Quality, Safety & Experience Committee

Tue 22 July 2025, 09:00 - 12:00

In Person Meeting, The Hub, Royal Glamorgan Hospital

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Independent Member/Committee Chair*

09:05 - 09:10
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

09:10 - 09:15
5 min

3. COMMITTEE GOVERNANCE ARRANGEMENTS

3.1. Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

3.1 QSEC Action Log QSEC 22 July 2025.pdf (6 pages)

3.2. Matters Arising not contained within the Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

09:15 - 09:35
20 min

4. STAFF AND SERVICE USER EXPERIENCE

4.1. Shared Listening & Learning Story - Unpaid Carers

Discussion *David Watkins, Unpaid Carers Lead*

Board and Committee Presentation Template - as at 17.02.2025.pdf (7 pages)

09:35 - 10:35
60 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Report from the Clinical Executives

Discussion *Clinical Executives*

5.1a Clinical Executive Directors update QSEC 22 July 2025 v2.pdf (14 pages)

5.2. Care Group Highlight Reports

5.2.1. Children & Families Care Group

Discussion *Suzanne Hardacre, Care Group Nurse Director*

- 5.2.1a C&F Highlight Report July 2025 QSEC 22 July 2025.pdf (10 pages)
- 5.2.1b Appendix 1 InspectionActionPlan (2) QSEC 22 July 2025.pdf (31 pages)

5.2.2. Unscheduled Care Care Group

Discussion *Owen Weeks, Care Group Medical Director*

- 5.2.2 USC QS Highlight Report QSEC 22 July 2025.pdf (9 pages)

5.2.3. Planned Care Care Group

Discussion *Sharon O Brien, Care Group Nurse Director*

- 5.2.3 Planned Care Highlight Report QSEC 22 July 2025.pdf (7 pages)

5.2.4. Mental Health & Learning Disabilities Care Group

Discussion *Lloyd Griffiths, Head of Mental Health Nursing*

- 5.2.4 MHLD Highlight Report QSEC 22 July 2025.pdf (8 pages)

5.2.5. Diagnostics, Therapies, Pharmacy & Specialities

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

- 5.2.5 Highlight Report - DTPS QSEC 22 July 2025.pdf (12 pages)

5.2.6. Primary Care & Communities Care Group

Discussion *Lucie Owen, Primary Care & Communities Care Group Director*

- 5.2.6 PCC highlight report QSEC 22nd July 2025.pdf (9 pages)

5.3. Stroke Services Progress Report

Discussion *Lauren Edwards, Executive Director of Allied Health Professionals & Healthcare Sciences*

- 5.3 USC Stroke Services Report QSEC 22 July 2025 FINAL.pdf (16 pages)

10:35 - 11:35
60 min

6. DELIVERING OUR PLAN

6.1. Patient Safety, Quality & Experience Dashboard

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

- 6.1 Patient Safety and Quality Dashboard Report QSEC 2025-07-22 Approved.pdf (18 pages)
- 6.1a Appendix Peoples Experience Activity Report QSEC 22 July 2025.pdf (8 pages)

6.1.1. Committee Referral - Details of the medical negligence claims from the losses and special payments report - Verbal Update

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

6.2. Overview of the Development & Delivery of the Research & Development Strategy

Discussion *John Geen, Assistant Director for R&D & Rhian Beynon, R&D Manager*

- 6.2a RD Strategy QSEC 22 July 2025.pdf (5 pages)
- 6.2b CTMUHB RD Strategy 2025-2030 QSEC 22 July 2025.pdf (23 pages)

6.3. Annual Duty of Quality Report 2025

Discussion *Richard Hughes, Deputy Director of Nursing*

6.3 DOQ Annual Report 2025 QSEC 22 July 2025.pdf (4 pages)

6.4. People Experience Forum Update

Discussion *Richard Hughes, Deputy Director of Nursing*

6.4 People Experience Forum Highlight Report QSEC 22 July 2025 v2.pdf (6 pages)

11:35 - 11:50
15 min

7. GOVERNANCE, RISK AND ASSURANCE

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

Discussion *Gareth Watts, Director of Corporate Governance/Board Secretary*

7.1a Org RR July 25 - QSEC CP.docx (8 pages)
7.1b App 1 - Org RR July 2025 - QSEC.xlsx (7 pages)

7.2. Health Inspectorate Wales (HIW) Audit Tracker Report

Discussion *Gareth Watts, Director of Corporate Governance/Board Secretary & Greg Dix, Executive Director of Nursing/Deputy CEO*

7.2a HIW Tracker Inspection Improvement Plans QSEC 22 July 2025.docx (7 pages)
7.2b Copy of HIW Inspections Recommendations Tracker QSEC 22 July 2025.xlsx (7 pages)

11:50 - 11:55
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the Meeting held on 20 May 2025

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

8.1.1 Unconfirmed Minutes QSEC 20 May 2025 Final QSEC 22 July 2025.pdf (14 pages)

8.1.2. Unconfirmed Minutes of the In Committee Meeting held on 20 May 2025

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

8.1.2 Unconfirmed Minutes IC QSEC 20 May 2025 Final QSEC 220725.pdf (2 pages)

8.1.3. Quality, Safety & Experience Committee Terms of Reference

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

8.1.3a QSE Committee TOR 22 July 2025.pdf (4 pages)

8.1.4. Health, Safety & Fire Sub Committee Highlight Report 5 June 2025 (including the Health, Safety & Fire Sub Committee Annual Report)

Decision *Hywel Daniel, Executive Director for People*

8.1.4a Health, Safety & Fire Sub Committee Highlight Report QSEC 22 July 2025.pdf (6 pages)
8.1.4b Appendix 1 HS&F Sub-CMt Annual Report QSEC 22 July 2025.pdf (7 pages)

8.2. FOR NOTING

8.2.1. Non-Routine Committee Business (Forward Plan)

Information *Carolyn Donoghue, Independent Member/Committee Chair*

8.2.1 CTMUHB QSEC Non Routine Bus QSEC 22 July 2025.pdf (3 pages)

8.2.2. Annual Cycle of Business

Information *Carolyn Donoghue, Independent Member/Committee Chair*

8.2.2 CTMUHB QSEC Cycle of Business QSEC 22 July 2025.pdf (5 pages)

8.2.3. CTMUHB National Clinical Audit Programme Quarter 1 Update 2025-2026

Information *Dom Hurford, Executive Medical Director*

8.2.3 Clinical Audit Quarterly Report QSEC 22 July 2025.pdf (8 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 July 22nd 2025.pdf (7 pages)

8.2.5. Organ Donation Sub Committee Highlight Report

Information *Dom Hurford, Executive Medical Director*

8.2.5 Hightlight report Organ Donation Subcommitte QSEC 22 07 25.pdf (6 pages)

8.2.6. Internal Audit Review Duty of Candour

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

8.2.6 IA Review Duty of Candour Audit Report Final QSEC 22 July 2025.pdf (22 pages)

8.2.7. Internal Audit Review Service User Experience

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

8.2.7 Service User Experience Final Report QSEC 22 July 2025.pdf (7 pages)

8.2.8. Annual Unpaid Carer's Report

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

8.2.8a Unpaid Carers Report QSEC 22 July 2025.pdf (6 pages)
8.2.8b Appendix 1 CMTRPB-ShortBreaks-Booklet-2025.pdf (11 pages)

11:55 - 12:00
5 min

9. CLOSE OUT BUSINESS

9.1. Committee Highlight Report to the Board

Discussion *Gareth Watts, Director of Corporate Governance/Board Secretary*

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?

9.3. Any Other Business

Information *Carolyn Donoghue, Independent Member/Committee Chair*

12:00 - 12:00
0 min

10. Private / Closed Session Business

Information *Carolyn Donoghue, Independent Member/Committee Chair*

The following reports will be received in the Closed Session of the meeting:

- Cwm Taf Morgannwg Stillbirth and Neonatal Death Thematic Review 2023 Births & MBRRACE-UK Perinatal Mortality Report: 2023 Births;
- Learning through Lived Experience
- Organisational Risk Register - Closed Risks

12:00 - 12:00
0 min

11. Date & Time of the Next Meeting

Information *Carolyn Donoghue, Independent Member/Committee Chair*

Tuesday 23 September 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
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 remain ongoing amongst the Executive Team on the most appropriate way of reporting estates issues
21.01.2025	6,1	9	Patient Safety, Quality & Experience Dashboard	Internal Audit Review of Patient Experience to be presented to a future meeting of the Committee	Deputy Director of Nursing	Executive Director of Nursing/Deputy CEO	22-jul-25	Open	**On agenda - Proposed for Closure** Report is on the consent agenda for information for the 22 July 2025 meeting
21/01/205	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	WAST produced Quality Report to be shared with Members at future meetings of the Committee to help Independent Members to triangulate data between WAST and the Health Board	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	20/05/2025 Now 22/07/2025 **Now November 2025**	Open	**In progress** Agreed that this agenda item is put on hold until the new USC DoN is appointed. Agreed that this item will be deferred until July QSEC with any urgent issues being provided through the USC Care Group highlight report; Matter will be kept under review regarding frequency of reporting and the report requirements will be made to allow for regular updates to be provided by the Care Group in respect of the joint working with WAST looking at the People's Experience and Quality of Care. **Update as at July 2025 - the Care Group Nurse Director unlikely to be in post until October 2025. Discussion to be held at next agenda planning session as to whether this should be scheduled in for a discussion at the November 2025 meeting.**

21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	Consideration to be given outside the meeting on the frequency of reporting on this matter to future Committee meetings. Deputy Director of Nursing to discuss further with Committee Chair to determine the level of information required moving forwards	Committee Chair	Executive Director of Nursing/Deputy CEO	25/03/2025 Now 22/07/2025 **Now November 2025**	Open	**In progress** Agreed that this agenda item is put on hold until the new USC DoN is appointed. Agreed that this item will be deferred until July QSEC with any urgent issues being provided through the USC Care Group highlight report; Matter will be kept under review regarding frequency of reporting and the report requirements will be made to allow for regular updates to be provided by the Care Group in respect of the joint working with WAST looking at the People's Experience and Quality of Care. **Update as at July 2025 - the Care Group Nurse Director unlikely to be in post until October 2025. Discussion to be held at next agenda planning session as to whether this should be scheduled in for a discussion at the November 2025 meeting.**
21.01.2025	5.3e	8	Primary & Community Care Group Highlight Report	Progress report on Dental Services to be presented to a future meeting of the Committee. Discussion to be held at next agenda planning session in regards to scheduling the item for discussion	Primary Care & Community Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	20.05.2025	Open	**Completed - Proposed for Closure** Report received and discussed at the May 2025 meeting
21.01.2025	2.1 (CLOSED)	2	Listening & Learning Story – Experience of Care received from the Adult Mental Health Service	Update to be presented at a future meeting which demonstrated the impact of the lessons that had been learnt.	Mental Health & Learning Disabilities Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	22.07.2025	Open	**Completed - Proposed for Closure** On agenda for In Committee discussion at the 22 July 2025 meeting
25.03.2025	5,1	4	Spotlight Presentation - Stroke Unit Temporary Centralisation	Concerns raised in regard to service inequity and the potential risk to patients to be fed into the Allied Health Professionals Group	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20/05/2025 **Now 22 July 2025**	Open	**On agenda** An update on this will be captured in the Stroke Services Progress report being presnted to the 22 July 2025 meeting
25.03.2025	5,1	5	Spotlight Presentation - Stroke Unit Temporary Centralisation	Report to be presented to a future meeting to outline progress made in this area	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20/05/2025 **Now 22 July 2025**	Open	**On agenda** An update on this will be captured in the Stroke Services Progress report being presnted to the 22 July 2025 meeting
25.03.2025	5.3a	6	Children & Families Care Group Highlight Report	Next iteration of the report to include a narrative explanation of the data to enable Independent Members to draw conclusions as to how the Health Board were performing in a number of areas	Children & Families Care Group Nurse Director	Children & Families Care Group Nurse Director	20.05.2025	Open	**Completed - Proposed for Closure** Narrative explanation has now been included in the metrics being received at the July 2025 meeting

25.03.2025	5.3b	7	Unscheduled Care Group Highlight Report	Spotlight presentation to be presented to a future meeting in relation to the positive experiences that had been achieved in regard to the opening of two wards at Ysbyty George Thomas during the critical incident at the Princess of Wales Hospital	Unscheduled Care Group Nurse Director	Unscheduled Care Group Nurse Director	30.07.2025	Open	**In progress** This item will be discussed at a future agenda planning session to agree scheduling
25.03.2025	5.3f	9	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report	Further clarity to be provided in regard to the discrepancies highlighted in relation to the higher than average number of clinical incidents being reported within stroke services which did not correlate with the update provided on stroke services earlier in the meeting	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20.05.2025	Open	**On agenda** An update on this will be captured in the Stroke Services Progress report being presnted to the 22 July 2025 meeting
25.03.2025	6,1	10	Patient Safety, Quality & Experience Dashboard	Update to be provided at the next meeting which identifies whether the locally reportable incidents were now being picked up via the Duty of Candour. Ombudsman report to be shared with Committee Members for information and awareness.	Assistant Director of Quality & Safety	Assistant Director of Quality & Safety	20/05/2025 **Now 22/07/2025**	Open	**In progress** The implementation of Duty of Candour on the 01.04.23 introduced an additional layer of scrutiny which includes a process of corporate review that ensures all incidents previously identified as LRIs would be picked up. Progress needs to be made in relation to adding more detail into the Duty of Candour section of the dashboard, which will be undertaken once the 2024/2025 annual report has been produced.
20.05.2025	3,3	3	Committee Annual Report for 2024/2025	Annual Report to be amended prior to Board approval to reflect that N Milligan's tenure as Committee Member ended in July 2024 as opposed to July 2025.	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	29.05.2025	Open	**Completed - Proposed for Closure** Annual Report updated prior to submission to the Board for approval at the Board meeting on 29/05/2025
20.05.2025	4,1	3	Listening & Learning Story - Maternity Services	Update to be provided at a future meeting on the work being undertaken by the Team on how it was reaching the wider population via digital platforms.	Care Group Nurse Director, Children & Families	Care Group Nurse Director, Children & Families	TBC	Open	**In progress** Date to be agreed with Team

20.05.2025	4,2	4	Executive and Independent Member Walkaround Framework Cover Paper	Review of proposed frequency of walkrounds to be undertaken alongside a wider review of the new process once one round of walkrounds had been completed	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	18.11.2025	Open	**In progress** Each Buddy Team will be expected to complete one Walkround per quarter, meaning that each Executive and IM will participate in four Walkrounds per year. Should an Executive or IM wish to conduct additional Walkrounds beyond this minimum, these will be arranged accordingly. Once a full cycle has been completed—allowing every Executive and IM to carry out a Walkround under the new framework—a comprehensive review will be conducted to evaluate the feedback and effectiveness of the process. Please note that the updated framework and Buddy Team structure will be implemented starting Quarter 2 of this
20.05.2025	5,1	6	Spotlight Report Update on cluster of incidents within maternity services at the Princess of Wales Hospital (March – May 2025).	Further update on progress to be presented to the July meeting of the Committee.	Care Group Nurse Director, Children & Families	Care Group Nurse Director, Children & Families	22.07.2025	Open	**Completed - Proposed for Closure** Improvement plan has been included within the papers for the July meeting
20.05.2025	5.3.3	9	Planned Care Group Highlight Report	Highlight report to reflect the concerns raised regarding the number of did not attends being reported into Health, Safety & Fire Safety Committee for Manual Handling and Violence & Aggression training	Assistant Director of Governance & Risk	Assistant Director of Governance & Risk	31.07.2025	Open	**Proposed for Closure - Completed** Included in highlight report which is on the agenda for discussion at the July 2025 Board
20.05.2025	6,1	11	Patient Safety, Quality and Experience Dashboard	Update to be provided outside of meeting as to the timescale for completion of the development of the Failed Discharge Policy	Head of Concerns & Business Intelligence	Head of Concerns and Business Intelligence	22.07.2025	Open	**Completed - Proposed for Closure** The policy has now been approved. The regulation 28 report has been drafted and has been reviewed by Counsel. It will be issued imminently.

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	Closed	**Completed** This was included in March and May's report within the PSOW section - May's report the PSOW section is page 4 to top of page 6. Specifically lessons learned will be identified from any upheld / partially upheld final reports issued. During this period only 1 partially upheld report was received, the learning from this case is included at the bottom of page 5.
25.03.2025	4,1	3	Listening & Learning Story - Care received at the Snowdrop Breast Centre	Positive feedback to be shared with the Team at the Snowdrop Breast Centre along with the concerns identified in regards to communication of histology results	Planned Care - Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	20.05.2025	Closed	**Completed** Feedback has been shared with the Team at the Snowdrop Breast Centre
25.03.2025	5,1	4	Spotlight Presentation - Stroke Unit Temporary Centralisation	Concerns raised in regard to service inequity and the potential risk to patients to be included in the alert/escalate section of the Highlight Report to Board	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	29.05.2025	Closed	**Completed** This has been included in the alert/escalate section of the Highlight Report being presented to the May 2025 Board
25.03.2025	5.3c	7	Planned Care Group Highlight Report	Future iterations of the report to not include reference to clinical matters if an explanation was not being provided to make the matters clearer to members of the public	Planned Care - Care Group Nurse Director	Planned Care Group Nurse Director	20.05.2025	Closed	**Completed** Care Group Nurse Director will ensure future reports do not include reference to clinical matters moving forward
25.03.2025	5.3f	9	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report	Concerns raised by Members in regard to the prescribing practices for the new weight management drug given that there was currently no screening process in place and the long term implications of the drug were not yet known to be included in the alert/escalate section of the Highlight report to Board	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	29.05.2025	Closed	**Completed** This has been included in the alert/escalate section of the Highlight Report being presented to the May 2025 Board

25.03.2025	7,1	13	Organisational Risk Register - Risks Assigned to the Quality, Safety & Experience Committee	Review to be undertaken of the reduction in the risk score for risk 5462 Adult Weight Management Service and the request made for the risk score to be reverted back to 20	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	20.05.2025	Closed	**Completed** Following discussion outside the Committee meeting it was agreed that the risk captured in the Organisational Risk Register (Datix Risk ID 5462) reflected the service delivery risk and was appropriately decreased in risk score in March 2025. It was agreed that the Strategic Risk Owner for this risk should be Gethin Hughes, Chief Operating Officer. In response to the wider strategic risks around Population Health, Philip Daniels has proposed that he will reframe the Strategic Risk on the Board Assurance Framework to reflect the discussions at the Committee

(Agenda Item)	(Date of Meeting)	(Name of Meeting)	(Title of Item)

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	
Prepared By: *If you do not wish for your name to be included in the public domain, please only include your job title*	David Watkins
Presented By: *If you do not wish for your name to be included in the public domain, please only include your job title*	David Watkins & Craig Read (Unpaid Carer)
Approving Executive Sponsor:	Gregory Padmore-Dix
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	
Related Health and Care Standard	e.g. Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes (include date) No (Explain why)
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Sustaining Our Future Inspiring People Improving Care Creating Health

Connecting Carers – Creativity, Voice, and Impact

Project Overview

•Funded by: Welsh Government's Sustainable Social Services Grant

•Delivered by: Cwmpas & Tanio, Bridgend

•Duration: 11-week creative programme with unpaid carers

Purpose

•To explore innovative, creative ways for carers to tell their stories

•To provide carers with a voice, space, and validation

Activities & Engagement

Unpaid carers shared experiences through:

• Songwriting and performance

• Visual arts and activities

• Spoken word and storytelling

• Culminated in a **live performance** and the original song *"Who Cares?"*

Impact

•**Feedback** "Powerful, moving, and unforgettable – carers finally felt heard"

Connecting Carers – Creativity, Voice, and Impact



Craig Read – Grandfather and Unpaid Carer















Listening to Action – What CTMUHB Has Done

- **"We're introducing the principles of John's Campaign across inpatient settings…"**
  → *This ensures Carers are treated as partners in care – not just visitors – especially during hospital stays. These principles will guide how we engage Carers in discharge planning and care decisions.*

- **"We've developed and tested the CTM Carers Passport…"**
  → *The passport helps identify Carers early and provides a structured way for Carers and staff to agree on roles and support needs during admission.*

- **"We launched Carer Awareness Training for Band 6/7 and new-to-trust nurses…"**
  → *Embedding Carer understanding at the frontline ensures staff recognise, involve, and support Carers from day one.*

- **"We've expanded the Staff Carers Café…"**
  → *This supports our own NHS colleagues who are Carers – helping them balance work and caring responsibilities, which promotes wellbeing and retention.*

- **"We're building Carer identification into hospital digital whiteboards…"**
  → *An icon will soon help all ward staff and visiting partners instantly know that a patient has a Carer – triggering timely engagement and support.*

- **"And finally, we're ensuring Carers' voices shape future planning…"**
  → *Insights from our recent Carers survey, staff cafés, and creative engagement like the **'Who Cares?'** project are now influencing policies – including changes to visiting hours.*

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Specific Matters for Consideration:

•CTMUHB has taken forward a programme of work focused on recognising and involving unpaid carers across hospital settings, shaped by feedback from carers and third sector partners.

•Key initiatives include the development of the **Carers Passport**, the introduction of **John's Campaign Principles** across inpatient care, and **Carer awareness training** for Band 6/7 and new-to-trust nurses.

•Work is underway to embed **carer identification into digital hospital whiteboards**, improving visibility for staff and partner organisations.

•A **Staff Carers Café** has been established to support NHS employees balancing work and caring responsibilities.

•These developments are aligned with broader strategic changes, including the Health Board's **hospital visiting guidance review**, to ensure carer involvement is safe, equitable, and person-centred.

•"Embedding creative and co-produced approaches to carer voice into ongoing strategic planning, including hospital visiting policies."

Key Risks / Matters for Escalation:

•The **Corporate Lead for Unpaid Carers** role is currently funded through the Regional Integration Fund (RIF). With the national strategy and funding mechanisms under review, longer-term sustainability for this work remains uncertain.

•Ongoing clarity is needed from Welsh Government on future priorities for unpaid carers following the upcoming strategy refresh.

•While early engagement work has been positive, continued investment in **training, digital infrastructure**, and **staff support** will be required to embed this work fully and realise long-term cultural change.

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Recommendation

The Committee is asked to:

•Note the innovative approach taken through the Connecting Carers programme to capture and amplify the voices of unpaid carers in Bridgend.

•Recognise the Health Board's actions in response, including development of the Carers Passport, implementation of John's Campaign Principles, and wider work to improve carer visibility and support.

•Consider the longer-term benefits of embedding carer involvement within hospital policy and practice, and note the potential risk to sustainability without secure ongoing funding.

• Next Steps

- Continue embedding carer-related initiatives into core policy and operational frameworks, including hospital visiting guidance.
- Launch and evaluate the Carers Passport and digital ward icon following planned implementation.
- Sustain engagement with unpaid carers, third sector partners, and staff through carer feedback mechanisms and the Staff Carers Café.
- Maintain dialogue with Welsh Government regarding future funding and strategic alignment as the national carers strategy is revised.

Agenda Item
5.1

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes-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
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Greg Padmore-Dix-Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Therapies and Health Sciences, 4. Philip Daniels-Executive Director Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	1. Greg Padmore-Dix-Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Therapies and Health Sciences, 4. Philip Daniels-Executive Director Public Health

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
CEO	Chief Executive Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
VTE	Venous Thromboembolism

1. Situation /Background

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

- Greg Padmore-Dix Executive Director Nursing, Midwifery & Patient Care/Deputy CEO
- Dom Hurford-Executive 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 each of the Quality, Safety & Experience Committee meetings through the Quality, Safety & Patient Experience Dashboard.

2. Specific Matters for Consideration

Section 2.1 Clinical Executive Director updates: Nursing & Midwifery

Specific Matters for Consideration:

CTM's School Nursing Team first e-consent system pilot CTM's School Nursing

CTMUHB recently launched an e-consent pilot led by the School Nursing Team at Afon Taf Comprehensive School in Merthyr Tydfil. This initiative marked the first use of a digital consent system within the health board, aimed at improving the efficiency of obtaining parental consent for school-based vaccinations. The system allows consent forms to be distributed via school communication platforms, returned electronically, and stored in a new system for use during immunisation sessions.

This approach has significantly reduced the administrative workload and travel time for nursing staff, enabling them to focus more on public health delivery. The pilot achieved an 86% return rate on consent forms, a notable improvement over traditional paper-based method.

Following this success, CTMUHB plans to expand the system to other schools for the autumn nasal flu vaccination programme, with the goal of becoming fully paperless by January 2026. The initiative has been highlighted in internal performance dashboards and committee reports as a key step toward improving population health and sustainability. While the pilot currently focuses on parental e-consent, there is precedent within NHS Wales for nurse-led consent in clinical procedures, which could inform future developments in vaccination consent protocols.

Lifetime achievement award for Advanced Nurse Practitioner

Andrea Croft, an Anticoagulation Advanced Nurse Practitioner at Cwm Taf Morgannwg University Health Board, has been honoured with the inaugural Lifetime Achievement Award at the 2025 Thrombosis UK VTE Awards. Presented at the Houses of Parliament, the award recognises Andrea's significant and lasting contributions to VTE prevention and management, highlighting her dedication to patient safety and influence on local and national practice. Andrea expressed gratitude for the support of her family, friends, and colleagues, reflecting on a fulfilling career centred on improving patient care. CTMUHB's Pharmacy-led Anticoagulation Service at Royal Glamorgan Hospital was also recognised for its work in perioperative anticoagulant management.

