wales Hospital and had been temporary deployed to other units. Members noted that steps had been taken with neighbouring organisations at the start of the project to ensure that clinical supervision, practice development support and other support mechanisms had been put into place, together with regular touch points with individuals. S Hardacre advised that regular site visits by senior team members were being undertaken to check in on the wellbeing of staff affected by the moves, she also noted that steps are being undertaken to ensure staff return to work safely and in a timely manner. The Committee Chair referred to the update provided in the assure section which stated that Health Visiting Bridgend records will transfer from digital

	to paper from 1st November due to cessation of access to the clinical portal hosted by Swansea Bay University Health Board. The Committee Chair expressed concerns that this did not align with the digital transformation agenda. S Hardacre advised that whilst she agreed with the views expressed by the Committee Chair, at present there was no digital solution in place and a decision had to be made as to the most appropriate short-term solution whilst a longer-term digital solution was being sourced.
Resolution	The report was NOTED
5.2b	Unscheduled Care Group Highlight Report
	E James presented the report and highlighted the matters contained within the alert/escalate section of the report. E James advised that since the report was written, there had been some further moves undertaken in relation to the decanting of patients from the Princess of Wales Hospital. Members noted that within Unscheduled Care there were 16 ward moves from Princess of Wales Hospital to Royal Glamorgan Hospital and Ysbyty George Thomas. Members noted that the Stroke Ward had now been located on Ward 20 at Royal Glamorgan Hospital. Members noted that weekly 'Question and Answer' sessions were being held for staff within the Care Group. Members noted the suggestion made within the report in regard to sharing a spotlight presentation to a future meeting in regard to the Welsh Ambulance Services NHS Trust (WAST) joint investigation framework thematic review that had recently been completed to highlight the analysis undertaken and associated recommendations. The Committee Chair advised that the Committee would welcome a future spotlight report on this matter. The Committee Chair advised that she was encouraged to hear that the positive moves that had taken place had made a real difference, particularly within Respiratory. C Bear referred to the update provided in the assure section in relation to the Emergency Department National Patient Reported Experience Measures (PREM) survey and advised that she had spent some time at the Emergency Department and Ward 9 at Royal Glamorgan Hospital over the last couple of weeks. C Bear referred to the update provided within the report that stated that only 17% of respondents had commented on the long waiting times and advised that from her discussions with patients over the last couple of weeks, they all advised that whilst they had been waiting long lengths of times, their expectations were that waits would be lengthy. Members noted that all patients spoken to praised the healthcare professionals that had been caring for them. The Committee Chair advised that it was interesting to hear the expectations of patients and how this had changed and added that it was important to not lose sight of what could now be considered the norm in terms of long waiting times in Emergency Departments.
Resolution	The report was NOTED.

Action:	Spotlight presentation to be presented to a future meeting in regard to the WAST joint investigation framework thematic review that had recently completed. Presentation to highlight the analysis undertaken and associated recommendations
5.2c	Planned Care Group Highlight Report
	S O Brien presented the report and highlighted the matters contained within the alert/escalate section. Members noted the significant impact the Critical Incident at Princess of Wales Hospital had on the Planned Care position. G Hughes acknowledged the extraordinary efforts of the Care Group Teams in responding to the critical incident at the Princess of Wales Hospital, which they had managed to do with very little negative impact on patients. G Hughes advised that in relation to Planned Care, the Health Board had secured some Welsh Government funding, and it was hoped that this would support the Health Board to secure additional Theatre capacity, given that those patients waiting for elective care procedures had been impacted the most negatively. Members noted that the work that had been undertaken during the 'perfect fortnight' had enabled the Health Board to re-establish an elective orthopaedic programme with a smaller bed base. G Hughes advised that this level of innovation was so important to enable the needs of patients to be met. The Committee Chair echoed the comments that had been made by G Hughes in relation to the effort made by all staff to address the issues that had been faced during the critical incident and advised that she was encouraged to hear of the positive pieces of work being undertaken alongside this.
Resolution	The report was NOTED
5.2d	Mental Health & Learning Disabilities Care Group Highlight Report
	L Griffiths presented the report and highlighted the matters contained within the alert/escalate section. The Committee Chair advised that she was pleased to see the improvements that had been made in relation to registered nurse recruitment which had been an area of concern for the Committee for some time, and added that it would be helpful to see if there was any learning that could be shared with other areas as to how the Care Group had managed to address this. K Palmer echoed the comments made by the Committee Chair and referred to the risks in relation to the Mental Health Workforce and the work being undertaken by Health Education Improvement Wales in regard to Mental Health workforce planning. K Palmer sought clarity as to how the team could try to anticipate where there could be issues in areas where there were vacancies and questioned what more could be done to address this. L Griffiths advised that the Care Group were undertaking a review of the whole medical workforce, which included a review of portfolios, overseas

	recruitment and alternative use of Advanced Clinical Practice posts. G Hughes confirmed that the Care Group did have an extensive programme of work in place to address medical workforce, which included recruitment, role diversification and further development of the service model. K Palmer raised concerns in relation to Estates issues and the impact this had on quality and safety and questioned how this could be looked at by the Committee across all Care Groups. G Hughes advised that a Healthcare Inspectorate Wales feedback session was held earlier this week at Princess of Wales Hospital, where they identified several significant estates issues. G Hughes added that it would be helpful to establish a mechanism which identifies the estates issues where they provide a risk to the quality and safety of the services provided to patients. The Committee Chair advised that consideration would be given to the most appropriate way of reporting estates issues to the Committee outside of this meeting, to ensure the Committee were provided with assurance. L Edwards provided Members with an update in relation to the work being undertaken within the Mental Health & Learning Disabilities Care Group to address the estates issues, which is a significant issue that was impacting the team's ability to deliver a service safely. In relation to Ligature risks, which were previously being managed at Ward level, L Edwards advised that a group had been established, which was being led by the Care Group Nurse Director, and queried whether the wider issues in regard to estates could feed into that group. In relation to workforce, L Edwards advised that this was an All-Wales issue that was due to be discussed at the Ministerial Mental Health summit which had been subsequently cancelled due to limited Executive and Clinical Executive engagement. Members noted that L Edwards and G Hughes provided suggestions as to how engagement could potentially be increased and how learning could be gained from other national programmes of work. Members noted that the Team had undertaken some preparatory work to address the workforce issues. L Edwards advised that there had been a refresh of the Mental Health Inpatient Improvement Programme which had now been structured in line with the national programme. Members noted that focus was being placed on alternative workforce models and roles. G Jones sought confirmation that registered nurses that were leaving the Acute Mental Health Wards were remaining in the organisation and were moving into different nursing roles within other services, such as Primary Care. L Griffiths confirmed that this was correct and advised that a large number of community roles had been created, which had provided promotional opportunities for staff working on acute wards. Members noted that because of the recent establishment review, the skill mix had been changed to provide more promotional opportunities and to try and retain the skilled practitioners on acute wards, which had been a positive experience to date.

Resolution	The report was NOTED
Action	Consideration to be given to the most appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes.
5.2e	Primary & Community Care Group Highlight Report L. Davies presented the report and highlighted the matters contained within the alert/escalate section. J Denley advised that in relation to the Dental Contract Review, there had been several contract hand backs since the contract reform came into place 18 months ago. Members noted that the Health Board had to date been successful in re-contracting with alternative providers. J Denley advised that given that there had been a delay in this process, support was being sought from neighbouring dental practices to temporarily take on additional patients and increase their contracts in order to mitigate the risks. K Palmer raised concerns in relation to waiting times for dental services, particularly for patients requiring general anaesthetic, and questioned whether there was anything further that could be done to address the position. J Denley advised that in order to address the waiting list position, options were being explored in relation to commissioning external capacity. D Hurford added that this was a significant issue to manage and advised that many of the issues in regard to dental services patients were linked to deprivation and social factors, which would require some work to be undertaken on prevention and public health messaging in regard to the importance of maintaining good oral health. G Hughes advised that as a result of additional theatre capacity on hospital sites, this would create some additional flexibility. G Hughes advised that there would be challenges in relation to linking theatre availability with the availability of operating dentists and added that the Executive Team all share the concerns that had been expressed by K Palmer and were working hard to source a solution for these children.
Resolution	The report was NOTED
5.2f	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report S. Bolt presented the report and highlighted the matters contained within the alert/escalate section.
Resolution	The report was NOTED.
6.	GOVERNANCE, RISK AND ASSURANCE
6.1	Organisational Risk Register – Risks Assigned to the Quality & Safety Committee
	Questions were raised by the Committee Chair ahead of the meeting as outlined below, together with the responses provided: Question: 5417 – “Paediatric General Anaesthetic (GA) list is there an opportunity to outsource? (Primary Care and Community Care Group)”

	Response: "Yes this is being explored with Swansea Bay unused sessions but also directly with a provider". Question: 4691- Mental Health In Patient (IP) unit. "I think I am right in thinking that this does not relate to the anti-ligature work which has already been covered (Mental Health & Learning Disability (MHLD) Care Group)" *Response: "It is different to ligature one – it's a general estate no longer fit for purpose issue covering multiple sites. Update as below.* *Some works are due to commence in Princess of Wales (POW) Mental Health inpatient estate in January. The wider review took significant time to commission but has progressed and the results of this will then inform future options."* C Hamblyn presented the report and highlighted the key matters for Members attention. The Committee Chair extended her thanks to C Hamblyn for presenting the report.
Resolution	The report was REVIEWED and CONSIDERED
6.2	HMP Parc and Young Persons Unit A Year On
	The Committee Chair highlighted that this item had been deferred from the previous meeting. S. Gwynne presented the report that outlines the progress made with providing health care services within the prison since the 15th December 2022. The report evaluates service delivery, key achievements to date and future recommendations aimed at enhancing the quality of care for prisoners. The Committee Chair extended her thanks to S Gwynne for presenting the report which she had found to be interesting and recognised the significant amount of work undertaken in such a short space of time. D Hurford referred to the remarkable turnaround that had been achieved within the service over the last year and commended the Team for the work undertaken in this area. D Hurford added that the Pharmacy Team within the service had been awarded a Seren Award for their achievements in managing access to medicines within a challenging environment. K Palmer echoed the comments made by D Hurford and advised that Committee Members recognised the challenging environment the Team were faced with and commended the Team for the significant work that had been undertaken within the service, whilst recognising there was further work that needed to be undertaken to strengthen processes. K Palmer queried that whilst understandably focus was being placed on the patients within Parc Prison, were the Team able to reach out to families and

	community members, particularly when there were incidents of deaths within the prison. S Gwynne advised that engagement was difficult within this area, given that any engagement undertaken via social media channels to publicise the work being undertaken was being met with a negative response. S Gwynne added that there was some further work to be undertaken in relation to communication and engagement with family members who were asking questions in relation to their loved ones within the prison and advised that there were two Patient Advice Liaison Services officers in post who could undertake further work in relation to communication and engagement if they could be released from undertaken some administrative duties. J Denley extended her thanks to S Gwynne and L Davies for the work they had undertaken in this area and queried whether Independent Members would find it helpful if a detailed update was provided to them on Parc Prison at a future Board Development Session given the number of complexities within the service. The Committee Chair welcomed the suggestion of having a focussed session on Parc Prison at a future Board Development session and advised that it would also be helpful if Committee Members could be provided with an update on what the scope was felt to be at the start and the scope of the whole service in regards to the boundaries of what could be provided by the Health Board. J Denley confirmed that the service had a set budget from the HM Prison and Probation Service (HMPPS) who commission the service, with the budget being underspent at present. Members noted that HMPPS were open to considering bids from the Health Board for additional funding which could be used to improve services, whilst monitoring the Health Board's delivery of the current contract position. P Daniels advised that the population within the prison service was vulnerable and added that the individuals would not remain in prison for an infinite amount of time and would return into communities. P Daniels advised that consideration needed to be given to population health interventions, for example, vaccinations and screening, and extended his thanks to S Gwynne and the Team for their support in regard to this. Following a query raised by the Committee Chair as to whether future stand-alone reports would need to be presented to the Committee on this matter, J Denley suggested that future updates on progress were included in the Primary Care & Community Care Group Highlight reports, in addition to focussed updates being presented to future Board Development Sessions.
Resolution:	The Committee NOTED the report.
Action:	Focussed session to be provided to Board Members on Parc Prison at a future Board Development Session given the number of complexities within the service.
6.3	Healthcare Inspectorate Wales Action Plan Tracker C. Hamblyn presented the tracker that updated the Quality & Safety Committee on progress against the open actions held on the Healthcare

	Inspectorate Wales (HIW) tracker of the accepted improvement plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 5th September to 22nd October 2024. The Committee Chair noted that there were a number of updates still outstanding and was pleased to see this item had been added to the main agenda for discussion and focus. The Committee Chair also noted the significant scale of this piece of work.
Resolution	The Committee NOTED the report.
6.4	Coroners Cases / Inquests N. Downes presented the report that provided an overview of inquest activity within the Health Board. In addition, the report outlined the plan for future reporting in relation to themes and trends. K Palmer extended her thanks to N Downes for presenting the report which she had found to be helpful, particularly given that this was information that had been requested by Committee Members at a previous meeting. H Lentle echoed the comments made by K Palmer and queried as to whether there may be an issue with resources moving forward, given the potential increase in the number of inquests, and whether this would have an impact on the Health Board being able to sustain the level of learning. N Downes advised that in relation to the potential increase in cases, this was because of the coroner employing an additional six Coroners Assistants across the summer period. N Downes added that the Coroner's Office also appeared to be requesting a faster turnaround of investigations which was resulting in the Health Board's Legal Team having to submit information to them in a suitably timely fashion. N Downes added that the structure of the Legal Team was being changed to create a defined Inquest Team in addition to a defined Claims and Redress Team which should hopefully help to address the position.
Resolution	The report was NOTED
6.5	Duty of Candour Annual Report N. Downes presented the report that provided an annual report that describes how the requirements under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 are being fulfilled. The Committee Chair extended her thanks to N Downes for presenting the report and noted that it was stated within the report that there was a limited response to undertaking the duty of candour training and questioned whether this was being addressed. N Downes confirmed that this was being addressed, with awareness being raised at the Listening & Learning Events in relation to duty of candour. The Committee Chair referred to there being no set template for the Duty of Candour report and questioned whether there was a set template to determine report content and format. N Downes advised that whilst there

	was no set template in place, engagement had been undertaken with colleagues within other Health Board's to ensure consistent reporting was in place. N Downes added that a set template would be welcomed moving forwards.
Resolution	The report was NOTED
6.6	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24 N. Downes presented the report that updated the higher-than-average rate of clinical negligence and personal injury matters closed without damages and explored how these successful defence strategies can be further enhanced. C Bear referred to Maternity Services, and advised that at this Committee and Board, Members had been congratulating Maternity Services regarding the improvements that had been made in service delivery and changes that had been put into place. C Bear advised that the report identified that Maternity Services was amongst the highest value in terms of litigation moving forwards and sought clarity as to how these two matters balanced. N Downes advised that Maternity claims were high value given the complex nature of the cases resulting in more costs and damages associated with these claims… The Committee Chair extended her thanks to N Downes for presenting the report and noted that a discussion would be held with the Corporate Governance Team to confirm future reporting requirements moving forwards.
Resolution	The report was NOTED
Action	Discussion to be held with the Corporate Governance Team outside the meeting to confirm future reporting requirements moving forwards.
6.7	Covid 19 Inquiry – Verbal Update C. Hamblyn presented the committee with a verbal update on the COVID – 19 Inquiry. C Hamblyn advised that despite the Committee not receiving an update on progress for some time, activity was still being undertaken, with the Health Board being fully engaged in responding to the inquiry as required. Members noted that the Health Board was a core participant for Module 3, which was the focus of the Health Board responses, and noted that the Health Board had not been chosen to provide witness evidence. C Hamblyn advised that the Health Board had not engaged in being a core participant for any other modules and added that Board Members would be aware that they were being consulted each time a new module was released to ensure they were content with the status as to whether or not the Health Board was going to be a core participant. Members noted that the Legal Team continue to be instructed and were only being used as and when required to support on rule 9 requests and witness statements. C Hamblyn advised that consideration was being given to the use of Artificial Intelligence software to assist in cataloguing the data, with the Health Board currently holding a significant repository of data and information related to the inquiry within a central place.

	The Committee Chair extended her thanks to C Hamblyn for providing the verbal update.
Resolution	The report was NOTED
7.	DELIVERING OUT PLAN
7.1	Patient Safety, Quality and Experience Dashboard N. Downes presented the report of the Patient Safety & Quality Dashboard to Committee Members that provided data from 01.09.24 to 31.10.24 taken from systems on 11.11.24. E James extended her thanks to the Bereavement Lead Nurse and Patient Advice Liaison Service Team for the work undertaken during the critical incident to engage with patients and families in regard to the moves that needed to be undertaken. E James added that in relation to medication scrutiny, Heads of Nursing were also identifying an increase in medication incidents and added that additional medication scrutiny meetings had been established supported by Diagnostic, Therapies, Pharmacy and Sciences (DTPS) colleagues in order to monitor the position. The Committee Chair extended her thanks to N Downes for presenting the report and recognised the significant improvements that had been made in several quality performance areas.
Resolution	The report was NOTED
8.	CONSENT AGENDA
8.	CONSENT AGENDA
8.1	FOR APPROVAL
8.1.1	Unconfirmed Minutes of the meeting held on 18 September 2024 The minutes were APPROVED.
8.1.2	Unconfirmed Minutes of the In Committee meeting held on 18 September 2024 The minutes were APPROVED
8.2	FOR NOTING
8.2.1	Committee Annual Cycle of Business 2024 and 2025 The Cycle was NOTED
8.2.2	Forward Work Programme The forward programme was NOTED
8.2.3	Quality, Safety & Experience Committee Terms of Reference The terms of reference were NOTED
8.2.4	National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement The Committee NOTED the statement.
8.2.5	Joint Commissioning Committee Quality & Patient Safety Committee Chairs Report The report was NOTED
8.2.6	Clinical Policies Highlight Report

	The Committee NOTED the highlight report
8.2.7	Safeguarding & Public Protection Annual Report The Annual report was NOTED
8.2.8	Prescribing Annual Report The report was NOTED
8.2.9	Clinical Audit Quarterly Report The Committee NOTED the report
8.2.10	Clinical Education Annual Report The report was NOTED by the Committee
8.2.11	Antimicrobial Resistance Report The report was NOTED
8.2.12	Organ Donation Committee Annual Report The Annual report was NOTED
8.2.13	Access to Medicines Committee Annual Update The Committee NOTED the update
9.	CLOSE OUT BUSINESS
9.1	Any Other Business
	There was no other business to report.
9.2	Highlight Report to Board
	The Committee Chair noted that the Assistant Director of Governance & Risk had helpfully identified some potential areas for inclusion within the Committee Highlight Report which would be considered further outside the meeting.
9.3	How Did we do in this Meeting
	G Jones advised that she felt that the discussions held during this meeting had been interesting and informative and added that she found the meeting to be well chaired.
9.4	Identification of Future Spotlights and Thematic Presentations
	The Committee Chair advised that a number of suggestions had been made for spotlight reports throughout the meeting today.
10.	Items to be discussed at the In Committee Quality & Safety Committee held following this meeting
	It was noted the following item would be discussed at the In Committee session: • CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24
11.	DATE AND TIME OF NEXT MEETING The next meeting takes place on Tuesday 21st January 2025 at 9:00. The Chair also confirmed the name of the Committee would be changing to the Quality, Safety & Experience Committee because of the revised Committee structure.
12.	CLOSE OF MEETING

Agenda Item	8.1.2

Unapproved Minutes of the In Committee Quality & Safety Committee

Date and Time of Meeting	Tuesday 19th November 2024 at 16:30hrs
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Hayley Proctor	Independent Member
	Helen Lentle	Independent Member
In Attendance	Gethin Hughes	Chief Operating Officer
	Lauren Edwards	Executive Director of Allied Health Professionals and Healthcare Sciences
	Dom Hurford	Executive Medical Director
	Richard Hughes	Deputy Director of Nursing
	Nigel Downes	Assistant Director of Quality & Safety
	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business (Secretariat)
Meeting Observers	Nil	

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	The Committee Chair welcomed everyone to the meeting.
1.2	Apologies for Absence
	• Dilys Jouvenat, Independent Member; • Greg Dix, Executive Director of Nursing/Deputy Chief Executive;
1.3	Declarations of Interest There were no interests declared.
2.	MAIN AGENDA
2.1	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24

	N Downes presented the Cwm Taf Morgannwg specific element of the report following a suggestion made by the Welsh Risk Pool to discuss this in a closed session of the Committee as there may be identifiable data contained within the report. In response to a query raised by H Lentle as to the reasons why the figure for personal injury matters closed without damages were almost a quarter higher than the All Wales average, N Downes advised that there had been challenges in relation to capacity within the Claims Team however, as a result of structure changes it is hoped that the position will improve. Members noted the data contained within the report was being regularly reviewed at the weekly Patient Safety meetings and steps were being taken to improve the numbers reported. R Hughes provided assurance to Members that the Executive Director of Nursing was looking to increase assurance to Committee Members in relation to Team outputs. Members noted that aspects of this report had also been presented to the Audit & Risk Committee. The Committee Chair advised that she would welcome an update on progress against actions at a future meeting of the Committee.
Resolution:	The report was NOTED
Action:	Update on progress against actions to be presented at a future meeting of the Committee.
3.0	Any Other Business
	H Lentle advised that as a result of the new Committee structure, she would not be a Member of this Committee and wished good luck to the Committee moving forwards. H Lentle added that she had found the meeting to be very well chaired by C Donoghue.
4.0	DATE AND TIME OF NEXT MEETING The next public meeting takes place on Tuesday 21st January 2025 at 9:00am
5.0	CLOSE OF MEETING

Agenda Item
8.1.3

Quality, Safety & Experience Committee

CTM Learning Academy

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Janet Gilbertson Assistant Director Clinical Education
Cyflwynydd yr Adroddiad / Report Presenter	Janet Gilbertson, Assistant Director Clinical Education
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
Clinical Education Forum	11/11/2024	Approved

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience Committee regarding the launch the CTM Learning Academy in April 2025.

1.2 The Committee will be aware of the progress made over the last 5 years in the delivery of Strategic Direction for Clinical Education through the Annual Clinical Education Report, particularly the development of interprofessional learning activity, where we are leading the way in Wales.

1.3 The launch of the CTM Learning Academy (CTMLA) represents the next phase of the maturity journey and Strategic Direction for Clinical Education in CTMUHB.

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 is key and as our workforce is forever changing, this is an ongoing need.

2.2 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.

2.3 Investing in education is not just about investing in the health of the population and in the individual, it also contributes to the economic health of the nation.

2.4 Healthcare education and training must deliver excellence in practice but must also strive to ensure that a world class healthcare education system is developed and maintained.

CTM Learning Academy

2.5 CTMLA Vision: To develop an ambitious and capable multi-professional clinical workforce, improving patient and population health outcomes and wellbeing.

2.6 CTMLA 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.

2.7 CTMLA 4 Strategic Aims:

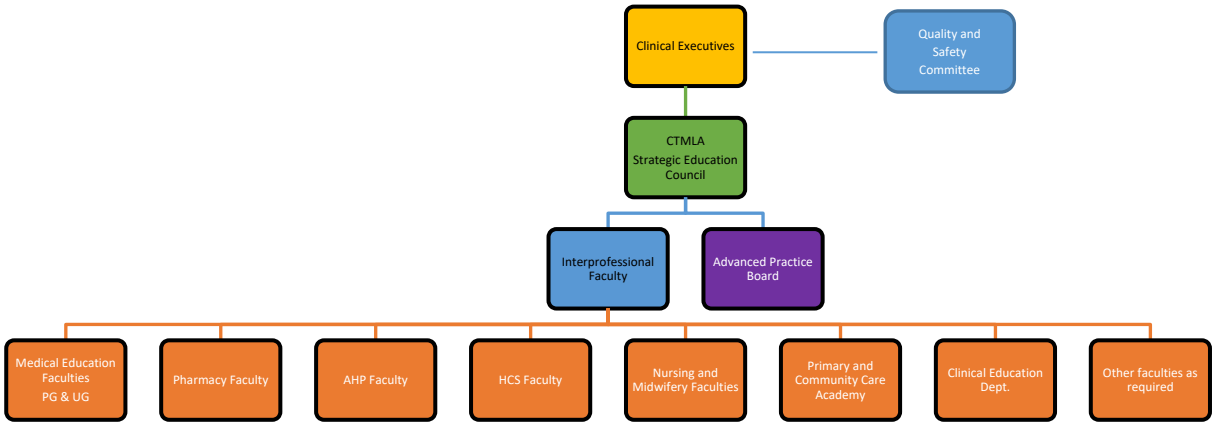
2.8 There are changes proposed to the existing governance routes:

2.8.1 Establishment of a Strategic Education Council (SEC) underpinned by an Interprofessional Faculty.

2.8.2 Development of a faculty structure for existing education activity within professions feeding up into the Interprofessional Faculty (IPF).