Nursing and Midwifery Delivery Plan

CTMUHB continues to make progress in aligning its work to the Nursing and Midwifery Delivery Plan 2024–2027, which sets out five strategic ambitions: workforce development, leadership, quality improvement, research and innovation, and professional identity. These ambitions are being embedded through care group level initiatives, professional leadership development as well as in the development of the Nursing and Midwifery faculty in the CTMUHB Clinical Learning Academy. Key examples include the development of a revised preceptorship model and the initiation of restorative clinical supervision (RCS) to support staff wellbeing and retention.

The organisation's alignment with the All-Wales Nursing Workforce Plan is reflected in its active participation in national forums and its contributions to shaping policy on new roles, job profiles, and inclusive leadership. CTMUHB has taken a leading role in advocating for equity in nursing, with workstreams focused on supporting global majority nurses into leadership roles. This is complemented by the work of our Assistant Director of Nursing, who is working together with workforce and development colleagues to design and deliver a leadership development programme for ward managers, senior nurses, and lead nurses. This programme aims to build confidence, capability, and compassionate leadership across all levels of the nursing workforce.

Care Groups also play a vital role in delivering the plan. Each group has set out to develop its improvement plans aligned to the Duty of Quality, focusing on embedding RCS, strengthening clinical supervision, and modernising nursing roles. For example, the Children & Families Care Group has set out to map its priorities to the delivery plan. The Mental Health Care Group has actively contributed to the strategic ambitions of the delivery plan through its operational policy updates and governance workstreams. Strategically, the Mental Health Care Group is also embedded in broader transformation efforts and during the CTM UHB Palliative and End of Life Care Strategic Implementation Group, representatives, including Primary Care and Community Care Groups, contributed to discussions on redesigning palliative care pathways, integrating bereavement support, and

aligning with national frameworks. The group's involvement in this cross-cutting work reflects its commitment to collaborative leadership and system-wide improvement, key pillars of the Nursing and Midwifery Delivery Plan.

Looking ahead, CTMUHB intends to expand its efforts across all five ambitions—enhancing career pathways, increasing research participation, and celebrating professional identity—while introducing a refreshed governance framework to monitor delivery and ensure accountability. These collective efforts reflect a system-wide commitment to building a compassionate, skilled, and future-ready nursing and midwifery workforce.

Present Challenges

Unscheduled Care Nurse Director Vacancy

During May and June, Cwm Taf Morgannwg UHB identified an increase in pressure ulcer incidents, particularly within unscheduled care settings. This situation highlighted the need for enhanced focus on patient safety. In response, several closure bundles were prepared for executive review.

Operationally, the organisation implemented a series of governance and assurance measures aimed at improving outcomes. The Business Intelligence Team began producing weekly reports to monitor incident trends. Additionally, the Pressure Ulcer Prevention Management Care Plan (V7) and updated pressure ulcer guidance were put into action to reinforce best practices. A dedicated senior nurse-led prevention day was conducted, engaging over 90 staff members and fostering a proactive culture focused on harm reduction.

While these steps indicate progress, the ongoing occurrence of harm cases suggests the need for continued efforts to establish consistent prevention strategies and improve early detection, particularly in high-pressure unscheduled care environments. The Unscheduled Care Group leadership team is work together with the Pressure Damage Steering Group, corporate nursing, and service leaders to review and develop specific actions, which will be presented at the next Executive Management Board meeting.

Clinical care during adverse weather conditions

Corporate Nursing Services at CTMUHB are working together with key stakeholders—including Workforce, Facilities, Pharmacy, Therapies, and Operations—alongside Civil Contingency experts to establish a unified policy on staff uniforms during periods of adverse weather. This initiative was prompted by the previous need for ad hoc memoranda issued in response to MET Office alerts and local escalations, highlighting the absence of a formalised, system-wide approach. With representation from key stakeholders and our Civil Contingency Manager, a working group has been proposed to ensure that any guidance developed is operationally feasible and aligned with emergency preparedness protocols. The aim is to create a framework that can be interpreted consistently

across site and care group leadership, reducing ambiguity and ensuring staff safety and comfort without compromising professional standards.

In the interim, and recognising the urgency posed by rising temperatures and increasingly hot clinical environments, the Deputy Executive Director of Nursing has committed to issuing advisory guidance. This will be developed with Infection Prevention and Control (IPC) specialists and Allied Health Professionals to support staff and patients during hot weather and confirmed heatwaves. The guidance will address uniform adaptations, hydration strategies, and environmental adjustments to maintain safe care delivery. This proactive stance reflects CTMUHB's commitment to staff wellbeing and patient safety, while longer-term policy solutions are being formalised.

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:

1. Revalidation and Appraisal 2024-25
2. Health Board Level Report for the 2024 Epilepsy12
3. Future Clinical Leaders Day

Achievements

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

Achievements

This section covers the following achievements:

1. Princess of Wales – Intensive Care Medicine
2. Saving Lives Through Early Recognition: Early Warning Scores (EWS) Update 2025
3. Reg 28 discharge and return policy
4. Transition care
5. Clinical Advisory Group

Princess of Wales – Intensive Care Medicine

We are pleased to confirm that the risk regarding CTM ICM residents in Princess of Wales Hospital from the Health Education Improvement Wales (HEIW) Medical Training Concerns Risk Report has now been closed. The risk related to below average rota management, educational supervision and overall trainee satisfaction.

Measures have been implemented to improve Consultant numbers, rearrange working patterns to allow leave to be taken appropriately, and supervision and education provision.

All residents have fed back on these improvements with ICU training experience and supervision, confirming that they would recommend a post in POW Intensive Care to other residents.

Saving Lives Through Early Recognition: Early Warning Scores (EWS) Update 2025

We've successfully launched PEWS (Paediatrics) MEWS (Maternity) and NEWTT2 (Neonates).

On Tuesday, 15th of July, NEWS2 in all our secondary care sites, including ED and Mental Health, went live. E-learning has been taken up well in all areas, and there have been many drop-in sessions put on by the Outreach teams. There is also a supportive large piece guide on SharePoint.
Thanks for Richard Jones and Vanessa Jones for their leadership here and all the teams involved in adopting, training and implementing.

Reg 28 Discharge and Return Policy

A regulatory 28 notice was issued following a serious incident involving a patient who was subsequently discharged. In response, a new policy has been implemented requiring all returning patients to be reviewed by the relevant speciality team. This policy has been clearly communicated across departments, and all clinical staff have been engaged in its rollout. The organisation has reflected on this event and taken meaningful steps to improve patient safety through this updated approach.

Transition care

The Children and Family Care Group are leading on the transition from Paediatric to Adult services. This is a national piece of work spearheaded by Cardiff & Vale UHB (C&VUHB), however, we are the furthest forward health board other than them. There is a national plan that we are helping shape and internally we are developing pathways and documents to align services to improve the movement of patients into adult services. Complex multi-specialty care remains the most difficult area to resolve, single specialty transition is relatively straight forward. However, different specialties transition at different times with differing support processes. We are developing a CTM approach to focus on these areas.

Related to this was a recent case where an 18-year-old died in a critical care setting within CTMUHB. The Transition process that had taken place prior to it made the sadly, inevitable death, very supportive and caring for the patient and those caring for them. The critical care teams approach to care using transition care approach has been much praised by those who cared for the individual.

Clinical Advisory Group (CAG)

Many thanks to Sally Bolt for serving two terms as Chair. CAG will be recommending an individual to take over the role. This particular appointment is made by the Cabinet Secretary, and not the Health Board.

Areas of Focus

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

1. Haematology Day Unit Relocation
2. Gender Services

Haematology Day Unit Relocation

Some patients are being managed back in RGH, but a tight criteria has been needed. Bigger plans are being made by the team to manage the service going forwards to ensure a service closer to patients' homes.

We are receiving several patient concerns on this matter and we have explained the reasons it was needed (not financial). This relocation has taken place due to capacity and space at RGH due to the decamp from POW. We are looking at a new version of the service to support all patients. This work is currently being undertaken by the Care Group.

Gender Services

A recent case has highlighted challenges related to the provision of Gender Services in Wales. We encountered limitations in overseeing surgical interventions due to governance constraints and the fact that only specific centres are accredited to handle Gender Service patients. We have addressed this matter with Cardiff and Vale University Health Board (C&VUHB), which is responsible for overseeing services in Wales; however, surgeries related to these services fall under the commissioning authority of NHS England and are not within NHS Wales.

Section 4 ALLIED HEALTH PROFESSIONS (AHPs)

Research, innovation, and recognition

A Clinical Associate in Applied Psychology (CAAP), from CTM Older Adult Mental Health services, had their work in developing a Mild Cognitive Impairment (MCI) group accepted for publication in the British Psychology Society's Clinical Psychology Forum, as well as for presentation at Alzheimer's Europe Conference in Bologna. The MCI course has also been highlighted in Age Cymru EnvisAGE journal as an area of good practice and AHP-led innovation in Wales.

A CTM Clinical Psychologist is presenting at the British Psychological Society's Division of Health Psychology national forum. They are sharing i) the creation of a preventative intervention aiming to reduce the risk of young people living with Type 1 Diabetes developing an eating disorder (T1DE) and ii) a pilot clinic which they and a Highly Specialist Paediatric Diabetes Dietitian are piloting with young people from CTM, focused on supporting Health Behaviour Change in Diabetes.

The Cardiology Department at the Princess of Wales Hospital has been nominated by students for 'Best team for student education and support' and a Specialist Cardiac Physiologist has been nominated for 'Most inspiring educator', with an awards ceremony this summer.

Members of CTMUHB's paediatric Dietetic service were recipients of the British Dietetic Association group of the year for their work in advancing the paediatric Dietetic service.

As part of the Diabetes MDT, Diabetes Dietitians are involved with the Cloud Care trial in RGH. RGH is the first Diabetes centre to pilot the Cloud Care system in UK and will include approximately 400 patients on insulin pumps. Cloud Care uses data from patients' pump/glucose sensor to help the MDT monitor remotely via an app. This is an innovate development within the team that will support the team to focus on those in most need of medical support, whilst also providing a platform to remotely review those with better control providing a more robust, clinically focused prioritisation approach to patient care and follow up.

Good practice and service developments

The Physiotherapy paediatric service hosted The INSPIRE Games at the National Indoor Athletics Centre in May. The purpose of this event was to showcase and demonstrate the strengths and abilities of children with additional needs. The focus was on activity and participation for all, and at all levels. There were 150 young people from across five schools participating in multiple tailored events.

We have commenced roll out of the All-Wales Diabetes Prevention Programme to improve equity of access and to support people to reduce their risk of developing Type 2 Diabetes. National evaluation is showing 25% reduction in the development of Type 2 Diabetes in people invited to attend AWDPP, and so the service has an opportunity to significantly impact rates of Type 2 Diabetes across the CTM footprint.

Affina, an internationally recognised framework commissioned by Workforce and OD, is being rolled out across the new leadership team in Dietetics. Through supported coaching, the teams will be guided through the 10 stages of the team journey, facilitated by practitioners in the Workforce and OD team.

An upload feature on the Welsh Clinical Portal (WCP) is being trialled in Orthotics in POW, ahead of site-wide roll out August 2025. This will allow for de-

commissioning of the orthotic digital system (OPAS) on 30/9/25 and enable closure of a Care Group risk.

All AHP departments have moved to using recycled paper for standard printing, which is more cost efficient and a more sustainable option (as digital solutions are progressed across the HB).

Care Aims training has been delivered to all Speech & Language Therapy (SLT) staff and some other AHP colleagues, funded by WG, to enable further prudent effective care and shared decision making.

Physiotherapy is in the process of setting up PROMPTLY for patients accessing their Valed Based Healthcare (VBHC) funded project in Musculoskeletal (MSK) and prudent triage which will improve timely access to MSK services. PROMPTLY is the digital healthcare assessment platform, allowing services to receive PROMS and PREMS data.

Coproduction workshops have begun with the AHP neonate team and parents of neonatal babies. Initial feedback is very positive with more workshops planned. The aims are to continue to develop a neonatal follow-up service that is coproduced and will meet the needs of the service users. Having the "voice of the baby" is a theme being developed by the service following the workshops.

There has been a successful VBHC bid for Diabetes remission. This fixed term funding supports development of a service model that will provide patients with a 12-month intervention to put them in diabetes remission in the short term, and to provide people with the knowledge and skills to prevent them from having diabetes in the long term.

A new Band 6 Occupational Therapy (OT) Development Framework is being rolled out across the OT Service. This self-directed resource was co-produced between OT Leaders and Band 6 OTs and is based on RCOT’s pillars of practice. It is available to all Band 6 OTs across CTMUHB and will sit alongside the PDR process and supervision.

Other developments

Funding has been granted by Moondance Cancer Initiative for the CTM cancer prehabilitation team to visit and experience the prehabilitation services in Montreal, Canada. This has allowed the prehabilitation team to gain knowledge, experience and skills in delivering prehabilitation service from the world leaders in this area.

Our OT Service is proud to have co-produced a Cognitive Disabilities Model (CDM) eLearning course for Occupational Therapists, launched in June on HEIW’s digital learning platform. The course is a mix of knowledge acquisition via self-directed digital learning resources interspersed with online lectures, assignments and support from local mentors. It facilitates the translation of knowledge into clinical practice and will be delivered on an all-Wales basis.

CTM OTs co-produced this resource with OT colleagues and people living with Dementia across Wales. Our Band 7 OT workforce across Older Persons Mental Services demonstrated their vision and commitment in the development of this unique training resource.

CDM training has been included in the 'OT Service Training Passport' for a number of identified posts in the OT Workforce. Our local experts are mentoring CTM OT registrants undertaking the training so that they can develop their competencies and embed their knowledge and skills into clinical practice to continue to improve the quality of patient. Our OT Service continues to share knowledge, expertise and our ongoing learning through the national mentors' network.

Launch of Cognitive Disabilities Model eLearning course for Occupational Therapists - HEIW

For Awareness

In June 2025, three kits used for Evoked Potential testing in babies (ABR testing), used by Audiology pan-CTM, were found to be out of their annual Stage B calibration. These tests form part of Newborn Hearing Screening Wales (NBHSW) pathways, with test results supporting the diagnosis and management of deaf babies. Early amplification is vital for progress in speech development, social development, and early years learning.

The kits were new and provided in May 2024, with the assurance of having been calibrated and supplied ready to use. However, calibration certificates were not supplied with the kits and there was no 'date of calibration' sticker attached to the kits (this is the usual approach as it clearly shows calibration due dates, which are checked every time the kit is used). When the company responded to requests, it was found that the kits were calibrated over 10 weeks before being delivered: 8th March 2024, meaning the stage B calibration renewal date had already passed by 10 weeks (March 2025).

A detailed review of this incident was completed, and swift actions were taken to understand the potential impact on patients and to address the risks. When the company came to recalibrate, all three kits were found to be within calibration and so no retests were required. A comprehensive suite of actions have been taken to avoid a similar situation occurring in the future, along with cascade of learning outside of the department and Health Board. The incident has been recorded as a 'no harm' incident.

Challenges

Multiple short term funded posts across the Dietetic service. Sustainable funding is required for the All-Wales Diabetes Prevention Programme (AWDPP) and PIPYN from March 2026 onwards. A high proportion of fixed term post holders are likely to leave prior to the end of their contracts, impacting delivery. Work is underway

on the evaluation of these programmes and working with Welsh Government and stakeholders to identify possible funding solutions for these programmes.

Section 5 Public Health Update

A new diabetes programme board and diabetes operational board have been set up to provide governance and strategic direction for the CTM diabetes programme. In the process of developing a CTM 5-year diabetes strategic action plan a gap analysis was completed by clinical teams. This gap analysis revealed some variation in delivery of diabetes services and staff capacity across CTM. Key findings from this gap analysis are:

1. Structured diabetes education

- CTMUHB adults with type 1 diabetes face inequity in accessing DAFNE courses. There is no DAFNE provision (face-to-face or virtual) at Princess of Wales Hospital due to staff capacity. Instead, Carbohydrate Counting groups are run 5 times a year.

- No SEREN Connect courses (adolescent course) provided at POW due to reduce diabetic specialist nurse capacity

2. Podiatry

- Independent podiatry prescribers only available at POW.

3. Inpatient adult diabetes treatment pathways

- There are diabetic ketoacidosis policies in CTM (one at RGH and PCH; one in POW). This variation has continued since Bridgend joined the UHB in 2019.

4. Preconception care and diabetes in pregnancy

- There is a dedicated consultant diabetologist led preconception clinic held at RGH – referrals from healthcare professions or self-referral route available. This clinic will see patients from across CTM if they are referred, but there is limited capacity for this as there's no dedicated preconception clinics at PCH/POW.

- Variation in postnatal follow up of women with gestational diabetes. No agreement between primary and secondary care regarding which service is responsible for postnatal Hba1c testing

Key actions to address these variations are included within the 5 years diabetes strategic action plan.

Work to develop a CTM adult diabetes pathway covering all these aspects of patient care has commenced.

6. Key Risks / Matters for Escalation

All challenges identified for this reporting period have been highlighted under each section of the updates from each of the four Clinical Executive Directors.

7. 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 list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	Efficient Equitable Person Centred Timely Safe
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 paper is presented for information and noting purposes.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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 paper 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 paper covers items as a broad update for assurance to the members of the Quality, Safety & Experience Committee however, under the directorship and leadership of the four Clinical Executive Directors who hold joint responsibility for this paper, there is a collective strive and dedicated commitment to protect the health board's reputation.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

8. Recommendation

8.1 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.

9. Next Steps

9.1 Members of the Quality, Safety & Experience Committee will continue to receive regular updates for assurance and for awareness of successes and challenges together with any identified risks.

Agenda Item
5.2.1

Quality, Safety & Experience Committee

Highlight Report from the Children & Families Care Group Quality, Safety and Experience Meeting held on 12th June 2025

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Suzanne Hardacre, Director of Midwifery & Nursing, Carl Verrecchia, Service Director Mohamed Elnasharty, Medical Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Suzanne Hardacre, Director of Midwifery & Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
ACEs	Adverse Childhood Experiences
BFI	Baby Friendly Initiative
BR+ ®	Birthrate Plus (Nationally recommended workforce acuity tool)
CNO	Chief Nursing Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
CYP	Children and Young People

DMC	Digital Maternity Cymru
EWS	Early Warning Score
GP	General Practitioner
HCWP	Healthy Child Wales Programme
HSJ	Health Service Journal
HV	Health Visitor
LD	Learning Disabilities
MEWS	Maternity Early Warning Score
MNPB	Maternity and Neonatal Programme Board
MNSB	Maternity and Neonatal Safety Board
MNVP	Maternity and Neonatal Voices Partnership
MoD	Ministry of Defence
ND	Neurodevelopment
NEWTT 2	Newborn Early Warning Track and Trigger tool (2)
PACE	Playfulness, Acceptance, Curiosity, Empathy Framework
PEWS	Paediatric Early Warning Score
PROMPT	**PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining
RCN	Royal College of Nursing
RCM	Royal College of Midwives
SCBU	Special Care Baby Unit
WG	Welsh Government
WHC	Welsh Health Circular

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Children and Families Care Group at its meeting on 12th June 2025.

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

2. Purpose of this Meeting

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

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

- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

Alert / Escalate	• Maternity and Neonatal Programme Board (MNPB) held 23.6.25 and Maternity and Neonatal Safety Board (MNSB) held 3.7.25; providing assurance and progress against Bridgend maternity improvement plan (Appendix 1). Well-Being team supporting colleagues, PACE work completed, report received, meeting planned w/c 23rd July with wellbeing and workforce colleagues to determine next steps. A full external thematic review is being undertaken on all 4 cases to assure that the correct pathways and protocols were followed, and any early learning is taken, shared and any recommendations will be embedded. This has been reported through Executive leadership team. The external midwifery reviewer has concluded their review; obstetric and anaesthetic reports awaited. • Special School Nursing: Fragility within the service due to resignations, sickness absence. Head of Nursing and Service Manager working closely with Headteachers. Special school nursing remains a high risk in Children and Families – workforce vacancies and long-term sickness absence resulting in increased pressures and gaps in provision, also impacting on community consultant caseloads. Meeting to outline challenges held with executive colleagues on 3rd June. Further discussion being held with Local Education authorities and CTMUHB to work through solutions. Concerns raised via LLAIS; response being prepared.
Advise	• Head of Nursing for Children & Young People (CYP) appointed, the Panel included a young person (age 12). • Senior Nurse for Paediatrics at Princess of Wales hospital appointed and now in post. • Clinical informatics, bereavement leads, senior midwifery manager community, concerns lead midwife, neonatal governance and MatNeoSSP champions all appointed • School Entry Hearing service requires transfer to audiology. The Health Board remain out of compliance with Welsh Government recommendations. • Successful pilot of a "diagnosis at triage" fast-track pathway for autism referrals in children/young people aged 5 or above where there are no significant learning difficulties (LD), Adverse Childhood Experiences (ACEs) or safeguarding concerns and school/family have provided detailed information to reach a conclusion. Spotlight presentation will

take place at August Care Group QSE meeting. The Neurodevelopmental (ND) team are continuing to deliver a sustained improvement in the waiting times and Meetings with NHS Executive colleagues has now been reduced to fortnightly as we are providing assurance that the plan is on track. There are no patients waiting at 104 weeks at the end of May.

- Women's Health Hub discussions are ongoing. We have submitted a draft plan to the network, still looking to identify a Primary care lead to help us position this more appropriately in the community. Good engagement from the Primary Care and Community Care group and further work to be established to progress the plan of a pathfinder service for the Health Board by March 2026. The initial resource to set this in motion is non-recurrent
- Improvements in delivery of Healthy Child Wales Programme (HCWP) and Health Visiting (HV) monitored via Care Group Oversight Board, encouraging progress noted at Board held on 24th June. Figures 1 & 2 demonstrate notable improvements since cessation of industrial action in 2024.

Fig 1 - HCWP Contacts July-Sept 2024

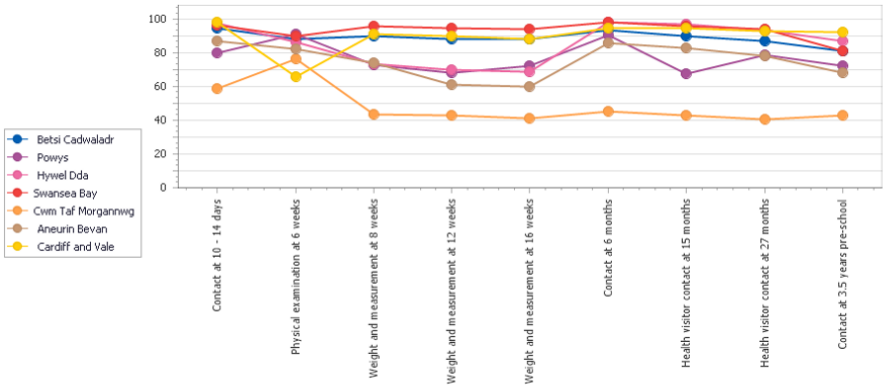
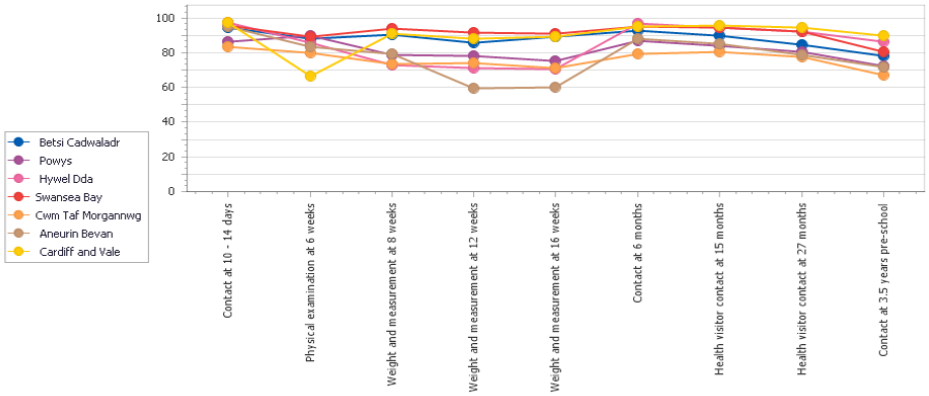


Fig 2 - HCWP Contacts Oct-Dec 2024



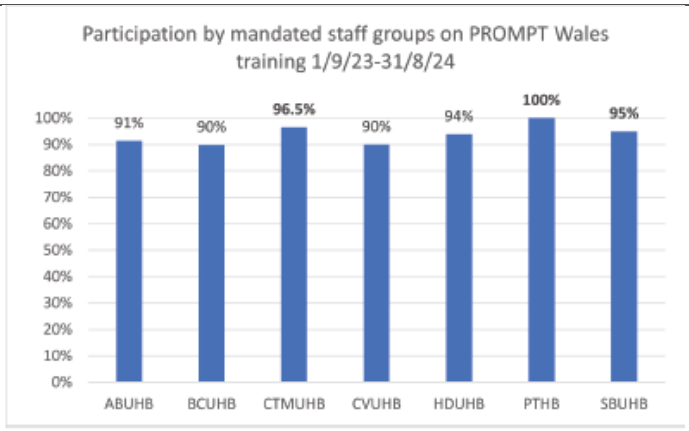
Assure

Risk Register

There is currently one risk scoring high with 15 or more

Risk ID	Description	Score
5753	**Inadequate Special School Nurse provision**	**20**

- Badgernet Maternity Information System implementation: Programme Board inaugural meeting 14th July 2025. Deployment of the system on track for end of March 2026 in accordance with Welsh Government Quality Statement for Maternity and Neonatal Services.
- Birthrate +® (BR+) Workforce review within maternity services progressing well. Report due early August 2025.
- MEWS, PEWS and NEWTT 2 Early Warning Scores successfully implemented across the Care Group as required by Welsh Health Circular (WHC) (2025) 002 Timeliness and Responsibilities for the Implementation of Early Warning Scores (EWS) to identify Acute Deterioration.
- Annual PROMPT Wales compliance report received (2023-2024). 97.5% attendance of Midwives (Standard 95%),
- Overall Multi-Disciplinary Team (MDT) attendance 96.5% (Standard 95%).
- Current overall midwifery compliance at 30th June is 74.5%, additional training days added throughout July and August to improve compliance (recognised on local Risk Register).



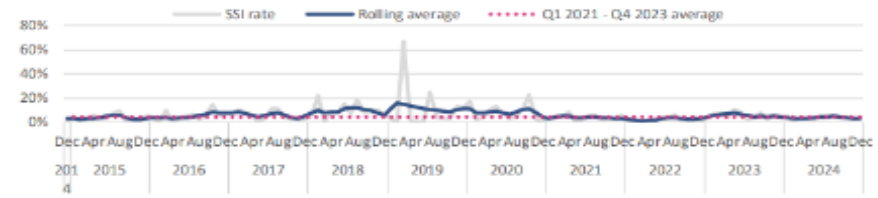
- Nursery Fluenz – discussions taking place with Public Health and Health Protection teams to develop a delivery model for September.
- High sickness absence across Special Care Baby Units, (SCBU) affecting training compliance, workforce colleagues supporting senior nurse.
- Safe paediatric transfers from tertiary unit – potential incidents being monitored and recorded via DATIX system. Risk and Governance lead within CYP undertaking 'deep dive' to inform further action.
- Annual midwifery safeguarding report received. Notable improvements in Level 3 safeguarding training, safe sleep advice audit evidence 100% on discharge from hospital, 88% on first postnatal visit. Further work underway to improve information sharing with health visitors and GPs.
- Llais report (family experience of maternity and neonatal care in Swansea Bay) received. Formal CTMUHB response returned.
- Children and Young People (CYP) teams are working through plans to develop an immunisation workforce with Public Health and Health Protection Teams. Comments awaited with consideration for any alternative models by working in partnership.
- Cultural competency certification progressing well across the Care Group, submission planned for late July.
- Remunerated Maternity and Neonatal Voices Partnership (MNVP) Chair appointed, due to start end of July in accordance with the WG Quality Statement for Maternity and Neonatal Services.
- Estates colleagues working to resolve air handling ventilation failures within labour ward at PoW.
- Phased implementation of Hybrid Closed Loop (HCL) pumps for children with Type 1 diabetes has begun, this will ensure the service meets NICE recommendations (TA947, 2023).

- Increase in formal gynaecology concerns since last reporting period. Outcome of deep dive (concerns, patient experience and incident reporting) presented at Care Group QSE meeting on 12th June, no emergent themes identified.
- The all Wales SSI rate in 2023 was **4.58%.** Health board rates across Wales in 2023 ranged from 2.51% to 10.44%. POW rate in 2023 was **2.53%** and PCH **5.7%.**

Hospital and health board data from 1st Jan 2024 – 31st Dec 2024

	SSI rate	Change	Data received**	Valid data**
Prince Charles				
Q1 2024 - Q4 2024	**3.8%**	↓ 10%	100%	99%
Q1 2021 - Q4 2023*	**4.2%**		100%	97%
Cwm Taf Morgannwg UHB				
Q1 2024 - Q4 2024	**3.1%**	↓ 14%	99%	99%
Q1 2021 - Q4 2023*	**3.6%**		99%	94%

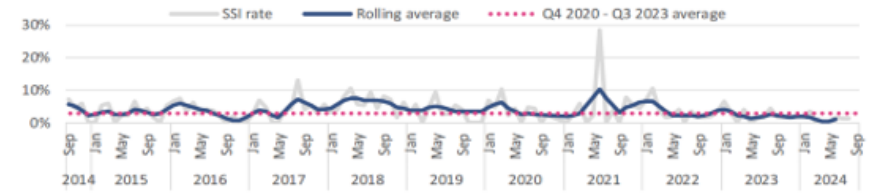
**Previous three years data for the hospital/health board.*



Hospital and health board data from 1st Oct 2023 – 30th Sep 2024

	SSI rate	Change	Data received**	Valid data**
Princess of Wales				
Q4 2023 - Q3 2024	**1.4%**	↓ 52%	94%	94%
Q4 2020 - Q3 2023*	**3.0%**		98%	88%
Cwm Taf Morgannwg UHB				
Q4 2023 - Q3 2024	**2.1%**	↓ 43%	87%	87%
Q4 2020 - Q3 2023*	**3.7%**		96%	89%

**Previous three years data for the hospital/health board.*



Inform	• Care Group Senior team are working through the timescales set out in the action plan from the staff survey to address the three lowest scoring areas from the feedback. • Successful application to be a research site for the next phase of the Institute of Health Visiting, Alarm Distress Baby Scale (ADBB) Study. Cwm Taf Morgannwg are the only site in Wales participating. The Royal Foundation Centre for Early Childhood is funding Phase 2 in partnership with University of Oxford. • Digital Informatics Midwife has won two NHS Wales Sustainability Awards in June (Chief Nursing Officer (CNO) sustainability in Nursing & Midwifery and Wellbeing of Future Generations categories), Shortlisted in two categories and received Highly Commended in National Health Service Journal Digital Awards. • Wellbeing events planned across maternity and neonates 30.7.25 • Several nominations for RCN Nurse of the Year Wales and RCM UK awards submitted from across the Care Group • Two midwives supported to commence RCM/WG Midwifery Leadership Development Programme 2025. • Positive Baby Friendly Initiative (BFI) assessment across community midwifery, Princess of Wales Maternity and Tirion Birth centre on 3rd July – 72 of 75 actions passed, full accreditation will be achieved within 6 months. • Research, Development and Service Improvement update received at Care Group Quality and Safety Committee in June. Several clinical research portfolio, non-portfolio, commercial, non-commercial and service evaluation projects underway across the Care Group. • School Nursing E-Consent pilot in Merthyr successful with 86% uptake. Evaluation being completed with plans to introduce across CTMUHB. • A health visitor has had their work published within community practitioner on alcohol harm and supporting families, and a further health visitor has produced mini webinars embracing equity in breastfeeding (gypsies and travellers) • Care Group Ministry of Defence (MoD) leaders team building event held 5th and 16th June. Further dates planned for clinical teams.
Appendices	• Appendix 1 – Bridgend Improvement Plan Update June 2025. • Appendix 2 – Maternity & Neonatal Metrics (available within the documents folder on Admincontrol)

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below: • Creating Health • Inspiring People • Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well If more than one applies please list below: • Growing Well • Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below: • A Globally Responsible Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below: • Culture and Valuing People • Leadership • Learning, Improving and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe • If more than one applies please list below: • Timely • Equitable • Efficient • Effective • Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce If more than one applies please list below: • Repurpose • Reuse • Refine • Recycle

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not a policy or guideline

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

PoW Maternity Improvement Plan (Feb – May 2025) - Action plan

Inspection origin: Maternity (POWH): Concerns Tracker/ Action Log

Date of inspection: 03/02/2025

Inspection lead: Jodie Hodges

Inspection team: Bryany Tweedale-Bend, Charlene Andrews, Dawn Apsee, Debbie Jones, Emily Bacavitch, Frances Hodge, George Haroun, Janine Pugh, Jodie Hodges, Kate Strong, Kelly Godwin, Kiim Jenkins, Mohamed Elnasharty, Pooja Munjal, Rachel Griffiths, Victoria Box, Victoria Healey

Date action plan generated: 8th July 2025

Recommendations & actions

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD1	MD	Enhance the Incident management education for Band 7 operational leads	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & Effective Care	NO	Safe	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD1/1	Patient safety team to provide Datix, national incident framework training to operational leads/governance team.	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Met with all the operational and governance leads and provided training on datix and IMF. Ongoing on a weekly basis 7.7.25 update PST on site weekly to support governance team	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD2	MD	Incident/Datix training Midwifery staff	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & Effective Care	NO	Safe	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD2/1	Patient safety team to attend CSfM training sessions to provide training and awareness of the national incident framework and the incident management process (Datix)	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Patient safety team have scheduled session to attend supervision throughout the year and dates have been arranged	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD3	MD	Patient safety to increase visibility on maternity sites in CTM	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD3/1	Patient safety team to base within the maternity sites 1 day per week per acute site	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Completed – Patient on site 1 day per week Tuesday PoW Wednesday PCH	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD4	MD	Quality assurance – complete spot clinical audits of monitor and track compliance of key clinical practice. (deteriorating patient, escalation, Hypernatremia)	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD4/1	Critical care to undertake MEOWS audits	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Initial spot check audit completed Out reach attending the ward area to meet and discuss with staff (Treat and teach) 8.7.25 - critical care include maternity MEOWS audit on HB wide assurance tracking and monitoring - actions are escalated via SWAG	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD5	MD	Quality assurance/Clinical Audits	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD5/1	Undertake on spot clinical audits of key clinical proformas which align to key themes within risk: Fluid balance MEOWS charts HDU charts CTG proforma's	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Initial audit completed – Compliance for fluid balance charts was poor. Progress update – Updated and amended fluid balance chart now ratified and due to be implemented 1.5.25 June Update - MEOW audit complete following the role out of MatNeo SSP MEOWS and NEWTT2 charts. compliance was strong - results presented a Programme board June 25, including action plan	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD6	MD	Clinical Skills and Drills Education/Training	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	4/4	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD6/1	Undertake emergency drill training of key clinical emergencies	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	01/05/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Emergency drills scheduled vaginal Breech drill completed July update - further additional emergency drill are scheduled, including baby abduction drill. compliance PROMPT in PoW monitored monthly and presented at SWAG	None	None	1	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD6/2	Undertake a training needs gap analysis and ensure staff members have allocated training dates (NLS,BLS etc)	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Complete – all staff members allocated mandatory training dates 1. All Midwives, Healthcare suport workers and Staff nurses in Maternity have been allocated BLS/NLS dates for 2025.	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD6/3	Critical care outreach team to attend PROMPT training sessions to improve/enhance collaboration/ escalation	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	30/09/2025	Partially complete

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Outreach team attend PROMPT training in PCH – due to attend scheduled PROMPT in PoW UPDATE 8.7.25 Out reach attending PoW where service allows. In addition, outreach will be attending B7 meeting 25.7.25 to explore how the team can promote collaboration	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD6/4	Achievement of 95% PROMPT / CTG / GAP / GROW training attendance	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	30/08/2025	Partially complete

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Attendance monitored via SWAG/MNPB/MNSB / IQPD Monitored monthly. June compliance report attached - additional sessions added to support compliance, june compliance attached	None	None	1	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD7	MD	Training education for our Labour ward coordinators	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD7/1	Labour ward coordinators to complete HEIW labour ward coordinator framework	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	01/09/2025	In progress

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Discussion to commence to support B7 labour ward coordinators to commence the framework Launch expression of interest to support development of B6 to complete to framework	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD8	MD	Restructure Clinical Supervision of Midwives Supervision sessions	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD8/1	Restructure of supervision sessions, midwives to attend quality and safety (risk) meetings	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	01/08/2025	In progress

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Completed. PCH site midwives now attend Risk meeting. Challenges with room availability and standardising Risk day (Staff absence, roof)	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD9	MD	Review Annual Audit forward Plan	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	2/2	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD9/1	Review Annual Audit Forward Plan, complete a GANT chart of completion	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	30/09/2025	Partially complete

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Initial discussion with Clinical Audit team (corporate) April 25 – update clinical audit training to be undertaken June 25 Clinical audit training session completed by external team. Annual audit forward plan review has been undertaken by obs and clinical audit team. July 25 - CMW returned from secondment who will oversee Obs assurance plans	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD9/2	Undertake a gap analysis of the RCOG recommendations (IMSOP)	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Complete – currently updated onto AMaT June update - Actions uploaded onto AMaT and recent report presented at safety Board April 25	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD10	MD	Undertake a review to National compliance RCOG recommendation	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe & effective care	NO	Safe	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD10/1	Undertake a gap analysis of the RCOG recommendations (IMSOP)	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Completed action - currently on AMaT RCOG actions fully on AMaT, actions presented at safety board April 25	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD11	MD	Strengthen impartial oversight of quality assurance forums	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Safe and effective care	NO	Safe	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD11/1	Explore external quality assurance/ safety leads to attend RAPID review panel to enhance peer review	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	01/05/2025	Partially complete (Overdue)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
20/6/25 - Feed back received from maternity external reviewer. Feedback states that the previously held RAPID review meetings have identified learning/immediate action, points of escalation appropriately. 20/06/25 PMRT - internal pathologist attended PMRT panel for additional oversight	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD12	MD	Operational management/ Leadership	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management/ Culture	NO	Leadership	1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD12/1	Appoint operational leads to support and enhance consistency and leadership within the clinical areas LW and Ward 12	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Completed action, training and support proved by senior midwife and weekly reviews undertaken	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD13	MD	Safe staffing/rosters embedded with Maternity workforce	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management/ Culture	NO	Leadership	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD13/1	Complete a deep dive review of staff management – ensuring the attendance at work policy has been embedded	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	01/05/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Completed action - work completed and staff management files updated.	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD14	MD	Regular Senior Leadership Oversight/on site presence	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management/ Culture	NO	Leadership	5/5	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD14/1	Consultant midwife weekly presence to promote professional clinical practice/ clinical / professional curiosity	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	30/09/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Discussed in monthly catch up cons mw in attendance on site in PoW. Monthly one - 2 - one discussion continues. CMW presence is ongoing - review date amended September 25	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD14/2	PDMs weekly site presence to promote clinical professional practice	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	30/09/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
PDM's some staff are undertaking clinical shifts to support staff. Supporting with break relief and promoting clinical standards Completed action PDM's in attendance, included updated roster to ensure support coverage for both sites. Also exploring changing work station to increase visibility	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD14/3	CSfM weekly presence to support clinical practice/well being support	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
CSfM currently attend both sites regularly. Attending to support break relief, clinical curiosity. Completed action - regular attendance of CSfM, included roster which indicates site of work. also considering the change of work station to promote visibility	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD14/4	Clinical director presence biweekly	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Update July 7.7.25. update provided by CD. Attended weekly (Monday, Thursday or Friday, clinical commitments dependent)	None	None	1	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD14/5	Medical director presence weekly	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	03/03/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
7.7.25 July update Medical director attends weekly, attend handover and huddle.	None	None	1	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD15	MD	Quality assurance training/education	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management/ Culture	NO	Leadership	1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD15/1	Complete clinical methodology training to staff groups	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	20/05/2025	01/07/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
23/06/25 - Clinical audit team CAV attended PCH - 20 attendees completed the training	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD16	MD	Senior Midwifery Management	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management / Culture	NO	Leadership	1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD16/2	Appoint into vacant midwifery manager post	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	03/03/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Completed action - new senior midwifery manager due to start 9.6.25	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD17	MD	Launch MEWS and NEWTT2 (MatNeoSSP)	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management / Culture	NO	Leadership	2/2	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD17/2	Launch ESR training programme and achieve 80% across maternity work force MEWS and NEWTT2	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	01/05/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Completed action - ESR compliance achieved MEWS launched in the clinical area.	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD17/3	Undertake Clinical Audit of MEWS and NEWTT2 compliance 30 days post launch	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	30/09/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
MEWS and NEWTT2 launched - audit completed post 30 days implementation. escalation compliance evident, however, some incomplete scores and timing, action plan to drive compliance established. June update - completed action initial audit finding demonstrate good compliance - finding, including action plan presented at programme and safety board June 25	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD18	MD	Undertake a review of the handover (Medical Handover/GMP) to minimise the number of handovers	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management / Culture	NO	Leadership	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD18/1	Align GMP handover with Consultant obstetric handover	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	01/05/2025	Partially complete (Overdue)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
10.06.25 - HoM met with GMP's in support to align the handover times. aiming for july start time.	None	None	1	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD19	MD	Undertake a midwifery work force review to ensure safe staffing	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management / Culture	NO	Leadership	1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD19/1	Complete a midwifery workforce review Birthrate+	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	30/09/2025	Partially complete

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Birthrate + workforce continues. review date amended to coincide with agreed schedule. Date amended to 30th September when final report is due	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD20	MD	Staff wellbeing	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Leadership & Management / Culture	NO	Leadership	4/4	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD20/1	RCM to undertake wellbeing checks	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	01/05/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
RCM have undertaken site visits on 2 occasions (week of 22nd April 2025, RCM undertook a second walk about 30.5.25) July update - RCM have provided online drop in sessions throughout june	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD20/2	RCM colleagues to meet regularly to update 'Caring for You' action plan	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	30/09/2025	In progress

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
Update 8.7.25. Meeting previously held end Aug prior to closure. due to clinical/operational pressure and staff re-deployment meeting has not been re-scheduled. New RCM rep has been successfully appointed into the branch June 25. Regular RCM/HoM meetings have been established. Wellbeing events have been scheduled across both sites (PoW 30.7.25) RCM have been in attendance on each site for staff walkabouts also Updated review date for action end September 2025	None	None	1	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD20/3	Wellbeing team to commence PACE review	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	30/09/2025	Partially complete

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
7.7.25- PACE report complete - meeting established to for action plan 10.7.25 (head of WF, DoM and HoM) Review date amended to reflect implementation of action plan following the PACE meeting	None	None	0	

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD20/4	RCOG Workplace behaviour champion to be appointed	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	02/06/2025	Fully complete (Awaiting approval)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
8.7.25 update Consultant based at PoW appointed as Behaviours champion - consultant co-produced well-being event which is due to be held 30.7.25	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD21	MD	Ensure accurate capture / escalation of patient experience	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Women & Families Experience	NO	Safe	2/2	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD21/1	PALS to undertake site visits	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	01/08/2025	In progress

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
None	None	None	0	

Generated with AMaT

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD21/2	Complete 15 steps within the PoW settings	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	02/06/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
15 steps challenge completed, some actions are ongoing at present. report attached	None	None	1	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/MD22	MD	Learning from informal and formal concerns	Must do	Midwife	Princess of Wales Hospital	Maternity and Obstetric Care	Quality of Women & Families Experience	NO	Safe	1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Maternity (POWH): Concerns Tracker/ Action Log/ 2025/249/ MD22/1	Appoint a concerns lead within Maternity/ Gynaecology services	Princess of Wales Hospital	Maternity and Obstetric Care	Midwife	21/05/2025	01/05/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
completed action - interviews complete and successfully appointed	None	None	0	

Agenda Item
5.2.2

Quality, Safety & Experience Committee

Highlight Report from the Unscheduled Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows, Operational Director for Unscheduled care. Owen Weeks, Unscheduled Care Medical Director & Robin Martin, Unscheduled care Deputy Medical Director & Victoria Healey, Head of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Owen Weeks, Unscheduled Care 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**
Quality & Safety Committee	11/06/2025	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
YGT	Ysbyty George Thomas Hospital
MDU	Medical Day Unit
Q&S	Quality & Safety
HIW	Health Inspectorate Wales
USC	Unscheduled Care Group
ED	Emergency Department
AMaT	Audit Management and Tracking System
IPC	Infection prevention control
UHW	University of Wales Hospital
ANTT	Aseptic non touch technique
AMU	Acute Medical Unit
ANP	Advanced Nursing Practitioner
COTE	Care of the Elderly
ACE	Acute care of the elderly unit
MRI	Magnetic resonance imaging
OCP	Operational Change Policy
TIA	Transient Ischaemic Attack
PALS	Patient Advice and Liaison Service
SSNAP	The Sentinel Stroke National Audit Programme
QIM	Quality Management System
PACE	Patient Clinical Engagement
IA	Initial Assessment
PADR	Performance Appraisal and Development Review
WAST	Wesh Ambulance Service
SDEC	Same Day Emergency Care
COO	Chief Operating Officer
MDT	Multi- Disciplinary Team Meeting
PREM	Patient Reported Measure
RN	Registered Nurse
HCSW	Health Care Support Worker
CIVICA	Health and Care Information System
iCTM	Improvement Connect Transform Motivate
RTT	Referral to Treatment Time

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 11th June 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the Quality, Safety, Risk and Experience meeting is to provide assurance to the Care Group and the Health Boards Quality, Safety & Experience Committee (QSEC) with 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	An unannounced internal ward assurance visit was conducted on Ward 3 (27th March 2025) and ward 20 (20th March 2025) at the Royal Glamorgan Hospital (RGH) - Details of this was escalated at the last QSE Committee meeting. A robust improvement plan has been implemented across the 2 wards to address the issues identified and immediate infection control measures have been completed in order to improve the cleanliness of the ward (details in Assure section).
Advise	Complaints have been transferred to a central quality governance team within the organisation since February 2023. This has ensured that we maintain equity, consistency and strengthen resilience. USC compliance with the 30-day targets has slightly decreased from 91% to 88% in May 2025, this was due to closing 3 concerns over the 30-day period. Currently, there are 14 open complaints and 1 are over the 30-day compliance. This is a decrease from 16 to 14 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. During June'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. AMaT actions for USC as reviewed weekly by the USC Nurse Director (ND). There are no outstanding AMaT actions for the RGH Acute Site as of the 11th June 2025 - 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. With support from the outreach team Fluid balance compliance has improved, weekly audits continue and bespoke training by the outreach team has continued.
Assure	Highlights of improvements on Ward 3 (Respiratory) include: **IPC Concerns** • Daily environment audits have been undertaken by the senior nurse • IPC 2 compliance has reached the initial target of 85% as at 29/05/25 • Environment improvements have been made which include improved storage facilities on the ward and improved organisation of stock **Medications Management** • Spot check demonstrating improved compliance with safe storage of medications and compliance with the relevant standards **Leadership & Workforce Concerns** • PACE meetings have commenced and are being well received by the ward team • Vacancy and sickness leave remains high • Vacancies on TRAC and recruitment underway • Sickness being managed closely in line with the Sickness and Absence Policy • A communication group has been set up on the ward to improve the flow of information to and from the senior nurse leadership team into the ward team • Wall mounted communication boards have been installed and a ward diary to improve the flow of communication on the ward • Enhanced supervision paperwork in place and reviewed daily • Core respiratory training skills compliance improving and being closely monitored to ensure on-going improvement **Culture & Behaviour of Staff** • IAs undertaken and addressed with staff directly; no new issues raised following the issue of the red notice • Senior nurse working closely with PALs team to ensure feedback being shared around positive care experiences **Patient Safety Concerns**

- Spot check has demonstrated increasing compliance with fire regs with fire safety exits are being kept clear
- Patient safety champions within the ward team have been nominated to provide a focal point for improving patient safety concerns
- Fire safety and medical gas training compliance improving but more work required to get compliance up to target levels

Well Led Teams

- PADR compliance up to 59% with plan to increase to 85% by end of July
- Lessons learnt board in place on the ward

One Patient One Day / AMaT

- AMaT scores being used to ensure improvement in compliance for documentation, risk assessments, care bundle compliance, fall risks etc.
- Monthly completion of audits being undertaken by the full ward team with senior nurse review undertaken at least 3x per week
- Monthly senior nurse peer review being undertaken

Care Group Away Day

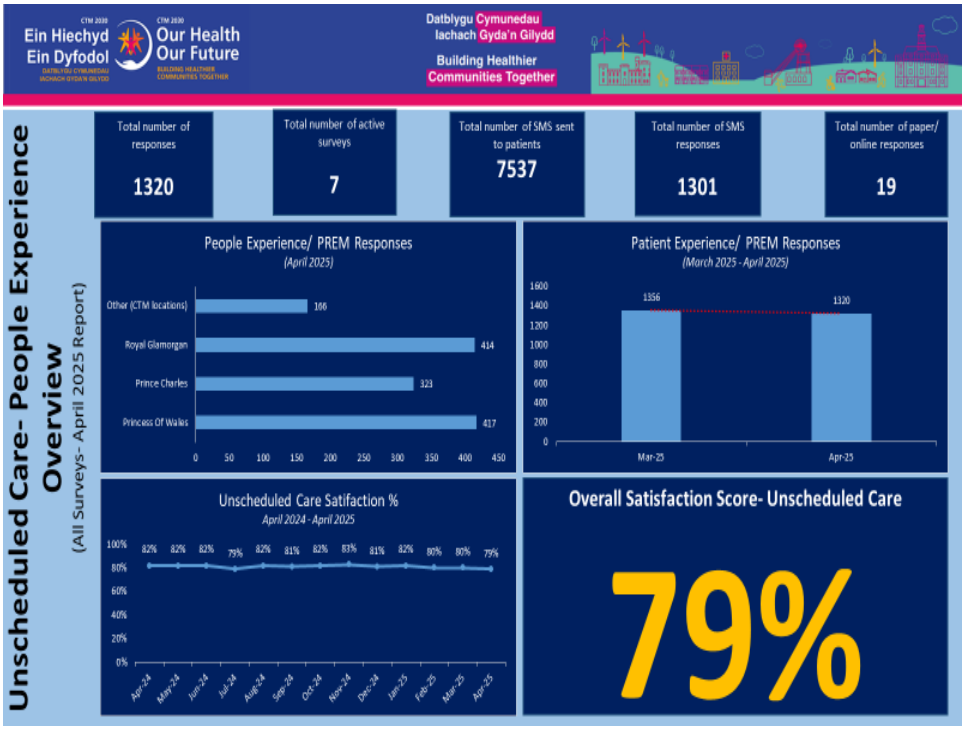
- Away day 18th June 2025, focus on celebrating achievements
- Updates from all 3 acute sites on celebrating success for Quality Safety and Experience

Prince Charles Hospital

- ✓ Refurbishment of the relative's room in PCH ED completed with very positive patient feedback reported
- ✓ ED Paediatric Department nearing the acquisition of an immersive sensory space
- ✓ Nursing teams now fully established
- ✓ Delivery of RITA (Reminiscence Interactive Therapy and Activities) system in PCH benefiting patients living with cognitive impairment
- ✓ PCH ED nominated by University of South Wales (USW) nursing students for Best Team for Student Education and Support

Princess of Wales

- ✓ Nursing teams now fully established
- ✓ Redecoration of the Paediatric waiting room complete with further plans to further expand the area in progress
- ✓ Redecoration of AMU treatment room almost complete

	✓ New mediation storage cupboards in place in each trolley space, reducing medication errors for ED ✓ 100% PDR compliance for POW ED nursing team ✓ ESR compliance improved to 85% POW ED nursing team ✓ Reduction in avoidable pressure damage reported on AMU *Royal Glamorgan Hospital* ✓ Helicopter role implemented in ED within current establishment to provide support to the highest acuity areas and undertaken safety checks within the department ✓ Dedicated area for Paediatrics up and running in ED ✓ WAST praised ED for significant improvement in Ambulance Handover performance ✓ 'Simply Do' project piloted by Practice Educator in ED where a Fire Safety Questionnaire has been introduced to improve education and knowledge ✓ AMU band 6 posts agreed ✓ SDEC trialling condensed Nursing bundle ✓ SDEC Virtual Ward well evaluated (Reminiscence)
Inform	 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.