2.8.3 Reporting lines from the IPF to the SEC, SEC to Clinical Executives and to Q&S.

2.8.4 Disestablishment of the Clinical Education Forum.



Proposed CTMLA Governance Structure.

2.9 The inclusion of the Advanced Practice Board and the Primary & Community Care Academy within CTMLA will ensure a CTM wide approach.

2.10 Recognition of the organisational contribution of education and training activities to safe working practices and patient care.

2.11 Improved efficiency, effectiveness and assurance through consistent education governance and the introduction of Quality Education Standards.

2.12 An interprofessional education and learning collaborative culture, improving the learner and educator experience, equipping health care professionals with the right skills in the right area at the right time and driving innovation.

3. Key Risks / Matters for Escalation

3.1 The establishment of CTMLA will provide a mechanism to ensure utilisation and allocation of internal and external education funding streams is more aligned with organisational priorities for service redesign and workforce modernisation.

3.2 An interprofessional learning focus for CTMLA will better inform education commissioning needs and strategic workforce planning activity by considering the workforce as a whole in order to support multi-disciplinary service redesign to deliver our Clinical Strategy.

3.3 Permanent accessible training accommodation 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 interprofessional Education and Learning facility is included as part of the strategic site development plan.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below: Inspiring People, Improving Care
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: Whole System Perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Safe, Efficient, Equitable, Timely, Person Centered
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 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 ENDORSES the establishment of the CTM Learning Academy for Board Approval.

Interprofessional Education in CTMUHB and Launch of CTMLA.

Janet Gilbertson Assistant Director Clinical Education

Cwm Taf Morgannwg University Health Board

January 2025

CTM 2030
Ein Hiechyd Ein Dyfodol
DATBLYGU CYMUNEDAU IACHACH GYDA'N GILYDD

CTM 2030
Our Health Our Future
BUILDING HEALTHIER COMMUNITIES TOGETHER

STARTING WELL | GROWING WELL | LIVING WELL | AGEING WELL | DYING WELL

WE LISTEN, LEARN AND IMPROVE

WE TREAT EVERYONE WITH RESPECT

WE ALL WORK TOGETHER AS ONE TEAM

CREATING HEALTH

- Reducing health inequalities
- Equal focus on mental and physical health
- Supporting our communities
- Being a healthy organisation

IMPROVING CARE

- Delivering safe and compassionate care
- Developing new models of care
- Digital transformation for patients and staff
- Ensuring timely access to care

Building Healthier Communities Together

INSPIRING PEOPLE

- Visible and inspiring leadership
- Promoting diversity and inclusion
- Embedding our values and behaviours
- Encouraging local employment

SUSTAINING OUR FUTURE

- Becoming a green organistion
- Ensuring our services' financial sustainability
- Embedding value-based healthcare
- Ensuring our estate is fit for the future

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

Plan for this presentation

- Where we were in 2019
- How we have got to where we are in 2024
- Where we are going 2025 and beyond……

Clinical Education Dept CTM 2019-

- 2019
  - Collection of separate departments

Medical Education

Nurse Education

Libraries & KMS

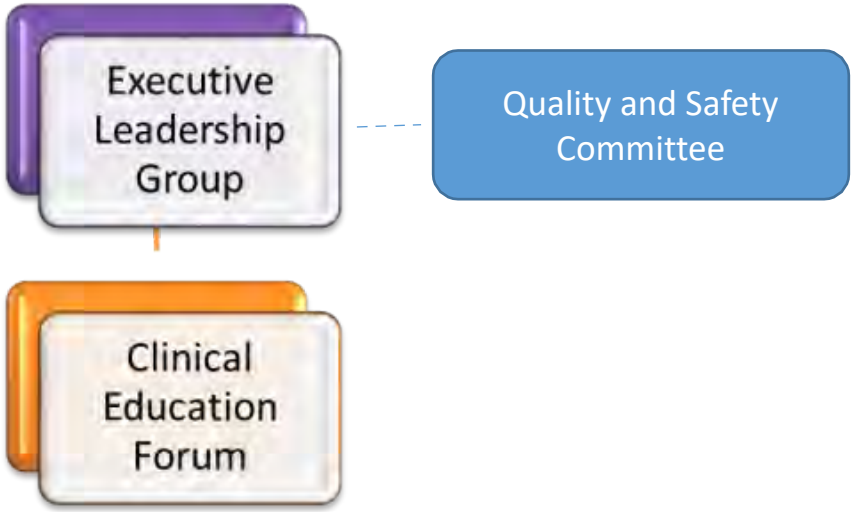
Resus

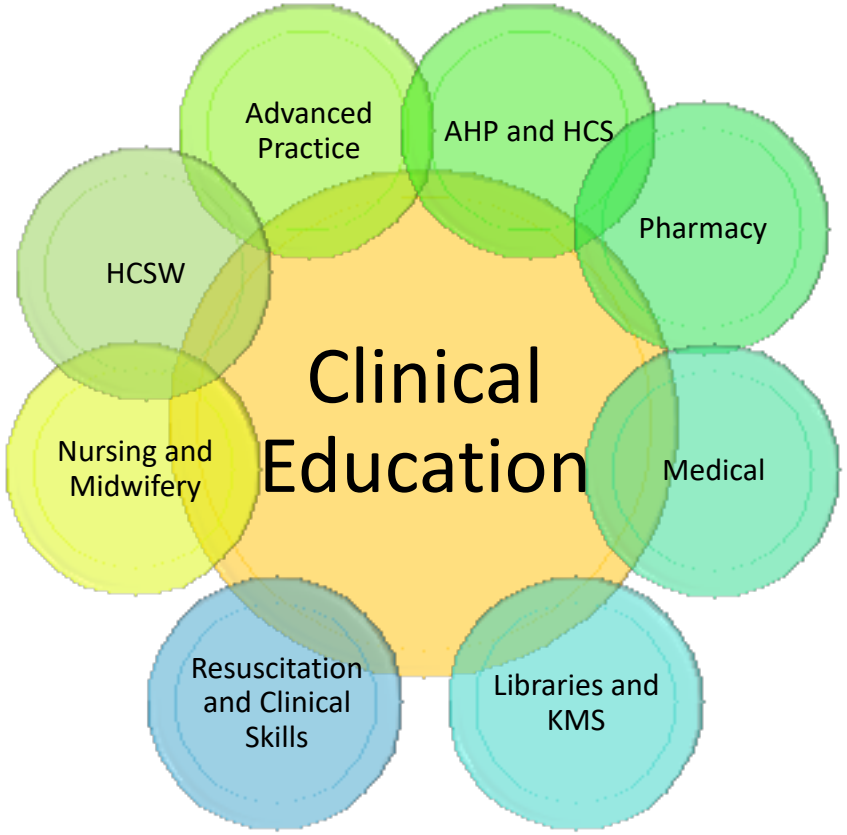
HCSW

- Strategic Direction

Governance: Clinical Education Forum 2022-24

- Co-chaired by Exec Dir.:
  - Nursing and Midwifery
  - Therapies and Health Care Science





CTMUHB 2024

- Each year our organisation delivers UG clinical placements including:
  - > 6000 medical student weeks
  - > 10,000 nurse student weeks
  - > 1600 AHP student weeks
  - > 140 Paramedic student weeks
  - > 340 Pharmacy student weeks

- Partnership with multiple universities
  - University of South Wales including–
    - *Nursing & Midwifery, ODP and Part-time OT & Physio.*
  - Cardiff University including
    - *Medical, Physio, OT, HCS & Pharmacy*
  - Swansea University including
    - *Nursing, Paramedics, PAs and Pharmacy*
  - Cardiff Metropolitan University including
    - *SLT, Dietetics, Podiatry.*
  - Open University *(Part time distance learning nursing)*
  - Bangor University *(Full time Distance Learning) Nursing*.

Structured IPE Placements

- Over 2000 structured IPE days facilitated during 2023- 24 academic year.
- Valuable learning opportunities aligned with their profession learning outcomes.

Radiology
Skills days with nurses
Ward experience

Podiatry
Teach other student groups in CMU clinics

Midwifery
Critical care rotation week
Theatre week

Neuro Physiology
Year 1 – Ophthalmology
Year 2 – Rotation week (MRI, Xray, Max fac, SLT)
Year 3 – Rotation week (Resp physiology, OT, epilepsy clinic).

Paediatric Nursing
Midwifery rotational week

Adult Nurses
Welsh Ambulance Service Trust Placement

Cardio Physiology
IPE rotational week within cardiology (nurse pracs, consultants, clinics, etc.)

Additional available clinics for any profession to book on to and attend;
Audiology, pharmacy, nursing, dietetics.

Mental Health Nursing
Clinical psychology

Dietetics
Year 1 – Rehab ward
Year 2 – Acute ward

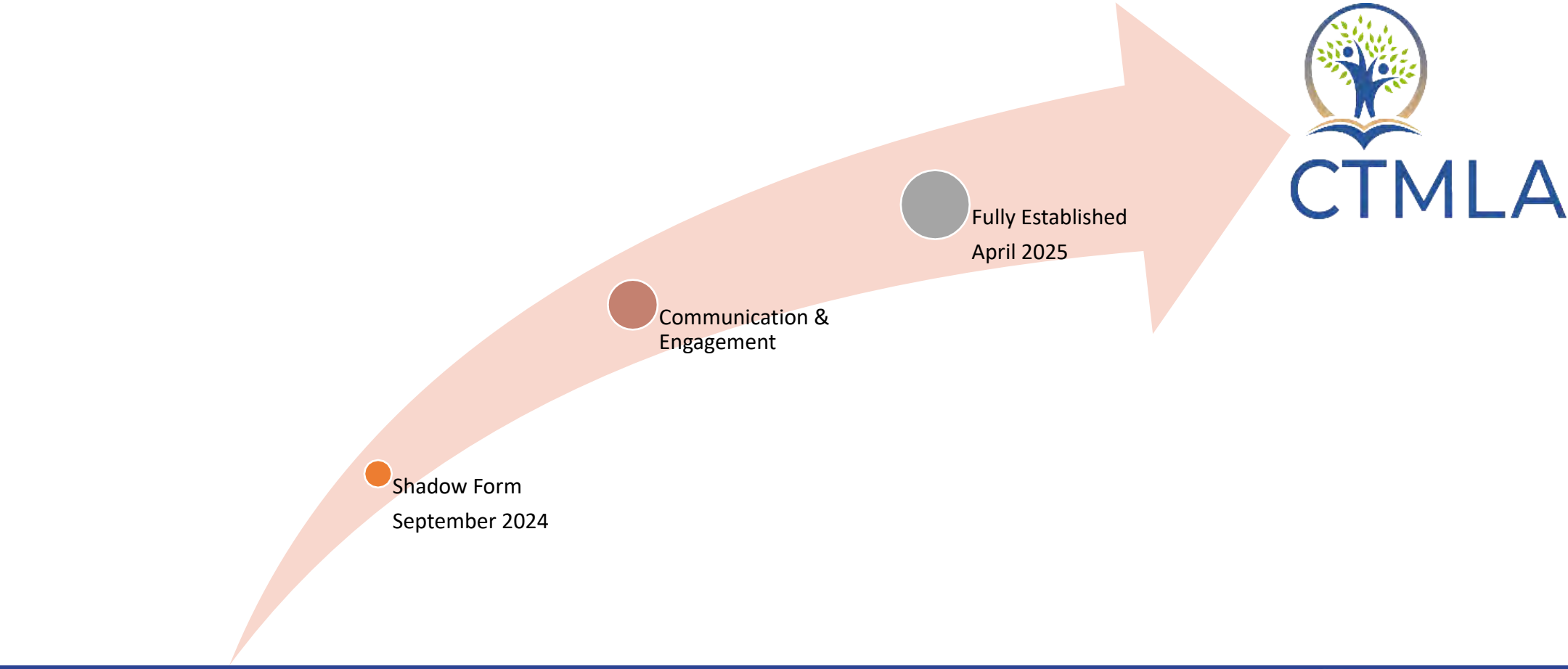
Speech and Language Therapy
Experience with health visitors

Physio and OT
Aligned placement "touch point" days

Audiology
Year 1 – Ophthalmology
Year 2 – Ward experience
Year 3 – New Project – Bite sized learning on wards

Pharmacy
IPE clinic each week

CTMLA Launch Timeline



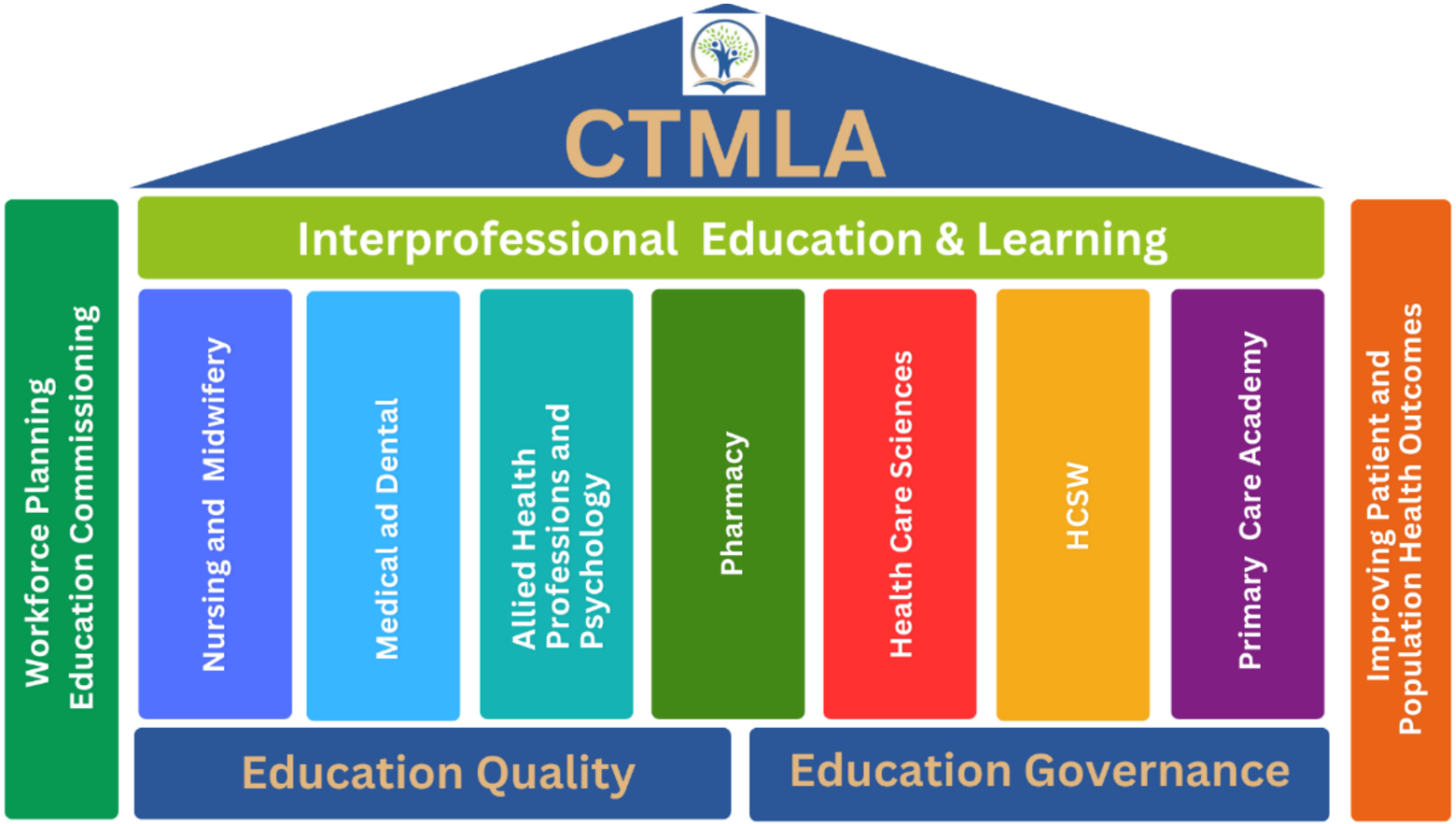
CTMLA

- Vision
  - Develop an ambitious and capable integrated multi-professional clinical workforce, improving patient and population health outcomes & 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.

CTMLA Aims

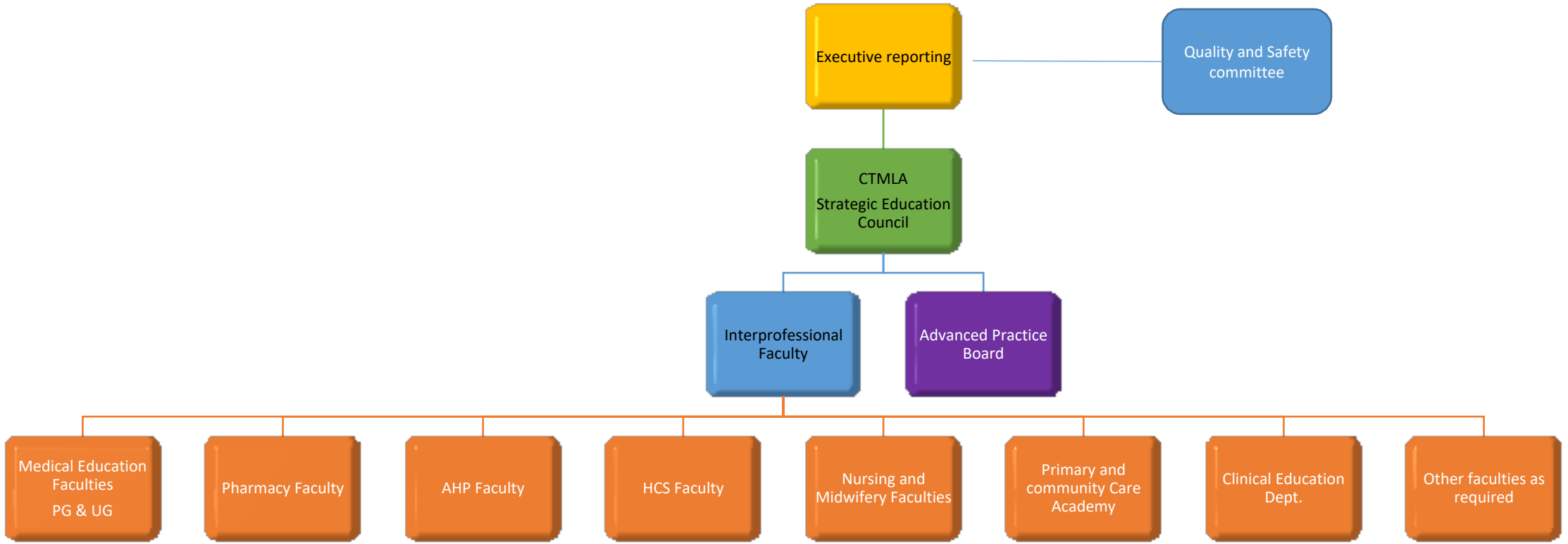

Developing and transforming our current workforce
Developing a culture of interprofessional learning
Establishing underpinning processes for education quality, governance and sustainability
Developing our Future workforce

2024-5……CTM Learning Academy



CTMLA

CTMLA Governance structure



SEC membership

- Deputy Director Nursing: Chair
- AD Clin Ed (Vice Chair)
- AMD Med Ed
- AD Corporate Nursing
- AD Strategic workforce planning
- Primary Care Academy Lead
- AD Research
- Director of Improvement

- Care Group representation:
  - Planned Care
  - Unscheduled care
  - Women, child and family
  - Primary & Community care
  - DTPS
    - Clin Dir AHP
    - Clin Dir HCS
    - Director Pharmacy

CTMLA Governance Aims

Quality

- *Improvement in the quality of healthcare services and patient safety*
- *Better understanding of the value and the contribution of education and learning in achieving organisational purpose and priorities.*
- *Innovation in education and learning activities*
- *Improved efficiency through a single quality framework for education*

Modernisation

- *Development of a more effective, flexible and modernised workforce.*
- *Education and learning commissioning informed by the skills needed in the workforce.*
- *Clarity of training demand and capacity across the organisation*
- *Clarity of utilisation of external funding streams*
- *Streamlining of training to develop an inter-disciplinary approach supporting multi-disciplinary working.*

Workforce

- *Improved Recruitment and Retention of staff and improved staff morale.*
- *Transparency in the way education and learning priorities are supported and measured*
- *Reduction of inequalities in access to education and learning opportunities and resources.*
- *Delivery of educational activities based upon best evidence and impact*
- *Improved learner satisfaction and enhancement of learning infrastructure and resources.*

Impacts of Education

For the Patient

- Equipping people with the right skills in the right area at the right time
- Embeds the right values and behaviour in person centered care
- Improvements in efficiency and effectiveness of the MDT
- Enhances evidence based practice
- Efficiencies surrounding the patient journey
- Improves safe and quality care
- Drives innovation

For the Individual

- Builds confidence
- Feels valued
- Offers new opportunities
- More transparent career progression
- More job satisfaction
- Supports career progression
- Clarity on educational achievements required for practice and career pathways.

For the Organisation

- Improves staff morale
- Attraction tool
- Improves retention
- Evidence shows it increases productivity
- Promotes informed decision making
- Provides assurance of training and competence.