Stroke

Following the assurance visit and with significant concerns about the high level of vacancies an overarching action plan was drawn up by the Lead Nurse and Directorate Manager with input from the senior team within Stroke. The action plan captures the immediate and ongoing actions in place along with RN and HCSW workforce action plans and outcomes of the Unit's daily multidisciplinary huddles.

- IPC level 2 compliance has improved from 73% to 89%.
- Successful recruitment of 4.2 RNs and 6.0 HCSW over the past month.

Progress against the action plan is reviewed every two weeks by the COO, Executive Stroke Lead and senior leadership team.

As part of the service review of the temporary service change centralising stroke services at RGH a quality dashboard has been developed by the central patient safety team to allow for detailed analysis of pre and post move allowing for the comparison of incidents, patient experience metrics, mortality and safeguarding. This allows for thematic analysis and for a detailed service review to be performed to evaluate the impact of the change.

An All Wales performance dashboard will be live in July 25 which will enable CTM to benchmark performance against other Health Boards. Stroke performance data is fed into the monthly Stroke Operational Group and Stroke Programme Board meetings.

The stroke service redesign programme is also included within the Stroke Programme Board. A programme of service redesign is underway to provide quality patient care across the stroke pathway and support improvement in performance metrics. The ambition is to provide a 7-day delivery model with the right sizing of beds, service capacity and multi-disciplinary workforce across each part of the pathway.

The ongoing fragility of the stroke service remains and is reflected on the risk register. However there has been some notable progress so far:

- Second B7 Ward Manager appointed for Stroke Unit. This will support improvement agenda and support 7-day service

	• B6 post vacancy (following Ward Manager appointment) • Interim Senior Nurse for Stroke in post. • Improved communication throughout the MDT. • 4.2 wte RNs appointed with ongoing recruitment for 5.0 wte on Trac • 6.0 wte HCSW appointed (all awaiting start dates) • Successful recruitment of a new Stroke Consultant • RTT targets achieved for year end with no patients waiting over 104 weeks. • Introduction of junior huddles to harness HCSW and RN ideas and solutions. • Input and support from iCTM team to improve communications through the Unit and help with stock and storage solutions. • Recent positive PALS ward walk – "Wonderful staff" "first class care" "Staff have been very good to me" "Amazing! Everyone has gone above and beyond" "Absolutely wonderful" **POW Ward Moves** • Several internal ward moves are being undertaken at POW during June/July and August. • Several wards have or are being refurbished which will enhance environments for patients. • Creation of a new day room for patients on the COTE unit is underway with "Dare to Dream" supporting decoration of this area.
Appendices	Not applicable

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: Inspiring People and 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	A Healthier Wales
	If more than one applies please list below:

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below: Safe Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reuse
	If more than one applies please list below:

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

5. Recommendation

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

Agenda Item
5.2.3

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
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	
OCP	Organisational Change Policy
LFER	Learning From Events
KPI	Key Performance Indicators
ANTT	Aseptic Non Touch Technique
GSGI	General Surgery & Gastro Intestinal
SAU	Surgical Assessment Unit

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 June 2025.

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

2.1 Purpose of this Meeting

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

2.2 The Planned Care/Surgery QSRE Group will:

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

3.0 Highlight Report

Alert / Escalate	**Trauma and Orthopaedics** From 1st September 2025, the trauma plan will be to consolidate the trauma surgery onto the RGH site and provide patient care on a single Trauma Unit by combining Ward 15 in RGH (was Ward 7 in PoW) and Ward 16 in RGH. There will also be a dedicated Trauma Assessment Unit created within this Trauma Unit. From 1st September 2025, the elective in-patient orthopaedic service will move to Ward 7 (28 beds) in the Princess of Wales Hospital. This will provide a dedicated in-patient elective orthopaedic service that creates a ring-fenced ward that will not be disrupted or impacted by the emergency trauma stream. **What are the advantages of these changes?** • Complies with Getting It Right First Time (GIRFT) recommendations • Delivers Ministerial Advisory Group (MAG) recommendations and Optimisation Framework.

	• Support sustainability re workforce/on call pressures • Improved service delivery • Decrease the waiting list for patients waiting for elective in-patient Orthopaedic surgery. • Dedicated ring-fenced ward and theatres for elective in-patient orthopaedics that will not be impacted by emergency trauma demand. Consultation has commenced via the UHB OCP with all staff affected by this change and this finishes on 9th July 2025. Insourcing and additional weekend activity continues for elective orthopaedics at both PCH and RGH. **Ophthalmology** An implementation group has commenced to deliver the cataract service change. The aim is to have a cataract treatment hub at the Princess of Wales Eye Unit by September 2025. The group are working through the staffing and equipment requirements to enable the change. **What are the advantages of these changes?** • Complies with Getting It Right First Time (GIRFT) recommendations • Delivers Ministerial Advisory Group (MAG) recommendations and Optimisation Framework. • Improved service delivery • Decrease the waiting list for patients waiting for elective in-patient Eye surgery. • Dedicated theatres for HVLC
Advise	• Some Planned Care ward moves post the Critical Incident have commenced in PoW, with Ward 21 and Bridgend Clinic now amalgamated onto Ward 11. • Gastro Day Unit to relocate back to Ward 9 in POW from Maesteg Hospital. • OPD Transformation work focusing on clinic utilisation and opportunity to increase virtual clinics where appropriate. • Staff survey feedback. Action plans now in place for each Directorate. **<u>Concerns & Incidents</u>** **Concerns- Early Resolutions (ER)** Early resolutions that are overdue has been escalated through the Care Group. A backlog has built across the Planned Care Directorates with a large volume of outstanding ERs. A new process has now been adopted by the Care Group Directors ensuring a nominated single

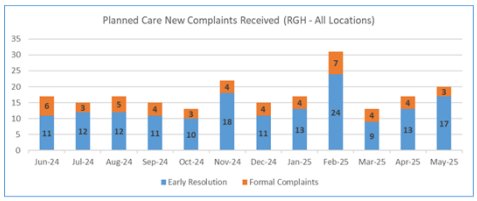
point of contact for each of the Service Groups to ensure timely responses to all ERs.

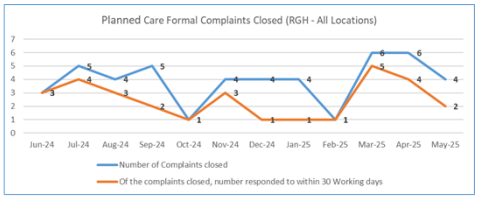
Incidents

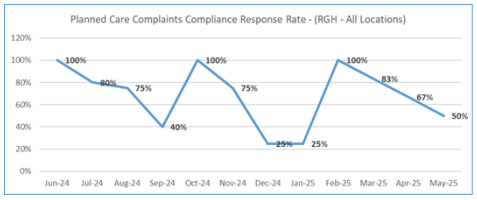
Incidents	PCH Incidents	PoW Incidents	RGH Incidents	Incidents
Total Number of Incidents Reported	51	44	122	12
Total Patient Safety	43	35	102	11
Total Non-Patient	7	6	10	1
Total Organisational Incidents	1	3	10	0
Total Number of Incidents Closed this month	70	42	129	8
Total Number of Open Incidents on Datix Cymru	56	269	328	78
New Incident	15	148	186	7
Management review/Make it safe plus	17	70	46	14
Under Investigation	8	24	57	25
Awaiting Closure	16	27	39	32
Number of Nationally Reportable Incidents	1	1	2	1
Number of Never Events reported	0	0	0	0
Number of Open Nationally Reportable Incidents	8	1	6	1

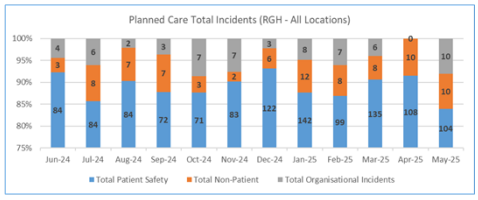
Dashboards

RGH

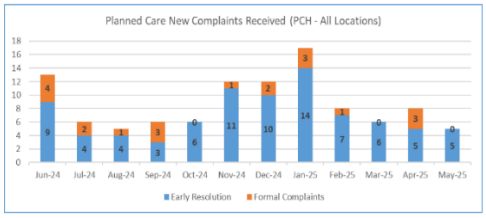


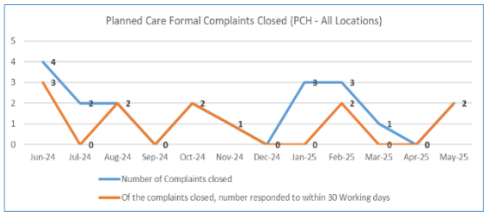


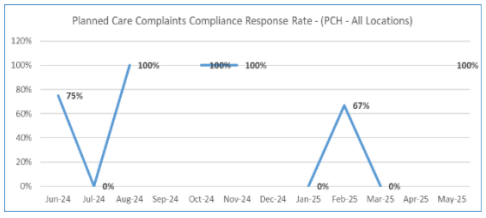


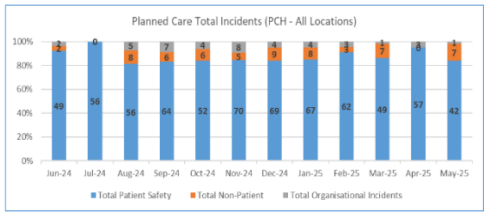


PCH

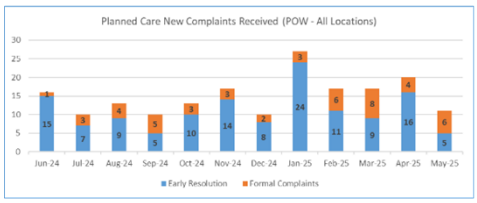


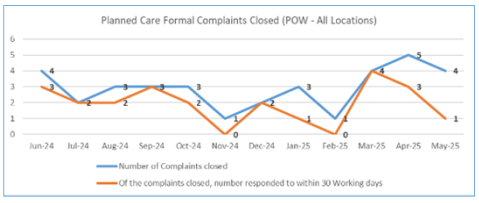


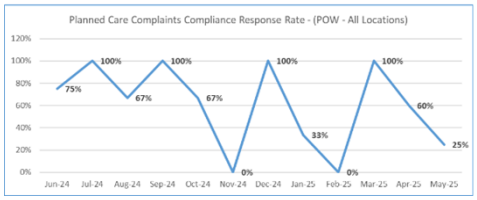


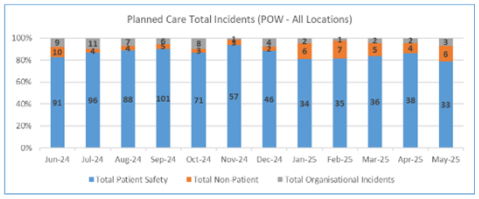


POW

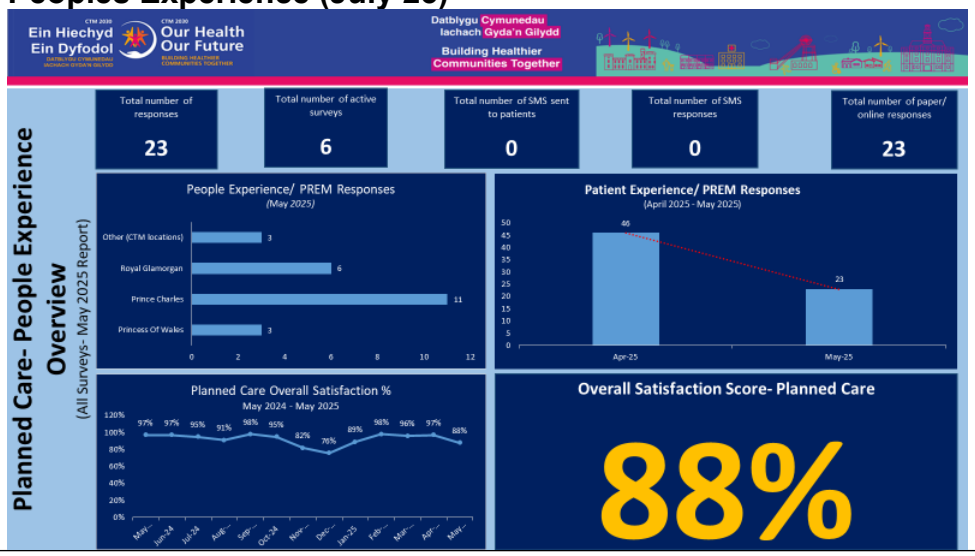








Peoples Experience (July 25)



Assure

Planned Care QSR&E has updated reporting structure from June 2025 which will ensure that the Directorates within Planned Care present their Governance Quality KPIs rather than a hospital site reporting. The Terms of Reference have been amended & approved to reflect this new structure.

Key Priorities

- To improve quality of Action Plans and LFER evidence across Planned Care with training session arranged for Lead/ Senior Nurses in July by Patient Safety Team and Welsh Risk pool representative.
- Improve Manual Handling and ANTT training compliance. Training dates shared with teams and Senior Nurses overseeing to evidence compliance improvement
- Improve Bladder and Bowel training across sites, in relation to assessment, manual evacuation and appropriate use of incontinence products

	• Improve Medical Gases training with compliance with GSGI ongoing. Plan in place to review in local workforce meetings and then report to Directors in monthly HB workforce meeting • IPC standards across clinical areas. (Focus remains on De-cluttering, stock review, outstanding estates jobs, cleaning regimes)
Inform	• Andrea Croft, Advanced Clinical Practitioner for Anticoagulation, has been awarded 'Lifetime Achievement Award' by Thrombosis UK. Gastroenterology and General surgery Advanced Practice newly created posts. • 2nd ACP in RGH recruited to support new SAU clinical model. • Vascular Nurse post, interviews scheduled • Creation of an 8A Colorectal Nurse Specialist in RGH • New post for 8B Gastroenterology Nurse Consultant post pan CTM out for recruitment • Clinical Educator for Endoscopy pan CTM. Quality Improvement Projects • RGH Colorectal Nursing team developing 'Stoma friendly' bathrooms for colorectal patients • POW development of a Gynae Assessment Unit, to improve patient care and experience. • PCH Ward 5 6 7 8, in collaboration with the District Nursing Teams are aiming to improve communication on a patient's needs on admission and discharge by creating a digital live document which can be used as in and out of hospital.
Appendices	Not applicable

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)	No - Not Applicable
	If more than one applies please list below:

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

3. Recommendation

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

Agenda Item
5.2.4

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths, Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	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
CTM	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
HIW	Health Inspectorate Wales
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
MHA	Mental Health Act
MH	Mental Health
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident
PICU	Psychiatric Intensive Care Unit
PMVA	Prevention and Management of Violence and Aggression
POW	Princess of Wales Hospital, Bridgend
PROMs	Patient Reported Outcome Measures
QAIS	Quality Assurance Improvement Service
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
ReQol	Recovering Quality of Life – a PROM
RCRP	Right Care Right Person
SWP	South Wales Police
YCC	Ysbyty'r Cwm Cynon

1. Situation /Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the MHLD Care Group at its QSE meeting on 04/06/2025.

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

2. Specific Matters for Consideration

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

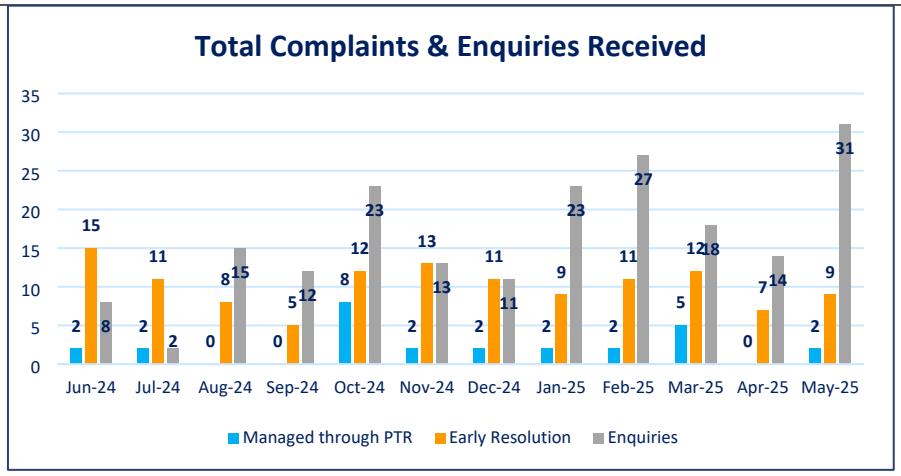
2.2 The MHLD Care Group QSE Board will:

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

3. Key Risks / Matters for Escalation

Alert / Escalate	• The Care Group is responsible for the delivery and update of PMVA Module D training to applicable MH staff. Following an options appraisal, the care group concluded that the previous train the trainer model was unsustainable, and the only viable option was to commission an external provider to deliver Module D. Funding has been secured through the IMTP process but as yet a private provider has not been commissioned. The in-house training ended in March 2025 meaning there is a risk that training compliance could fall. To mitigate against this the Care Group is spot purchasing individual courses to maintain compliance until a longer-term programme of training is procured. • Medical staffing remains fragile across the Care Group, including Medical staffing in Adult MH services and this has been added to the organisational risk register with a score of

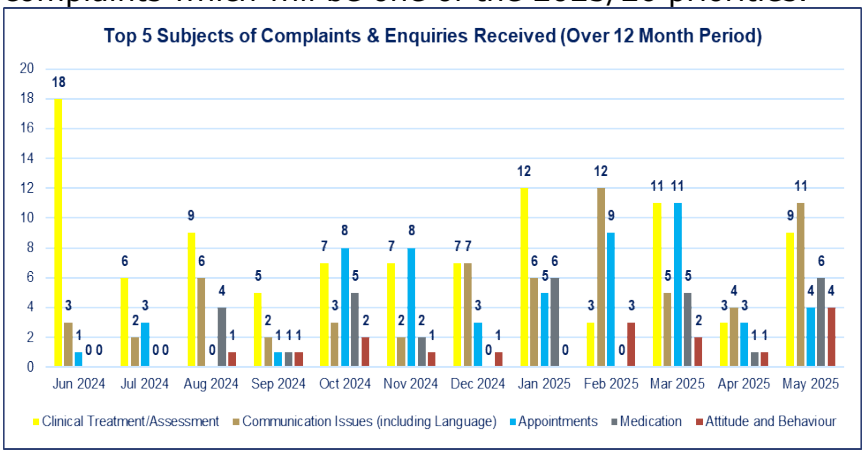
	16. The Care Group continues to manage medical staffing with daily scrutiny to identify and communicate pressures, prioritise work and release Consultant time. • Routine ligature audits have identified key environmental risks on one of our wards at Royal Glamorgan Hospital. Estates work is planned and until this is completed additional staff are being rostered to supervise the particular area. In addition, routine capital works at Princess of Wales Hospital is requiring additional supervisory staffing to monitor environmental risks and risks of egress during the period of estates work.
Advise	• To support a consistent national dataset, ReQol, a Cluster 1 tool from the Outcome Measures framework for Wales, has been recommended for use across adult and older adult mental health services across Wales. Further work is being done to agree a tool for children and young people's services. It is planned, from June 2025, that all adult and older adult inpatient mental health services across Wales shadow report on their use of PROMs and all other adult and older adult services shadow reporting from April 2026. It is expected ReQol will be completed at the start and end of a period of care. MHLD staff have had an introductory session to ReQol and a pilot rollout across the Bridgend and Merthyr CMHT to test manual reporting systems is planned. • Ty Cwm Rhondda, a privately operated low secure Mental health hospital, received a 2Q deduction (from the highest to the lowest level) following a QAIS review over issues related to security, observation, medication security/storage and a lack of meaningful opportunities and activities for patients. CTM has 6 patients at the site all of whom were quickly reviewed by MHLD Commissioning team with no concerns noted. Ty Cwm Rhondda provided assurance on improvements to QAIS and their 3Q rating (the highest level) was reinstated on 23.05.2025.
Assure	• The number of complaints received by the Care Group during this reporting period was identical to the mean (18 per month over the last 2 years). The number of formal complaints received in April and May was 2 which is within the monthly mean.



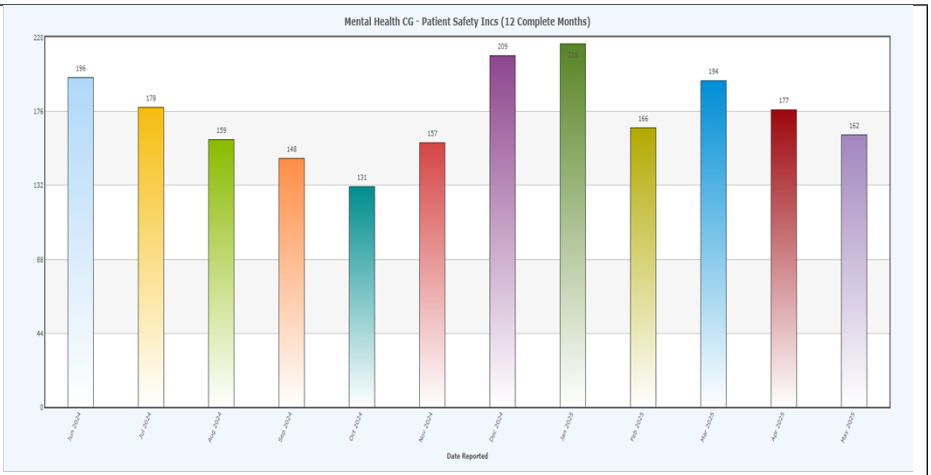
Complaint closure compliance in the Care Group was 100% in April and 33% in May, however, the low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.

Enquiries were higher than the mean in May, the themes are consistent with previous periods and the enquiries are spread across all areas. The Care Group will continue to monitor complaints and enquiries for themes and trends.

At the end of May there were 3 open formal complaints (the 2-year mean is 7). The new quality dashboard now enables the Care Group to thematically analyse the themes from complaints which will be one of the 2025/26 priorities.



- The Datix incidents reported this period, 177 in April and 162 in May are consistent with the 2-year mean of 198 and lower than the last reporting period despite high acuity in PICU, POW.



- There are 5 open NRIs which is consistent with the 2 year mean. 3 of these are overdue, all are in the process of approval.

  There were 2 new NRIs reported during this period.

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

Project	No. audits	Current compliance	Improvement	Overdue actions
Health & Safety	1			0
Health and Care Standards	2	G 98.6%		2
Infection Control	12	G 96.1%		20
Medicines Management	2	G 94.9%		1
Patient Safety	22	A 88.8%		19

  Patient safety compliance has gone down from 92.8% to 89%, however this is due to more audits being added, the number of overdue actions has actually fallen. Of the 19 overdue actions, 16 are RAG rated green with 3 RAG rated as amber, these relate to IPC and estates issues. No actions are rated as red. Performance against these audits is monitored in the individual directorate's QSE meetings.

- The implementation of Phases 3 and 4 of RCRP, which relate to the transportation of patients and patients who are detained under S136 of the MHA, commenced on the 10th March 2025.

  At present there is no agreed alternative approach to the transportation of patients who currently require police support, leaving individually commissioned, private transport as the only available alternative. SWP are continuing to transport patients in the absence of a viable alternative. No

	issues regarding the implementation of Phases 3 and 4 have been escalated.
Inform	• The HIW inspection report on Ward 7 YCC was recently published. Alun Jones, Chief Executive, said: *"It is encouraging to see the significant progress made at Ysbyty Cwm Cynon since our last inspection and previous review of the Cwm Taf Morgannwg University Health Board. The dedication of both staff and leadership to learning and continuous improvement is clearly having a positive impact on patient care and staff wellbeing. The ward's focus on patient initiatives is helping to improve patient care, with some examples of noteworthy practice identified during our inspection."* • The second session of Personality Disorder training, entitled "The Borderline Patient," which was compiled and delivered by an individual with lived experience. A total of 15 staff members attended the session. Initial feedback was highly positive, with several participants highlighting the value of gaining insight from the patient's perspective. • E-Whiteboards Work is currently underway to implement electronic whiteboards across our Adult Mental Health inpatient wards. This initiative aims to enhance communication, streamline handover processes, and improve the visibility of key information for all staff. The project is in its early planning phase, with initial site visits scheduled in collaboration with the Digital and Data team
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)	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:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

Agenda Item
5.2.5

Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	July 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Hannah Wilton, Director of Pharmacy and Medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

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

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 30th June 2025.

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

2. Purpose of this Meeting

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

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

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

1. Highlight Report

Alert / Escalate	**Pathology** • **LIMS 2.0:** (Laboratory Information System) is further delayed which remains as a high risk on the corporate risk register. This extends the timeframe for an all wales system and now impacts all health boards in Wales as we have to contribute financially to a temporary solution which does not have all the functionality required. This delays the opportunity for a once for wales digital solution. The Director for digital and the Chief Executive have written back to DHCW with the CTM stance. **Health Science** • Cardiac Physiology Predicted delays to Echo service provision due to decreased staffing levels over the coming months because of planned and unplanned leave. Plans are being developed to mitigate the impact of these shortages through maximisation of current resources and the use of additionality through bank and weekend working. **Medicines Management** • Staffing shortages reported on multiple sites: intake of new pharmacists on 1st August following skills mix review should alleviate issues; locums in place in the interim. • HMP Parc: incoming legislation around Fixed Term Recall for offenders serving Standard Determinate Sentences (SDS) will result in increased patient flow through HMP Parc. Numbers / impact at HMP Parc being evaluated. **Orthotics** • Orthotics contract commissioned via NWSSP for 6 Orthotist sessions per week. The provider changed 1/7/25, however due to delays in the tender process the new provider is unable to provide a clinician until 4/8/25. The previous provider is unable to provide a service and there are no locums available. During this period, outpatient activity will be severely impacted to maintain inpatient activity.
Advise	**AHPs** • Increase in incidents reported across AHPs; 28 in April and 27 in May 25 compared to an average of 13 incidents per month. Increase in incident reporting related to Sub-type 1) *access to services* (n=15) including risk ID: 5658 lack of POW ICU dietetic service and 2) *communication issues (n=5)*. 1) POW ICU dietetic service (risk ID: 5658) mitigations in place, SBAR has been shared with Planned Care and

meeting between care groups is planned for 14th July 25 to identify a solution.

2) Communication issues – increase in incidents related to lack of adherence to procedures and difficult contact departments. Impact of vacancies and is being addressed.

- Falls service unable to triage or run any classes at present due to vacancies and long-term sickness, resulting in no registrant in team. Education and public sessions have continued by the remaining members of the team. Band 6 has now been appointed and is going through TRAC process.

Radiology

IR(ME)R (Ionising Radiation (Medical Exposure) Regulations) incidents remain the most common source of incidents from January to March (n=24). We are not considered an outlier in the number of incidents and this is a healthy reporting and investigating culture that is required and recognised in a heavily regulated service. Thematic and root cause analyses have been conducted and identified that 41% of incidents occurred due to incorrect detector selection in the General X-ray departments at PCH/RGH. The manufacturer's applications team have installed a digital reminder alert prior to radiation exposure and have provided additional refresher training on the equipment. We have demonstrated a reduction in these incidents in April following the intervention.

The most common cause of patient concerns was administrative delays, leading to increased wait times for responses to queries and difficulties in contacting the department. Radiology is concerned that the challenges with administrative vacancies, without a digital solution, will result in further complaints.

Capacity issues remain an issue out of hours (OOH) for CT and X-Ray. With the temporary move of services to RGH, the service has temporarily rostered additional staffing to mitigate the risks. Additional funding is required for staffing resource to maintain a safe and resilient service OOHs and a paper has been submitted outlining the requirements. The OOH model will be reviewed following consideration of this paper.

Pathology

- **Impact of Medical Examiner Service (MES) reform on Mortuary Services:** New regulations came into force on September 9th, 2024, whereby all non-coronial deaths are now independently scrutinised by the MES. This has resulted in administrative changes to the death certification process, leading to increase length of stay for the deceased. This is impacting on Mortuary capacity, especially over the Winter

period. Winter pressures have now subsided and the time to complete death certification is showing signs of improvement. However, a significant amount work is required to improve the process further and CTM continues to engage with the MES to support this. A CTM local QR code has been formulated to support better compliance in terms of information provided to the MES and enable bereavement officers to monitor progress. We are currently awaiting support to implement the QR code in CTM. Bereavement team resource to support this process remains a concern.

- **Clinical Haematology:** transformation work is needed to improve service resilience, helping to meet current and future demand. The clinical team are currently considering utilising WLIs for both clinical vetting and new patient clinics. A clinical haematology business case was submitted in March 2025 and a decision is awaited.

- **Cellular Pathology – Transfer of reports from outsourcing**: currently all reports received from the outsourcing company are manually transferred from the results portal to the Pathology system. This has resulted in incidents where reports have been incorrectly transcribed, and the risk register score has been increased to reflect this. Cellular Pathology is currently working with the outsourcing company to implement an automated solution which will enable results to be electronically transmitted directly to the pathology system. A statement of need has been submitted to progress this; however, due to the timescales of the LIMS 2.0 project, implementation of an automated solution is no longer feasible until LIMS has gone live in Cellular Pathology.

- **Cellular Pathology Space:** The lack of space to adequately accommodate the Cellular Pathology service is a long-standing risk. This inhibits recruitment into both the consultant team and technical workforce as there is very little space to accommodate additional staff. The demand on Cellular Pathology services is ever increasing; to operate effectively there will be a requirement for additional equipment, improved workflows and adoption of Digital Pathology, which is impossible to achieve within the current space constraints. The resounding impact of this is the inability to repatriate work that is currently being outsourced or support future plans to repatriate Cell Path services from POW (currently delivered by Swansea Bay under SLA). Following initial options appraisal exercise, currently working with Capital Planning to scope the shortlisted options for feasibility, with a view to working up a more detailed proposal.

	• **Staff resource for Biochemistry service provision:** Due to staff shortages, urine metanephrines, a test used in the diagnosis of pheochromocytoma and related conditions, are now being referred to UHW. This will continue until experienced staff return, highlighting the service's limited resilience to absence. **Health Science** **Clinical Engineering** Following the previous escalation of inadequate bed management workforce provision at POW, Clinical Engineering colleagues reviewed their vacant posts to be able to provide more weekday cover at POW. Delays in the approval process for this post have paused the recruitment process resulting in continued difficulties in maintaining service cover. Approval is being actively pursued, with staff rotating where possible to provide cover.

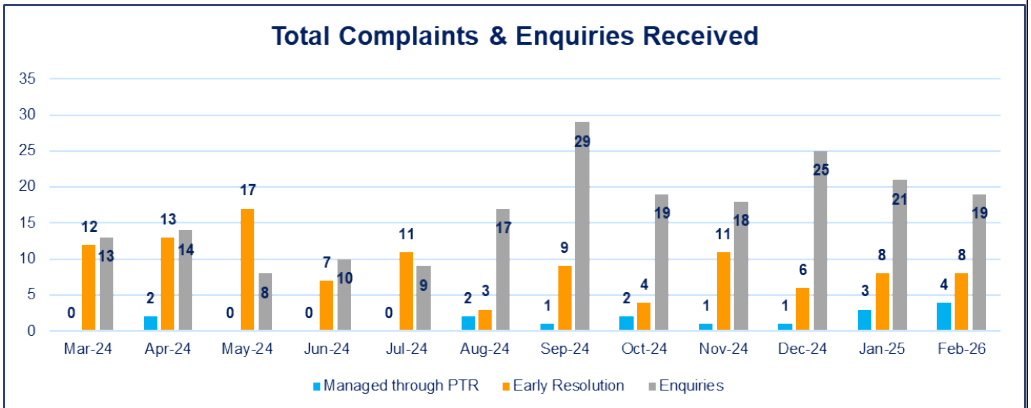
Assure	**Medicines Management**
	CD audits: Target= 100% Current figures for completion of CD audits are:
	
	• **RGH**: 100% [Previous Quarter 98%]
	• **PCH**: 100% [Previous Quarter 100%]
	• **POW**: 81% [Previous Quarter 92%]
	• **YCR:** 100%[Previous Quarter 100%]
	• **YCC:** 80%[Previous Quarter 100%]
	  ○ Local sites have plan in place to achieve 100% for the quarter.
	  ○ In future, Amat team looking to build dashboard to assist with planning and reporting on compliance
	  ○ (RGH) Learning from CD discrepancy actioned. All Gabapentinoids now stored in CD room
	  ○ (RGH) Regular audit of all non-registered CDs in place
	
	Homecare: PHP homecare provider have launched a new clinical portal to allow the homecare team to access patient information from an online gateway. Homecare team working with IG to complete DPIA for new portal access.
	
	Pathology
	Delays in pathology results for patients in the Bridgend area: The CTM PALS Team has alerted CTM Pathology in relation to an increase in calls regarding delays in receiving pathology results. Pathology services in the Bridgend region are currently provided by SBU under SLA, the Bridgend PALS team will look to link in with the PALS team in SBU to action. In addition, the Pathology Directorate

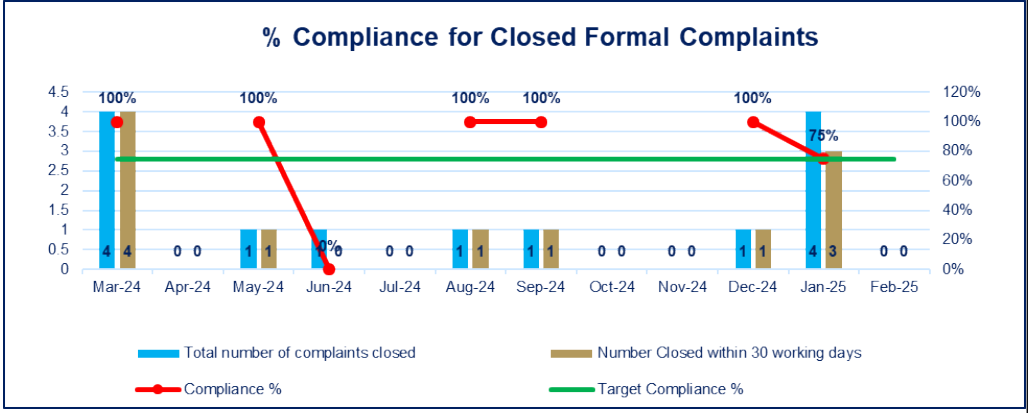
	Manager has monthly meetings scheduled with SBU counterparts to ensure communication lines remain open. **Mortuary Capacity:** This risk has now been de-escalated and downgraded to moderate, as seasonal pressures subside. However, delays in the death certification process still pose a risk to capacity management. **Biochemistry analyser upgrade:** From June to September 2025, the Biochemistry Department at Royal Glamorgan Hospital will be implementing new analysers. As a result, the department will operate with only one analyser for this period of time, posing a potential risk to diagnostics and patient care if it fails. For assurance there is an established contingency plan which includes support from the PCH site to mitigate this risk. **Health Science** **Audiology** In the New-born Hearing Screening Wales Quality Assurance Audit, undertaken in Spring 2025, CTMUHB met the 95% overall compliance for target 1-8 and 90% compliance target in each individual standard. This demonstrates that compliance was met for both the overall target, and for each of the nine individual standards. Areas of good practice for commendation which were identified in the audit included: Flexible service provision to meet the needs of families in terms of appointment day and timing; very detailed service planning report; comprehensive hearing assessment using the expected range of tests; very timely provision of clinical reports to referrer, and medical professionals and families following diagnostic assessment. Areas of risk included: fragility of service due to a small number of medical staffing providing the service. This risk is being investigated and escalated.
Inform	**Radiology** The HIW IR(ME)R inspection took place in May 2025. Feedback from the inspectors indicated that the self-assessment was comprehensive, and the inspection findings were positive overall. One immediate assurance finding regarding Diagnostic Reference Levels (DRL) documentation, which has now been resolved. **Medicines Management** • CD incident (not subject to register or CD storage requirements) in YCR. Meeting with senior site nurse on 11th July to discuss and plan. In the meantime, all non-registered CDs have been moved

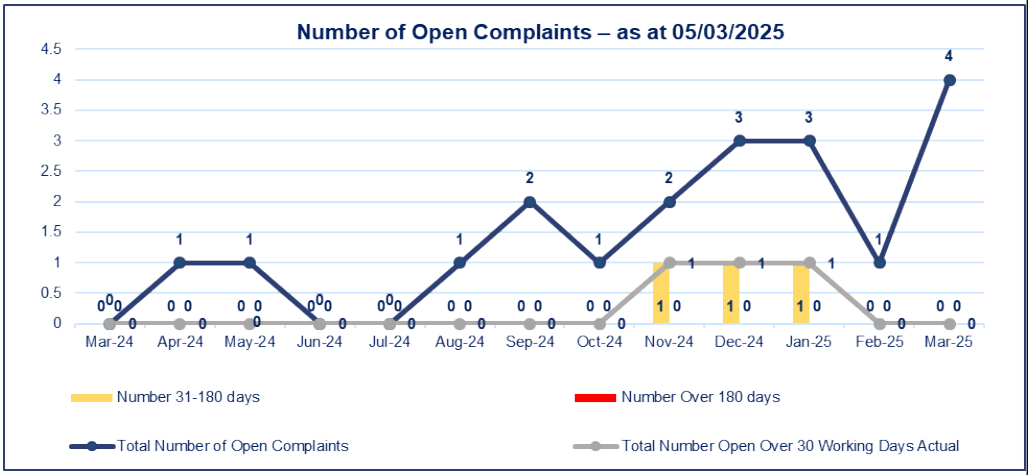
	to registers and in cupboard. Negative feedback from ward staff with regards to this leading to longer medication round. However assertive message around CD governance. Update: ○ 1- Clear communication with all wards on CD governance. ○ 2 -All CDs are now in registers until POD lockers are upgraded in line with PSN 055 ○ 3- Borrowing CDs (single dose) is now done as per agreed process and form completed for audit trail • Position of Home Office licenses: Supply licences are now in place in the 3 acute sites and possession licences in place in GPOOH and the prison. • (RGH) Elective T&O ward opened – patients with complex needs looked after by locum doctors, ward pharmacy service provided within existing establishment • (RGH) Procurement specification and Invitation to Tender (ITT) documents for Robot procurement at final check stage. Procurement schedule to be set once agreed. Aim to completes installation prior to Christmas 2025 **Health Science** Respiratory Physiology Colleagues are currently reviewing respiratory services and remodelling to incorporate use of healthcare science support staff following a Quality Improvement project. This review is mirroring a previously successful service review in cardiac physiology with the expectation being that remodelling will improve timely access to diagnostics for patients, reducing waits and avoiding patient concerns. Clinical Engineering Band 6 (Annex 21) Anaesthetics/Ventilation Technologist is now in post and training to re-establish this cover at RGH and PCH and remove requirement for expensive external service contracts. The establishment of this post is expected to improve on-site responses to any identified issues resulting in improved patient experience and safety. **Pathology:** **Microbiology:** The Microbiology department went live with their new urine analyser on Monday 23rd June, which will significantly reduce the number of urine specimens that need to be cultured, ultimately supporting the appropriate prescribing of antibiotics (antibiotic stewardship). The accompanying risk in relation to aging equipment can now be reduced to reflect this service development.

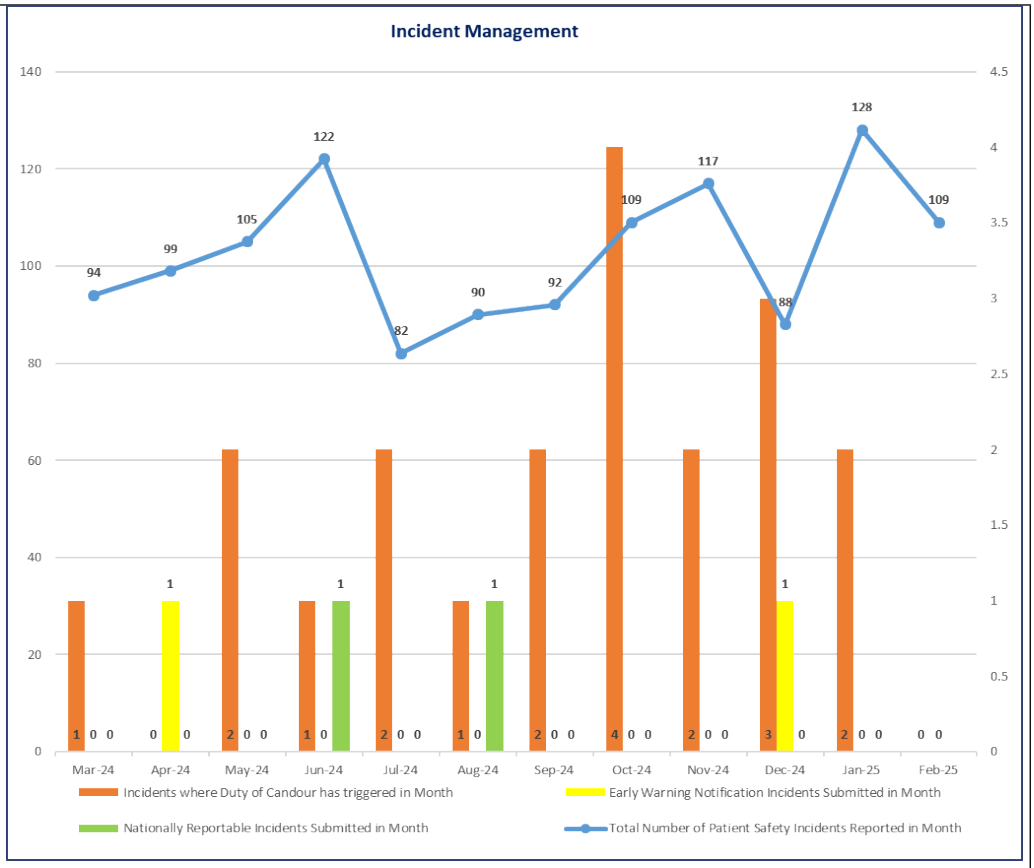
UKAS inspection underway at the end of June into July. Awaiting final report but no immediate assurance findings to date.

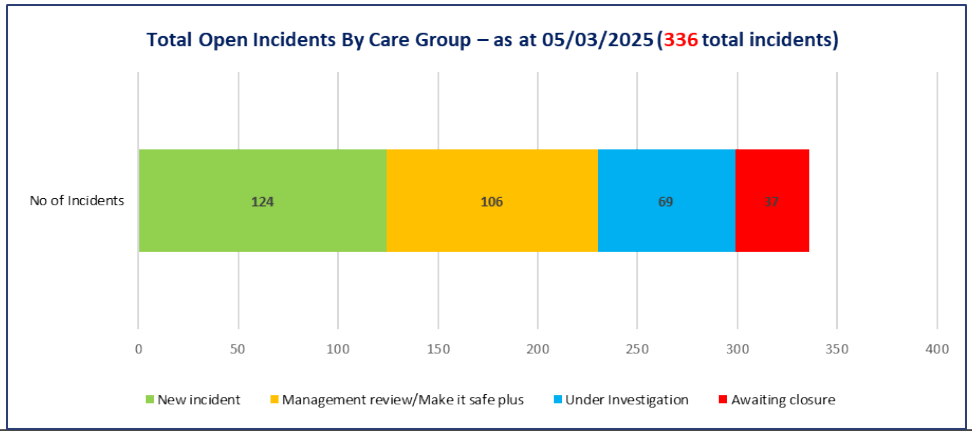
DTPS Complaints Received and Compliance











Appendix	Not applicable.

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 wed i 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
5.2.6

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Nurse Director, Primary Care & Communities
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Nurse Director, Primary Care & Communities
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	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	
CTM	Cwm Taf Morgannwg
DGH	District General Hospital
DN	District Nurses

GP	General Practitioner
HMP	His Majesty Prison
MH	Manual Handling
SLA	Supplementary Service
SPOA	Single point of access
SPQ	Specialist Practitioner Qualification
YOU	Young Offenders Unit

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience Primary Care and Communities Care Group at its meeting on the 16th June 2025.

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

2. Purpose of this Meeting

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

2.2 The Primary Care and Community Care Group QSRE Board will:

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

3. Highlight Report

Alert / Escalate	**Salaried Dental Service:** This service remains on the risk register and an updated report has been shared previously specifically on this service. **Paediatric GA List** There are currently 667 children on the waiting list for a General Anaesthetic Assessment and a further 318 children on the waiting list for Prevention and Behavioural Management Assessment which

	could lead to treatment under general anaesthetic. The Dental team are waiting to hear from planned care colleagues on list availability. **YCC Ward 6** Currently there is reduced medical cover on the ward, which means the team have stated there is to be no admissions Monday to Wednesday. Any urgent admissions are discussed with the other 2 palliative care inpatient areas for possible admission.
Advise	**Medication incidents at Parc Prison** Due to the increase of incidents, there is a now a task and finish group in place to discuss and determine clear process for these incidents due to the complexities of medication administration within the prison. **Lymphoedema Service** Current risk is due to change of non-recurrent funding for the service. A full-service review is required for this team. **Wound Clinic Service** This service requires a full-service review. The SLA agreements with GP practices also require review in regard to wound services offered, further negotiation and planning will be required to develop the service. **District Nursing Services -** Community Nursing Specification All Wales target is 80%, set by the Primary Care Strategic programme with the plan to reduce secondary care admissions and to increase weekend discharges from hospital. Weekend Capacity for CTM is currently at 69%, this will be the highest capacity that can be achieved due to no further funding available. **District Nursing Service Bridgend** Manual handling remains on the risk register for the team. Due to a significant decrease in compliance over the last 12 months. This has been due to lack of capacity within the MH team to provide training sessions. The DN team now have their own trained assessors and have an action plan in place to increase compliance over 90% by end of July. **Bridgend DN SPOA** – Consultation process has completed, along with staff engagement and support proposed changes. This change would provide a single contact number for the DN services, in line with the community nursing specification.

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

Prison Operational Staffing Challenges
Any fluctuations in operational staffing levels and resulting regime changes, can pose challenges to health care resource allocation and service delivery. The Directorate will continue to work with G4S to review the possibility to provide wing-based medicine, which will reduce the demand on healthcare runners.

Care Home Fees
Dyffryn Ffrwd Manor House has made a decision to give 28 days' notice to all residents for CHC without initial discussions with CTM. This is due to the care home requesting a significant financial increase each week for each patient. The CHC team have met with the home to discuss in more detail and are awaiting the outcome of the meeting.

Primary Care
Primary Care – A risk has been identified in relation to failure to secure an alternative Clinical System for GP practices. This is a significant risk to the 29 GP Practices who remain using the system whilst awaiting transition to a new system. Heads of Primary Care seeking engagement from the National Emergency Planning Team in addition to HB Level and Practice Level Business Continuity Planning.

Hospital at Home
The implementation of this team will allow for more patients to be cared for at home as opposed to in hospital. The ECC team have reconfigured current services and will provide new services for patients. It is important to note this team have not changed or stopped any clinical provisions whilst increasing the offer of services available.

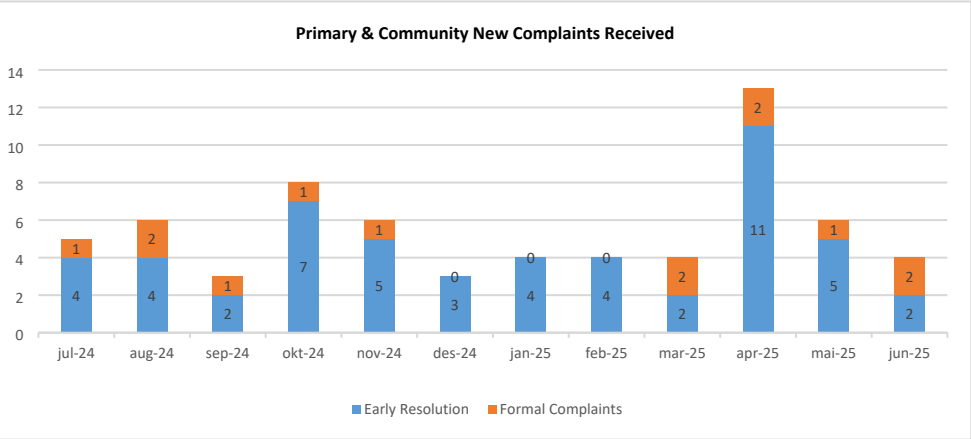
GP Practices
The All Wales reported Diabetes 8 Care Processes compliance data for CTM shows the total percentage of all Type 1 & Type 2 patients who have had all 8 Care Processes recorded is now improving due to targeted focus.
Current compliance is 46.61% with demonstrable improvement from 32 % at month 12.