Quality, Safety & Experience Committee – Non Routine Committee Business Forward Plan

(1st January 2025 to the 31st December 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
	Request made by the Quality & Safety Committee Chair	Committee Chair	Annual Quality Work Plan	The Annual Quality Report was presented for endorsing by Board at the July Q&SC and this was endorsed at July Board. Annual Quality work plan to be presented to the a future meeting of the Committee	Executive Director of Nursing/Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Nursing/Executive Director of Allied Health Professionals and Health Sciences	To be agreed	In progress Assistant Director of Allied Health Professionals and Health Sciences to discuss further with the Executive Director of Allied Health Professionals and Health Sciences and the Executive Director of Nursing in regards to the most appropriate time to present the Annual Quality work plan to the Committee
16 May 2024	Request made at agenda planning session for this item to be added to the agenda	Executive Director of Nursing	Nursing & Midwifery Plan	Nursing & Midwifery Plan received at the May 2024 meeting. Agreed at May 2024 meeting that annual updates on progress would be included in the Clinical Executives report.	Executive Director of Nursing	Executive Director of Nursing	May 2025	In progress Will be presented to the May 2025 meeting of the Committee.
16 May 2024	Suggested at the 16 May 2024 meeting that report would be presented to a future meeting on this item	Chief Operating Officer	CTM 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	In progress Following discussion with the Chief Operating Officers Business Team, this Policy is in the process of being reviewed and updated and will be available for circulation in early 2025.
14 August 2024	Request received by email for this to be presented as a spotlight presentation to a future meeting of the Committee	Senior Nurse Acute Deterioration and Outreach Services	Spotlight Presentation Decision Making around ACP/DNACPR/TEP	Case presentation to highlight the need for more resource in end-of-life education and training	Senior Nurse Acute Deterioration and Outreach Services	Executive Medical Director	25 March 2025	In progress Agreed at agenda planning session held on 12 December that this should be scheduled in for the meeting taking place on 25 March 2025

18 September 2024	Action captured at the In Committee session held on 18 September 2024	Director of Midwifery	Health Visiting Services Bridgend	Action plan to be presented to a future meeting of the Committee.	Director of Midwifery	Executive Director of Nursing	21 January 2025	Proposed for Closure Agreed at agenda planning on 12 December that this could be presented as an appendix to the Children & Families Care Group Highlight report. This has been made available to Members to view on request.
24 September 2024	Request received by email from the Assistant Head of Assets Governance and Technical Services	Assistant Head of Assets Governance and Technical Services	Estates Policies	Estates Policies for approval: • Asbestos Management Plan • Water Safety Plan • Medical Gases Policy • Ventilation Policy	Assistant Head of Assets Governance and Technical Services	Executive Director of Finance	19 November 2024	In Progress Will now be presented to the meeting scheduled for 21 January 2025 (now deferred to 25 March 2025)
1 October 2024	Request received by email from the Medical Directors Office	Anaesthetic Consultant	Report from the Medicines Safety Committee	To update the Committee on the work of the group since it was established a year ago	Executive Medical Director	Executive Medical Director	21 January 2025	Proposed for Closure - On agenda
22 October 2024	Request received by email from the Assistant Director of Governance & Risk	Director of Midwifery	Infant Feeding Strategy	To be presented to the Committee for Approval	Director of Midwifery	Executive Director of Nursing	21 January 2025	Proposed for Closure - On agenda
4 November 2024	Request received by email from the Patient Care & Safety Business Manager for this item to be added to the agenda for the January 2025 meeting	Head of Safeguarding	Safeguarding Strategy	To be presented to the Committee for Endorsement prior to Board approval	Head of Safeguarding	Executive Director of Nursing	21 January 2025	Proposed for Closure - On agenda
11 November 2024	Request received by email from the Assistant Director of Improvement	Assistant Director of Improvement	Quality Management Systems	To be presented to the Committee for information and awareness	Assistant Director of Improvement	Executive Director of Nursing	25 March 2025	In progress Will be presented to the March 2025 meeting of the Committee
5 December 2024	Request received by email from the Patient Care & Safety Business Manager	Assistant Director Clinical Education	CTM Learning Academy	To be presented to the Committee for endorsing prior to Board Approval	Assistant Director Clinical Education	Executive Director of Nursing	21 January 2025	Proposed for Closure – On agenda
6 December 2024	Request received by email from the Patient Care & Safety Business Manager	Patient Care & Safety Business Manager	Pressure Ulcer Prevalence Audit	To be presented to the Committee for noting	Assistant Director of Nursing and People's Experience	Executive Director of Nursing	21 January 2025	Proposed for Closure – On agenda
19 December 2024	Request received by email from the Assistant Director of Governance & Risk	Assistant Director of Governance & Risk	Stroke Services Update	To be presented to the Committee for discussion	Chief Operating Officer	Chief Operating Officer	21 January 2025	On agenda

Completed Items								
17 April 2024	Request received by email for this item to be added to the agenda	Deputy Chief Operating Officer	Parc Prison Health Care - A Year on Report	Report to reflect the good work undertaken since taking on the service and how this compares to other services. Report to cover governance arrangements, remaining risks and mitigations/further actions being taken	Deputy Chief Operating Officer	Chief Operating Officer	23 July 2024	Completed Deferred to 18 September 2024 On agenda for 19 November 2024
20 August 2024	Request made by the Executive Director of Nursing in meeting to discuss the Annual Cycle of Business for 2025	Executive Director of Nursing	Coroners Cases/Inquests	Report to identify the plan for reporting moving forwards in relation to Lessons Learnt and Themes and Trends.	Assistant Director of Concerns & Claims	Executive Director of Nursing	18 September 2024	Completed Report received at the meeting held on 19 November 2024
13 August 2024	Request received by email from the Medical Directors Office	Executive Medical Director	Antimicrobial Resistance Report	Six Monthly update reports to be presented to the Committee moving forwards	Chief Pharmacist	Executive Medical Director	19 November 2024	Completed Report received at the meeting held on 19 November 2024. Six monthly progress reports added to annual cycle of business
18 September 2024	Assistant Director of Quality & Safety Committee advised at the meeting held on 18 September 2024 that this would be presented to the November 2024 meeting	Assistant Director of Quality & Safety	Duty of Candour Annual Report	Duty of Candour Annual Report to be presented to the November 2024 meeting	Assistant Director of Quality & Safety	Executive Medical Director	19 November 2024	Completed Report presented to the meeting held on 19 November 2024
23 September 2024	Request received by email from the Director of Corporate Governance/Board Secretary	Assistant Director of Quality & Safety	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24 to be presented to the November 2024 meeting	Assistant Director of Quality & Safety	Executive Director of Nursing	19 November 2024	Completed Report presented to the meeting held on 19 November 2024
18 September 2024	Advised by the Deputy Director of Nursing at the September 2024 meeting that this item would be presented to a future meeting	Deputy Director of Nursing	Spotlight Presentation - Work being undertaken to address sexual safety issues within healthcare settings	Spotlight Presentation - Work being undertaken to address sexual safety issues within healthcare settings	Deputy Director of Nursing	Executive Director of Nursing	19 November 2024	Completed Report presented to the meeting held on 19 November 2024

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 November	⚑ 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					⚑								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.			⚑						⚑					
Setting the Scene – Service Delivery																
10. Thematic Spotlight Presentation	Lead Clinical Executive	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		X	⚑
11. Report from the Clinical Executives	Clinical Executives	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		X	⚑
12. Care Group Highlight Reports	Care Group Nurse Directors	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		X	⚑
Delivering our Plan																
13. Quality Dashboard Report	Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		X	⚑
14. Stroke Services Progress Report *(also captured in the regular Unscheduled Care, Care Group report)*	Executive Director of Therapies & Health Science / Chief Operating Officer	Twice per annum	⚑						⚑						X	⚑
Governance, Risk and Assurance																
15. Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		X	⚑
16. Health Inspectorate Wales (HIW) Audit Tracker Report	Director of Corporate Governance & Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		X	⚑
17. Coroner's Inquest – Case Activity & Lessons Learned	Executive Medical Director Executive Nurse Director / Deputy Chief Executive	Bi Annually			⚑						⚑				X	⚑
18. Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi Annually	⚑										⚑		X	⚑
19. Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Nurse Director / Deputy Chief Executive	Annually			⚑										X	⚑

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Governance, Risk and Assurance Contd.																
20. Infection, Prevention & Control Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually													X	
21. Infection, Prevention & Control Strategy Implementation Plan	Executive Nurse Director / Deputy Chief Executive	Annually														
22. Putting Things Right Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
23. Non Clinical Policies for approval	Executive Portfolio determined.	As and when required														X
24. Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually														X
25. Safeguarding & Public Protection Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
26. Nurse Staffing Levels Wales Act 2016	Executive Nurse Director / Deputy Chief Executive	Twice per Annum														X
27. Medicines Management *(Including Controlled Drugs Local Intelligence Network (CDLIN) / Prescribing Annual Report) Prescribing errors captured in quality dashboard)*	Executive Medical Director	Annually plus exception reporting													X	
28. Oversight on the delivery of the R&D Strategy	Executive Nurse Director / Deputy Chief Executive	Bi Annually														
29. Cancer Services Annual Report	Executive Medical Director	Annually														X
30. RADAR Committee Highlight Annual Report	Executive Medical Director	Annually plus exception reporting														X
31. Clinical Audit Quarterly Report	Executive Medical Director	Quarterly	Defer to March 25													X
32. Clinical Audit Annual Plan	Executive Medical Director	Annually														X
33. Clinical Education Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
34. Individual Patient Funding Request Annual Report	Executive Director of Strategy & Transformation	Annually														X

35. Radiation Safety Committee Annual and Mid-Year Updates	Executive Director of Therapies & Health Science	Bi Annually			⚑									⚑		⚑	X
36. Ombudsman's Annual Letter and Annual Report	Executive Director of Nursing / Deputy Chief Executive	Annually										⚑				⚑	X
37. Human Tissue Authority Act Progress Report	Executive Medical Director	Bi Annually					⚑							⚑		⚑	X
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.																
38. CTM Carers End of Year Progress Report	Executive Director of Nursing / Deputy Chief Executive	Annually							⚑						⚑	X
39. Health, Safety & Fire Sub Committee Highlight Reports	Executive Director of People	All meetings following a Sub Committee			⚑				⚑		⚑		⚑		⚑ Unless there is an area for escalation	X
40. Health, Safety & Fire Sub Committee Annual Committee Report	Executive Director of People	Annually					⚑								⚑	X
41. Organ Donation Sub Committee Highlight Reports	Executive Medical Director	All meetings following a Sub Committee	⚑ Defer to March 25		⚑		⚑		⚑				⚑		⚑ Unless there is an area for escalation	X
42. Organ Donation Sub Committee Annual Committee Report	Executive Medical Director	Annually					⚑								⚑	X
43. Hosted Organisations Quality, Safety & Experience Updates	JCC Chief Commissioner NIAW Programme Director	TBD													⚑ Unless there is an area for escalation	X
44. Anti-Microbial Resistance reports	Executive Medical Director	Twice Per Annum					⚑						⚑			

Agenda Item
8.2.3

Quality, Safety & Experience Committee

Report from the Medicines Safety Group

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Huw Carson, Principal Pharmacist- Quality and Safety
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
N/A	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
MSG	Medication Safety Group
NICE	National institute for health & care excellence
AWMSG	All Wales medicines strategy group

1. Situation /Background

1.1 The CTM Medication Safety Group (MSG) was re-established in November 2023.

1.2 The group is chaired by the Assistant Medical Director for Quality and Safety

1.3 The group meets bi-monthly. There have been six meetings of the group to date.

1.4 The remit of the group is to provide assurance, guidance, leadership and direction on safe medication use. It is the key forum underpinning the governance and assurance frameworks for all the processes involving medication safety within CTMUHB. The remit covers primary and secondary care medicines management. The Terms of reference is attached in appendix 1

2. Specific Matters for Consideration

2.1 The development of the Medication Safety Group and the items discussed has been a developing process since the group was established.

2.2 The group now receives reports from each established 'Local Assurance Medication Panel' (which generally aligns with the Care Groups)

- Unscheduled Care
- Planned Care
- Parc Prison
- Mental Health and Learning Disabilities
- Children and families
- Community Care Group

2.3 The group receives reports/ standing agenda items from:

- Thrombosis/ Anticoagulation update from the Principal Pharmacist (As no Health Board group yet established)- This will be replaced by update from the Thrombosis/ Anticoagulation group when it is established
- Analgesia stewardship update from analgesic stewardship Principal Pharmacist (As no Health Board group established)- This will be replaced by update from the Analgesia Stewardship group when established
- the Electronic Prescribing and Medicines Administration (EPMA) group
- the Teratogenic Medicines Safety Group
- the Dose Error Reduction Software (DERS) clinical reference group

2.4 The group discusses any issues National medication Patient Safety Alerts.

2.5 The group can inform and discuss any local Medication Safety alerts to be issued by the Medication Safety Officer.

2.6 The group also discusses any nationally reportable incidents.

3. Key Risks / Matters for Escalation

Representatives from all care groups are invited to the group. However, attendance from the medical colleagues has been variable. This is being reviewed by the Assistant Medical Director- Quality and Safety to ensure that all care groups and all members of the health care team are represented appropriately.

4. Assessment

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

5. Recommendation

5.1 The committee are asked to NOTE the contents of the report.

Appendix 1

Cwm Taf Morgannwg Medication Safety Group

TERMS OF REFERENCE

Purpose

The Medication Safety Group will provide guidance, assurance & strategic direction on managing and reducing risks to patients from medication related errors. In addition, it will seek to promote a culture of safe medication use within Cwm Taf Morgannwg University Health Board (CTMUHB) by empowering individuals to contribute to the medication safety agenda.

Accountability and Reporting

The Medication Safety Group (MSG) is accountable to, and will report to the CTMUHB Operational Management Board/ Executive Leadership Group, and then to the Quality, Safety and Risk Committee. Each site's local Medication Scrutiny Meetings will feed into the MSG with respect to local incident investigations/learning/actions.

Remit and Responsibility

The group will:

- Provide assurance, guidance, leadership and direction on safe medication use.
- Encourage and promote medication error and near miss reporting in line with CTMUHB policy.
- Develop and implement strategies to improve the medicines safety culture across CTMUHB (e.g. "Druggles" and local Medication Safety Meetings) and to support the wellbeing of staff involved with errors
- Work in conjunction with the local Medication Safety Meetings to review and analyse themes and patterns in medication errors and near misses across CTMUHB to identify system and other failures and implement actions to reduce these risks.
- To co-operate and collaborate with the investigating team to provide expert advice in the case of Serious Incident Investigations.
- Establish effective communication processes to share good practice and lessons learned associated with medication errors across the organisation including providing regular medication safety newsletters and regularly updating the medication safety page on SharePoint.
- Identify the education and training requirements to improve medication safety, giving advice to education providers to meet these requirements.
- Review and act upon external medication safety guidance (e.g. NPSA alerts), overseeing the implementation and monitoring of the required actions.
- Work with partnership organisations and private contractors to improve safe medication practices across the Health Locality from lessons learnt.
- Work with clinical audit/QI faculty to inform and direct medication audit projects/service improvement projects in areas of identified risk.
- Advise the CTMUHB prescribing committees and care groups on changes and actions that need to be implemented to manage the risks associated with medication prescribing, dispensing and administration.
- Work collaboratively with other health boards within Wales by means of the national Medication Safety Officer Network Group.

- Review the monthly 'medication safety thermometer' audit data and address any issues arising from this.
- Promote and encourage medication safety research.
- Provide an annual / bi-annual report to the CTMUHB Quality, Safety and Risk Committee.

Membership

The membership aligns the organisational structure with relevant professional participation pertinent to overseeing the improvement of safe medication practice.

Members are responsible for communicating and disseminating information back through the organisational structure.

Other individuals/ groups may be involved in specific tasks as directed by the steering group.

Members:

- Assistant Medical Director- Quality and Safety
- Director of nursing/ Deputy director of nursing (or suitably senior individual within the organisation)
- Heads of Nursing from each site, Head of Midwifery, Head of Children's Nursing, Head of Nursing Mental Health, Community and Primary Care Head of Nursing
- Assistant Director of Quality & Safety
- Patient safety representative(s)
- Medical Director from Care Groups
- Head of Clinical Audit & Quality Informatics
- Clinical director of pharmacy and medicines management/deputy clinical director of pharmacy and medicines management
- Heads of Pharmacy (acute sites, community sites & primary care)
- Medication Safety Officer
- Lead Nurse Adviser Medicines Management and Medication Safety
- Principal Pharmacist Thrombosis and Anticoagulation
- Principal Pharmacist - Pain, Analgesic Stewardship and Harm Reduction

Chair: Assistant Medical Director- Quality and Safety

Members should send a suitable deputy when unable to attend the meetings.

In attendance: Medicines management administrative support.

Professional secretariat & support

Pharmacy / Medicines management will provide the professional & administrative support to the committee.

Quorum: will be 6 to include at least one chief pharmacist, MSO or medicines management nurse advisor, one acute site pharmacist team leader, one head of nursing, one patient safety representative and one medical representative.

Meetings

Meetings will be held bimonthly via Teams for 2 hours duration. Agenda items should be received 14 days prior to the meeting and papers for the meeting will be circulated 7 days in advance.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
8.2.4.

Quality, Safety & Experience Committee

Human Tissue Act (2004)
Compliance and Progress Report

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr Paul D Davies, Designated Individual for the Human Tissue Act
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	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 /Forum Individuals	Date	Outcome
Dr Dom Hurford Mr Carl Verrecchia	17/12/2024	Approved

Acronyms / Glossary of Terms	
HTA	Human Tissue Act
HTAuth	Human Tissue Authority
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
HTARI	Human Tissue Act Reportable Incident
PLR	Pregnancy Loss Remains

1. Situation / Background

1.1 The Health Board is licensed by the HTAuth through compliance inspections which are undertaken every three years or as required through unannounced inspections.

1.2 This report presents an updated status from the last report submitted to the Quality and Safety Committee in May 2024.

2. Specific matters for consideration

Quality Control

2.1 The Quality Control Department within Pathology conduct an annual and cyclic programme of audit around the specific standards with the HTAuth Codes, predominantly Code A (Consent) and Code B (Post Mortem).

2.2 This quality system is augmented through regular inspections of a range of services by the DI including Mortuary Departments, Maternity Services, Emergency Departments, Theatres and Gynaecology Wards.

2.3 During 2023 and in 2024 there has been a focus upon security following the Fuller Inquiry. A detailed update on the Health Board response and status regarding the Fuller Inquiry was submitted to the Quality and Safety Committee on 23rd July 2024.

2.4 More recently at the HTA's request, the Health Board submitted an *Evidential Compliance Assessment* for evaluation of compliance against a subset of standards relevant to GQ1(a), GQ2(a), GQ6(c), PFE1(d), PFE1(e).

2.5 This assessment was undertaken across the National Health Service following the Fuller Inquiry and focused upon mortuary security.

2.6 As part of this process, the DI submitted evidence of factors pertaining to mortuary security standards. Based upon the information provided, the HTAuth assessed the overall compliance of the Health Board to be satisfactory with 4 advisory items;

- Increasing the frequency of CCTV audit to monthly (*action completed; previously quarterly*)
- Two party review of the CCTV audit between Facilities and Mortuary (*action completed*)
- Follow up failed swipe card attempts to access the Mortuary as a non-conformance finding of your security audit (*action completed; previously was performed but not recorded*)
- Unauthorised access of bodies in the hazards/risks section of the security risk assessment to be updated (*action completed*)

2.7 In a follow-up review meeting (16th September) with the Executive Medical Director, DI and Head of Cellular Pathology the HTAuth commended the Health Board for their prompt actions to address the four advisory items.

2.8 During November 2024 the DI undertook a joint *Deep Dive* exercise with Pathology examining Consent and Post Mortem HTA standards to ensure compliance and overall readiness for future inspection.

2.9 The *Deep Dive* revealed 8 advisory items for timely action by the Pathology team and overall, there was compliance with all relevant standards.

Legal Compliance

2.10 The Health Board is determined to be legally compliant with the HTA as assessed in the last inspection of February 2023. The next cyclic inspection is likely to be early 2026 with an unannounced inspection in mid-2025.

2.11 The DI has put in place a number of continual actions to ensure the service maintains its compliance including continual audit, local inspections, incident analysis and *Deep Dive* exercises.

2.12 The DI also reports quarterly to the HTA Board in terms of compliance and to ensure good governance. This meeting is chaired by the Care Group Service Director (DTPS and Children and Families), reporting to the Corporate Licence Holder (Executive Medical Director).

2.13 In relation to unannounced inspections the DI, with support from Pathology, has developed an *Unannounced Inspection Action Card* to ensure staff carry out the initial security checks in good order and ensure relevant documents can be accessed if requested by HTA inspectors.

2.14 The Medical Examiner (Wales) Regulations has come into force on 9 September 2024. From that date all deaths in England and Wales will be independently reviewed, without exception, either by a medical examiner or a coroner.

2.15 A new satellite Post Mortem HTA Licence was granted for the Princess of Wales Hospital Mortuary Department by the HTAuth.

2.16 This additional satellite Post Mortem to assist Cardiff and Vales University Health Board in their Forensic Post Mortem activity whilst refurbishment work is undertaken at their Mortuary Department.

2.17 The RGH Mortuary Department has increased its storage capacity to ensure there is sufficient contingency planning over the winter months with an additional 12 spaces using a Flexmort refrigerated system.

2.18 The DI has inspected the system to ensure it meets the HTA standards for security, temperature monitoring, traceability and ensuring patient dignity.

2.19 The HTA have been informed of the new temporary arrangement on 19th December 2024 in terms of the HTA Licence conditions.

Incident Analysis

2.20 All HTA related incidents are collated by the DI and presented on a quarterly basis to the HTA Board and Persons Designated. Table 1 presents data collated from 2021 to the end of calendar year 2024 (Appendix 1).

2.21 The importance of collating such data is primarily to analyse trends and seek improvements in clinical and service areas which may be experiencing issues with training compliance and high staff turnover.

2.22 The overall reduction in the trend of reported incidents continues to be evident and can be attributed to diligent follow-up and learning post incidents, general awareness raising and regular inspection and audit.

2.23 Since the last progress report there have been three near-miss HTARIs.

2.24 A near-miss HTARI is an incident that was prevented from happening by chance or a factor external to the establishment's own procedures; or an incident that occurred but there was no adverse outcome (HTAuth, 2024).

2.25 The first HTARI near-miss related to a tissue block loss with a low harm consequence. All Corrective and Preventative Actions have been met.

2.26 The second HTARI related to a CCTV failure at PCH and a delayed period for full restoration. All Corrective and Preventative Actions have been met. A briefing report regarding the incident and corrective actions was submitted to the Executive Management Board in September 2024.

2.27 The third HTARI near-miss related to a complaint from a previous case and all Corrective and Preventative Actions had already been met.

2.28 Shared learning from the outcomes of the incidents is communicated within the Persons Designated group and HTA Board.

2.29 A detailed update on reported HTARIs since April 2023 was submitted to the Quality and Safety Committee in September 2024.

2.30 In terms of differences between hospital sites for HTA incidents, the Royal Glamorgan Hospital site has fewer incidents because it has less Maternity and Gynaecology clinical services.

2.31 In terms of type of incidents the leading two categories are reports regarding the adult deceased, followed by PLRs.

2.32 The majority of PLR incidents relate to incomplete or incorrect paperwork from clinical areas. The majority of adult deceased incidents relate to incorrect identification from clinical areas.

Welsh Government Guidelines for Community Body Stores

2.33 Welsh Government has published interim recommendations to Health Boards in Wales following the Fuller Inquiry in 2021.

2.34 At the time of the published recommendations in 2021 both YCC and YCR were determined to be secure however a plan to consolidate the management of the body stores and align these to mortuary services in Pathology was assessed to have an annual cost implication.

2.35 This resource challenge has now been resolved and there is a plan to move forward with the necessary changes via a Memorandum of Understanding between Pathology, Facilities, Nursing and Hospital Management.

2.36 This plan will ensure that the relevant HTAct post-mortem sector licensing standards and guidance (where practically possible) will be applied to body storage areas and confirm the recommendations are met.

2.37 The Pathology Directorate will have overall responsibility of standards with the support of the DI; a similar set up to the main HTA licenced sites.

2.38 At present the Memorandum of Understanding remains outstanding as we await a decision from Corporate Nursing regarding the involvement of Registered Nurses in the safe release of the deceased from the Community Hospital Body stores to Funeral Directors.

3. Key Risks / Matters for Escalation

3.1 There is a need to address the recommendations from Welsh Government for the consolidation of community body stores to the overall management of mortuary services within the Pathology Directorate.

3.2 There is a delay in the decision from Corporate Nursing regarding the involvement of Registered Nurses in the safe release of the deceased from the Community Hospital Body stores to Funeral Directors.

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

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

Have you undertaken a Quality Impact Assessment Screening?		Compliance is statutory and longstanding.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate): NEUTRAL	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	HTA Compliance at POW/RGH/PCH is a legal requirement and the Designated Individual has primary legal responsibility under Section 18 of the Human Tissue Act	
Enw da / Reputational	Yes (Include further detail below)	
	Non-compliance with the HTA is a reputational risk for the Health Board.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The paper is for discussion and NOTING.

6. Next Steps

6.1 Continue to implement the governance framework key themes to maintain compliance with the Human Tissue Act.

6.2 Implement HTA standards within the YCC and YCR body stores through consolidation within mortuary services. This is subject to confirmation of a decision from Corporate Nursing regarding the support from Registered Nurses for safe body release to Funeral Directors.

APPENDIX 1

Table 1 – Number of Incidents by Category and Site. From April 2021 – December 2024 (n = 165)

		PLR	Deceased	Equipment	Security	PCH	RGH	POW	Other	TOTAL	HTARI	Near-Miss
2021/22	**Q1**	3	9	0	0	0	2	10	0	**12**	1	0
	Q2	7	14	1	0	8	7	6	1	**22**	1	0
	Q3	11	15	2	0	10	10	8	0	**28**	0	1
	Q4	4	5	0	0	4	1	2	2	**9**	0	0
2022/23	**Q1**	4	4	0	3	6	0	4	1	**11**	0	1
	Q2	3	5	0	0	3	3	2	0	**8**	1	0
	Q3	6	6	0	1	5	2	6	0	**13**	0	1
	Q4	7	3	0	0	8	1	1	0	**10**	1	0
2023/24	**Q1**	2	2	0	0	0	0	4	0	**4**	0	0
	Q2	1	8	1	1	5	1	5	0	**11**	0	0
	Q3	4	2	0	0	4	2	0	0	**6**	1	0
	Q4	6	3	0	0	4	3	1	1	**9**	0	2
2024/25	**Q1**	0	5	0	0	0	1	4	0	**5**	0	1
	Q2	4	4	0	1	3	2	4	0	**9**	0	2
	Q3	4	4	0	0	5	2	0	1	**8**	0	0
		66	**89**	**4**	**6**	**65**	**37**	**57**	**6**	**165**	**5**	**8**

Reporting Committee	Quality and Patient Safety Committee (QPSC)
Chaired by	Ian Green
Lead Executive Director	Director of Nursing & Quality
Date of Meeting	4th November 2024

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

1. PATIENT STORY

Members received a video of a patient and donor's experience whist undergoing a Bone Marrow Transplant. The service is commissioned from Cardiff & Vale University Health Board in the South and The Christie in the North. The video demonstrated the needs for a whole team approach and the support the patients receive during and after the transplant. As well as outlining the process the Lead clinician spoke about the need to increase the bank of donors. A member of the Joint Commissioning Committee (JCC) Quality Team attended a celebration event when the donor visited Wales to be reunited with the recipient one year after his transplant.

2. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the Welsh Kidney Network (WKN) and a summary of risk register was provided. Concerns were raised regarding the importance of early intervention and the role of public health going forward. The Committee were reassured that the appointment of a Public Health Advisor was progressing within the JCC and an update would be provided at the next meeting.