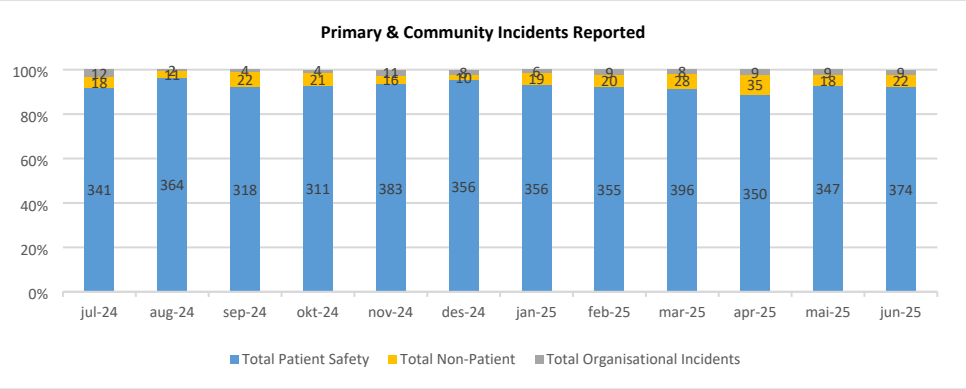
HMP Parc Prison
As previously reported the Health and Social Care assessment, CTM commissioned a HSCNA to be undertaken to better

	understand the health needs of the prisoner population in HMP & YOU Parc, and to assess the extent to which the current need and demand for health and social care in the prison establishment were being met. The report identified several key areas for consideration if health and social care needs were to be appropriately addressed, including: • Facilities • Data • Mental health • Substance misuse • forward planning

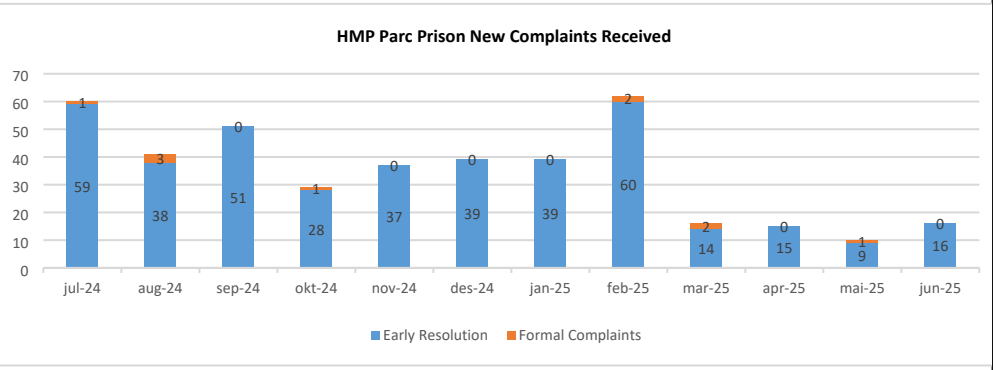
Assure

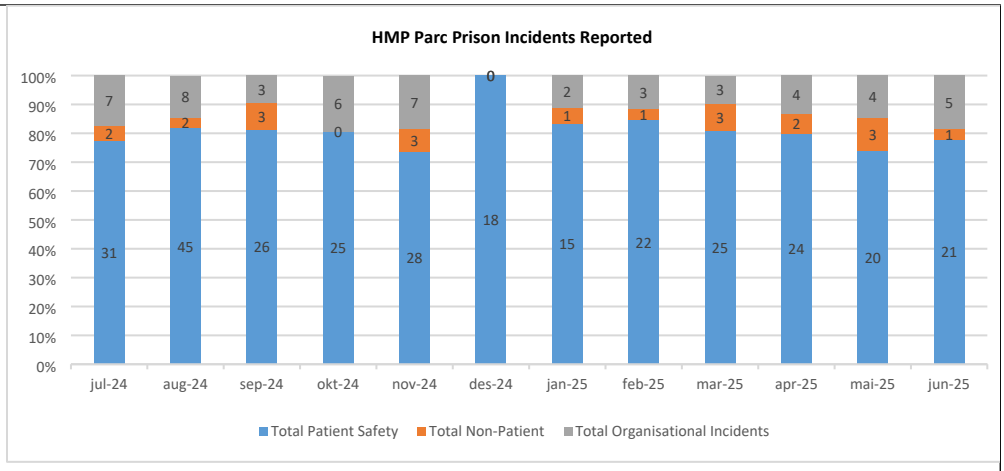
Concerns and incidents (excluding Parc Prison)





HMP Parc Prison concerns and incidents





Dental Access current waiting list numbers on Dental Access Portal is 8364 patients. This should reduce during 25/26 as patients are allocated to 17 practices awarded new funding since October 2024. Level of urgent access appointments in practices has been reduced due to the new 25/26 contract metrics, this could impact access to urgent care, this will be closely monitored over the next few months and practices asked to amend metrics to support provision of access which can be actioned under the contract variation notice if required and practices agree.

HMP Parc
The pharmacy department within HMP Parc identified three instances of unaccounted CD from the pharmacy dispensary during January to March 2025. The Home Office and Police were notified of each of these incidents at the time they were discovered. Following the actions undertaken by the pharmacy department within the prison, to date no further discrepancies have been noted. The Directorate will continue to monitor the situation and the new processes will be adopted going forward.

Inform

District Nursing Interviews have identified 10 staff members this year to undertake the DN SPQ qualification, we were restricted to numbers from the university this year. Others that were not successful this year are being supported with next year's applications.

District Nursing to launch Civica patient feedback via QR code which is now included within the NEW patient leaflet planned for June 2025. Training arranged to support data collection of the feedback.

Primary Care Transformation Board
1st Engagement Workshop with GPs was undertaken on 4th June and this was supported by the National Association for Primary Care.

	Mobile vaccination unit Following ELG approval on 30th June, we are now progressing with the procurement of a three-year lease vehicle to address vaccine equity and equality within the community. **Covid 19- Spring vaccination campaign** The Spring programme commenced 1st April and ended on 30th June, with the below eligible cohorts being offered more than two appointment invitation. • adults aged 75 years and over. • residents in a care home for older adults • individuals aged 6 months and over who are immunosuppressed. The Spring campaign saw an overall uptake of 54.40%, against the Welsh average of 52.27% **Salaried Dental Services** The team in Salaried Dental Services have been supporting with the delivery of training to ward-based staff on a DGH site and have promoted the completion of the mouthcare module available on ESR to improve mouthcare moving forward.
Appendices	Not applicable

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well If more than one applies please list below:
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**	Learning, Improvement & Research If more than one applies please list below: Culture and valuing people Leadership

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

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

5. Recommendation

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

5.3	22/07/25	Quality, Safety and experience Committee	Stroke Update

Report Details:	
FOI Status:	Open
If closed please indicate reason:	Not applicable
Prepared By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows – Unscheduled Care Service Director
Presented By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows – Unscheduled Care Service Director
Approving Executive Sponsor:	Lauren Edwards - Executive Director of Allied Health Professions (AHPs) and Health Science
Report Purpose	For Noting
Engagement undertaken to date:	N/A

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Quality, Saftey & Patient Experience
Related Health and Care Standard	Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No – the presentation is to provide an update
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes
Link to Strategic Goals	Please Select: Sustaining Our Future Improving Care Creating Health

Equity of access to rehabilitation

- Following the relocation of stroke services from Bridgend, patients remained on the RGH Acute Stroke Unit (ASU) for rehabilitation. This was in keeping with the previous model of care on the stroke unit in POW. This pathway has now been adapted to ensure all appropriate patients (including Bridgend patients) are now listed for ward D4, YCR. Patients will also continue to receive their rehab on the RGH site.

- Despite this, there continues to be an unmet need for stroke specialist rehab across CTM due to a deficit in specialist stroke rehab workforce. At present, there is 46.6% of the recommended Allied Health Professional (AHP) workforce to deliver stroke rehab on the RGH and YCR stroke units as a 5 days service.

- A proposal was submitted as part of the IMTP to increase the stroke rehab workforce to deliver a 7-day service. In the meantime, the AHP stroke team have reviewed their ways of working to maximise efficiency to improve rehab time for patients.

Early Supported Discharge (ESD)

- All suitable patients who live and are registered with a GP in CTM and who meet the criteria, can access the stroke Early Supported Discharge service (ESD).

- Following an MDT (Multi-Disciplinary Team) improvement project in YCR, the ESD performance position was 57.9% in April 2025 (All-Wales position: 34.7%), and 69.4% in May 2025 (All-Wales position: 35%).

Stroke Unit Temporary Centralisation

Timeline

October 24	POW Stroke Ward moved to RGH due to Critical Incident
January 25	PCH Stroke Ward moved to RGH – due to shortages in senior medical workforce.
	Inpatient stroke service centralised on Wards 19 & 20 at RGH, and workforce moved from POW and PCH to support.
February 25	IM & Exec Walkthrough – areas of good practice noted but number of concerns also raised.
March 25	Corporate Assurance Visit – areas of improvement identified and red notice issued
April 25	Overarching Improvement Action Plan in place covering immediate improvements and workforce challenges
May 25	Return IM & Exec Walkthrough – improvements noted, positive patient feedback but ongoing concern re vacancy position
July 25	CEO Visit –met staff and patients. Positive feedback and improvements and progress noted.
August 25	Follow up quality assurance visit requested with specific focus.

CTM Stroke Service – Improvement Action Plan

Phase 1 - Overarching immediate improvement plan commenced in April to support stabilisation

- All improvement triggers and specific actions RAG rated on action plan
- Initial action plan rating April – 13 red - April 2025
- Updated actions plan rating – 5 red – July 2025

Key Actions:

- Quality and assurance
- Workforce – Nursing and Medical
- Leadership – Directorate Management, Lead Nurse, Senior Nurse, Ward Manager 7/7
- Environment – iCTM
- Governance structure
- MDT communication
- AMaT
- Daily improvement huddles

Outcomes

- Significant de-escalation of risks and stabilisation of service

CTM Stroke Service – Improvement Action Plan

Phase 2 - Development of Stroke Service Transformation Programme (SSTP) – 30/60/90 days

The Stroke Services Transformation Programme (SSTP) has been established to develop a programme of work to enable the CTM UHB to provide high-quality Stroke Service based on international best practices.

The initial focus of the SSTP will be in relation to a 30/60/90-day improvement plan which addresses two key priorities:

- CT Scan within 20 minutes
- Admission to Acute Stroke Unit within 4 hours

Establishment of Stroke Services Transformation Programme (SSTP) to include Emergency Department (ED), Radiology, Clinical Site Management, medical teams, Welsh Ambulance Services Trust (WAST), CTM operational teams.

- Process map all stages of Key Performance Indicators (KPI) pathway to identify barriers to improvement.
- Development of HB dashboard to provide daily performance data.
- Following process mapping, establish 30/60/30-day improvement programme
- Plan launch 30-day cycle 1st August 2025 – trajectories for improvement to be agreed as part of programme

Stroke– Nursing Workforce Plan

Nursing Workforce	Recruitment of substantive additional ward manager to support 7 day ward manager cover – Post on Trac awaiting approval. Interviews planned for early June	Interviews scheduled for 25/06/25 – 3 candidates. Successful appointment. Start date 14/07/25	Lead Nurse	22/05/25	02/06/25
	Recent band 5 advert closed 20.05.25. Interviews arranged for 28.05.25 8 candidates invited to interview.	4.2 wte appointed, awaiting start dates. Further 5.0 wte now on Trac (100 applicants to date) 1 streamlining student for informal visit next week	Lead Nurse Senior Nurse		09/07/25
	Streamlining – 2 applications shortlisted with 9 in total requested for Stroke	No successful applications from streamlining. Some students currently without posts – potential for recruitment	Senior Nurse		
	Agreement to use ID Medical to support nursing vacancies in the short term. SF to liaise with Procurement and ID Medical team to understand if suitable staff available.	ID Medical not a viable option. Expression of interest sent to other providers – awaiting Procurement update	Sarah Follows		
	6 x band 2 HCA posts now approved on Trac. Awaiting advertising 2 HCAs to start work within next 2 weeks.	HCA x 5.0 appointed. Awaiting start dates. 6.0 wte further posts on Trac	Lead Nurse Senior Nurse		
	Agency block booking where possible to support continuity of care. 1 x RN moved from Ward 14 for 6 months to support Stroke Unit staffing position	Exploring re-establishment of therapy nurse posts in order to support stroke enabling ethos on the unit and closer working across therapies and nursing.	Ward Manager		
	All nurse recruitment now being led by Lead Nurse Support sought from Recruitment and Retention Lead. Meeting planned for 23/05/25	Meeting held with Recruitment and Retention Lead. Support and advice given re pre-interview tips and possibilities of open days etc	Lead Nurse Directorate Manager	22/05/25	02/06/25

Stroke - Medical Workforce Plan

Medical Workforce	Substantive Consultant Recruitment Consultant interviews planned for 11.06.25 – one candidate. If successful, candidate unable to start until December 25	Successful appointment of substantive consultant. Start date tbc – likely January 2026	Clinical Director Medical Workforce		
	2 x agency locums currently in post. To be extended to support consultant gaps	Locums contacted and both agreed to extend placement. Retinue informed and placements updated	Directorate Manager	22/05/25	05/06/25
	1 consultant on maternity leave until October 25. Clinical Director to ascertain return to work plan.	Awaiting RTW update. Likely January 26.	Clinical Director		
	1 consultant returned from LTS this week. Phased return over a number of months, with potential for further absence. RTW arrangements being managed by Directorate Manager	RTW going well. Weekly touchpoint in place. Undertaking patient admin at POWH.	Directorate Manager		
	Junior workforce from POW / PCH to remain at RGH. On call commitments will transfer from POW / PCH to RGH as per HEIW recommendations. Rotas currently being built for all three sites	Rota builds now complete and August intake aware of RGH base	Directorate Manager		09/07/26

Stroke Unit – Environmental Update

Concern	Action	Update - 09/07/25	Timescale / Owner	RAG	
Leadership	Senior Nurse supporting with PADR compliance and monitor through monthly workforce meetings Senior nursing workforce updates Stroke Senior and Lead Nurses increased visibility on Stroke Unit Recruitment of additional Ward Manager to provide 7 day cover Monthly ward meetings with minutes shared with teams Lessons learnt to be shared with teams Senior Therapy visibility on unit weekly Therapies stroke meetings and therapy stroke leads meeting	01/07/25 – PADR compliance 56%. Plan in place to achieve 75% by end of July Senior Nurse reorganisation. Interim SN for 3/12 until appointment of Professional Lead for Stroke. Second Ward Manager appointed. Start date 14/07/25 Ongoing therapy meetings and visibility on the unit	End June 25 Senior Nurse Lead Nurse Ward Manager Head of SLT / AHP CD		09/07/25
MDT Communication	• Review of notes storage – Simply Do recognition • Bedhead communication – boards now in place and MDT information shared (eg fluid and diet charts) • Support from iCTM re communication	Improvements noted by teams re accuracy of bedhead information. Physio Tech checking daily. iCTM / Innovation team looking at practical solutions to support bedhead comms. Daily checklist reviewed by Nurse in Charge	June 25 Ward Manager		09/07/25
Environment IP&C	Daily checks by Senior Nurse – ward environment / sluice / stockroom Monitor AMaT performance (75% at 15/05/25) Regular peer review IPC Level 2 training at 85%. Improvement noted from 73% at 16/04/25 to 84% at 21/05/25 Estates walk through 12/05/25 Regular and ad hoc PPE / HH audits. 22/05/25 - Immediate feedback given to individual staff and reminders to all staff. Regular communication with Hotel Services New bins ordered – await delivery Staff member allocated to unpack stores every Friday and cleaning schedule in place.	Requested updated peer / IPC team audit 04/07/25 IPC Level 2 compliance - 92% iCTM supported with stock and storage management. All systems now in place. New bins delivered and in use. Senior Nurse review stores put away compliance every Friday	Immediate and Ongoing Senior Nurse Lead Nurse Ward Manager		09/07/25
15 Steps	Ward environment challenging for patient selection. Bathrooms unsuitable for double handling and tilt hoisting. Estates team supporting with grab rails, mirrors and curtains in cubicles to maintain dignity Bathrooms added to the wider stroke risk on risk register (risk ID 4632)	Risk assessments completed by Senior Nurse	End June 25 Senior Nurse Estates Teams		

Stroke Unit – Environmental Update

Concern	Action	Update - 09/07/25	Timescale / Owner	RAG - April 25	RAG - updated
Leadership	PADR compliance, senior nursing visibility, monthly ward meetings, share lessons learnt Recruitment of additional Ward Manager to provide 7 day cover Senior Therapy visibility on unit weekly Therapies stroke meetings and therapy stroke leads meeting	01/07/25 – PADR compliance 56%. Plan in place to achieve 75% by end of July Senior Nurse in post Second Ward Manager appointed. Start date 14/07/25	End June 25 Senior Nurse Lead Nurse		09/07/2025
MDT Communication	•Review of notes storage – Simply Do recognition •Bedhead communication – boards now in place and MDT information shared (eg fluid and diet charts) •Support from iCTM re communication	Improvements noted by teams re accuracy of bedhead information. Physio Tech checking daily. iCTM / Innovation team looking at practical solutions to support bedhead comms. Daily checklist reviewed by Nurse in Charge	Jun-25 Ward Manager		**09/07/2025**
Environment IP&C	Daily checks by Senior Nurse – ward environment / sluice / stockroom Monitor AMaT performance (75% at 15/05/25) Regular peer review and ad hoc audits - PPE / HH IPC Level 2 training at 85%. Improvement noted from 73% at 16/04/25 to 84% at 21/05/25 Regular communication with Hotel Services Staff member allocated to unpack stores every Friday and cleaning schedule in place.	Requested updated peer / IPC team audit 04/07/25 IPC Level 2 compliance - 92% iCTM supported with stock and storage management. All systems now in place. Senior Nurse review stores put away compliance every Friday	Immediate and Ongoing Senior Nurse Lead Nurse Ward Manager		**09/07/2025**
15 Steps	Ward environment challenging for patient selection. Bathrooms unsuitable for double handling and tilt hoisting. Estates team supporting with grab rails, mirrors and curtains in cubicles to maintain dignity Bathrooms added to the wider stroke risk on risk register (risk ID 4632)	Risk assessments completed by Senior Nurse Bathrooms added to risk register	End June 25 Senior Nurse Estates Teams		
Pharmacy	Daily check of medication fridge, CD keys and medication spot check. Concerns raised through Medications Scrutiny Panel. Weekly medication chart reviews. Patient information leaflet to request that staff are not disturbed when on medication rounds. Leaflet produced and awaiting Welsh translation.	Daily checklist in place and compliance monitored Pharmacy colleagues asked to support with medication reviews Information leaflets (English and Welsh) now available to patients and staff	Immediate and Ongoing Senior Nurse Lead Nurse		**09/07/2025**
One Patient One Day	Assurance that care bundles, falls assessment, risk assessments, lying and standing BPs are all complete within 6 hour timeframe.	Falls audit 94% June 25, AMaT care bundle compliance 95% Care Falls Training 59% WNCR compliance improvement	Immediate and ongoing Senior Nurse weekly audit		**09/07/2025**
Health Roster	Ensure roster rules are met Timely and effective return to work meetings held and ensure Managing Attendance at Work policy adhered to	Senior Nurse checking roster prior to approval	Immediate and ongoing Ward Manager		
AMaT	Monitor AMaT compliance and performance and share with teams. Senior Nurse oversight of audits and ensure plans in place to improve performance where required with consistency of results > 85%	Ward 19 – 84%, Ward 20 - 91.25% Ward 19 & 20 now combined reporting in AMaT – need updated to results to ensure compliance improvement	Immediate and ongoing Ward Manager		
Patient Safety	Daily checks assurance Bed head information spot checks and results to be monitored and shared with staff Zero incidents related to wrong diet / fluids – ensure incidents are fully investigated and findings shared with staff.	Ward Manager confirming that daily checks are complete and non-compliance addressed. Feedback to staff via noticeboard and newsletter. Verbal feedback from therapies that oral care and SALT compliance is improving. Datix reviews – no moderate harm.	Immediate and ongoing Ward Manager Senior Nurse		**09/07/2025**

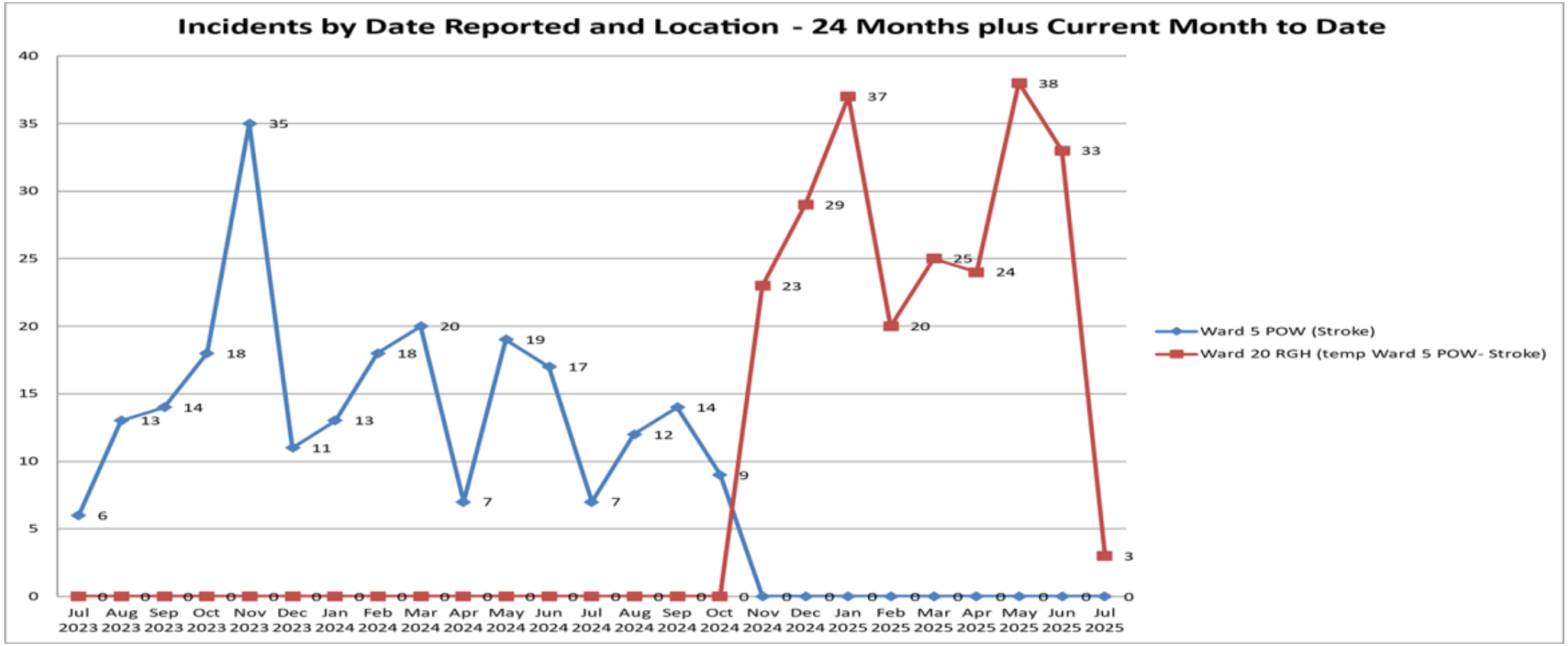
Quality & Assurance - Improvement Actions

Action	Lead	Timeline	Update Due
HCA Interviews	Senior Nurse	10/06/25	08/07/25 – 6.0 wte appointed. 21/07/25 – 6.0 further posts on Trac
Ward Manager recruitment	Senior Nurse Lead Nurse	15/06/25	08/07/25 – 2nd Ward Manager appointed. Start date 14/07/25 Backfill B6 post on Trac
ID Medical	Service Director	09/06/25	08/07/25 – unable to use ID Medical. EOI shared with other providers via Procurement team. Awaiting update
AMaT compliance	Senior Nurse	19/06/25	21/07/25 to confirm improvement above 85% for both wards
Consultant recruitment	Directorate Manager	11/06/25	08/07/25 – expected CCT date confirmed as 24th November 25. Start date likely January 25.
Reporting Digital patient tracking Weekly performance reports	Head of Information / Andrew Nelson	19/06/25	08/07/25 – Information team supporting with weekly data from SSNAP database. 21/07/25 Discussion with Rob Jones re stroke dashboard requirements. Will need to confirm patient identifiers to track through systems. (AVN asked to develop digital tracking for stroke patients to support QIM and weekly performance report to support improvement action plans).
Recruitment of Professional Lead, Stroke	Head of Nursing Service Director	01/09/25	04/07/25 – review of similar roles in other organisations and development of job description to meet CTM requirements.
MDT meeting for unit staff	Professional Director of Nursing / CD for AHPs	02/06/25	21/07/25 – previous date postponed. New date tbc

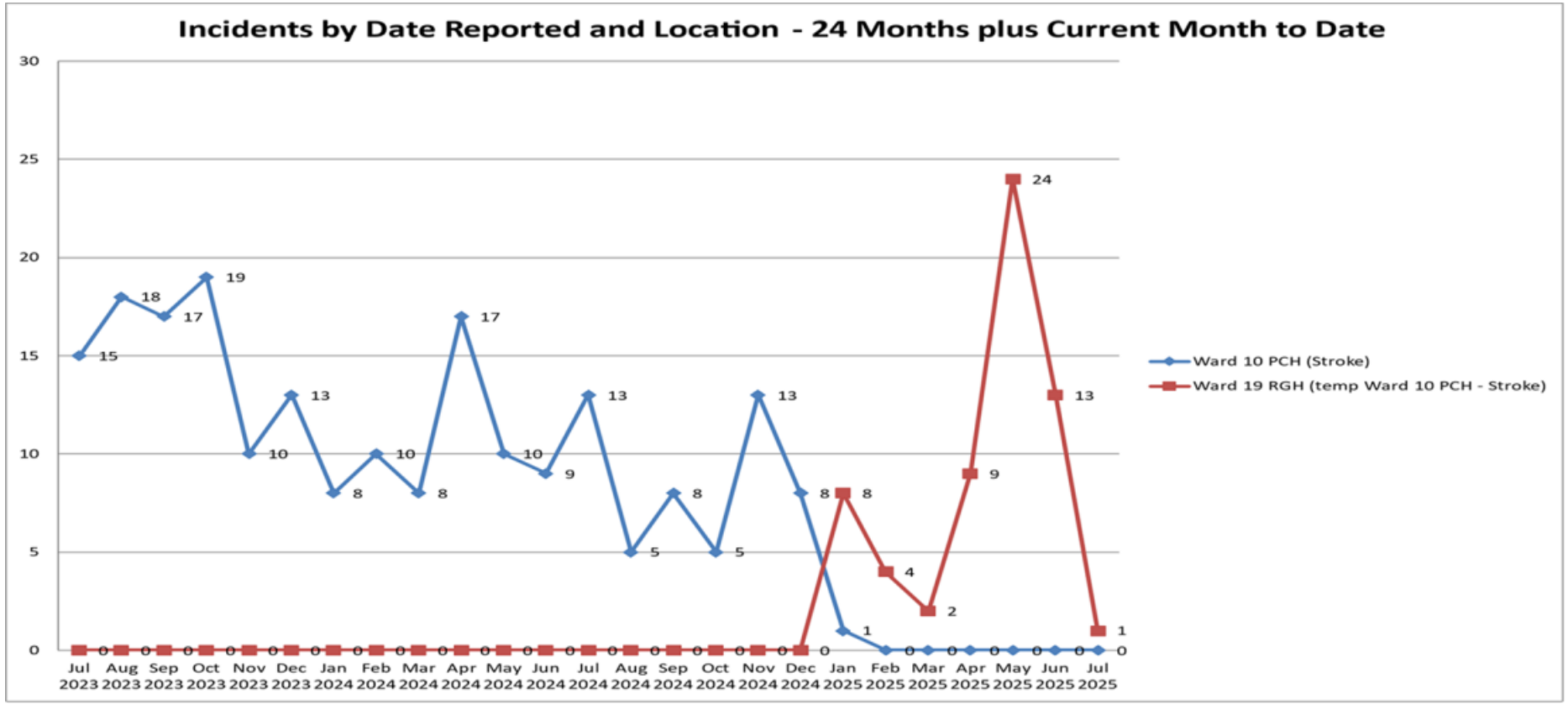
Governance & Assurance

- Weekly Q&A action plan review meeting with senior team
- Fortnightly stroke performance touchpoint meetings with Exec team
- Action log highlight report on monthly Stroke Operational Group meeting
- Stroke Operational Group highlight report fed into monthly Stroke Performance Board meetings

Data


Incidents by Date Reported and Location - 24 Months plus Current Month to Date
40
35
30
25
20
15
10
5
0
6
13
14
18
35
11
13
18
20
7
19
17
7
12
14
9
0
0
0
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0
0
0
0
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23
29
37
20
25
24
38
33
3
Jul 2023
Aug 2023
Sep 2023
Oct 2023
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
Jun 2024
Jul 2024
Aug 2024
Sep 2024
Oct 2024
Nov 2024
Dec 2024
Jan 2025
Feb 2025
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Ward 5 POW (Stroke)
Ward 20 RGH (temp Ward 5 POW- Stroke)

Data


Incidents by Date Reported and Location - 24 Months plus Current Month to Date
30
25
20
15
10
5
0
Jul 2023
Aug 2023
Sep 2023
Oct 2023
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
Jun 2024
Jul 2024
Aug 2024
Sep 2024
Oct 2024
Nov 2024
Dec 2024
Jan 2025
Feb 2025
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
15
18
17
19
10
13
8
10
8
17
10
9
13
5
8
5
13
8
1
0
8
8
4
2
9
24
13
1
0
Ward 10 PCH (Stroke)
Ward 19 RGH (temp Ward 10 PCH - Stroke)

Data Update

Issues

- Increase in overall incident reporting following transfers of Stroke wards from POW and PCH temporary centralised Stroke unit at RGH
- Quality and assurance review provided additional scrutiny
- Environmental and workforce challenges contributary factors

Actions

- Detailed improvement action plan
- Development and roll out of a Stroke dashboard to ensure one single data source
- Follow-up quality and assurance review scheduled August 2025

Specific Matters for Consideration:

The presentation on stroke aims to provide assurance on several key aspects of the stroke services. It focuses on the quality, safety, and patient experience implications of the services provided. The presentation highlights the efforts made to ensure equity of access to rehabilitation, the performance of the Early Supported Discharge (ESD) service, and the centralization of stroke units to address workforce shortages and improve service delivery.
Additionally, the presentation outlines the improvement action plans, including the immediate stabilisation efforts and the development of the Stroke Service Transformation Programme (SSTP) to enhance the quality of stroke services based on international best practices. The presentation also addresses the nursing and medical workforce plans, environmental updates, and the development of a stroke dashboard to ensure a single data source for performance monitoring.

Key Risks / Matters for Escalation:

The aim of the presentation is to provide assurances that the following risks have been noted and are actively being monitored and managed, with necessary actions taken to deliver high quality stroke services.

Workforce
Centralisation challenges
Quality and assurance concerns
Environmental challenges
Data and performance monitoring

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Recommendation

The Committee are asked to:

- *Consider whether the Committee can seek assurance from the presentation that all necessary actions are being taken to deliver high-quality stroke services and manage any associated risks*

Next Steps

- *As noted on slide 14*

Agenda Item
6.1

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Review

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

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

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.05.25 and 30.06.25 taken from systems on 09.07.25, unless otherwise specified.

1.1 Key areas to note in this reporting period are:

- The number of new complaints received remained relatively consistent
- Compliance was above the National Target of 75% for responding to complaints within 30 working days in June 2025
- Improved compliance with Public Service Ombudsman of Wales recommendations
- Increase in number of National Reportable Incidents submitted to NHS Wales Executive during May 2025
- Reduced number of open inquests following consolidation exercise undertaken with Coroner's Officer
- Summary of Clinical Negligence Activity
- Decrease in medication incidents reported
- Decrease in patient fall incidents reported
- Decrease in restrictive incidents reported

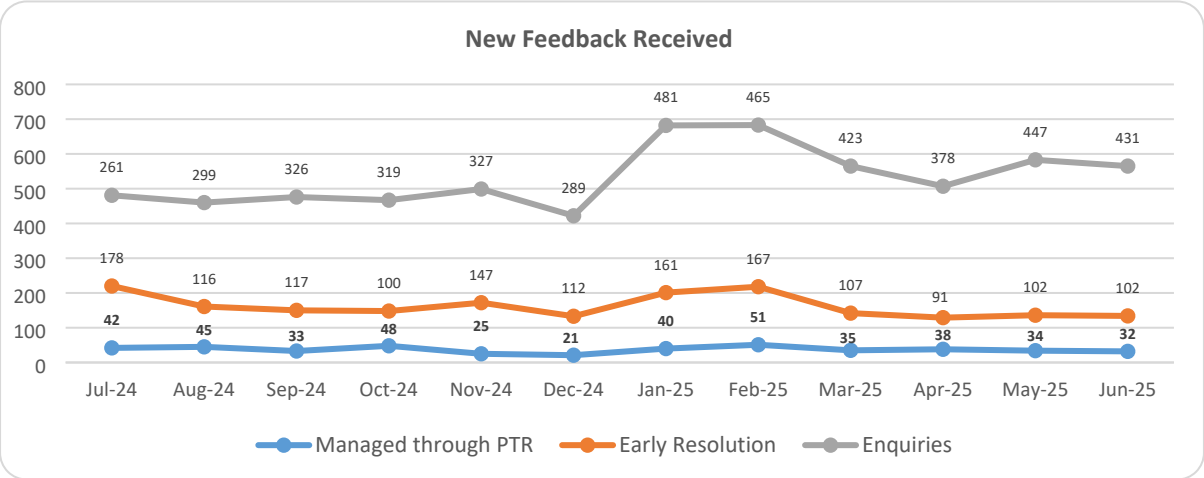
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

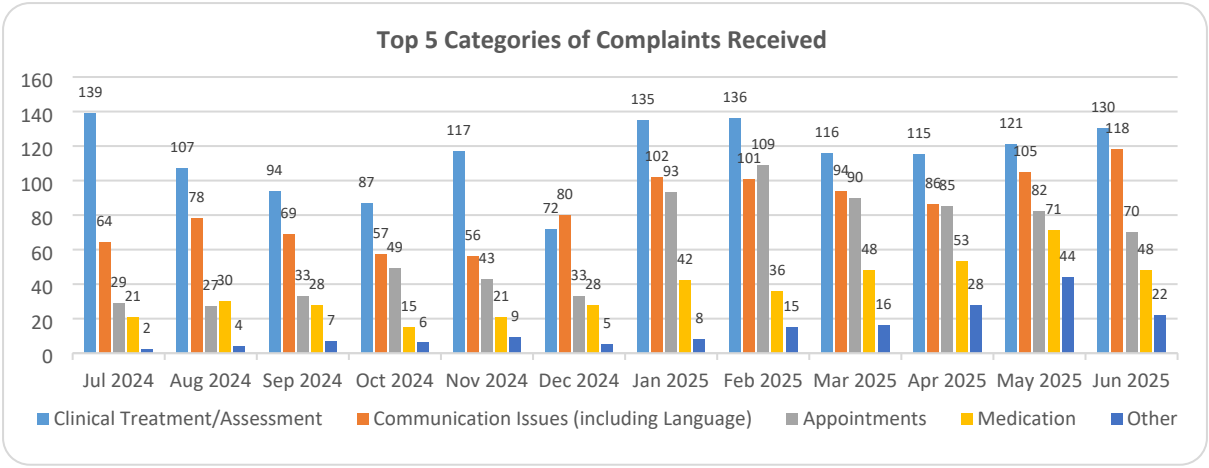
Complaints & Enquiries

New Complaints Received

Between the 01.05.25 and 30.06.25 the Health Board received a total of 270 complaints and 878 enquiries. Of 270 complaints received, 66 were categorised as formal and managed under the Putting Things Right Regulations (PTR). During the period the number of complaints received remained relatively consistent with the previous 2 months, while the number of enquiries received slightly increased.

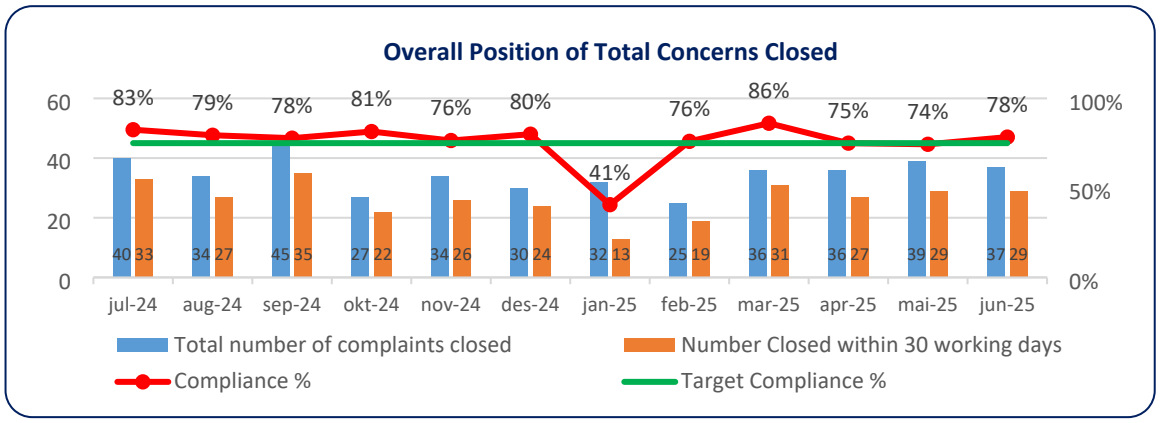


For all feedback (Complaints and Enquiries) received in May and June 2025, accounting for 57% of the feedback received, the top 3 types remain consistent with previous months. These relate to Clinical Treatment / Assessment (251), Communication Issues (223) and Appointments (152).



Closed Complaints

Within the period of 01.05.25 to 30.06.25, the Health Board closed a total of 76 formal complaints (managed through PTR). During the 2-month period, the national target of 75% compliance for responding to complaints within 30 working days was achieved. As at 07.07.25, the Health Board had 54 open formal complaints. Of these, 20 complaints were open over 30 working days.



Public Services Ombudsman for Wales

Open cases

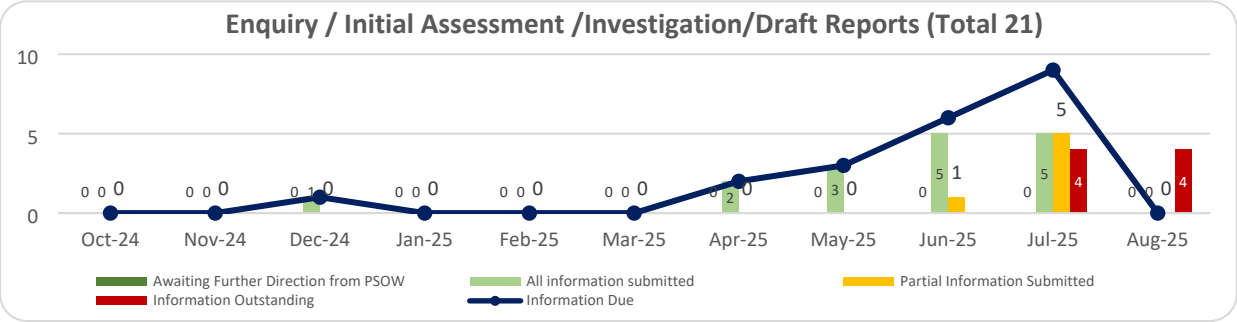
As at the 09.07.25 the Health Board has 32 open Public Services Ombudsman for Wales (PSOW) Cases. Of these, 21 are awaiting a response from the PSOW.

Current Status	Enquiry / Initial Assessment/ Investigation	Early Settlement	Draft Report Comments	Final Report Compliance	Information Only	Total
All evidence submitted and awaiting closure by PSOW	0	0	0	0	0	0
Awaiting further direction from PSOW	0	0	0	0	2	2
Information Received	0	0	0	0	0	0
Information Submitted	15	2	1	1	0	19
Information Outstanding	2	3	2	1	0	8
Information Partially Submitted	1	1	0	1	0	3
Total	**18**	**6**	**3**	**3**	**2**	**32**

New PSOW Cases Received

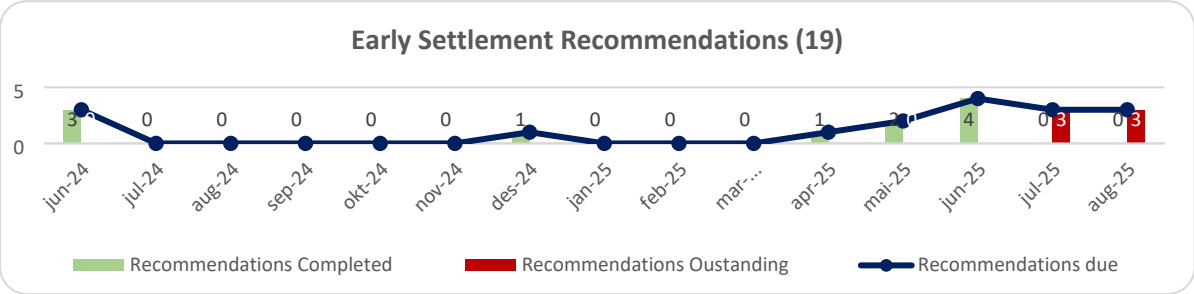
The Health Board received notification of 20 new referrals to the Public Services Ombudsman for Wales (PSOW) between the 01.05.25 and 30.06.25. Of the 20, 14 were received as enquiries, 5 as a decision not to investigate and 1 as an early settlement proposal. There were no full investigations received during this time period.

Of the 21 cases, the Health Board currently has at 09.07.25 in the enquiry / initial assessment/investigation or draft stage, 5 cases have outstanding actions. One action is currently overdue, with only partial information submitted. This is reflected in the chart below:



Early Settlement Proposal

During the same period the Health Board agreed 1 early settlement proposal. It should be noted that more than one action can be attributed to a case. As at the 09.07.25, the Health Board has 6 open early settlement cases, with 19 associated case actions. Of the 19 actions, none are overdue the deadline agreed with the PSOW.



Final Reports

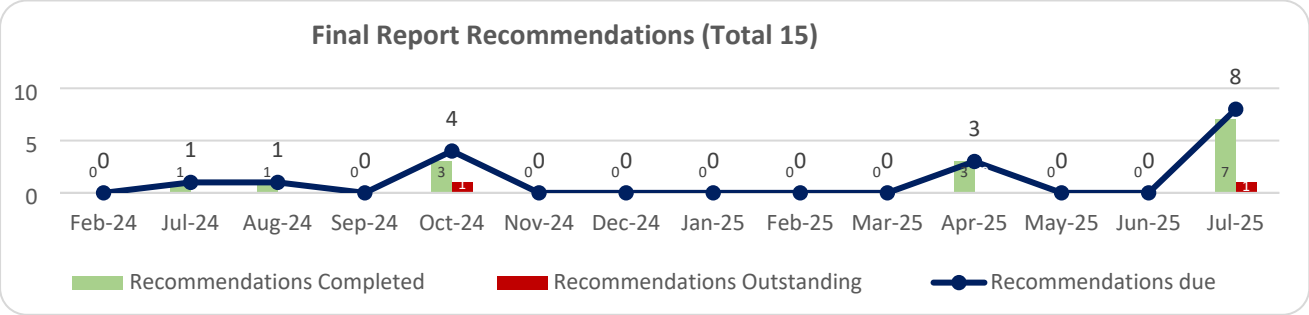
During May and June 2025, the PSOW issued 2 final reports to the Health Board. Of these, 1 was partially upheld and 1 was not upheld.

The PSOW issued a partially upheld case following its investigation in care and treatment provided at Prince Charles Hospital during April 2024, specifically around end of life. The Ombudsman's investigation highlighted failures in the care provided to the patient in relation to monitoring of the patient's pain, delays in using a syringe driver, administering of medication and referral of the patient to an appropriate ward. In recognition of the findings of the report, the PSOW recommended that the Health Board remind staff of:

- importance of using appropriate pain assessment tools to ensure accurate pain scores are obtained

- need to ensure accurate record keeping, including the completion of food and fluid charts and responses to PRN medication
- need to ensure timely actions are taken and referrals made, following medical reviews, including referrals to palliative care and ensuring syringe drivers are administered when requested

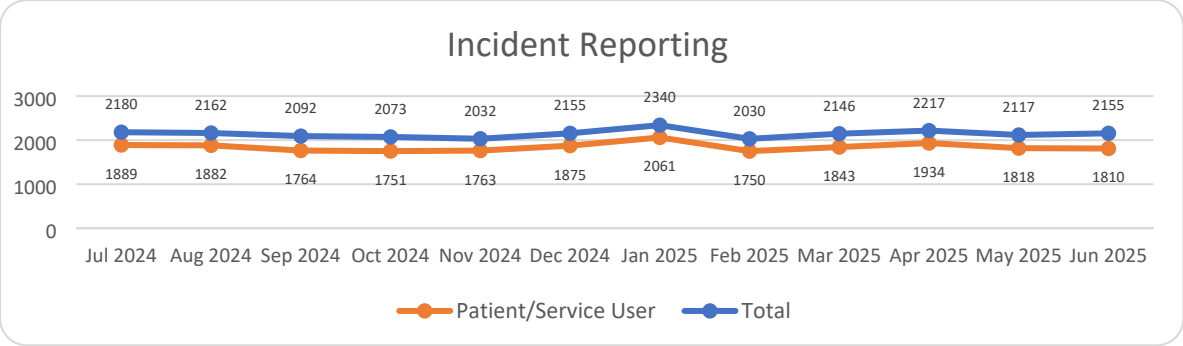
As at 02.05.25, the Health Board has 3 cases which are currently in the final report stage of the PSOW process. These cases have 17 associated recommendations. Of these recommendations, 2 are currently outstanding, with 1 currently overdue the timescale for completion.



2.2 Patient Safety Incidents

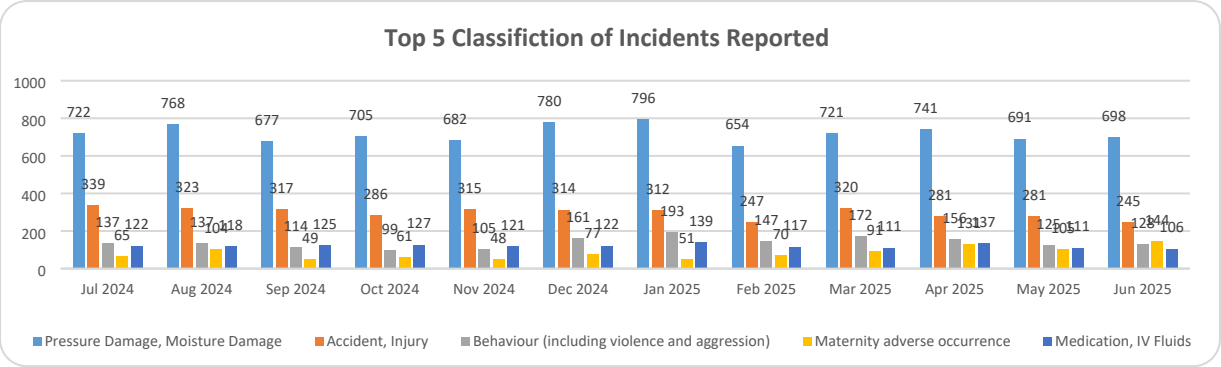
Total Patient Safety Incidents

A total of 4,272 incidents were reported as occurring between 01.05.25 to 30.06.25, this represents a decrease of 91 when compared with the previous 2 months (4,363). The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,272 incidents reported, 85% (3,628) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.



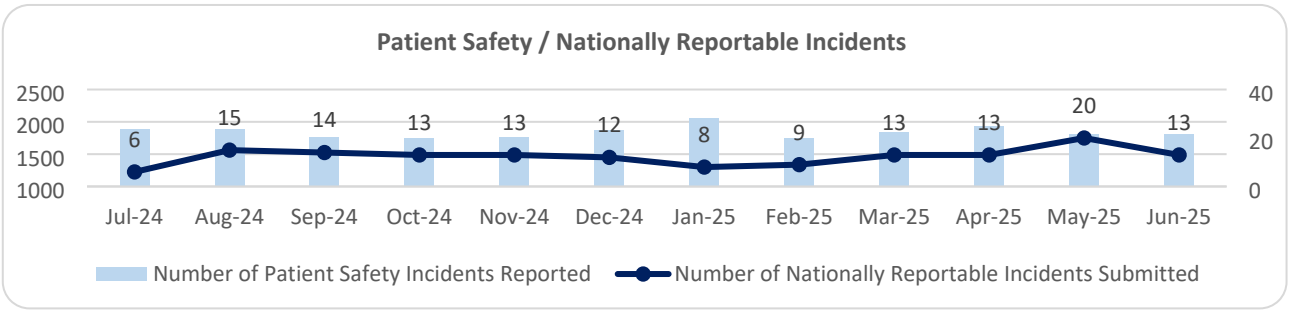
The top 5 classification of incidents reported as occurring in March and April 2025, linked to a patient affected incident are: Pressure Damage /Moisture Lesion (1,389), Accident, Injury (526) and Behaviour (including violence and aggression)

(253), Maternity Adverse Event (249) and Medication, IV fluids (217). This represents a change in comparison with the previous two month period as maternity adverse event has replaced access, admission in the top 5. The trend for the top 5 classification of incidents is highlighted in the chart below:



Nationally Reportable Incidents

Between 01.05.25 and 30.06.25, 33 Nationally Reportable Incidents were submitted to NHS Performance and Improvement (PI). The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.