3. COMMISSIONING TEAM AND NETWORK UPDATES

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

4.1 Cancer & Blood
Plastic Surgery
It was noted that the JCC had agreed additional funding that will achieve the Key Performance Indicators (KPI) for identified higher priority patients (including

paediatric patients and patients waiting for Deep Inferior Epigastric Perforator (DIEP) reconstruction after cancer surgery) awaiting plastic surgery. The trajectory is currently being finalised however, the committee requested that in the meantime any direct harm to paediatric patients needed to be considered and escalated appropriately.

Neuroendocrine Tumours

Cardiff & Vale University Health Board received confirmation from the European auditors on the 3rd October that following submission of their annual return data they have maintained the European Neuroendocrine Tumour Society (ENETS) certificate for another year. This maintains accreditation status as a European Centre of Excellence.

4.2 Cardiac

Obesity Surgery Waiting Times

It was reported that there had been no improvement in the waiting list positon for Salford which was resulting in an inequity of service provision between the North and South Wales obesity services. As a result the JCC Senior Leadership Team endorsed a proposal submitted by the Commissioning Team for a portion of the resource allocated to SBUHB to be used to support the recruitment of an additional dietician. This will enable the Welsh Institute of Metabolic and Obesity Surgery (WIMOS) to undertake a number of additional procedures for BCHUB and North Powys patients. The Committee asked if the NHS England service needed to be placed into escalation as a direct result and it was agreed that the Commissioning Team would now consider this as a matter of urgency.

Cardiac Surgery

Cardiff and Vale Cardiac Surgery Service was de-escalated from Level 2 to Level 1 of the Escalation Framework in May 2024. The JCC team have been informed that the Health Board are undertaking an internal review of cardiac services following a number of incidents. The team will request the Terms of Reference and ensure that the JCC are fully sighted on the timescales of the review and its findings.

4.3 Neurosciences and Long-Term Conditions

Deep Brain Stimulation

It was noted that significant progress had been made with North Bristol to secure the pathway for South Wales patients and will monitored over the coming months.

4.3 Women & Children

Children's Hospital For Wales

A reset meeting took place on the 18th September to consider the services in escalation and undertake a collaborative approach to agreeing the way forward. Further work was required to agree the data set for monitoring and the next

escalation meeting is scheduled for 25th November. A detailed update with actions is provided in the escalation table.

Wales Fertility Institute

Members noted the significant work that had been undertaken to improve the service. The risk score has been reduced from 15 to 8, following receipt of 3 months comprehensive dataset received from the provider. The Commissioning Team reviewed the evidence and the level of escalation has been reduced from three to one as a result. Quarterly meetings will continue to be held and data submissions will be required in order to ensure the service remains at an appropriate level of service provision with reduced risks. A Letter has been sent to provider to inform them of the decision to reduce the level of escalation.

Infection Prevention & Control Issues

The committee were given an update on the two Methicillin-resistant Staphylococcus aureus (MRSA) outbreaks in the neonatal units in SBUHB and CVUHB. The JCC Quality team we part of the outbreak meetings and will continue to provide support into the units. Welsh Government are aware of the position. Further work will need to be undertaken to fully understand if the units are outliers and what actions are required to prevent further outbreaks and transmission.

4.4 Mental Health

High Secure Services

The service at Rampton High Secure Unit remains in enhanced monitoring via NHS England & the Care Quality Commissioning (CQC) due to significant staffing issues. There are beds available but all admissions are managed via this process. There is one Welsh patient awaiting admission. The Commissioning Team continue to have oversight of commissioning of high secure services via the National Oversight Group (NOG) which include fortnightly SITREP's, site visits and Bi Monthly Strategic Executive Information System (StEIS) meetings.

4.5 Intestinal Failure (IF) – Home Parenteral Nutrition

Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio.

5.0 OTHER REPORTS RECEIVED

Members received reports on the following.

5.1 Services in Escalation Summary

Members noted that there were a number of examples given where services had been in escalation for a considerable length of time and in some instances this was due to a lack of data being submitted in a timely fashion by the provider.

The committee requested that any delays were escalated to the JCC Senior Leadership team and the provider Health Bards made aware at Executive Level.

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

5.2 Quality and Safety Report - Ambulance and 111

A report providing an update on quality and safety matters for the Ambulance and 111 commissioned services was received. The committee received a copy of the Quality Dashboard which has been produced in line with the requirements of the Duty of Candour and the Duty of Quality and reports around the Six Quality Domains.

Regulation 28

The committee was informed that it had recently received a regulation 28 order as a result of a delay of an ambulance getting to a patient. This would need to be considered in a system wide approach and joint working with the NHS Executive and WAST was required. A further update would be provided at a future meeting.

5.3 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to JCC and the actions taken for assurance. This excluded both Mental Health and Ambulance as they were included within their separate reports. Work is planned to align the processes going forward.

5.4 Joint Commissioning Committee Risk Register

The risk register for the JCC was presented to the committee, which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former EASC, NCCU and WHSSC predecessor organisation risk registers. This Risk Register was approved by the JCC in September 2024, and considered by the CTM Hosted Bodies Audit and Risk Committee (ARC) in August October. Members noted the significant amount of work done to bring this together, mindful there was still a lot of work to be done with scores and assessing risks to ensure consistency across the range of NWJCC services.

A summary of the risks related to the Ambulance and 111 service was presented to the Committee and a paper was due to be received by the JCC next week.

5.5 Policy Group Report

Members received an update on activity and output from the JCC Policy Group during the period 01 July 2024 – 30 September 2024 together with an updated overview of all JCC policies and service specifications including those published during the current financial year. The Committee acknowledged the significant work that had been undertaken.

6. ANY OTHER BUSINESS

QUALITY SAFETY AND OUTCOMES SUB COMMITTEE (QSOSC) Terms of Reference & Operating Arrangements (Schedule 3.1 of the Standing Orders)

A discussion took place regarding the Terms of Reference for the new Quality Safety and Outcomes Committee and the changes to the membership following the appointment of Independent Members for the JCC. The Chair assured the Committee that the JCC would continue to work with the Health Board Board Secretaries to ensure that a Chairs Report would still be made available to the Health Boards QPS for assurance purposes. As the meetings would be held in public the papers would be readily available and anyone could attend as an observer.

It was noted that the Director of Nursing wrote the Health Board QPSC members on the 25th October outlining progress and changes in establishing the new Joint Commissioning Committee (JCC) Quality, Safety and Outcomes (QSOSC) sub-committee and thanked them for their significant contribution and commitment to the Committee. The Chair also took the opportunity to thank them personally at the meeting.

Key risks and issues/matters of concern and any mitigating actions

- Confirmation of appointment of Public Health expertise into the JCC
- Assurance on any harm resulting in delays in plastic service for paediatrics to be confirmed
- Note position of obesity pathway and consider if the service for North Wales patients' needs to go into the escalation process.
- Escalation objectives to be agreed for services in escalation in Childrens Hospital for Wales
- Risks relating to ambulance services will be considered by the JCC next week
- Continue to input into the MRSA outbreaks within the neonatal units and provide an update to the next meeting

Summary of services in Escalation

- Attached (Appendix 1)
- Escalation to SLT if delay in data information received into JCC

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	TBC

Executive Director Lead: Carole Bell
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	→ OCT 2024
→	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:

Escalation History:

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

Rationale for Escalation Status :

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

Background Information:

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

JCC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	-	17th July 2024
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024

Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. JCC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Escalation status being discussed at executive level within the JCC. The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement. Actions/Objectives agreed on the 18th September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25th November to monitor progress.	Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	25th November 2024
Issues/Risks:				

Executive Director Lead: Carole Bell
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

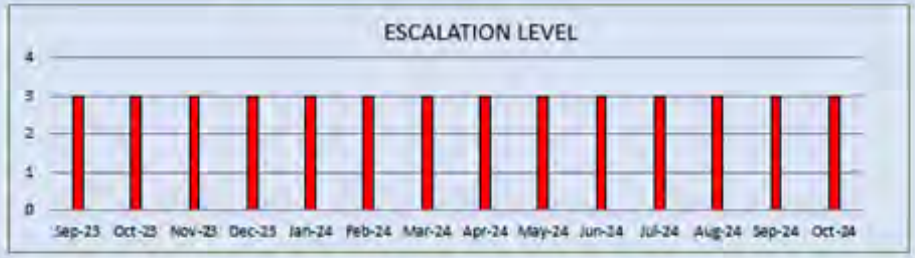
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	→ OCT 2024
→	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Ratio Plot Area **Escalation Status :**

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

Background Information:

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

NWJCC assurance and confidence level in developments:

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

The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	See comment in development section
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024
Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	25th November 2024

objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement. Actions/Objectives agreed on the 18th September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25th November to monitor progress. Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live – Phase 1 implementation paper to be taken to management group on 28th November to recommend a way forward to progress with the implementation of the new baseline.	
Issues/Risks: March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered. May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.	

JCC assurance and confidence level in developments:	14th March 2024

Executive Director Lead: Iolo Doull
Commissioning Lead:

Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24, 13/06/24, 18/07/24, 08/08/24, 12/09/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

Service in Escalation: Wales Fertility Institute

Current Escalation Level 1

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ SEPT 2024
→	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:

Escalation History:

Date	Escalation Level
July 2023 – JCC escalation	3
November 2023 – JCC escalation	4
July 2024 – JCC escalation	3
September 2024 – JCC escalation	1

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

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

Actions:

Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024	Assistant Specialised Planner	Monthly	13 June 2024

Agenda Item
8.2.6

Quality, Safety & Experience Committee

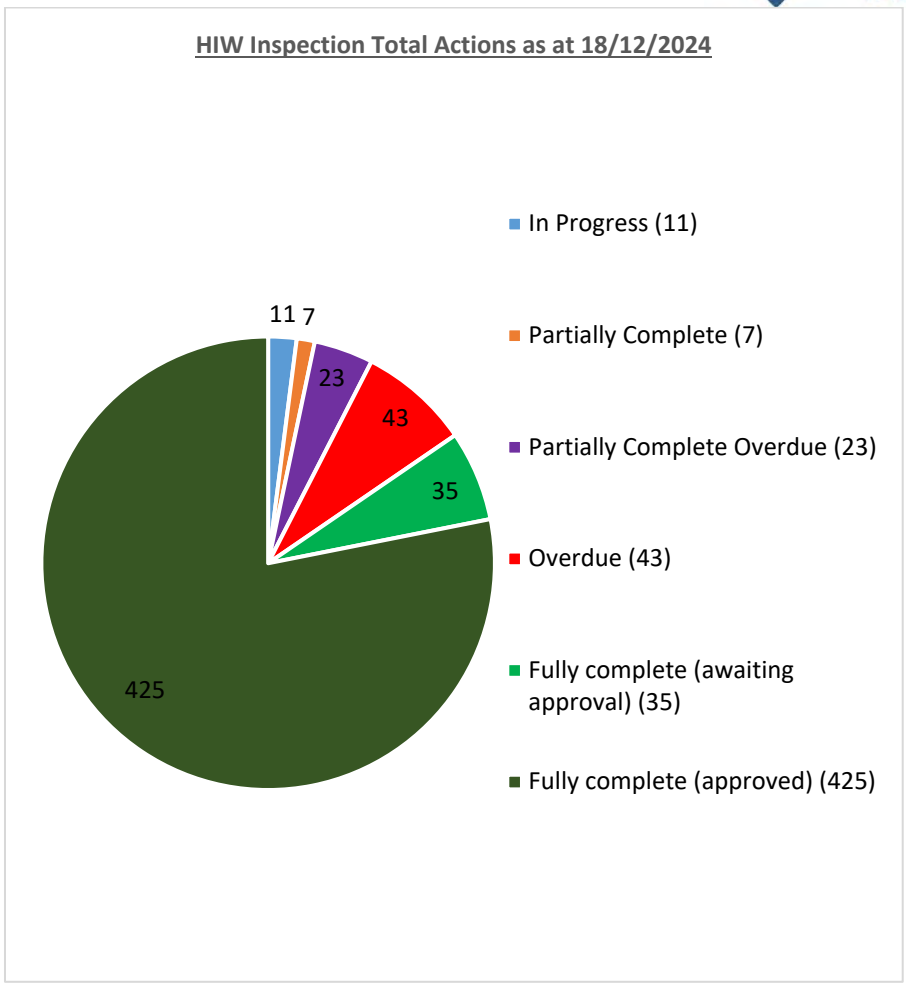
HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

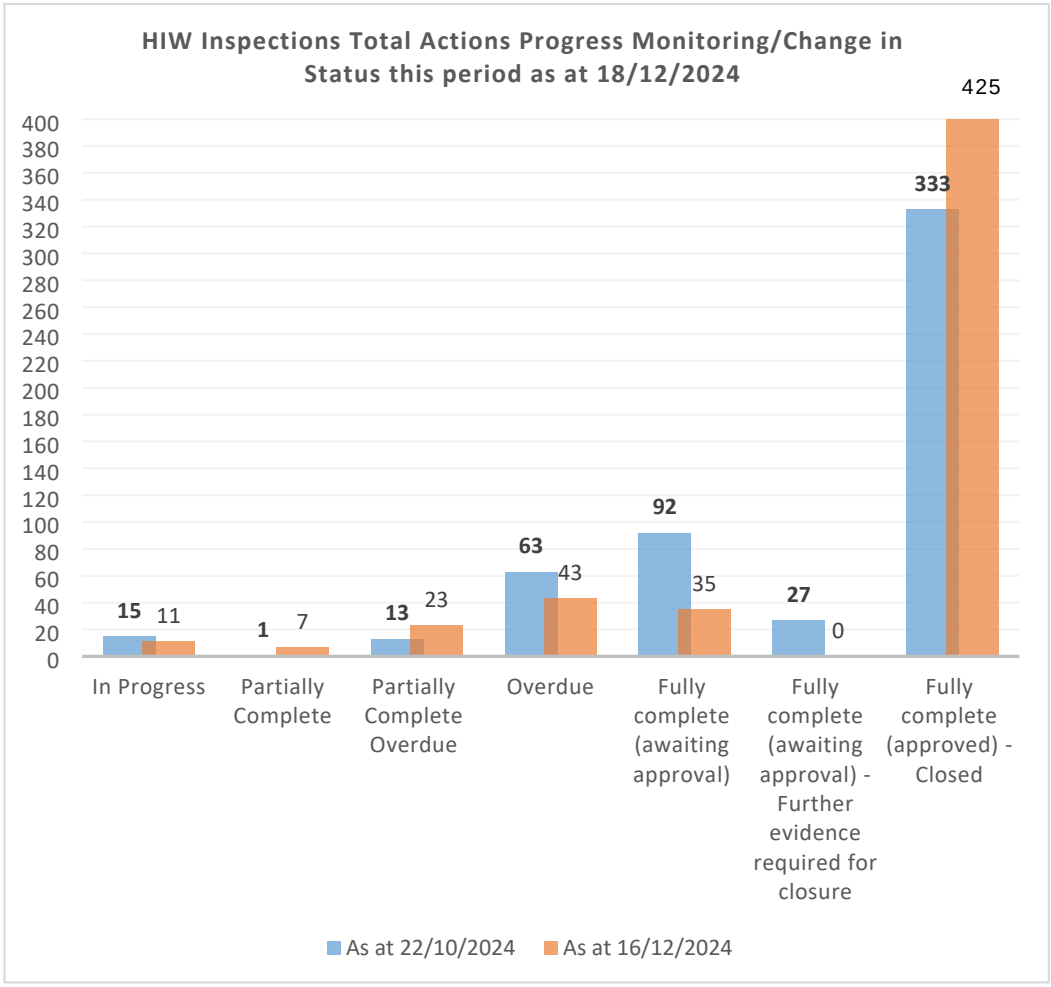
Dyddiad y Cyfarfod / Date of Meeting	21st January 2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown- Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

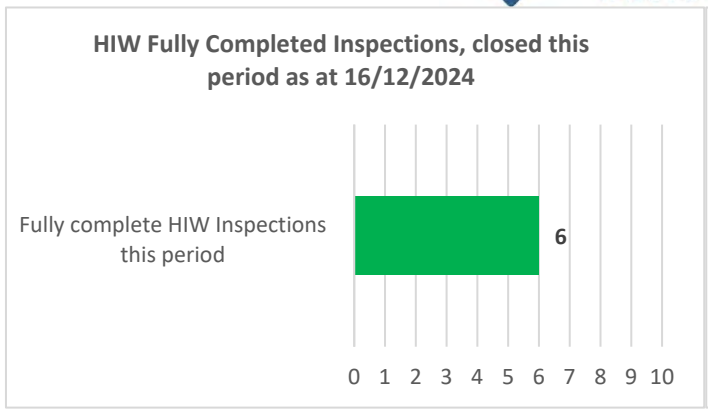
Pwrpas yr Adroddiad / Report Purpose	For Noting

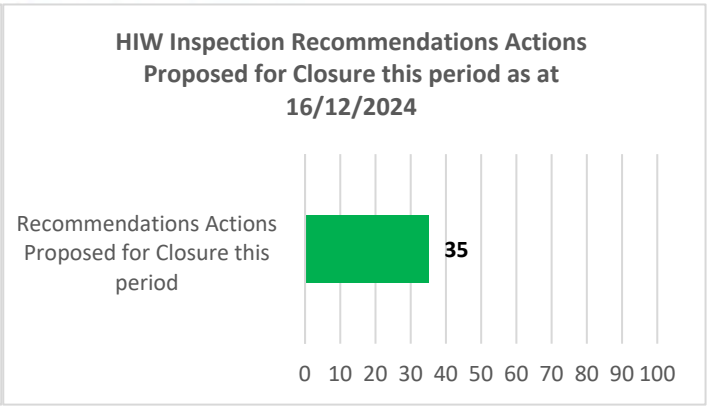
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

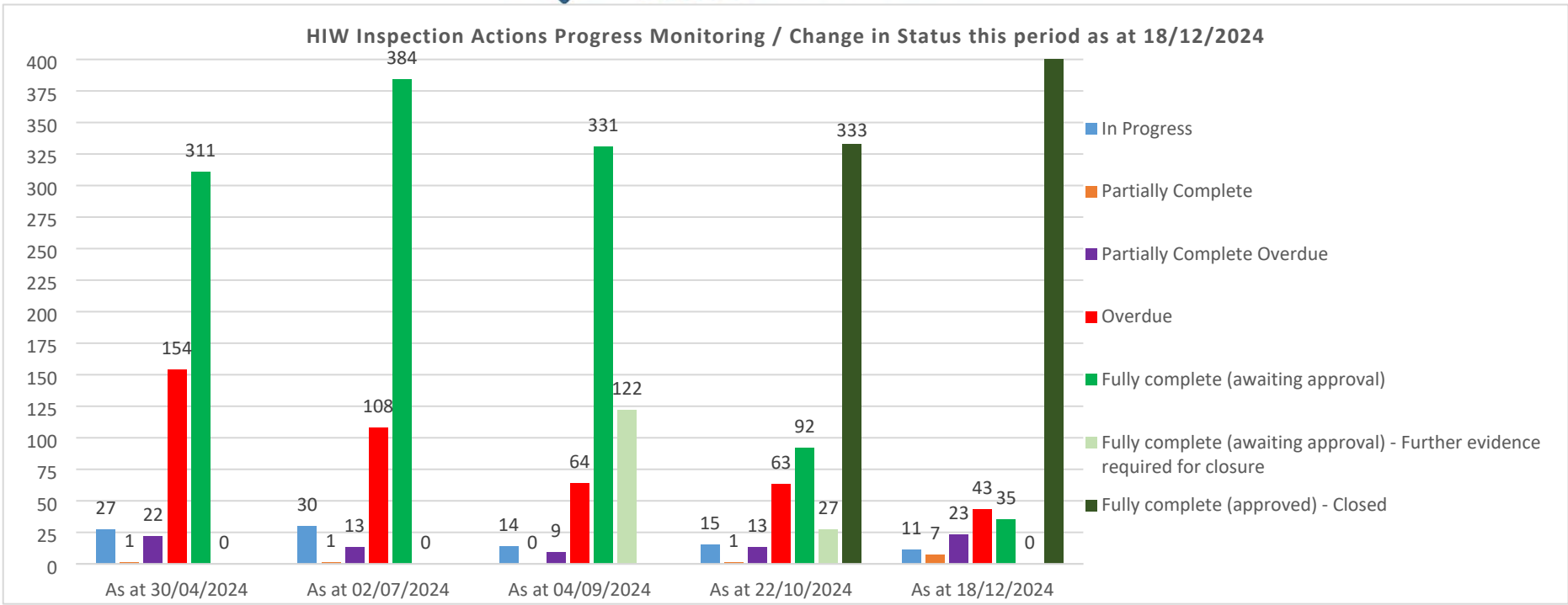
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking


HIW Inspection Total Actions as at 18/12/2024
11
7
23
43
35
425
In Progress (11)
Partially Complete (7)
Partially Complete Overdue (23)
Overdue (43)
Fully complete (awaiting approval) (35)
Fully complete (approved) (425)


HIW Inspections Total Actions Progress Monitoring/Change in Status this period as at 18/12/2024
400
380
360
340
320
300
280
260
240
220
200
180
160
140
120
100
80
60
40
20
0
15
11
1
7
13
23
63
43
92
35
27
0
333
425
In Progress
Partially Complete
Partially Complete Overdue
Overdue
Fully complete (awaiting approval)
Fully complete (awaiting approval) - Further evidence required for closure
Fully complete (approved) - Closed
As at 22/10/2024
As at 16/12/2024


HIW Fully Completed Inspections, closed this period as at 16/12/2024
Fully complete HIW Inspections this period
6
0 1 2 3 4 5 6 7 8 9 10


HIW Inspection Recommendations Actions Proposed for Closure this period as at 16/12/2024
Recommendations Actions Proposed for Closure this period
35
0 10 20 30 40 50 60 70 80 90 100


HIW Inspection Actions Progress Monitoring / Change in Status this period as at 18/12/2024
400
375
350
325
300
275
250
225
200
175
150
125
100
75
50
25
0
27
1
22
154
311
0
30
1
13
108
384
0
14
0
9
64
331
122
15
1
13
63
92
27
333
11
7
23
43
35
0
As at 30/04/2024
As at 02/07/2024
As at 04/09/2024
As at 22/10/2024
As at 18/12/2024
In Progress
Partially Complete
Partially Complete Overdue
Overdue
Fully complete (awaiting approval)
Fully complete (awaiting approval) - Further evidence required for closure
Fully complete (approved) - Closed

1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker of the accepted improvement plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 18th December 2024.

1.2 All open and live HIW inspection improvement plans continue to be recorded on AMaT however there remains the requirement for manual inputting of manipulation in order to produce and present the relevant data and report. The team are continuing to use work arounds and are working with the system developers to find the best solution. Collaboration with Care Groups is ongoing, and progress has been made in enabling care groups to take ownership of completing their data responses independently prior the deadline for updates as well as in cleansing the historical inspections and actions.

1.3 The Assistant Director of Governance & Risk met with each Care Group during August and it has been agreed that Care Groups will transition to using the AMaT system for reporting following the September submission. Following the September submission, the Head of Quality Assurance and Compliance offered support to Care Group Leads to facilitate independent inputting of updates into AMaT. Following the extensive work of the team over the summer, Care groups have, on the whole been engaging with the team in order to ensure the updates provided are on time, to the point and suitable for public reading. Positive progress has been made to close down historic inspections within some care groups. Collaboration is expected to continue in order to include the tracking and management of Death in Custody reports as well as the inspections in Primary Care areas not managed by CTM. It is hoped that this will allow a more finite overview of all HIW activity involving services offered to patients of CTM.

2. Specific Matters for Consideration

2.1 The HIW tracker continues to be a live document and each iteration evolves as actions are completed or the date surpasses as well as following the submission and acceptance by HIW of new inspection improvement plans. Therefore, members will note some changes and progress on the actions which remain as open as they transition to closed/completed actions throughout this and future reports.

2.2 Care Groups are responsible for providing regular updates on the improvement plans within their care group portfolios in order that the tracker can remain live and up to date ensuring all actions are completed in

a timely manner. Reminders are sent out in advance of reporting deadlines to encourage and request further updates from Care Groups. There has been a notable improvement in engagement from leads to close long-standing inspection actions that required further evidence to support the governance and assurance of inspections.

2.3 As previously described, a data cleanse has commenced of the inspections and actions in an attempt to remove completed historic actions as well as review actions that may again be historic but not measurable or attainable. There has been significant engagement by the relevant Care Groups to provide evidence in support of fully closing these outstanding actions down as reflected in the dashboard graphs at the beginning of this report.

In the Mental Health and Learning Disability Care Group on-going work has enabled the Quality Assurance and Compliance team to document sufficient evidence supporting the closure of a large number of out-standing actions which will be reflected in the next report if approved.

2.4 A breakdown of the status position with regards to all actions up to the 18th December 2024 is detailed below.

- A total of 544 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.
- 425 Actions were Fully complete, approved and closed with a further 35 actions fully complete and awaiting approval

2.5 New Inspections / Actions

- There were 0 new Improvement Plans and 0 actions added this period.

2.6 Healthcare Inspectorate Wales request regular three-monthly updates on all improvement plans where ongoing or outstanding actions remain following the initial submission of the improvement plan, these are updated by the responsible Care Group and submitted to HIW following Executive Director Review and sign off.

3. Key Risks / Matters for Escalation

3.1 Care Groups are encouraged to continue to work with the Quality Assurance team to provide pertinent update to their inspections via AMaT. Care Groups are also asked to note that it is their responsibility to record the evidence supporting the closure and completion of any action.

3.2 Ongoing AMaT system developments and requests are continuing in order to deliver a system and process that is required for improved governance. Some small system changes have been completed by the developers which

is allowing the team to further adapt the way we capture and analyse the data.

3.3 As outlined above, the HIW actions tracker will continue to be updated with a targeted focus on actions where the action agreed due by date has passed or no update has been received. As work on the tracker develops and service developments from AMaT come into fruition, it is the intention that the information collected and managed may be utilised within each Care Group and CTM to improve the quality of care provided.

3.4 Continued engagement is required from Care Groups to continue to update and cleanse the current and historic Inspection actions to make analysis more meaningful. The Quality Assurance and Compliance team will continue to work with Care Groups to continue to track and manage the ongoing improvements to services and to complete outstanding actions and provide sufficient assurance.

4. Assessment

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

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

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

5. Recommendation

5.1 The Quality, Safety & Experience Committee are asked to NOTE the contents of this report and the activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.

6. Next Steps

6.1 The Head of Quality Assurance and Compliance will continue to work with Care Group Leads in order to provide assurance of the Health Board's engagement and compliance with HIW recommendations and Improvement Plans.

Inspection Code	Title	Date of Inspection	Care Group & DoN Lead	DoN Lead	Recommendations	Actions
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	14/08/2024	**Primary Care and Community**	Lucie Williams, Nurse Director	3	3
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	14/08/2024	**Primary Care and Community**	Lucie Williams, Nurse Director	5	5
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	**Planned Care**	Sharon O'Brien, Nurse Director	22	22
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	**Primary Care and Community**	Lucie Williams, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	20/04/2021	**Mental Health & Learning Disabilities**	Ana Llewelyn, Nurse Director	1	1
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	**Mental Health & Learning Disabilities**	Ana Llewelyn, Nurse Director	17	18
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	20/07/2021	**Mental Health & Learning Disabilities**	Ana Llewelyn, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2022/129	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189)]	01/11/2022	**Mental Health & Learning Disabilities**	Ana Llewelyn, Nurse Director	6	10
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22/03/2022	**Children & Families**	Suzanne Hardacre, Director of Midwifery	7	7
Healthcare Inspectorate Wales (HIW)/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	17/10/2022	**Unscheduled Care**	Emma James, Nurse Director	1	2
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07/03/2023	**Mental Health & Learning Disabilities**	Ana Llewelyn, Nurse Director	39	180
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	**Unscheduled Care**	Emma James, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	**Primary Care and Community**	Lucie Williams, Nurse Director	7	7
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	**Unscheduled Care**	Emma James, Nurse Director	50	50
Healthcare Inspectorate Wales (HIW)/2023/156	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	25/09/2023	**Children & Families**	Suzanne Hardacre, Director of Midwifery	2	2
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13/11/2023	**Mental Health & Learning Disabilities**	Ana Llewelyn, Nurse Director	25	26
Healthcare Inspectorate Wales (HIW)/2023/158	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	20/11/2023	**Mental Health & Learning Disabilities**	Ana Llewelyn, Nurse Director	19	19
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	**Unscheduled Care**	Emma James, Nurse Director	31	36
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	09/01/2024	**Children & Families**	Suzanne Hardacre, Director of Midwifery	2	27
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	**Children & Families**	Suzanne Hardacre, Director of Midwifery	14	36

In progress	**Inspection action is in the process of being completed and has not yet reached the deadline.**
Partially complete	**Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.**
Partially complete (Overdue)	**Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.**
Overdue	**Inspection action deadline has been reached and no recommendations have been completed.**
Fully complete (Awaiting approval)	**Inspection actions have been fully completed and are waiting to be approved to be closed.**
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.

AMaT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14/08/2024	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	Reception screening for any prisoner with known risks such as significant medical history or substance misuse is undertaken by a qualified nurse, to ensure that any concerns regarding health or risks are recognised and acted upon. Entries in the clinical record is made by a named member of staff and is done so contemporaneously where possible.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/MD1/1	New admissions are now screened by a qualified nurse. A documentation audit to is to be completed and any issues identified to be reported on the Data management system .	Primary Care & Community	30.09.2024	30.09.2024	Partially complete (Overdue)	December 2024 Update - Evidence to be approved at next QPSE meeting due 05.02.2025	
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14/08/2024	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	Inter-prison transfers should not be made unless it is clear that a service exists to deliver the health needs of the patient at the appropriate destination, by a confirmed age-off between both prisons heads of healthcare. When arriving at HMP Parc, currently there is no commissioned service for patients with confirmed or suspected ADHD to receive specialist input into care management. CTM/LHB commissioners urgently seek to provide a clinical service to HMP Parc that would enable timely assessment and treatment optimisation for prisoners with ADHD.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/MD2/1	A review of the current processes regarding the inter-prison transfers and the sharing of information between prison healthcare departments to be undertaken in partnership with GAS team. For patients who require ADHD assessments are currently reviewed by mental health services within secondary care. Whilst this is in line with the care provided within Community Services, the team are undertaking a review with Mental Health services to understand any further improvements that could be made to the service. Prison Healthcare Directorate representation included as part of the CTM Regional Neurodivergence Steering and Improvement Board to review current provision and identify work streams to improve services.	Primary Care & Community	31.12.2024	31.12.2024	In progress	December 2024 Update - Progress and evidence: Process to be embedded once agreed.	
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14/08/2024	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	CTM/LHB commissioners ensure that all contracted services providing any input into the health of the patient are required to maintain records in the main healthcare clinical record system.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/MD3/1	Email to be sent to all contracted services to remind them of the importance that when providing any input to the health of a patient that all records are maintained with the clinical system. The requirement to add relevant information in the main healthcare clinical record system (System One) to be included in all future SLA and tender documentations. Healthcare Needs Assessment commissioned to provide baseline for service provision and resulting action plan to address identified recommendations.	Primary Care & Community	31.12.2024	31.12.2024	In progress	December 2024 Update - Progress and evidence: Email to be embedded. Specific part of contract to be embedded. Needs Assessment to be embedded and evidence.	
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	The Head of Healthcare should ensure that all prisoners, by the end of second reception screening, have a full set of baseline clinical observations to act as baseline for staff to monitor for changes from the patient normal values. Reception screening should always involve at least one registered health professional undertaking the assessment with the patient. They should arrange clinical audit of compliance against this standard.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD1/1	New admissions are now screened by a qualified nurse. Audit for 15 admissions to be undertaken to ensure that clinical observations have been undertaken. All staff have been informed that baseline observations must be recorded on admission screening. All staff will be issued with written guidance.	Primary Care & Community	30.09.2024	30.09.2024	Partially complete (Overdue)	December 2024 Update - Awaiting approval via QPSE Feb 2025.	
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	Patients with seizures (full loss of consciousness) without an established diagnosis of the cause of seizures should be treated as a clinical emergency by all healthcare staff, and should receive review urgently by a registered medical practitioner. If none is available onsite, then the patient should be referred to hospital for emergency assessment.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD2/1	Emergency medicine training sessions to be devised and provided to ensure that all staff have adequate skills and knowledge to treat clinical emergencies and to identify those who require referral to hospital for an emergency assessment. All staff have been reminded that any patients reporting seizure activity in the absence of a diagnosis of epilepsy must be referred for an urgent GP appointment. All staff have been informed that the GP must be informed of any patients with a diagnosis of epilepsy have any seizure activity. These patients will be reviewed by the practice nurse.	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Overdue)	December 2024 Update - Awaiting approval via QPSE Feb 2025.	
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	Healthcare staff should ensure that when reviewing clinical discharge summaries from hospital teams, the information on which they have based their assessment is accurate (for example, in this case, it was incorrect for the consultant neurologist to state this was a single episode of seizure) from the clinical record. These errors or omissions should be alerted to the relevant specialist, so that they can revise the management plan for the patient.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD3/1	Admissions staff to be provided have access to the Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge summaries will be reviewed by a GP and Senior Nurse. The discharge summaries will be checked for accuracy and outstanding actions. Once checked and signed by Senior Nurse and GP they will be scanned onto records. Audit to be undertaken in relation to 10 discharges to ensure all summaries have been checked by the GP and Senior Nurse	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Overdue)	December 2024 Update - Progress and evidence: Meeting with Digital Health Care Wales w/c 02/09/24. Audit and findings to be embedded.	
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	Where a hospital letter is requesting potential actions if a future event should occur (e.g. 'refer back to my service should a further seizure occur') this should be flagged on the clinical record as an 'alert', so this potential action / request is visible to all staff.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD4/1	Admissions staff to have access to Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge letters will be checked by a Senior Nurse and a GP and any requests for actions to be taken if a future event should occur this will be flagged as an alert on medical records.	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Overdue)	December 2024 Update - Progress and evidence: Register of staff with dates of access provided to be embedded. Audit in number 3 will evidence the findings. Awaiting approval via QPSE Feb 2025 - evidence embedded.	
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	Clinical teams in other services providing care to prisoners (e.g. psychiatry) should clearly document that they have considered the risk of their prescribing recommendations to general practitioners, where those recommendations increase the risk of worsening of other illness (e.g. increasing risk of seizure). Formal letters of referral and assessment need to be conducted between HMP Parc primary care and In-Reach Psychiatry teams, to ensure that all relevant information on the clinical history of the patient is available to both parties (e.g. to ensure that psychiatric colleagues are aware of risk of seizures, and that these colleagues make recommendations for prescribing that clearly document that risk has been considered in their assessment).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD5/1	Recommendation shared and teams reminded of the importance for enhanced communication and documentation between clinical teams providing care to prisoners at HMP Parc. A task and finish Group to be established to address the recommendation and to improve processes between clinical teams and to identify standardisation for referral and assessment to include patient's clinical history, prescribing recommendations, risk assessment and communication protocols.	Primary Care & Community	30.11.2024	30.11.2024	Partially complete (Overdue)	December 2024 Update - Progress and evidence: Email to be embedded. Findings from the task and finish group to be embedded. Awaiting approval via QPSE Feb 2025 - evidence embedded.	
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 IT&CT 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 13 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	31.12.2025	Partially complete	December 2024 Update - Stage 1 is complete, further stages on hold due to delayed national DHCW digital programme rollout - E-referral system (ERS) has returned to tender stage of national procurement. Dept working with IG leads on identifying clinicians/consultant Ophthalmology SRO to help drive this, need to identify HB/Digital representation on DHCW national EPB/ERS meetings and ensure feedback to Ophthalmology. 100% of HB primary care optometrists issued NHS email addresses (91% live) with new shared secretarial inbox at BGH to receive urgent referrals (from primary care [GP & optometry] & A and E) launching Jan 2025 (by line being decommissed) until ERS in situ. Dept continue to attend DHCW workshops to contribute to national ERS design. Due to significant national programme delays, a revised implementation date of 31/12/2025 is required. August 2024 Update - August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme. E-referral software under national tender, CTM contributing to DHCW's national working groups to establish necessary minimum standards of ERS. Primary care optometry M365/NHS email rollout progressing (84% live across HB) which will support direct email referral into secondary care (until ERS in place). No recent local progression with EPR rollout beyond glaucoma clinics (no OpenEyes business project manager), await EPR programme updates from DHCW.	Significant delays to national DHCW ERS programme rollout, still in tender stage with no publication of awarded contract as yet.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	The CHC's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. (Patient Referrals - Referral Process). All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD2/1	Primary care has produced and shared patient information on CTM social media platforms to explain changes in patient referrals and enhanced services now being delivered in primary care/closer to home. Recent recruitment of additional Optometry Advisor (jan'23) will support practices to improve communication and referral pathways for patients and will support practices where poor quality referrals are flagged. HES updates on waiting times are shared with practices via SEWROC to support conversations with patients and manage expectation.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 18/11/2024. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) A) Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate care pathway in a timely and efficient manner, avoiding unnecessary visits.	Healthcare Inspectorate Wales (HIW)/2017/141/MD3/1	Primary Care /HES have already established a number of referral refinement schemes within practices in CTM: • Independent Prescribing • Wet AMD • Diabetic Retinopathy • Glaucoma [develop existing service in place	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 18/11/2024. Fully complete (Awaiting approval- Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. Completed: all schemes are now established within CTM	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) B) Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways.	Healthcare Inspectorate Wales (HIW)/2017/141/MD4/1	Practices are notified when new local referral pathways are introduced and updates circulated to practices. Optometry newsletter to be produced in primary care and circulated 4 times a year. Accelerated Cluster Development will allow closer working for practices within clusters. CTM to hold first event jan'23	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 18/11/2024. Fully complete (Awaiting approval- Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) C) Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.	Healthcare Inspectorate Wales (HIW)/2017/141/MD5/1	> 90% of referrals come directly from optometrist with good communication between primary and secondary care. Optometry dept. working with OA developed letter templates to communicate insufficient referral detail to primary care for glaucoma referrals which has improved referral detail.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 18/11/2024. Fully complete (Awaiting approval- Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) A) Health Boards should ensure fiveback of diagnosis and a treatment plan is provided to referring optometrists following every referral made to the service, including whether a referral to a low vision service has been made.	Healthcare Inspectorate Wales (HIW)/2017/141/MD6/1	Optometrists are copied into all clinic correspondence for new patients when the referral has come from the optometrist in POWH - this will be done across all sites within CTM.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 18/11/2024. Fully complete (Awaiting approval- Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) B) Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible.	Healthcare Inspectorate Wales (HIW)/2017/141/MD7/1	Primary care to work with HES to identify where this is an issue within practices and provide support via OA to ensure appropriate information is shared in the referral. New recruitment OA to undertake referral audits to support this. Optometrists contact details are not always clear on the referral form, internal arrangements being made to monitor the quality and individually feedback to the Optometrists via Local advisor.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 18/11/2024. Fully complete (Awaiting approval- Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. Dec 23 update this will be an ongoing process. Optometry Advisors will continue to work with both practices and HES to ensure the submission of high quality referrals. Implementation of the EOR system will also support /improve referral process.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	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	Dec 2024 Update - completion delayed due to national DHCW digital eye care programme rollout delays. EPR implemented in community glaucoma pathway, practices provided with detailed case note/discharge summaries, allowing seamless transfer of care. New primary care optometry contract has defined new national datasets and discharge summary templates mandating minimum data standards on discharge to Optometry - to be implemented in CTM glaucoma, medical retina, and eye casualty pathways (by March 2025). National DHCW work ongoing to provide primary care optometrists with access to WCP (no published timeline). Due to national delays in EPR implementation, a revised due date of 31/12/25 is required. August 2024 Update - August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme.	National/DHCW Eye Care Digitisation programme setbacks delaying local implementation of EPR across both primary and secondary care.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	CHC reports concerns around lack of information provided within secondary care prior to treatment (Patient Referrals – Communication Following referral) - Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent.	Healthcare Inspectorate Wales (HIW)/2017/141/MD9/1	RCO leaflets provided about consent process in pre assessment Information leaflets provided for any eye emergency care Laser information Cataract information ECLO services Blepharitis leaflets FFA – Information Surgery information leaflets • CM08: Cosmetic Blepharoplasty • CM09: Cosmetic Ptosis Surgery • CP01: Cataract Surgery (phacoemulsification) with Monofocical Intraocular Lens Implant • CP02: Blepharoplasty • CP03: Glaucoma Surgery (Trabeculectomy) • CP04: Retinal Detachment Surgery • CP05: Corneal Transplant Surgery • CP06: Correcting a Squint (child) • CP07: Entropion and Ectropion Repair • CP08: Ptosis Surgery (adult) • CP09: Correcting a Squint (adult) • CP10: Ptosis Surgery (child) • CP11: Intravitreal (Anti-VEGF) Injection • CP12: YAG Capsulotomy • CP13: Removing a Chalazion • CP14: LASIK Surgery • CP15: Removal of Pterygium • CP16: LASEK Surgery • CP17: Macular Hole Surgery	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 18/11/2024. Fully complete (Awaiting approval- Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	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)	December 2024 Update - Service Manager continuing with regular FUNB updates at weekly RTT meetings. Approval for closure to be reviewed at Care Group SMT 20/12/24. August 2024 Update - No update received this period.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Healthcare Inspectorate Wales (HIW)/2017/141/MD11/1	Patients on the FUNB and New list are all given a HRF and target date. When booking clinics the booking office will filter by target date and HRF ensuring that patients are booked into the most appropriate sub-specialty clinic by priority status. However, we continue to hold significant risk with the FUNB cohort and further resource in terms of validation and capacity is required.	Planned Care	01.04.2024	01.06.2025	Partially complete	December 2024 Update - Glaucome waiting list validation of longest waiters completed, with appt prioritisation by clinical risk factor. Updated local HRF guidance to primary & secondary care in development, to be issued cross-sector to ensure all across HB are applying HRF consistently/appropriately (including at point of referral and transfer of care between sectors). Utilising HRF will be a new request for the primary care optometry profession - complete by Feb 2025. SOP for regular clinical validation of WLs in development - complete by June 2025. New admin post for Appointment Failsafe Coordinator approved under Glaucoma Diagnostic Hub Business Case, to ensure high risk patients are booked safely and timely across their long-term RTT journey (necessary to complete this action) - review funding award for this April 2025, estimated recruited in post date June 2025. Therefore a revised implementation date of 01/06/2025 is required. August 2024 Update - No update received this period.	Appointment Failsafe Coordinator role needs to be in post to ensure safe prioritisation and monitoring of follow-up patients - funding for this to be reviewed under later phases of approved Glaucoma Diagnostic Hub business case.
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: Rates 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	In progress	December 2024 Update - SBAR review of booking pathways/WL (& validation SOP) in development (due Feb and June 2025 respectively). Glaucoma team developing clinician guidance/training/posters on prudent FU intervals & appt booking, including the most appropriate clinic setting by clinical risk (due Feb 2025). A revised implementation date of 01/06/2025 is required. August 2024 Update - No update received this period. June 2024 Update - Validation both clinically and clerically ongoing for high risk patients initially. December 2023 Update - this work will be ongoing to ensure lists re kept up to date and 'clean' at all times. Ongoing review by the service manager to validated and ensure correct ratio of new and follow patients in all clinic templates.	

AMaT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
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)	December 2024 Update - Q&S historic harm review work continuing, completing outstanding NRI investigations and providing process learning for Ophthalmology team in readiness for end of fixed term project/handover (March 2025). Central team providing coaching for RCA investigations to Ophthalmology senior MDT and good uptake of HB RCA training in the team. Regular harm review and RCA quality assurance panels continuing, with good subspecialty consultant representation and input. Action to be reviewed for approval for closure at Care Group SLT 30/12/24. August 2024 Update - No update received this period.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) A). Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	Healthcare Inspectorate Wales (HIW)/2017/141/MD14/1	a) CTM has a well established optometry department which has a number of experienced, highly skilled and qualified optometrists working across glaucoma, medical retina, DRSS, unscheduled care, paediatric clinics and specialist contact lenses. Recent expansion of the service to include community optometrists on a sessional basis which has increased our capacity across these services whilst additionally improving training to community optometrists to in turn reduce referrals and improve referral quality. Hospital based optometry due to start implementing an optometry laser led pathway to improve SLT and laser capacity in the coming months.	Planned Care	01.04.2024	01.06.2025	Partially complete	December 2024 Update - Optometry-led laser pathway successfully implemented v12/12 with significant improvement in laser waiting times. MDT recruitment for glaucoma diagnostic hubs in progress (recruitment for phase 1 posts to be completed Jan 2025). Nursing workforce development in progress to expand roles and responsibilities of Band 2 HCSWs (with rebanding evaluation to Band 3, to be completed April 2025). Longstanding vacancies in Heads of Optometry & Orthoptics roles - given this significant obstacle to MDT workforce development, a revised implementation date of 01/06/2025 is required. August 2024 Update - August 2024 Update - Recruitment in progress for additional permanent non-medical staff to create additional capacity in glaucoma clinics (Band 3 tech, Band 4 tech, Band 6a Optometrist)	Longstanding vacancies in senior MDT Head of Optometry & Head of Orthoptics posts - obstacle to MDT workforce development.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HIW)/2017/141/MD15/1	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new-referral refinement pathway (CARROS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete	December 2024 Update - External funding (£236k) secured from HEIW to facilitate cross-sector optometry placements (under consultant mentorship) to further upskill local primary care optometrist workforce. Recruitment in progress for 0.2wte B4 admin coordinator to support this. Continued opportune use of dual sector/secondary care optometrist in primary care advisory role, for seamless intersector working. Strong consultant engagement in WGOS (primary care optometry contract) rollout of new pathways - glaucoma and AMD filtering (referral refinement) pathways now fully WGOS-compliant (autonomous in primary care). WG Transformation Funds (£57k) secured to support primary care optometry contract implementation (admin & clinician resourced). ECOS supporting Hydroxychloroquine Retinopathy Screening pathway implementation in primary care (due March 2025) and development of cross-sector Regional Coordinator role (for safe transfer of care of patients to primary care). Primary care contract implementation is complex and in many cases novel, and with secondary care stakeholder concerns - a revised implementation date of 31/12/2025 is required. August 2024 Update - August 2024 Update - AMD referral refinement pathway working well, moving to direct optometrist inter-practice referral 2/3/24 (currently coordinated by hospital team). This will reduce admin burden and shorten turnaround time for patients.	Safe and effective primary care contract implementation relies on cross-sector implementation of electronic patient record & referral systems - national programme delayed. Logistics and job description of regional coordinator role (1 post shared between 3 HBs) is not yet defined, and funding for this is fixed-term (2 years) with no plan from WG to support HBs with this beyond 2026 as yet. Secondary care stakeholder concerns regarding discharging patients from shared-care pathways to autonomous primary care management without EPR and adequate administrative support.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Health boards should learn from the experiences following progress made in other areas (Treatment – Initiatives to improve Capacity) A). Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from/with staff in other areas.	Healthcare Inspectorate Wales (HIW)/2017/141/MD16/1	Weekly performance meeting have been arranged between the Clinical Service Group Manager (CSGM) and Interim Director of Planned Care to discuss key performance measures and any ad hoc issues which arise. CSGM from other sites are in attendance for shared learning purposes. Any risks we have assessed in the service is held on the corporate risk register which we update regularly with mitigations to reduce the risks. We also provide regular updates on the above to the Quality, Safety and Risk Group, as well as to the Planned Care Recovery Finance Group and the Joint Executive Team Meetings.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2024 Update - CD fully engaged with national Ophthalmology CIN work, good cross-discipline/MDT representation/engagement in all CIN subgroups including CTM helping establish the first national Hospital Optometry Wales' forum (reporting to CIN), to raise the profile of the profession in Wales and share best practice. Local dissemination of new National Clinical Strategy for Ophthalmology complete, and good departmental attendance/engagement at strategy launch events. Action to be reviewed for approval for closure at Care Group SLT 30/12/24. August 2024 Update - No update received this period.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B). Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common theme/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)	December 2024 Update - strong CTM engagement with national Ophthalmology CIN, including ratifying national shared JDs, SOPs, letter templates etc. Learning from RCAs shared with national CIN leads. Non-medical injectors utilised since 2019, with an established SOP and training pathway. Action to be reviewed for approval for closure at Care Group SLT 30/12/24. August 2024 Update - No further update, complete. Not marked as fully complete as need CQRE sign off.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	ECLO – Limited capacity/cover (Service Support Staff – Eye Care Liaison Officer) Health Boards should ensure that there is ECLO for their eye care clinics at all times and consideration should be given as to whether one ECLO is sufficient for the eye care service.	Healthcare Inspectorate Wales (HIW)/2017/141/MD18/2	POW – RNSB ECLO coverage 4 days RGH / PCH / YCR – NHS ECLO for RGH, PCH, YCR – coverage 3 days ? Commissioning issue - ask Elizabeth Baadie	Planned Care	01.04.2024	01.04.2024	fully complete (Awaiting approval)	December 2024 Update - 2 x substantive ECLOs in post (1.4wte across all sites). Action to be reviewed for approval for closure at Quality & Safety Committee on Tuesday 21st January 2025. August 2024 Update - No further update, complete. Not marked as fully complete as need CQRE sign off.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Move 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	December 2024 Update - strong national engagement from CTM on this issue, including key role in national ESR workforce updates for Optometry. Longstanding vacancy in Head of Optometry post obstacle to continued workforce development for secondary care. Implementation of national primary care optometry contract (WGOS) continues to progress. In light of head of service vacancy, a revised implementation date of 01/08/2025. August 2024 Update - August 2024 Update - CTM Optometry presented proposal to develop a Welsh Hospital Optometry forum, at CIN June '24 which was well supported. Initial planning meeting to develop national subgroup reporting to CIN 6/9/24. Heads of Service vacancies (Optometry/Orthoptics) still ongoing.	Longstanding vacancy in Head of Optometry post an obstacle to continued optometry workforce development for secondary care.
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	December 2024 Update - Longstanding vacancy in Head of Optometry post an obstacle to continued workforce development for secondary care. Primary care optometrist filtering (referral refinement) pathways live for glaucoma & AMD, continued monitoring schemes for glaucoma & diabetic retinopathy (under WGOS transition), high volume IPOS (acute eye care) pathway continuing - all of which reduce secondary care appointment demand/improve referral quality. Cross-sector work underway to enable discharge/deflection of suitable patients from Eye Casualty to IPOS (further reducing secondary care pressures). In light of head of service vacancy, a revised implementation date of 01/08/2025 is required. August 2024 Update - Additional 8a optometrist for glaucoma services in recruitment.	Longstanding vacancy in Head of Optometry post an obstacle to continued workforce development for secondary care optometry.
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/MD1/1	A revised Emergency Pressures Escalation Plan has been drafted (6th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care & Community	01.10.2020	01.10.2020	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The Emergency Preparedness Resilience and Response Manager is following up with Operational colleagues on the development of the Emergency Pressures Escalation Procedure. Draft version is developed and confirmation of approval is being sought. Once confirmed this action will be marked as closed.	
Healthcare Inspectorate Wales (HIW)/2021/135	20/04/2021	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20295)]	The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure future compliance with mandatory training.	Healthcare Inspectorate Wales (HIW)/2021/135/MD1/1	85% of applicable staff groups will be fully compliant with mandatory training in PMVA, ILS/BLS and Fire training. Progress towards this target and future training compliance rates will be managed using ESR and monitored through line management arrangements. Deviation from the proposed improvement trajectory and failure to maintain the target levels of compliance will be escalated at Clinical Service Group Performance Review meetings. Mandatory training compliance to be included as a standing agenda item during line management sessions. Compliance to be reported on and monitored in the Clinical Service Group (CSG) Workforce and Organisational Development meeting and ILG Performance Review meeting.	Mental Health & Learning Disabilities	30.08.2021	30.07.2021	Fully complete (Awaiting approval)	December 2024 Update - action completed CQRE Sept 2023. October 2024 Update - Closed – developed mandatory training monitoring as part of discharge review. August 2024 - Ongoing monitoring via the MHLD Care Group in relation to compliance	
Healthcare Inspectorate Wales (HIW)/2021/137	30/06/2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must 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/MD1/1	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)	December 2024 Update - Plan to complete TOR within the physical health improvement forcus group and to then close by Feb 2025. October 2024 Update - Remains open to discuss at next QRSE. August 2024 - MHLD has one outstanding action to be discussed at next QRSE in September 2024.	
Healthcare Inspectorate Wales (HIW)/2021/138	20/07/2021	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	The health board must provide assurance on how it will meet principle nine outlined by the Chief Nursing Officer for Wales for at least two registered nurses to be rostered every shift, or if determined as not necessary, that there must be the ability to deploy a second registered nurse without delay.	Healthcare Inspectorate Wales (HIW)/2021/138/MD1/1	Undertake a review of the night time staffing resource across the rehabilitation service in CTM and develop an options appraisal to address the risk of one registrant by night.	Mental Health & Learning Disabilities	30.11.2021	30.11.2021	Fully complete (Awaiting approval)	December 2024 Update - completed Nov 2021, when under RTE ILG. October 2023 Update (Date of Review: 20/10/2021) - Further to discussions with the Head of Mental Health Nursing it has been advised that that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however, continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times.	
Healthcare Inspectorate Wales (HIW)/2021/138	20/07/2021	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	The health board must provide assurance of its plans to ensure all staff are fully compliant with their mandatory training as soon as possible.	Healthcare Inspectorate Wales (HIW)/2021/138/MD2/1	Review all core competencies across the rehab service with an improvement plan for 85%+ compliance.	Mental Health & Learning Disabilities	30.11.2021	30.11.2021	Fully complete (Awaiting approval)	December 2024 Update - COMPLETED NOV 2021 WHEN UNDER RTE ILG. October 2023 Update (Date of Review: 14/10/2021) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&D department: 1) Review hierarchy lists; 2) Ensure Group alignment numbers are correct; 3) Look at appropriate required compliance and accurate records and L&D department will take forward to the subject experts on teams' behalf. Regular meetings with new L&D representatives to address and correct the issues associated with core mandatory training compliance.	
Healthcare Inspectorate Wales (HIW)/2022/129	01/11/2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report [Announced] Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 31893)]	The health board must ensure that medical staff complete all safeguarding related refresher training in a timely manner	Healthcare Inspectorate Wales (HIW)/2022/129/MD5/1	All medical staff to attend 'Safeguarding People' Day	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	December 2024 Update - Completed, approved through CQRE November 2024. August 2024 Update - remains overdue Medical staff booked in to attend 'Safeguarding People Completed approved through CQRE	
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection [Announced] Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Healthcare Inspectorate Wales (HIW)/2022/131/MD1/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Business Case currently on hold as from early September 2024, there will be a temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW) to allow for essential maintenance works on both units. This action will be revisited in January 2025.	
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection [Announced] Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	Risk assessments are undertaken and recorded in patient records. Medical discussion and decisions are accurately recorded in patient records.	Healthcare Inspectorate Wales (HIW)/2022/131/MD4/1	The specific areas of risk assessment, medical discussions and decisions will be added to the record keeping audit and all service medical staff to participate in this annual audit to drive multi professional improvement in this area.	Children & Families	01.08.2022	01.08.2022	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Update requested from the Medical Director in the Children and Family Care Group. September Update (Date of Review: 08/09/23) – email sent to Medical Director of care group for advice on how to progress this recommendation.	
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection [Announced] Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Additional welfare support is available for IOT staff.	Healthcare Inspectorate Wales (HIW)/2022/131/MD6/1	Workforce team asked for specific resources for IOT staff going forward.	Children & Families	01.06.2022	01.10.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - IOT update to be taken to next Care Group Workforce meeting on the 28th August and the Local Partnership Forum. September Update (Date of Review: 08/09/23) - email sent to care group's People's Services Lead to advice on progress with this recommendation.	
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection [Announced] Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: The backlog of incidents are cleared and consideration of further funding should continue.	Healthcare Inspectorate Wales (HIW)/2022/131/MD7/1	Incident backlog due to be closed by 31.5.22. Service agreed target: All incidents managed and closed within 3 months – using Datix action tracker for ongoing work.	Children & Families	01.06.2022	01.10.2023	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.	
Healthcare Inspectorate Wales (HIW)/2022/133	17/10/2022	Hospital Inspection Report [Unannounced] Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Healthcare Inspectorate Wales (HIW)/2022/133/MD1/1	Plan to work with corporate nursing team to review options of creating a digital solution for audit surveillance and daily checks to further improve oversight of status.	Unscheduled Care	01.02.2023	01.02.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use. June 2024 Update - We have progressed towards standardised audits on AMaT across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved.	
Healthcare Inspectorate Wales (HIW)/2022/133	17/10/2022	Hospital Inspection Report [Unannounced] Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Healthcare Inspectorate Wales (HIW)/2022/133/MD1/2	Work with Care Group Directors of Nursing and Midwifery and Heads of Nursing across the three acute sites and community hospital sites in establishing a consistent model of surveillance and checking practice.	Unscheduled Care	01.12.2023	01.12.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use. June 2024 Update - We have progressed towards standardised audits on AMaT across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved.	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 20230301)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MD18/1	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Overdue	December 2024 Update - progress is being made, remains ongoing at this time. October 2024 Update - Currently in process of drafting a local business case for CTM/UHB to move rapidly with our own procurement process to obtain the single clinical record. August 2024 Update - this remains on going	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 20230301)	Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MD23/2	This standard is explicit within the Health Board Discharge Procedure (MH40) standards.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved as complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 20230301)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Healthcare Inspectorate Wales (HIW)/2023/130/MD28/6	Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved as complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 20230301)	Recommendation 33 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	Healthcare Inspectorate Wales (HIW)/2023/130/MD32/3	The care group uses a range of methods to seek feedback and input form the staff group. A programme of feedback and analysis of a regular Staff wellbeing survey is coordinated by the Health Board Peoples Services, a senior Business partner of which works alongside the care group leadership team. Triangulation of these methods will enable the care group to more fully evaluate impact of the measures implemented.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved as complete November 2023 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.	

AMaT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 35 The health board must ensure that the audit process is reviewed within its mental health services, and that a robust and sustainable audit action management plan is implemented (as applicable), to ensure actions are monitored and to assure itself that implemented improvements are being sustained.	Healthcare Inspectorate Wales (HIW)/2023/130/MD34/2	This resource will be work in partnership with the clinical teams to embed both a culture of improvement and shared learning. Engagement with staff at all levels will be a key objective of this team.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved as complete November 2023 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant CQRE meeting.	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board-wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/1	The oversight of this recommendation will be via the Policies Group. The newly established Policy Review group will have an operational scope to: •Review & RAG all of existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review Following agreement of ToR at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	December 2024 update - currently 16 policies to update. October 2024 remains on going to discuss further at CQRE August 2024 Update - •21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •16 under review (17 have slipped completion dates from June/July to Sept/Oct/Nov 24) as below:	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board-wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/2	Mental health policies will follow the agreed organisational process for ratification. All MH specific policies were reviewed by 1 June 2023 and of the 40 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 42 current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	December 2024 Update - 16 policies remain to be updated. October 24 - . 21 policies up to date . 31 ,under review 12 awaiting approval August 2024 Update - 21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •16 under review (17 have slipped completion dates from June/July to Sept/Oct/Nov 24) as below:	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	Healthcare Inspectorate Wales (HIW)/2023/130/MD38/1	The oversight of risk registers will be dually via the Care Group Quality Safety Risk and Experience Group and the Performance, Planning and Finance Group. Accountability for the management of risk registers at Clinical Service Group will be via operational leaders	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved as complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant CQRE meeting.	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	Healthcare Inspectorate Wales (HIW)/2023/130/MD38/2	The organisational risk register includes risk with a score of over 15. The organisational risk register has been reviewed across the Health Board. Aggregate workforce shortage and training risks are included for CTM. Specific Mental Health risks including clinical records and environmental risks are recorded on the organisational risk register. Risk registers with scores over 12 are monitored at Care Group level via Quality Safety Risk and Experience Group – (see Appendix 1 for governance arrangements), and all other risks are monitored via the Clinical Service Group performance arrangements. The Head of Quality and Safety will lead an operational care group governance meeting to monitor compliance with Putting Things Right, action plans and risk review timescales. Agenda item in performance meeting at senior nurse level in order to encourage escalation and culture of owning risks and mitigation as local level.	Mental Health & Learning Disabilities	30.11.2024	30.11.2024	Fully complete (Awaiting approval)	December 2024 Update - Approved as complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant CQRE meeting.	
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 38 The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	Healthcare Inspectorate Wales (HIW)/2023/130/MD37/1	The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental health Governance lead will establish a working group with the Lead Nurses and Local Authority heads of service to develop a mechanism for multi-agency incident reporting.	Mental Health & Learning Disabilities	30.06.2023	31.10.2024	Fully complete (Awaiting approval)	December 2024 Update - this was completed in QRE October 2024. August 2024 Update - No update received this period. February 2024 Update - Update from Business Intelligence Team that they have explored ways for a social worker to be able to access the incident module of Datix, however a solution has not been found. Action agreed: SOP to be developed to describe the process for feedback, learning and actions to be shared with social workers as applicable. Previous Update - The Mental Health Care Group is exploring a way for social workers to be able to report incidents directly through Datix with the Health Board Governance Team and ICT team. This has been delayed by issues with allowing non HB personnel access to HB and NHS systems and organisational changes to the CTM governance and Datix teams. In the meantime, a process for reporting and feeding back on social worker identified incidents in multi-agency meetings and so that learning can be shared will be implemented.	
Healthcare Inspectorate Wales (HIW)/2023/134	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: 3899)	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)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - CDU BLS - 94%, ILS 40%. ED BLS - 80% ALS 65% CDU - Clinical Decisions Unit- (BLS) Basic Life support (ILS) Immediate Life Support (ED) Emergency Department (BLS) Basic Life support (ALS) Advanced Life Support.) February 2024 Update - CDU compliance ILS 40% (RN), BLS 68% and ED compliance ILS 43.75%, BLS 76%. It is important to note the RN's undertake ILS training and therefore BLS is not required - ESR Mandatory Training requires updating. Please note there has been 10 wte New Starters in the last 6 weeks, hence reducing the compliance rate - there is a plan to improve. Partially Completed – review date June 2024 (new recruitment has reduced trajectory of compliance as described). Previous Update - 65% compliance aim November 2023 with 100% compliance February 2024.	
Healthcare Inspectorate Wales (HIW)/2023/140	16/05/2023	HMP Parc Prison	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken. To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. October 2024 - Discussion with Head of Healthcare within HMP Parc, chaser email sent to GP contractors to request update on process with implementation of recommendation.	
Healthcare Inspectorate Wales (HIW)/2023/140	16/05/2023	HMP Parc Prison	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MD7/1	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include- flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. September 2023 Update - No update received August 2024 Update - Ongoing with Pharmacy lead and GP in HMP parc.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should engage with each other, to learn from the good patient education practice taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	Healthcare Inspectorate Wales (HIW)/2023/155/MD1/1	CTM UHB continues to work in partnership with Cardiff and Vale UHB in the Regional Network for stroke services and have collaborated on cross-health board workshops to share and learn from good practice for service development, including patient education. The Health Board will continue to engage in the national network for stroke to ensure that we work together with other Health Boards across Wales to develop and share good practice and learning for the benefit of our patients and teams. Work continues in our GP Practices to target patients at increased risk of stroke and we continue to build on this as part of CTM2030 and our Acute Clinical Services Plan. Governance and reporting have been refreshed and strengthened, with learning fed back through the CTM UHB Stroke Operational Group and Stroke Performance Board into the Stroke Strategy Group for implementation across the Health Board area.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms part of long term engagement and partnership working via the stroke programme board. Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	Healthcare Inspectorate Wales (HIW)/2023/155/MD2/1	This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - "This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support. Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and PHW should work closely with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Healthcare Inspectorate Wales (HIW)/2023/155/MD3/1	CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - "CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan." Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD5/1	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily Safe2Start meeting which provides assurance around site based escalation, staffing, patient safety and clinical priorities. The meeting allows the identification of clinical priorities, including stroke patients, and time frames for movement to appropriate inpatient beds. All patient flow constraints are discussed and risk is shared across the acute inpatient wards and community sites in order to balance risk within the Emergency Department. This remains an action-focused meeting, with clear ownership and delivery prior to the afternoon meeting. As part of this work, under the 6 Goals national programme, the Safe2Start template has been revised to include 'SAFER, Red2Green and both internal and external delay metrics. There was a delay in launching the new template due to access required into SAFECARE to display nurse staffing levels, this is being worked through by informatics colleagues with the new template expected to be completed and implemented by November 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Optimise, a programme of work under the national 6goals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Unscheduled Care	01.11.2023	01.11.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every other Q&S committee as part of the board update.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales (HIW)/2023/155/MD6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD7/1	Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this action is not being progressed as - Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed. Ongoing 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must 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 specialty demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - we remain in collaboration with the NHS exec on this however as an organisation we do not yet have predicted demand modelling available to us which constrains our ability to progress this work.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	Healthcare Inspectorate Wales (HIW)/2023/155/MD9/1	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into specialty and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. Revised Due Date - In 2024/25 timescale dependent on resource availability Timescale in 2023/24-exact timescale dependent on resource availability August 2024 Update - CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into specialty and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD10/1	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within ward 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 board meeting. This piece of work is Optimise and focuses of value added care. This work is ongoing and is large scale transformation with a detailed project plan and times lines for implementation that are monitored via 6goals Board.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - a proposal has been shared with the board for extension of the CNS workforce with Senior nurse oversight. this requires resource allocation. November launch. Full implementation 24-25.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Healthcare Inspectorate Wales (HIW)/2023/155/MD11/1	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD12/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this work remains a focus and is part of ongoing discussions as programme board - Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke. Revised Review - August 2024. Ongoing implementation. Review March 2024 Implementation October 2024	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	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	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - collaborative work with WAST in relation to patient pathways is ongoing.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD14/1	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support. Ongoing-targeted improvement	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Case submitted to Board in January 2024 and rejected - Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway. Ongoing 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - case submitted to board in January 2024 - Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients. Ongoing 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - remains ongoing with digital team - Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board. January 2025	

AMaT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
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	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this remain a priority - Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - USC Care Group continue to work towards equity across our sites and this forms part of stroke programme board discussions.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/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	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this work is continuous - The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address. Revised Due Date - Ongoing, 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD25/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - USC Care Group continue to explore regional solutions however this remains multifaceted and complex - Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants. Ongoing 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at POH this in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this work is ongoing as was a focus as part of the recent 'reset fortnight' - As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at POH this in continuously monitored and re/evaluated as required.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this continues to be a priority - As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD31/1	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed. Revised Due Date - 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this remains ongoing - This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 30. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this remains ongoing - CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 30. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - we continue to review this as a risk - Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD38/1	As part of the DORA 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 ICMB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - significant work ongoing under the optimise project to address MCA challenges with supported intervention from Head of nursing to maintain training and standards on their sites.	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (**table removed for AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this is ongoing - Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (**table removed for AMaT purposes).	
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	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this is ongoing but being prioritised - "A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director."	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD42/1	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this remains ongoing and requires capital funds - The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required. Ongoing 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update -As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required. Ongoing 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD44/1	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this work is ongoing with digital colleagues - The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged. Ongoing 2024/25	
Healthcare Inspectorate Wales (HIW)/2023/156	25/09/2023	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	The health board should display information on healthy eating and smoking cessation.	Healthcare Inspectorate Wales (HIW)/2023/156/MD2/1	Health promotion board on display on Childrens ward. Healthy diet and smoking risks, with signposting for additional advice and support will be added to the health promotion board.	Children & Families	31.12.2023	31.08.2024	Fully complete [Awaiting approval]	December 2024 Update - Display boards received and now invite, all parts of action completed. August 2024 Update - refurbishment of area now complete. Awaiting display boards and once in situ this action will be completed. May 2024 Update - The above iteration was actioned December 2023- However the childrens ward is currently undergoing refurbishment of the painting and decorating in the area new display boards are being purchased and the Health promotion elements of the action will be a priority on completion of the estates works. New timescales added.	
Healthcare Inspectorate Wales (HIW)/2022/157	13/11/2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Healthcare Inspectorate Wales (HIW)/2023/157/MD2/1	Angelton Clinic has a dedicated Physiotherapist. We have identified an area within Angleton Clinic to be used to support physical exercise, patient health and promotion. Appropriate equipment has been identified and is in place.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete [Awaiting approval]	December 2024 Update - Care Group agreed completed 28/12/2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.	
Healthcare Inspectorate Wales (HIW)/2022/157	13/11/2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should consider reinstating the hospital's dedicated wheelchair accessible vehicle to promote timely patient care.	Healthcare Inspectorate Wales (HIW)/2023/157/MD3/1	Angleton Clinic has always had access to a Wheelchair accessible vehicle however unfortunately it was inselved in an accident and wasn't repairable, a replacement is on order.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete [Awaiting approval]	December 2024 Update - Care Group agreed completed 28/12/2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed 28/12/2023 See Appendix 3	
Healthcare Inspectorate Wales (HIW)/2022/157	13/11/2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must undertake measures to improve mandatory Welsh language training compliance.	Healthcare Inspectorate Wales (HIW)/2023/157/MD4/1	Welsh Language Awareness training levels to reach a minimum of 85% whilst working toward 100% Ward 1 is currently 100% Ward 2 is currently 78.5%	Mental Health & Learning Disabilities	01.01.2024	01.01.2024	Fully complete [Awaiting approval]	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. April 2024 Update - Ward 1= 92% Ward 2=91.18% Previous Update - In Progress Estimated date for completion January 2024 See Appendix 4	
Healthcare Inspectorate Wales (HIW)/2022/157	13/11/2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure that hospital systems and processes can be suitably filtered to extract ward specific data to support effective supervision, governance oversight and shared learning.	Healthcare Inspectorate Wales (HIW)/2023/157/MD34/1	The incident management system Datix Cloud IQ can be filtered down to show specific data relating to areas, incident type and severity. The Head of Nursing is working with the Patient Care and Safety Business Intelligence officer to ensure all Lead Nurse, Senior Nurse and ward Managers have access to and training on Datix dashboards.	Mental Health & Learning Disabilities	31.01.2024	10.07.2024	Overdue	December 2024 Update - remains on going has been escalated to Nigel Downes and Greg Dix. October 2024 requiring updates to national system. August 2024 Update - The HoN is working with the Business Intelligence Manager in the Patient Care and Safety team on the development of a Quality Dashboard, the mapping of the new Care Group structure is complete and we are awaiting implementation. June 2024 Update - Working with Corporate and Patient Care Safety to align DATIX to new structure. Action updated as at May 2024 - Update10/05/2024 The Head of Nursing continues to work with the Datix team regarding this action. The new care group structures have created some delay. Revised completion date set for 10/07/2024. April 2024 Update - In progress. Work is ongoing between the head of nursing and the Datix team. Previous Update - In Progress Due for completion end of Jan 2024	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 23, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.	Healthcare Inspectorate Wales (HIW)/2023/158/MD1/1	The Health Board has reviewed the current ward environment. With consideration of the ward footprint, clinical need and bed capacity within the Adult Mental Health Directorate it is not possible at present to provide a fully single bedroom inpatient provision. To mitigate potential impact of the present arrangements the nursing teams ensure that all shared rooms are single sex, with identified curtained private space for each person. The specific need for single rooms is identified at point of admission/assessment, with consideration of individual need i.e., gender, sexual orientation, or physical need/risk, and care plan developed as required. The nursing team identify patients who wish to have shared rooms e.g. for company. If requested, an individual room will be provided when available and if there is no other pressing clinical need.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete [Awaiting approval]	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 23, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.	Healthcare Inspectorate Wales (HIW)/2023/158/MD2/1	The Health Board undertakes a fair and equitable recruitment process, in order to ensure that all staff are employed based on the qualities, values, skills and the experience they demonstrate during recruitment. It is, of course, not lawful to discriminate or make such decisions based on gender. The Royal Glamorgan Hospital (RGH) Senior Nursing team work across adult and older persons wards and will support each ward to ensure that there is an optimal skill, and when possible, gender mix. All shift requirements are monitored at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate Prevention and Management of Violence and Aggression (PMVA) trained staff on shift. Daily Huddle Documentation; Evidence 1 There is opportunity to alter staff skill and when necessary, gender mix to address needs of an individual e.g. If patient is sexually disinhibited or targeting staff due to gender. In extremis the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and CAMHS Mental Health wards, and there have been examples of recent good practice.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete [Awaiting approval]	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 23, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.	Healthcare Inspectorate Wales (HIW)/2023/158/MD3/1	It is a priority of the Health Board to support the communities we work with to make positive decisions about their health, and we maintain a commitment to support all patients and staff to give up smoking. Since the "Smoke-free Premises and Vehicles (Wales) Regulations 2020" came into force in the Mental Health Unit (MHU) in September 2022, smoking on there has been prohibited. Following implementation, the significant challenges this presented to individuals who found smoking cessation measures to be ineffective or unwelcome were noted, and after discussion with staff and patients the Mental Health Smoking Cessation group agreed that in the RGH MH unit we would create small designated outside smoking areas for restricted use. This seemed to be well received by the patient group, but following an anonymous concern being raised with the Health Inspectorate Wales in summer 2023, this arrangement was halted while the measures were reviewed. Following presentation of a mitigating paper to the Health Board Executive Leadership Group, a "Derogation in compliance" was agreed for a period of six months while the Mental Health Care Group develop options for a permanent solution across all Mental Health sites. It is recognised by the Health Board that this temporarily contravenes the Smoke-free Premises and Vehicles (Wales) Regulations 2020. Mental Health Directorate Smoking Mitigation Paper; Evidence 1.1 Practically, on the RGH MHU, this means that there is an availability of managed smoking sessions at designated times in a space within the footprint of the MHU on the patios/terraces directly off the ward corridor. This is an arrangement that is clearly documented within the care plan of all patients who identify this as being their wish following smoking cessation assessment. The conditions and restrictions of the designated smoking area are made clear to all patients and signposted across the wards. Ash trays are being purchased for designated smoking area, there is a bin currently in place as an alternative. Patio Photo; Evidence 2 Patio Photo; Evidence 3 There is routine discussion within the patient community groups around smoking arrangements and support by the patient groups of self-regulation of cleanliness of such areas by smokers. This is checked by ward staff regularly and extraordinary cleaning requested of facilities if required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete [Awaiting approval]	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	

AMaT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that a full review is undertaken on the appropriateness and reliability of the current personal alarm systems used.	Healthcare Inspectorate Wales (HIW)/2023/158/MD5/1	At time of the HIW inspection (November 2023) there was an Standard Operating Procedure (SOP) in place that directed that a dual personal alarm system was in place on the RGH MHU for all clinical staff. This was due to a recent increase in the frequency of incidents whereby the panic alarm failed to activate when tested. MHU Dual Alarm SoP; Evidence 6 A full diagnostic review of the "all call" system was undertaken in November 2023, with the system noted to be returned to a serviceable and operational state. This issue however remains on the Directorate Risk Register for the immediate future and incidents of alarm failure will be reviewed and reported via the Datix system. The SOP also remains in place on the MHU. A review of any activation failures will be undertaken by the MHU Inpatient Senior Nurse and Assistant Directorate Manager for inpatient services for discussion at Directorate Quality Safety Risk and Experience meeting (QSRE) in June 2024. Subsequently a decision will be made by the Adult Mental Health Senior Leadership Team as to whether the Safe System of working for a dual alarm system can be stepped down or will remain in place with the risk remaining on Directorate Risk Register.	Mental Health & Learning Disabilities	30.06.2024	30.09.2024	Fully complete (Awaiting approval)	December 2024 Update - completed QSRE July 24 October 2024 completed approved in QSRE Evidence to follow COMPLETED JULY 24 August 2024 - Update requested. June 2024 Update - update due in August 2024.	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must address the environmental issues and resolve them in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2023/158/MD6/1	The ward 22 damaged chair, with exposed foam filling which is not compliant with the relevant legislation has been condemned and removed with a temporary replacement now in place. A specialist furniture manufacturer has provided a quotation for new seating within the interview room and a Statement of Need submitted. Ward 22 interview Room Photo; Evidence 7 Psychiatric Intensive Care Unit (PICU) missing ceiling tiles have now been replaced. PICU Ceiling Photo; Evidence 8 Water damaged ceiling tiles in the Ward 22 office have all been replaced. There remain 6 water damaged tiles between the lounge & dining room awaiting replacement which have been logged with Estates Department. These have been prioritised by Estates as non-urgent, as they are considered decorative rather than safety sensitive, and the progress on replacement is monitored weekly by the Inpatient Deputy Directorate manager Ward 22 Ceiling Photo; Evidence 9 Ward 22 Ceiling Photo; Evidence 10 After consultation with a specialist furniture manufacturer the Inpatient Senior Nurse confirmed the suitability of the dining chairs currently in place in Ward 22.The dining room chairs are multipurpose and need to be moved between dining room and lounge for group discussions/activities and therefore need to be of a manageable weight. The Adult Mental Health Senior Leadership Team acknowledged that the weight of the current chair would allow them to be picked up and potentially brandished as a weapon, however this risk would not be completely eradicated unless the chairs were of a weight that would disadvantage patients with mobility restrictions and potentially increase risk of injury to staff when moving for cleaning purposes. The [nursing team mitigate risk of furniture being used in this way through individual risk assessment and maintaining observation of these areas when in use. Ward 21 bedroom rails and privacy curtains have been replaced. Ward 21 Curtain Photo; Evidence 11 There are long-standing difficulties with inadequacy of wastewater/ sewage capacity within the RGH MHU site. As a result, the PICU Extra Care Area (ECA) utilises a Sani-flo macerator system to move waste from ECA to the main sewage system. This can result in issues when foreign objects are placed in toilet in ECA. Groundwork investigations report that a permanent solution to connect ECA to main sewage system would require extensive excavation works with significant capital spend and long-term closure of the PICU. The Adult Mental Health Senior Leadership are of the opinion that this is not viable at present due to disruption of service. The development of a new Mental Health Inpatient facility remains on the Health Board Risk Register	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Healthcare Inspectorate Wales (HIW)/2023/158	The health board must ensure that COSHH equipment is stored correctly.	Healthcare Inspectorate Wales (HIW)/2023/158/MD7/1	All wards on the MHU have flammable lockers where all laundry detergents are stored. It is the responsibility of all Health Board staff to be aware of and undertake their responsibilities when using COSHH materials. The Inpatient Senior Nurse has emailed a reminder to all staff including HCSW about COSSH and requirement re storage. Standards for storage of COSHH materials; Evidence 13 Checks on the environment are undertaken by ward managers as part of weekly environmental checks (Ward Managers Assurance Audit) and matters of concern addressed with staff at the time or escalated in line with MHU Maintenance SOP; Evidence 12	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that out of date medication is disposed of appropriately.	Healthcare Inspectorate Wales (HIW)/2023/158/MD8/1	Following the HIW Review in November 2023, all medication cabinets across the MHU were inspected and no further out of date medications were found. Review of all medication dates and returns to pharmacy is monitored through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 14 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that MAR charts are fully completed.	Healthcare Inspectorate Wales (HIW)/2023/158/MD9/1	Inpatient Senior Nurse and Mental Health pharmacist will revisit the role of pharmacist technician to ensure that review of MARS charts will be included in their routine checks. An email has been sent by the Clinical Director to all medical team to reaffirm the documentation standards required on clerking and reviewing medication. A sample of MARS charts are reviewed through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 15 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 update - QSRE November 2023 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the wards and in clinical rooms.	Healthcare Inspectorate Wales (HIW)/2023/158/MD10/1	Reminder email from Senior Nurse reminding staff of agreed standard Safe Storage of medication; Evidence 16 Security arrangements of medication trolley are reviewed through the "Ward Managers Assurance Audit" which is undertaken monthly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that there are more variety of choices for patients with specific dietary requirements.	Healthcare Inspectorate Wales (HIW)/2023/158/MD12/1	All Health Boards in Wales follow a menu which is based on The All-Wales Catering & Nutrition Standards. The Health Board Catering Service works with clinical teams to adapt the patient menus to patient specific requirements. The present patient menu changed in September 2023 to a two-week rolling menu which replaced an 'a la carte' style menu. The new menu was reviewed by the All-Wales dietitians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing teams seek feedback from patients via the Inpatient Community Group and "Have Your Say" suggestion boxes (which are regularly monitored). This feedback informs discussions with the wider service i.e. Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Team recognise the need to increase the frequency of the menu review and change and are currently working on the new version for 2024.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HIW)/2023/158/MD13/1	The Mental Health Head of Nursing has recently concluded a thorough nursing establishment review that has considered levels of acuity and demand across the Mental Health Inpatient units. This review acknowledged the changing picture of inpatient work and environments since the last Mental Health inpatient staffing review in 2017 and recognised the challenges of maintaining a motivated and engaged workforce when pressures within these clinical settings are increasing. Using principles drawn from All Wales Mental Health Workstream on the implementation of the Nurse Staffing Levels Act, the report makes recommendations about amendments to skill mix and enhancement of Nursing leadership roles the better to improve opportunities for recruitment and particularly staff retention. The Staffing review report will be presented to the Mental Health Nursing Workforce meeting on 25 January 2024, for consideration by Director of Nursing on subsequent actions. Considerations of staffing levels day to day are a core role of the Ward Managers and Senior Nurse, with all shift requirements monitored initially at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate staff on shift. Review of clinical need is a dynamic process that involves all members of the Nursing team, and staffing levels are increased in response to increased levels of acuity e.g. 1:1 patient observations to maintain safety or a need for intensive personal care. At this time, there is an organisational acknowledgement of the particular challenges to recruitment of unregistered nurses into Mental Health posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate. While there is a high degree of scrutiny around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QSRE 28.12.23 complete. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
Healthcare Inspectorate Wales (HIW)/2023/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage recruitment into the hospital.	Healthcare Inspectorate Wales (HIW)/2023/158/MD16/1	Recruitment of band 5 registered nurses remains a challenge and the HB is taking steps to ensure that all vacancies are being filled. The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are currently exploring the financial implications and opportunities of the recommendations. The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maximise SSP opportunities for recruitment.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QSRE 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting. Completed	
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: 3395)	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	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - capital work ongoing - PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience. Delayed due to major capital works on site to December 2024.	
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3395)	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/MD5/5	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	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - work ongoing Awaiting date from Welsh Government following a successful bid for Funding. This will supply an extra toilet and showering facilities.	
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3395)	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	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - part of ongoing capital plans - We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3395)	The health board is required to provide HIW with an update on the systems in place to improve patient flow through the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD11/1	We are currently reviewing through large organisational change, the operational structures that will be key to patient flow and ensure senior leadership is present on site and pan CTM Health Board. Through the 6 goals programme work we are progressing improved patient flow as this is a multi-professional/whole system approach involving our Local Authority colleagues. The E White Board has been introduced across the organisation and this is key to patient flow and implementation of Red2Green as a quality metric for patient care. This will increase bed capacity through more efficient and sustainable processes where we explore value added time, measure internal and external delays and focus on marginal gains in length of stay. Consequently, this will improve flow through ED. As part of this work the senior team are also exploring the continuous flow model to review if this would be suitable for roll out across CTM. The ED Team use the Myndsyn IT System which is monitored by the responsible teams and reviewed as part of the ED Patient Safety Huddles. When it is identified that Triage Times are beginning to increase, there are internal escalation processes in place to ensure timely support and assessment of patients which additional staff being deployed to support. The ED Clinician Team will adopt a Rapid Assessment and Triage (RAT's) model to support any delays in triage, hence there will be senior assessment and streaming at the front-door of patients. ELI has recently recruited 2.8 wte Patient Flow Coordinators to support timely patient flow and escalation of patient flow delays. The USC group have developed updated Escalation Cards to support actions and provide assurances that ambulance delays are avoided. There are rigorous escalations in place, and when any patient is delayed over 4 hours an internal investigation is undertaken to provide assurances that no harm has occurred.	Unscheduled Care	01.03.2024	01.03.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - this work is ongoing - This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues. This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues.	
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3395)	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/MD20/1	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-RYN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months. ED MCA now 77% and fire 85% Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. ED MCA compliance is 56% and Fire is 76% (MCA overall compliance is reduced as a result of a number of newly recruited Registered Nurses and Health Care Support Workers, yet to complete training). There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.	
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3395)	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	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months. CDU fire is 100% Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.	
Healthcare Inspectorate Wales (HIW)/2024/165	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/7	g)Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024	01.02.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW). Commenced September 2023. Due for completion February 2024. A meeting took place with the lead nurse for Perioperative services and Finance to explore the feasibility for perioperative services to cover emergency and elective theatres 24/7. costings did not align with funding. The financing is now being revised to cover 3 elective theatres in the first instance, with meetings being arranged for May 2024	
Healthcare Inspectorate Wales (HIW)/2024/165	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/9	i)Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool.	Children & Families	31.01.2024	31.01.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation. Review of safe care tool has been undertaken to ensure that red flags according to NICE safe staffing 2015 are included in the tool	
Healthcare Inspectorate Wales (HIW)/2024/165	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/10	j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM/ UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.	
Healthcare Inspectorate Wales (HIW)/2024/165	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/17	q)The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.	
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	UNICEF Baby Friendly Initiative The health board must work to achieve the UNICEF Baby Friendly Initiative reaccreditation.	Healthcare Inspectorate Wales (HIW)/2024/166/MD1/1	There are dedicated infant feeding co-ordinators in place across the perinatal services who are working together toward BFI reaccreditation. The service is currently undertaking a number of audits in readiness for re-assessment which is planned for April 2024. Recent PREM data shows that infant feeding experience is positive. The service has implemented a feeding voice partnership.	Children & Families	01.05.2024	01.05.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - In response to a recent positive inspection audit there are a few actions underway. Accreditation being sought in the next couple of months.	
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/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	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW)	

AMaT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 036D3)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/8	Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool	Children & Families	31.01.2024	31.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.	
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 036D3)	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)	December 2024 Update - An update against this recommendation has not been provided on this occasion. Update 11/9/24 Filming of staff has commenced, currently on hold due to pressures due to PoW temporary closure. August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.	
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 036D3)	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)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.	
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 036D3)	Data reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	Healthcare Inspectorate Wales (HIW)/2024/166/MD13/1	All moderate and above are reviewed by the MDT and SMDT. A review of all no and low level incidents is underway to explore any emerging themes, trends and ensure that the service is addressing any concern / incident in a robust manner. A wider review of governance process is underway to ensure that there is sustainability and assurance in accordance with the Duty of Quality and Maternity and Neonatal Assurance Escalation Framework. The review was discussed in the Maternity and Neonatal Safety Board in February 2024, the outcome of this work and any recommendations will be presented at the Maternity and Neonatal Safety Board in April 2024.	Children & Families	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.	

Agenda Item
8.2.7

Quality, Safety & Experience Committee

Cwm Taf Morgannwg University Health Board
Infant Feeding Strategy 2025-2030

Dyddiad y Cyfarfod / Date of Meeting	21/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Clare Shears, Senior Nurse Children and Young People Suzanne Hardacre, Director of Midwifery Children and Families Care Group
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
Infant Feeding Strategic Group	04/12/2024	Approved.
Operational Management Board	17/01/2025	Pending Approval

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund

1. Situation /Background

1.1 The first 1000 days of life are critical for the outcomes of a child's health, growth and cognitive development. During this period, breastfeeding and responsive bottle feeding are essential to ensuring that every infant and child has the right to good nutrition (The United Nations Convention on the Rights of the Child 1989).

1.2 The aim of the Infant Feeding Strategy is to provide a road map to the steps needed to improve infant nutrition in the first 1000days across the Cwm Taf Morgannwg University Health Board (CTMUHB) region. The steps include, increasing breastfeeding rates, supporting safe and responsive formula feeding, supporting the parent/carer to develop a close and loving relationship with the infant and support the timely introduction of complementary foods.

1.3 The strategy is underpinned by national and local policy drivers and the UNICEF UK Baby Friendly Initiative standards for midwifery, neonatal and health visiting services. All of which will act as levers to set the direction for all staff groups within the health board whose work impacts on supporting parents in the first 1000 days of a child's life.

1.4 Increasing the number of infants receiving breastmilk and developing close and loving relationships are the foundation to improving health outcomes along the life course, reducing health inequalities and ensuring the best start to life for our future generations in CTMUHB.

1.5 The challenges of poorer health outcomes for the CTMUHB population are considerable, both compared with the rest of Wales and due to inequalities within the Health Board area. Evidence demonstrates the positive impact that breastfeeding and breast milk have on reducing inequalities in health and improve health outcomes.

2. Specific Matters for Consideration

2.1 The strategy is for the CTMUHB workforce, key partners and stakeholders who support infants and children, policy developers and the general public.

2.2 Whilst the strategy supports breastfeeding, it is imperative that all families have access to evidence based information to make an informed choice about feeding methods and that they are supported in whatever decisions are made.

2.3 An implementation and delivery plan accompanies the strategy. Progress against these plans are monitored through the Health Board Infant Feeding Strategic Group.

2.4 The strategy is consistent and aligned with the following:

- Child Poverty Strategy Wales (2024)
- Well-Being of Future Generations (Wales) Act (2015)
- A Healthier Wales (2018)
- Healthy Weight: Healthy Wales (2019)
- All Wales 5 year Breastfeeding Action Plan (2019)

2.5 The strategy has been developed in partnership with parents and wider key stakeholders (internal to Cwm Taf Morgannwg University Health Board and external).

3. Key Risks / Matters for Escalation

3.1 There is an associated 'Breastfeeding and Return to Work' policy soon to be ratified with support from Workforce colleagues.

3.2 Oversight and monitoring of the strategy will be through the Infant Feeding Strategic Group within Cwm Taf Morgannwg.

3.3 An 'Easy Read' version for the public will also accompany the strategy (expected early January 2025).

3.4 Equality Impact Assessment completed 28th October 2024.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: ➢ Improving Care ➢ Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	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:
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	Safe
	If more than one applies please list below: ➢ Timely ➢ Equitable

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

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

5. Recommendation

5.1 The Committee are asked to NOTE the Infant Feeding Strategy.

6. Next Steps

6.1 Publication on SharePoint and Health Board Internet sites.
6.2 Communication plan and public formal launch.
6.3 Share across all Care Groups within Cwm Taf Morgannwg University Health Board.
6.4 Work with workforce colleagues to ensure that the Strategy is socialised along with the 'Breastfeeding and Return to Work Policy'

Cwm Taf Morgannwg University Health Board Infant Feeding Strategy 2025 – 2030

Authors:
Cwm Taf Morgannwg University Health Board
Local Public Health, Healthy Weights Team
Cwm Taf Morgannwg University Health Board Infant Feeding Team

CONTENTS

EXECUTIVE SUMMARY

As the Executive Nurse Director for Cwm Taf Morgannwg University Health Board and the UNICEF UK Baby Friendly Guardian, I am honoured to present the Infant Feeding Strategy which aims to promote and support optimal infant feeding practices within our health board and local communities of Merthyr, Rhondda, Cynon, Taf and Bridgend.

This strategy focuses on the important role of early bonding and nutrition, and how this contributes to the growth and well-being of infants in their first 1000 days, while considering the long term health of both current and future generations.

The strategy clearly sets out areas where support in the infant's feeding journey is needed and our vision on how we aim to do this, keeping the baby's and toddler's voice at the heart of our work.

The infant feeding strategic group will oversee the implementation of the aims set out in this document, working collaboratively across the health board locality.

We recognise that every family is different and we want to give them the best beginning, based on their individual needs and wishes, supporting them in their feeding choices. Breastfeeding has many benefits for women and children, and is one of the most effective ways to ensure child and maternal health. This infant feeding strategic action plan fits with our ambitions around creating health, inspiring people, improving care and sustaining our future. It is based on our CTMUHB organisational values:

·We listen, learn and improve

·We work together as a team

·We treat everyone with respect

This strategy provides direction and intends to act as a driver for action for all staff groups within Cwm Taf Morgannwg University Health Board whose work impacts on families during the first years of a child's life.

Throughout our approach, we will integrate the five key principles from the Cwm Taf Morgannwg University Health Board Maternity & Neonatal Vision 2023 – 2026. Furthermore, we will work in alignment with the Healthy Child Wales Programme "To give all women, parents and families personalised care, with genuine choice, focussed on the safety and quality of experience, and giving all children the best start by providing safe and effective care in the first weeks of a child's life".

Executive Director of Nursing
Greg Dix

WHO and UNICEF recommend that children initiate breastfeeding within the first hour of birth and be exclusively breastfed for the first 6 months of life. From the age of 6 months, children should begin eating safe and adequate complementary foods while continuing to breastfeed for up to two years of age or beyond. (WHO 2019)

*Important note: we recognise that not all pregnant people will identify as women. When referencing pregnant women throughout this document, this is intended to be inclusive of pregnant and birthing people of all genders. We acknowledge not all people identify as having breasts or as breastfeeding and we will adapt care on an individual basis.

INTRODUCTION

WHY DO WE NEED AN INFANT FEEDING STRATEGY?

Cwm Taf Morgannwg University Health Board (CTMUHB) has one of the lowest initiation and continuation rates for breastfeeding in the United Kingdom.

CTMUHB sets out the direction to support our population, health board wide, to protect, promote, support and normalise breastfeeding. Parents may choose to breastfeed, use expressed breast milk or use infant formula and this is often a very personal decision. While the strategy promotes the choice of breastfeeding we want all parents to feel supported in how they feed their baby.

This strategic plan provides the vision and direction for increasing breastfeeding rates in Merthyr Tydfil, Rhondda Cynon Taf and Bridgend; by working together to build a better future for our children, communities and population health. The strategy is intended as a driver for action for all staff groups within the health board whose work impacts on supporting parents in the first years of a child's life.

OUR VISION

Our vision is to create a supportive culture across CTMUHB, with a well-trained workforce who provide ongoing support to families throughout their feeding journey, enabling parents to make informed choices about infant feeding that optimises nutrition of babies and infants and help them develop close, loving parent-infant relationships.

This strategy provides direction and intends to act as a driver for action for all staff groups within Cwm Taf Morgannwg University Health Board whose work impacts on families during the first years of a child's life.

Throughout our approach, we will integrate the five key principles from the **Cwm Taf Morgannwg University Health Board Maternity & Neonatal Vision 2023 – 2026** and will work in alignment with the Healthy Child Wales Programme "To give all women, parents and families personalised care, with genuine choice, focussed on the safety and quality of experience, and giving all children the best start by providing safe and effective care in the first weeks of a child's life.

OUR AIMS


The aims of the Cwm Taf Morgannwg University Health Board (CTMUHB) Infant Feeding Strategy are:
1. To ensure families are supported to make informed choices in relation to feeding and nurturing their child.
2. To increase the numbers of mothers providing breastmilk to their babies.
3. Creating a supportive culture by normalising breastfeeding.
4. Work collaboratively to drive improvements in health and wellbeing across the population of CTMUHB, including the promotion of parent-infant relationships.
5. To support families who choose to formula feed to do so safely and responsively.

THE VALUE OF BREASTFEEDING

The provision of human milk is available for the baby whenever they need it and is completely free. Breastmilk is a unique substance, constantly changing to meet the needs of a baby and bursting with protective antibodies. It prevents a range of infectious and non-communicable diseases (NCDs), including gastroenteritis, childhood obesity, type 2 diabetes and maternal breast cancer. We acknowledge the importance of breastfeeding for the health and development of infants and their mothers, and the link between breastfeeding and the prevention of major health inequalities (Renfrew et al, 2012).

There is clear evidence that breastfeeding has a profound positive influence on maternal and child health and child development. It is vital that breastfeeding is protected, promoted and supported.
The Unicef UK Baby Friendly Initiative (BFI)

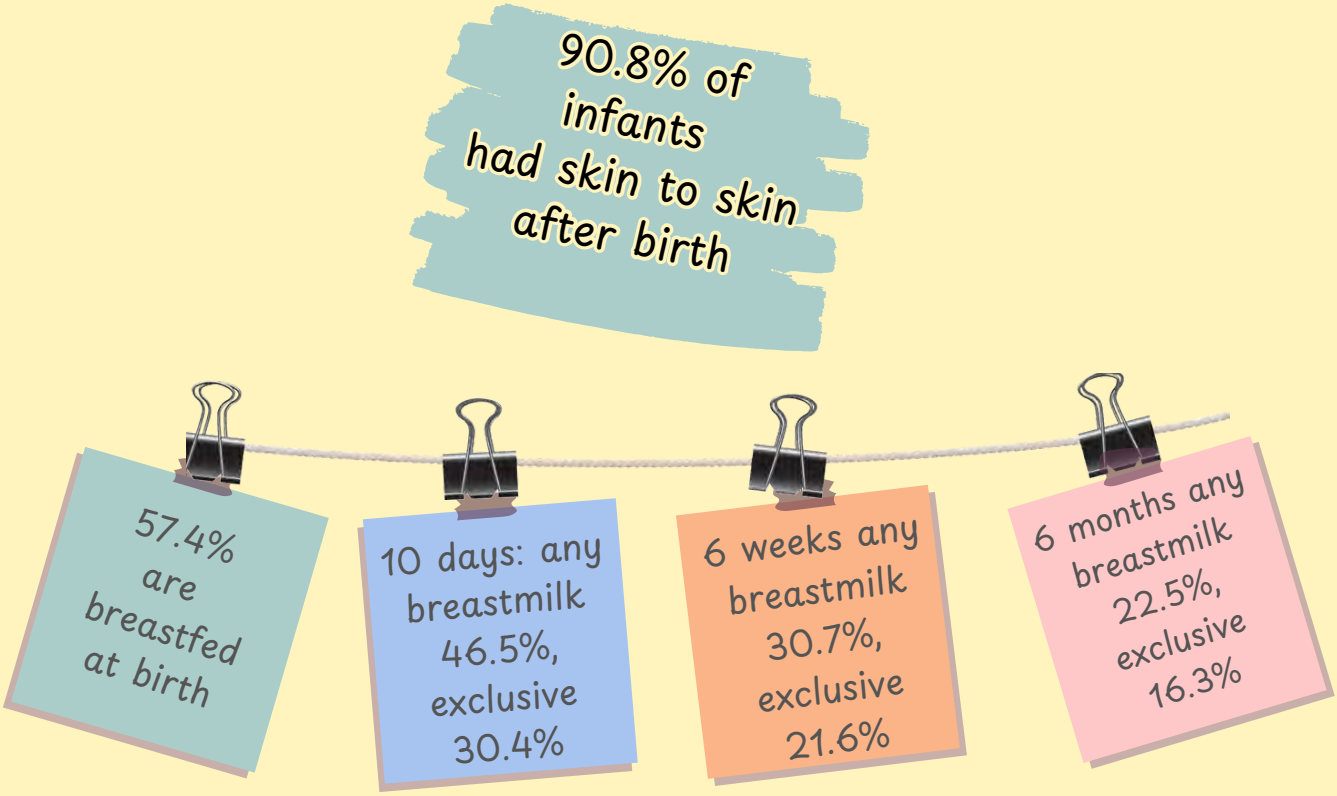
We are taking a whole systems approach to healthy weight. Infant feeding is a vital component of our approach to reduce the levels of childhood and adult obesity for our population within Cwm Taf Morgannwg. Increasing breastfeeding initiation and continuation rates across the population will impact on childhood and adult obesity rates. It requires a shift in the environment and culture across Merthyr Tydfil, Rhondda Cynon Taf and Bridgend.

Several mechanisms may potentially explain why breastfeeding protects against overweight or obesity. First, breastfeeding influences the development of a gut microbiota profile that is associated with a lower risk of obesity. Second, breastfeeding is associated with a healthier diet during childhood. Third, breastfeeding may also be associated with appetite regulation, as it may help children develop better satiety outcomes. *(Horta, 2022)*

CWM TAF MORGANNWG REGION BREASTFEEDING DATA

Each year, around 4,500 babies are born across Cwm Taf Morgannwg.

In 2023 the breastfeeding rates across Cwm Taf Morgannwg were as follows:



Reference – Breastfeeding by age of baby, type of breastfeeding and health board. Stats Wales (published July 2024)
Link: Breastfeeding by age of baby, type of breastfeeding and health board (gov.wales)

CHILD MEASUREMENT PROGRAMME REPORT 2022- 2023

The latest Child Measurement Programme report shows that obesity in Cwm Taf Morgannwg University Health Board is the highest in Wales, and is statistically significantly higher than the Wales average. The proportion of children with obesity in Wales is higher than those reported in England and Scotland. Child Measurement Programme 2022- 2023 (Public Health Wales NHS Trust. 2024)

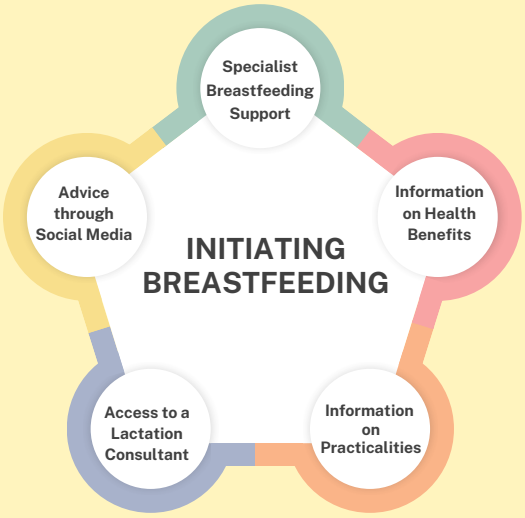
'Breastfeeding is important for the health and development of infants and their mothers, and is linked to the prevention of major health inequalities'
Welsh Government, 2019

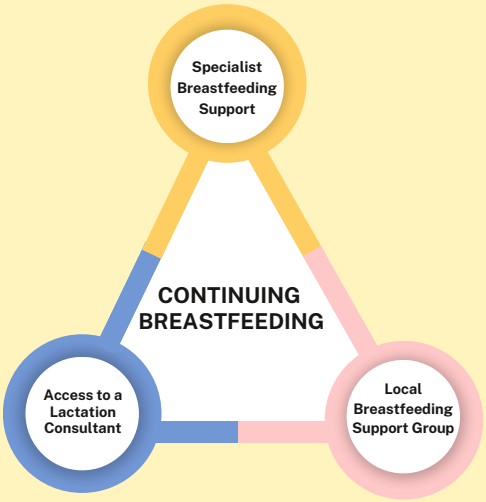
INFANT FEEDING: PATIENT EXPERIENCE SURVEY FINDINGS IN CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD AREA (2023)

The Local Public Health 'Healthy Weight Team' carried out an online survey into breastfeeding experiences in 2023. The survey provided a range of insights from 171 families from the Cwm Taf Morgannwg University Health Board area. This strategy plans to build on and address the insight gathered through the Strategic vision and Delivery Plan. A copy of the full results of the survey can be seen within the appendix, Activities which encouraged breastfeeding initiation and continuation are outlined below:

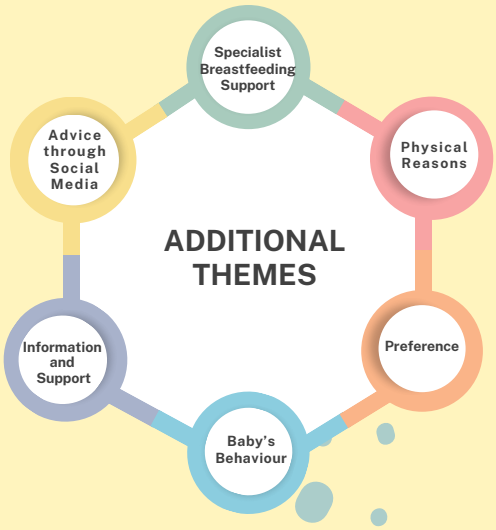
*Pre populated refers to answers which were suggested answers within the survey, other answers detailed below are free text.

Finding Support Mechanisms





Barriers to Continuing Breastfeeding



Mothers and their families require support to be able to maintain breastfeeding while having the freedom and support to continue to participate in other areas of life as they choose, such as education and employment. (Lancet 2023)

PATIENT EXPERIENCE INSIGHT

'I was very well supported regarding breastfeeding my baby. I had skin to skin contact straight after giving birth and the staff at PCH were all amazing. xxx, xxx and xxx were superstars, they all showed me how to get my baby to latch and supported me so well. The community midwifes I saw were also fantastic with feeding support, these were xxx, xxx and xxx. Thanks to these women, for their help and support, my baby is 13 months old and is exclusively breastfed.'

(Infant Feeding: Patient Experience Survey Respondent 2023)

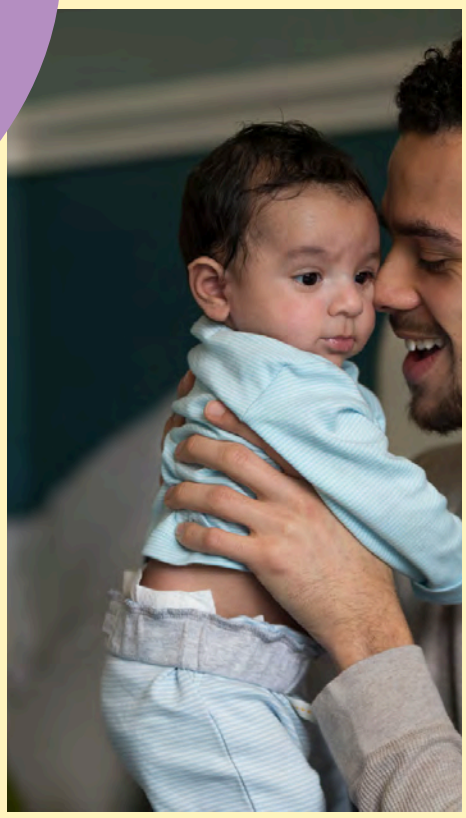
'I had a brilliant midwife who helped me in the hospital after birth. However, without her support I'd have been left completely alone as no one else checked on me or gave me advice or even asked if I was breast or bottle feeding. No one has checked my latch or progress since'

(Infant Feeding: Patient Experience Survey Respondent 2023)

*Please note the Infant Feeding Survey outcomes were based on survey received responses from 171 families living in the Cwm Taf Morgannwg University Health Board area, with 126 of these breastfed on at least one occasion, please see full limitations within the report detailed in the Appendix.

OUR INFANT FEEDING AIMS

"Involving children, parents and carers in developing child health policies and interventions is vital to ensuring their success. We recommend that diverse voices and perspectives of children, through or in addition to their parents and carers, should be included in the development of policies and interventions to ensure they address their needs, and that implementation is effective. This could enhance success by raising awareness and increasing uptake."
(Prioritising early childhood to promote the nation's health, wellbeing and prosperity report 2024).



1 To ensure families are supported to make informed choices in relation to feeding and nurturing their child.

a. Families will be offered a meaningful infant feeding discussion to explore feeding choices.

b. Antenatal resources will be made available; to ensure a reliable source of consistent information is available for all parents.

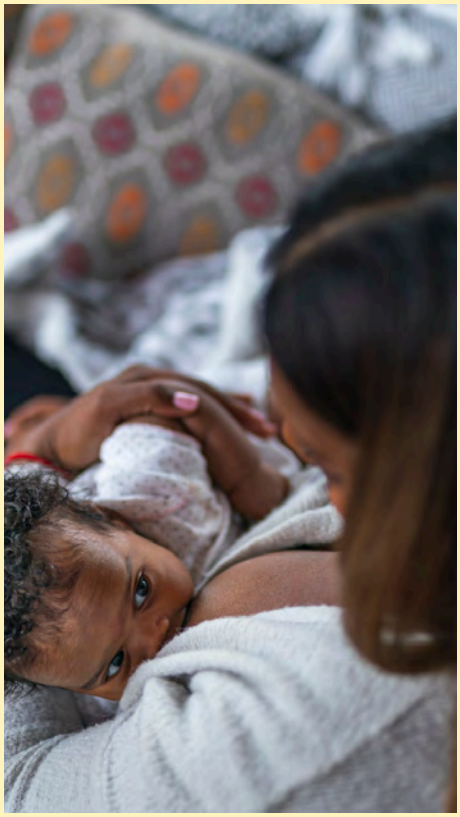
c. We will develop and deliver evidence-based interventions across CTMUHB to ensure an equitable service.

2 To increase the numbers of mothers providing breastmilk to their babies.

a. Parents will be given information and resources to enable them to harvest colostrum in the antenatal period.

b. Parents who encounter feeding difficulties will:
- Be fully supported by staff and given consistent information.
- Be appropriately referred to the right support.

c. Specialist services will be available for complex feeding issues.



3

Creating a supportive culture by normalising breastfeeding.

a. We will listen to families and staff, they will be valued and treated with dignity and respect.

b. We will seek out the views of our community and continue to listen to feedback from women, birthing people, families and professionals.

c. We will provide active support and encouragement to women, working collaboratively to support them to meet their feeding goals.

d. Staff working within CTMUHB will be supported with their breastfeeding journey.

e. Continue to develop and provide education for a competent workforce.

f. Have a collaborative communications strategy with targeted actions.

4

Work collaboratively to drive improvements in health and wellbeing across the population of CTMUHB, including the promotion of parent-infant relationships.

a. Analyse and act on feedback detailing the influencing factors on feeding decisions.

b. Introduce the 'voice of the baby' in decision making.

c. Engage with multi-agencies to gain commitment to collaborate in a wider societal change to normalise breastfeeding within our communities such as Children's Services, Libraries.

d. Work within the health board to have link nurses and to develop infant feeding pathways.

e. Link with schools and further education to promote positive messages around breastfeeding and responsive parenting.

5

To support families who choose to formula feed to do so safely and responsively.

a. We will continue to develop digital resources to ensure availability of clear, consistent information.

b. Communication and information will be clear, appropriate in format, relevant, consistent and easy to understand.

c. Families who chose to feed their babies with formula milk will be:
   - Signposted to appropriate resources to support decision making.
   - Supported by staff in accordance to the WHO International Code of Marketing Breastmilk Substitutes.
   - Educated in the safe preparation of formula milk.
   - Supported to responsively bottle feed their babies.
   - Supported to also to provide breastmilk for as long as they wish.

NATIONAL AND LOCAL DRIVERS

Cwm Taf Morgannwg University Health Board's Infant Feeding Strategy has been developed in accordance with the following:

NATIONAL DRIVERS

Baby Friendly Initiative Standards

The Baby Friendly Standards provide services with a roadmap for transforming care for all babies, their mothers and families. The standards enable public services to better support families with feeding and developing close, loving parent-infant relationships, ensuring that all babies get the best possible start.

All Wales Breastfeeding 5 Year Action Plan

This action plan has identified strategic goals and aims to guide action in both immediate support for women and families and the wider population health incentive to consider breastfeeding as an option and ensure it is culturally acceptable

Well-being of Future Generations (Wales) Act 2015 (Welsh Government, 2015)

Improving the social, economic, environmental and cultural well-being of Wales

Healthy Weight Healthy Wales (Welsh Government 2022-2024)

Long term strategy to prevent and reduce obesity in Wales

A Healthier Wales: our Plan for Health and Social Care (2018)

Plan sets out a long term future vision of a 'whole system approach to health and social care', which is focussed on health and wellbeing, and on preventing illness.

NICE Guidelines

The Post Natal NICE (2021) Guidelines cover the routine postnatal care that women and their babies should receive in the first 8 weeks after the birth. The guidelines outline planning and supporting babies feeding which will inform the development of this strategy and vision.

World Health Organisation/ Unicef Global infant feeding strategy (WHO and Unicef, 2003)

LOCAL DRIVERS

CTM 2030: Our Health, Our Future

Building Healthier Communities Together. Aims to unite people across Cwm Taf Morgannwg around a shared understanding of the everyday things affect people's health and wellbeing in our region.

Cwm Taf Morgannwg University Health Board Maternity & Neonatal Vision 2023 – 2026

The Lancet's breastfeeding series emphasises that breastfeeding is not the sole responsibility of women and that overcoming the cultural and practical barriers to breastfeeding is an important societal responsibility. *(Prioritising early childhood to promote the nation's health, wellbeing and prosperity report 2024)*

'Unicef UK's Baby Friendly Initiative is calling on the UK and devolved governments to take urgent steps to protect, promote and support breastfeeding in the UK. It is time to shift responsibility for tackling this public health issue away from individual parents, and change the conversation away from guilt and blame. Instead, we need to acknowledge the role we can all play in creating a supportive, informed environment for all parents, enabling mothers to breastfeed for as long as they wish. Find out more: www.unicef.uk/bficalltoaction.'
(Baby Friendly Initiative UK)

A WHOLE SYSTEM AND POPULATION APPROACH

Our vision will be delivered at two strategic levels working in parallel to benefit the population of Cwm Taf Morgannwg University Health Board (CTMUHB).

1. The Health and Care System.
2. The Whole System and Whole Population Approach.

1 The Health and Care System

- Strategic Lead for Infant Feeding
- All CTMUHB Staff to recieve training in breastfeeding awareness
- Baby Friendly Initiative accreditation across applicable CTMUHB Health Services
- Peer Support across CTMUHB
- Multidisciplinary training programme on infant feeding
- Specialist breastfeeding support for a breastfeeding infant and parent where required

2 Whole System and Population Level

- Clear information
- Journey to normalisation
- Baby Friendly environment across CTMUHB
- Healthy Schools - underlying beliefs
- WHO International Code of Marketing Breastmilk Substitutes compliant
- CTMUHB workforce to develop a positive and inclusive ethos towards breastfeeding

A BABY'S JOURNEY THROUGH CTMUHB

Our aims demonstrate that we are committed to nurturing a baby's feeding journey within the health board, this involves not only addressing their nutritional needs but also building a strong relationship between the parents and baby.

The Cwm Taf Morgannwg University Health Board Baby and Toddler Voice will be central to care provided within the health board. By "voice" we mean how the rights of the baby alongside the United Nations Convention on the Rights of the Child (UNCRC) can be considered in all decisions that concern them. This might include considering how the baby might be making sense of their environment and how they might describe how they're feeling if they were able to tell us.

There are many times that babies and infants may need services within Cwm Taf Morgannwg University Health Board and at every point it is vital that parents feel supported in their feeding journey. From the early days through to introducing solid foods and beyond.

Maternity, Neonatal and Health Visiting Services integrate the Unicef UK Baby Friendly Initiative standards to form part of the care delivered. These standards are to support, promote and protect breastfeeding and were expanded to include the importance of parents building a relationship with their baby, responsive feeding and safe formula feeding (UNICEF 2013).

RESPONSIVE FEEDING

This diagram explains how the connection between parents and babies can develop as part of feeding and the cycle of building a relationship. Beginning in the Antenatal period:

'I breast fed my first 2 boys and just loved the bond and closeness it gave us'
Parent comment Insight report 2023

'Baby decided it was time to stop (just shy of 12 months)'
Parent of breast fed baby comment Insight report 2023

Dr Karen Bateson, Head of Strategy and Development at the Parent-Infant Foundation said:

"It's surprisingly common for a parent to struggle to bond with their baby. The Securing Lives report (2021) report highlights the importance for a parent to seek help if they don't feel their relationship with their baby is quite right and shines a light on all the ways professionals can support families to get that relationship back on track".

Bateson et al (2021) highlights those problems in relationships that can unfold in future years and often result from unaddressed problems in the early years between babies and parents.
Placing value and importance on the time spent connecting and feeding baby is important for parents to know as this informs part of the early foundations for brain growth and development.

REALISING OUR VISION ACROSS THE CWM TAF MORGANNWG REGION

What will success look like?

- Within our Maternity Units, Neonatal Units and Health Visiting Service there are named Infant Feeding Co-ordinators who will support service improvement and improve the knowledge and skills of staff.

- Midwives, Neonatal Staff and Health Visitors with identified clinical interest will be supported to achieve additional breastfeeding/lactation training and create greater knowledge & skills for all members of the multi-professional team.

- All Maternity, Neonatal, Health Visiting and Paediatric Health Care settings will have achieved or will be working towards the UNICEF UK Baby Friendly Initiative accreditation with a vision of aiming for gold sustainability.

- There will be a team of Baby Friendly Guardians in every service within the CTMUHB and we will encourage them to work together as a group (including community and third sector guardians).

- All communities in CTMUHB will have active breastfeeding peer support and a retention and sustainability model in place.

- Hospital departments and organisations within CTMUHB will link together to promote breastfeeding friendliness in public spaces.

- Through our Maternity Voice Partnership with families, we will see an increase in the number of families reporting improved support and standards of care, who will:
    - Report meeting their breastfeeding goals.
    - Report antenatal conversations regarding feeding their baby.
    - Be supported to introduce solids alongside chosen method of feeding at the recommended age of 6 months.
    - Continue to report choices around infant feeding decisions were respected.
    - Continue to report that mothers are being given active support and encouragement.

- The infant feeding support service will have capacity to support the increased number of breastfeeding families by utilising community teams to allow timely access to breastfeeding support.

- Infant Feeding Co-ordinators will liaise with staff and Data Managers to ensure that robust, useful and accurate data is collected to monitor and improve breastfeeding rates and mothers' experiences of breastfeeding.

- Staff that support families with infant feeding will receive training in Community Food and Nutrition Skills for the Early Years and will have understanding of the benefits of good nutrition and hydration.

- Staff that support families with infant feeding will receive training in Making Every Contact Count to support health behaviour conversations.

- We will ensure we engage with other parts of the system including the Whole System Approach to Healthy Weight to develop further insight into families feeding choices across CTMUHB.

SUMMARY

The Infant Feeding Strategy for CTMUHB aims to promote and support optimal nutrition for babies and infants by normalising and creating a breastfeeding friendly culture. This strategy ensures families are well supported in making informed feeding and nurturing decisions, ultimately driving improvements in health and wellbeing across the population. Key objectives include increasing breastfeeding rates, enhancing parent-infant relationships, reducing childhood obesity, and supporting safe and responsive formula feeding.

Key initiatives involve enhancing antenatal resources and parent education, incorporating user feedback to provide individualised care, improving digital resources, and offering targeted support for feeding difficulties. Through these efforts, the strategy aims to create a supportive environment that prioritises the health and wellbeing of infants and their families, leading to improved nutritional outcomes and stronger community health.

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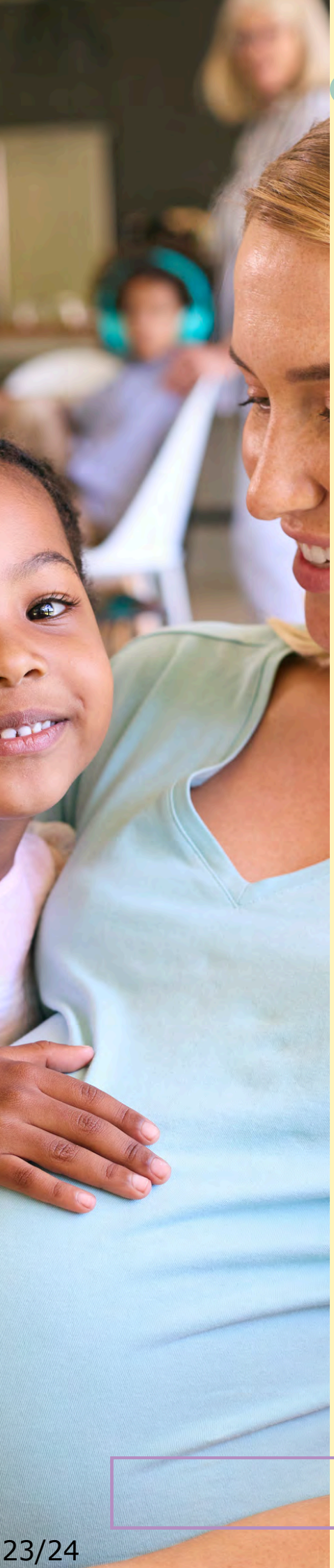

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Infant Feeding Voices Partnership

You can contact our women's experiences midwife via the email CTM.WomensExperiencesCTUHB@wales.nhs.uk.

DUTY OF QUALITY FOR INFANT FEEDING STRATEGY

The Infant Feeding Strategy has been created by applying the framework set out in the Duty of Quality guidance.
The Duty of Quality provides assurance to the Welsh Government and public that the health board is committed to improving and protecting the health, care and wellbeing of the current population and future generations.
We will achieve improvement by working with service users, wider partners and health board services, applying a Duty of Quality across all of the health services that serve the population of the Cwm Taf Morgannwg region.
Working together, we can ensure quality is embedded in a whole system. This approach will guarantee that the health board delivers services that are safe, timely, effective, efficient, equitable and person centred.

	Role	Responsibilities
Safe	We will learn lessons, be transparent, share learning and deliver best practice. This will ensure there are high quality, highly reliable and safe systems in place that avoid preventable harm.	➢ We will develop and deliver evidence-based interventions across CTMUHB to ensure an equitable service. ➢ We will continue to develop and provide education for a competent workforce ➢ We will work within the health board to have link nurses and to develop infant feeding pathways. ➢ We will analyse and act on feedback detailing the influencing factors on feeding decisions. ➢ We will monitor progress of the strategy through the Cwm Taf Morgannwg University Health Board Strategic Infant Feeding Group.
Timely	We will ensure that infants and families have access to evidence based, high quality advice, guidance and care when they need it.	➢ We will continue to work towards the UNICEF UK Baby Friendly Initiative standards. ➢ We will ensure robust and continual learning takes place across the whole organisation. ➢ Implementing and monitoring improvements from learning identified through incidents, audit, data, reviews, concerns and feedback ➢ Antenatal resources will be made available; to ensure a reliable source of consistent information is available for all parents.
Effective	We will ensure the care and treatment we provide is meaningful and will achieve optimal health outcomes for the infant, mother and families.	➢ Families will be offered a meaningful infant feeding discussion to explore feeding choices. ➢ Parents will be given information and resources to enable them to harvest colostrum in the antenatal period. ➢ Parents who encounter feeding difficulties will: · Be fully supported by staff and given consistent information. · Be appropriately referred to the right support. ➢ Specialist services will be available for complex feeding issues. ➢ We will provide active support and encouragement to women, working collaboratively to support them to meet their feeding goals.
Efficient	We will work collaboratively as a 'whole system' to make the most effective use of resources to improve health outcomes for our infants. Mothers and families.	➢ Engage with multi-agencies to gain commitment to collaborate in a wider societal change to normalise breastfeeding within our communities such as Children's Services, Libraries ➢ Link with schools and further education to promote positive messages around breastfeeding and responsive parenting. ➢ Staff working within CTMUHB will be supported with their breastfeeding journey
Equitable	We will ensure that infants, mothers and families have equitable access to health care which will provide a platform for them to attain their fullest potential. We will protect the welfare and safety of children and their families who become vulnerable or at risk.	➢ We will continue to develop digital resources to ensure availability of clear, consistent information. ➢ Communication and information will be clear, appropriate in format, relevant, consistent and easy to understand. ➢ All Health Board staff are responsible to adhering to Safeguarding policies and procedures. ➢ We will ensure that information is provided to individuals in their first language to enable them to be fully engaged with their care and support.
Person centred	We will incorporate the baby and toddler voice in everything we do. We will work in partnership and listen to all service users to ensure the best experience and outcomes.	➢ We will listen to families and staff, they will be valued and treated with dignity and respect. ➢ We will seek out the views of our community and continue to listen to feedback from women, birthing people, families and professionals. ➢ Introduce the 'voice of the baby' in decision making.