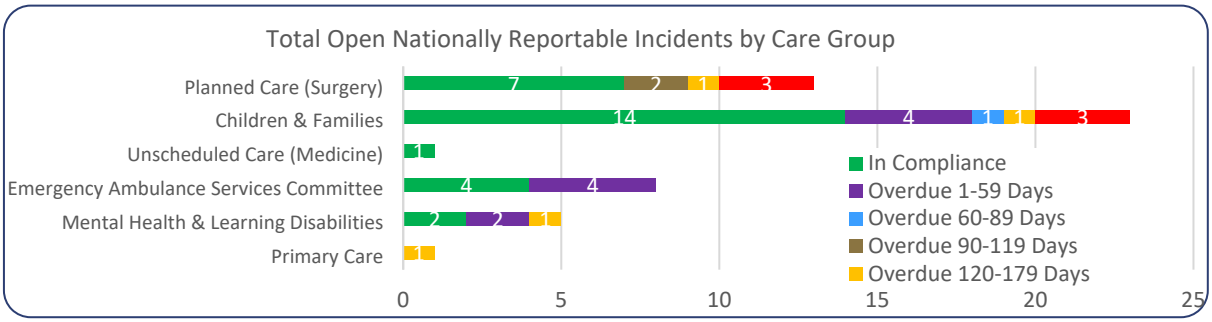


As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS PI. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Access, Admission	0	3	2	0	0	0	0	0	1	1	3	1	0
Accident, Injury	0	0	0	1	0	1	0	0	0	0	0	0	0
Assessment, Investigation, Diagnosis	0	2	2	1	0	0	0	0	1	0	2	0	2
Behaviour (including violence and aggression)	0	0	0	0	1	0	0	0	0	0	0	0	0
Communication	0	0	0	0	1	0	0	0	0	0	0	0	0
Equipment, Devices	0	0	0	0	0	0	0	0	0	1	0	0	0

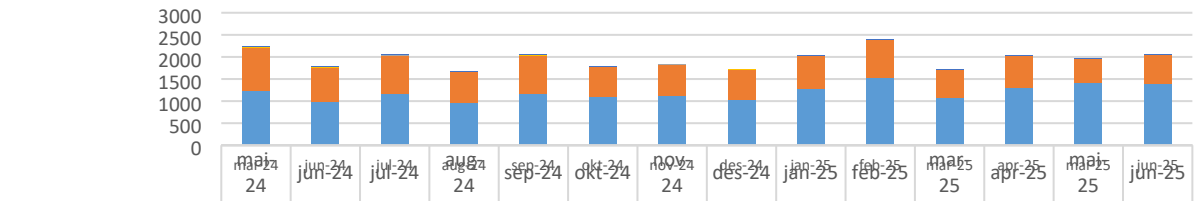
Infection Prevention and Control	1	1	3	0	0	2	0	0	4	3	2	0	0
Infrastructure (including staffing, facilities, environment, security)	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity adverse occurrence	0	2	1	3	2	2	4	1	3	0	5	2	0
Medication, IV Fluids	0	1	0	0	0	0	0	0	0	0	0	0	0
Monitoring, Observations	0	1	1	0	0	0	0	0	0	0	0	0	0
Nutrition, Hydration	0	0	0	0	0	0	0	1	0	0	0	0	0
Patient/service user death	1	0	0	0	2	0	1	1	0	1	1	1	0
Pressure Damage, Moisture Damage	4	3	3	8	6	7	2	4	4	3	7	6	4
Safeguarding	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer, Discharge	0	0	1	0	0	0	1	1	0	4	0	2	0
Treatment, Procedure	0	2	1	0	2	1	0	1	0	0	0	1	0
Total	6	15	14	13	14	13	8	9	13	13	20	13	6

As at the 07.07.25, the Health Board currently has 51 open Nationally Reportable Incidents, of which 23 are overdue the timescale for completion. Focused work continues to be undertaken to ensure investigations are concluded and ensure a timely outcome is provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

Between the 01.05.25 and 30.06.25 a total of 4,030 patient safety incidents were closed. The last 12 months trend is reflected in the table below.

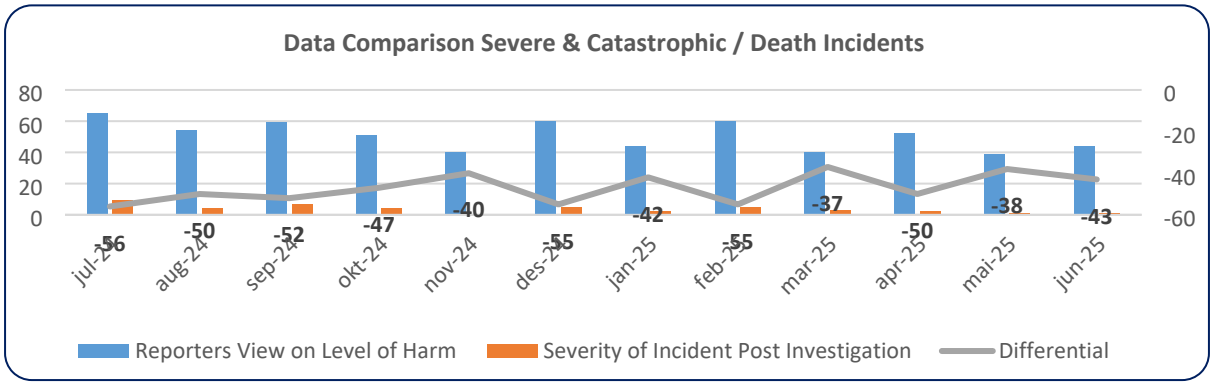


	maj-24	jun-24	jul-24	aug-24	sep-24	okt-24	nov-24	des-24	jan-25	feb-25	mar-25	apr-25	maj-25	jun-25
Catastrophic / Death	2	3	3	1	3	2	0	0	1	3	1	1	1	2
Severe	5	12	4	0	4	2	0	3	1	2	2	2	1	0
Moderate	20	13	19	14	13	12	18	19	15	17	6	19	7	10
Low	957	755	862	690	860	676	696	679	745	838	624	707	541	658
None	1244	992	1167	972	1167	1091	1120	1022	1273	1541	1085	1312	1416	1394

Of the 4,030 patient safety incidents closed, 4 were closed with severity post investigation of severe harm (1) or catastrophic/ death (3). A breakdown of incidents is provided in the table below:

	Diagnostics, Therapies and Specialist Care	Unscheduled Care (Medicine)	Planned Care (Surgery)	Total
Assessment, Investigation, Diagnosis	1	0	0	1
Infection Prevention & Control	0	2	0	2
Treatment, Procedure	0	0	1	1
Total	1	2	1	4

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

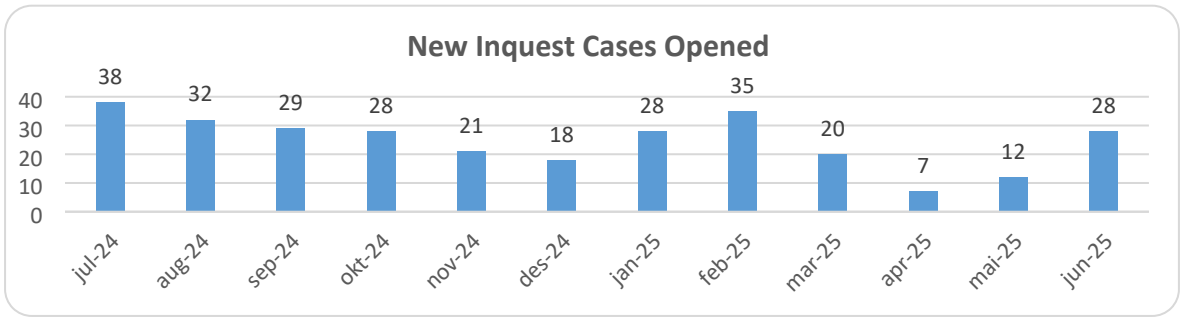
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

Number of Incidents	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	June 2025
Where Duty of Candour Triggered	11	11	13	7	15	11	9	5	13	15	21	16
Where In-person notification completed	8	8	12	4	14	8	8	4	12	13	17	16
Where letter of notification sent	6	6	12	4	14	8	7	4	11	11	16	13

2.3 Inquests Case Activity

New Inquests Received

In the time period 01.05.25 to 30.06.25, the Health Board received notification of 26 inquests. This is a significant decrease when compared with the previous 2-month period. A trend graph of the inquests opened during period is provided below.

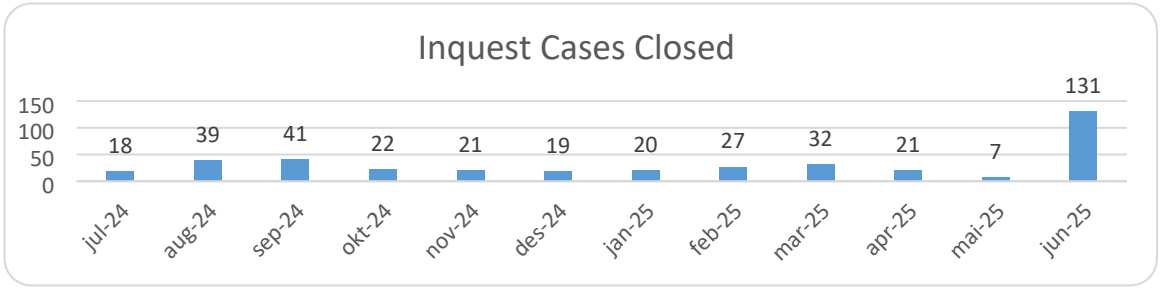


Of the 40, the highest number of inquests were received for the Unscheduled Care Group. A breakdown of inquests received by Care Group is provided below.

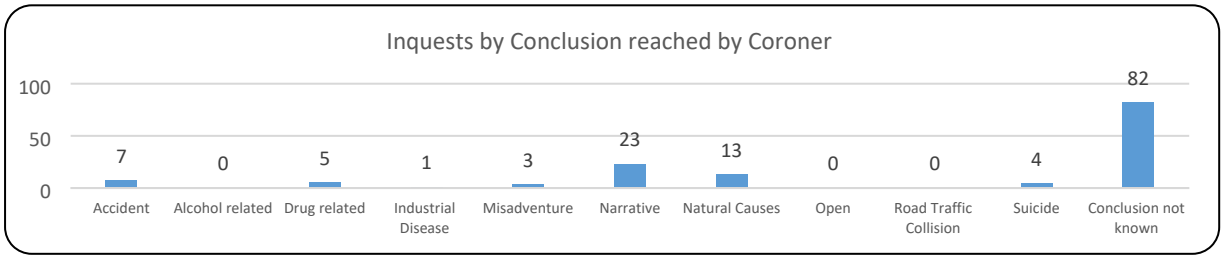
Care Group	Number Received
Community	0
Diagnostics, Therapies & Specialist Care	1
Families & Children	4
Mental Health	11
Planned Care (Surgery)	6
Primary Care	1
Unscheduled Care (Medicine)	15
Total	40

Inquests Concluded

During the same 2-month period, 138 inquest cases were closed on the Health Board's Datix system. A consolidation exercise was undertaken with the coroner's office during June 2025 which is reflected in the increase in the number of cases closed. A trend graph of inquests concluded during the period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 138 inquests cases closed on Datix, the conclusion has not been made available by the Coroner to the Health Board for 82 cases. Of the remaining cases, 64% were concluded with a narrative conclusion (23) or with an outcome of natural causes (13). A further breakdown of the outcome of inquests closed between the 01.05.25 and 30.06.25 is provided in the chart below.

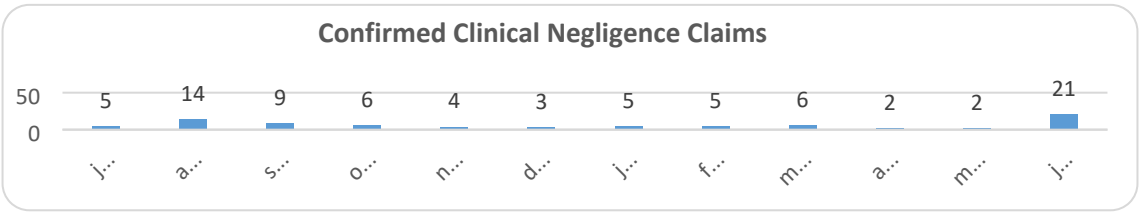


Regulation 28 Reports / HMC Letter Received

On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. Between the 01.05.25 and 30.05.25 the Coroner issued no regulation 28 reports to the Health Board relating to Hospital Death (Clinical Procedures and Medical Management) related deaths.

2.4 Clinical Negligence Claims

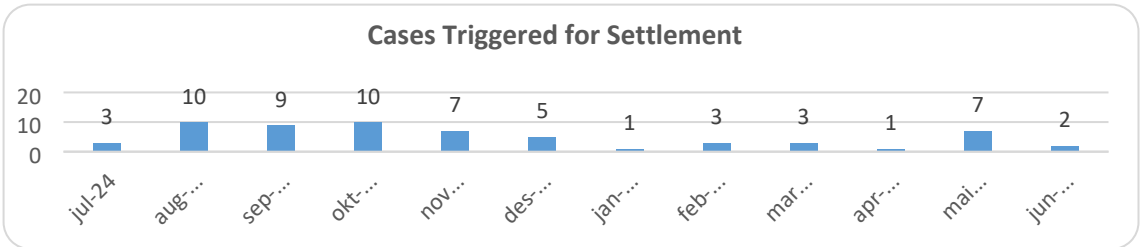
New Confirmed Clinical Negligence Claims



Between the 01.05.25 and 30.06.25 the Health Board received confirmation of a total of 23 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:

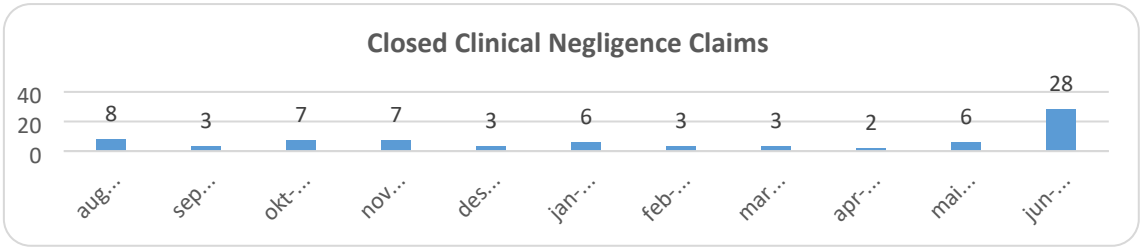
Clinical Negligence Claims triggered for settlement

Between the 01.05.25 and 30.06.25 the Health Board, 9 Clinical Negligence Claims were for triggered for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



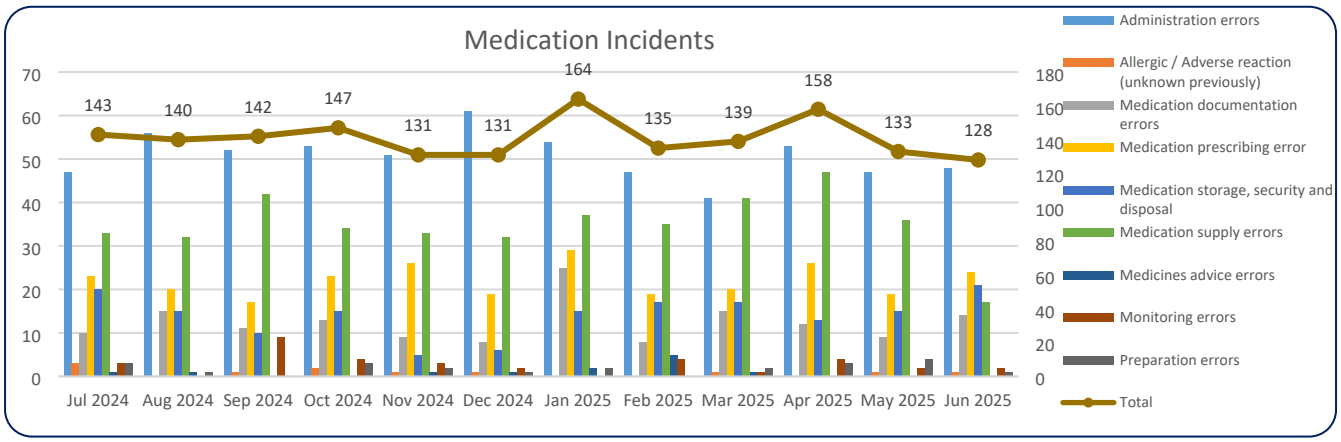
Closed Clinical Negligence Claims

Between the 01.05.25 and 30.06.25 the Health Board, 34 Clinical Negligence Claims were closed. A cleansing exercise was undertaken in June 2025 which is reflected in the chart below. The trend for clinical negligence claims closed in the last 12 months is highlighted in the chart below:



2.5 Specific Quality & Safety Metrics

2.5.1 Medication Safety



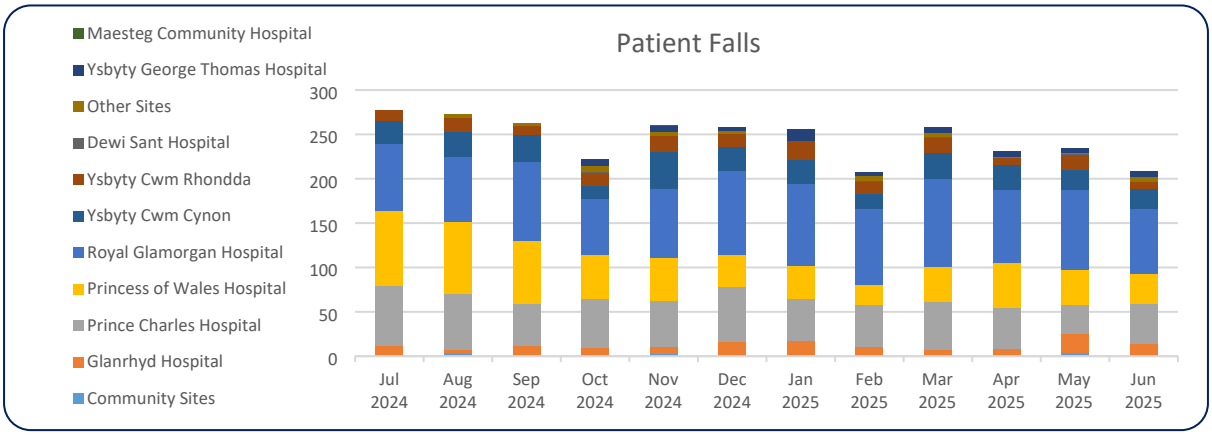
A total of 261 medication incidents were reported as occurring between 01.05.25 and 30.06.25. This is a decrease of 36 when compared with the previous 2-month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (95), medication supply errors (53), and medication prescribing errors (43).

90% of the medication incidents were reported as resulting in no (125) or low (110) harm, with the remaining reported as resulting in moderate harm (25) and Catastrophic/Death harm (1) harm. No incidents were reported as resulting in Severe harm. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.5.2 Patient Falls Incidents

A total number of 443 falls, where the person affected was a patient, were reported during May and June 2025. This represents a decrease of 46 compared with the previous two months.

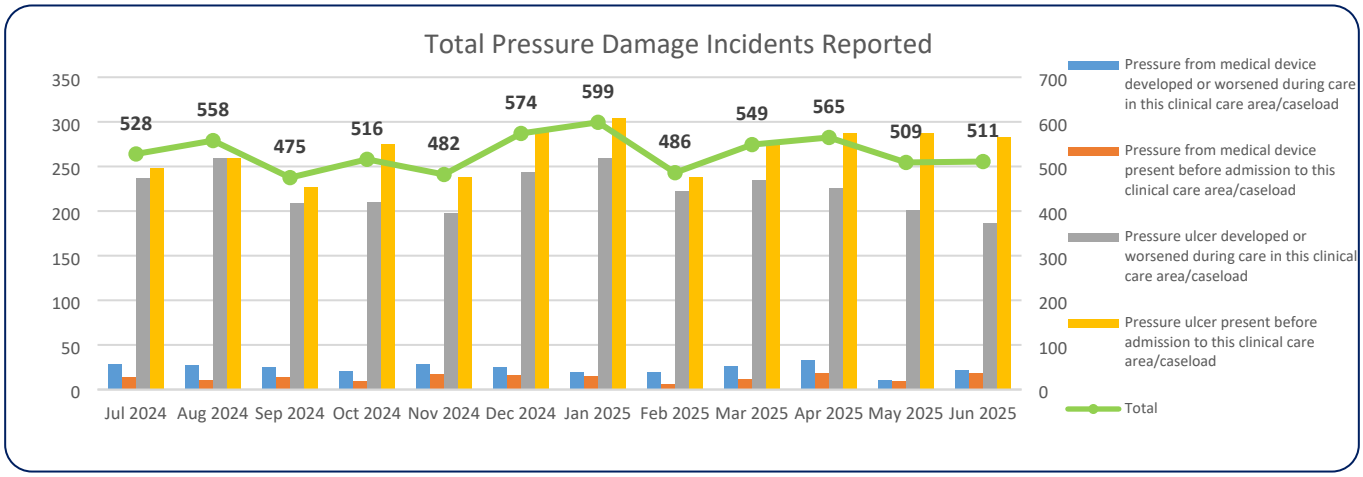
Of the falls incidents reported within the time period, 93% were reported as no (150) or low (263) harm. The remaining incidents were reported as resulting in moderate (28) and severe (2) harm. No incidents relating to patient falls were reported as resulting in catastrophic harm / death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



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

2.5.3 Pressure Damage

Between the 01.05.25 and 30.06.25, a total of 1,020 pressure damage incidents were reported, of which 421 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (599) were reported as being present before admission to this clinical care area/caseload.



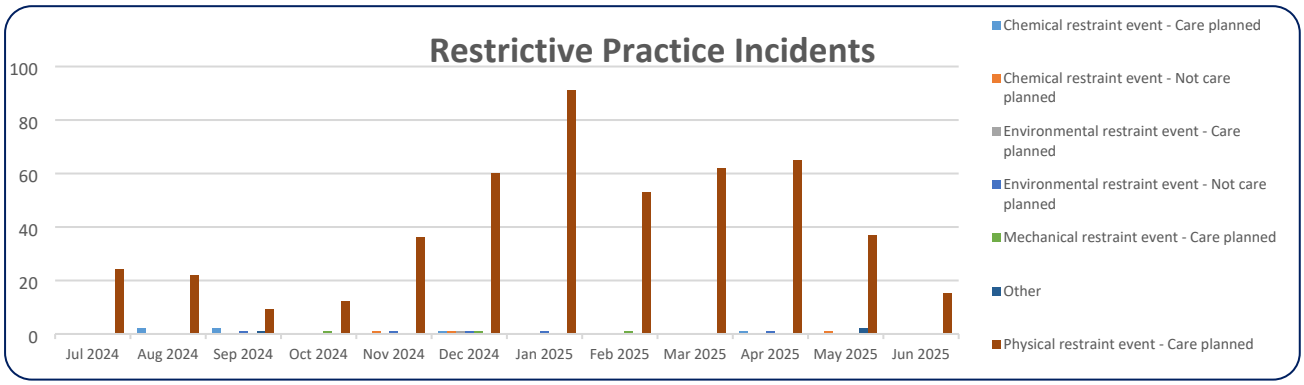
Of the 421, identified as developing or worsening during current caseload, 256 were identified as occurring within the community, which represents a decrease compared with the previous 2-month period.

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

2.5.4 Mental Health Metrics

Restrictive Practices

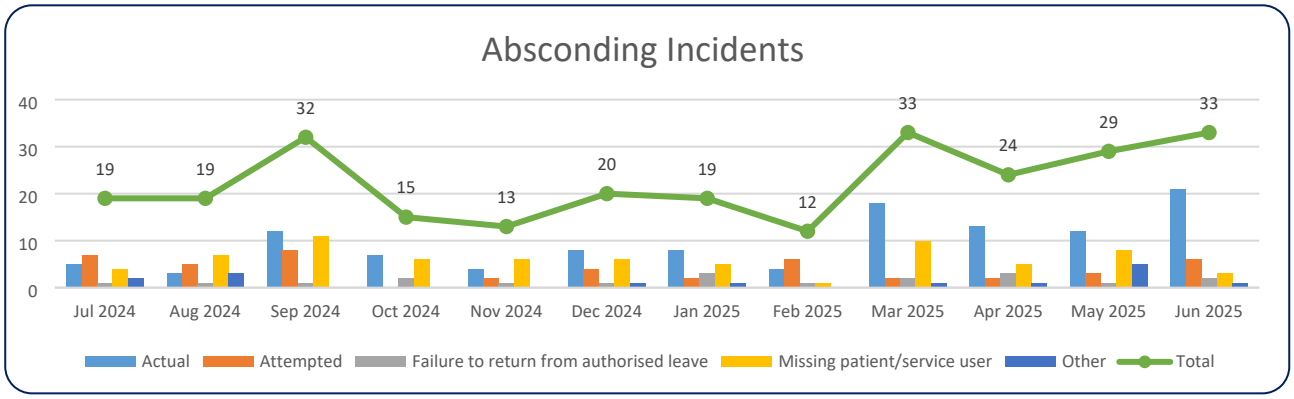
Between 01.05.25 and 30.06.25, a total of 81 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 69 incidents when compared to the previous two months.



Of the 81 incidents, 25 were reported as not care planned (not included in the care and treatment plan for the patient) and 54 were reported as care planned (included in the care and treatment plan for the patient), 2 were recorded as Other. The highest number of incidents were reported as occurring on the Enfys Ward, Princess of Wales Hospital (35).

Absconding incidents

During May and June 2025, a total of 62 incidents were reported under the category of absconding, which represents an increase of 5 when compared with the previous 2-month period. 33 were recorded as actual absconding, with the remaining recorded as missing patient/service user (11), attempted absconding (9), other (6) and failure to return from authorised leave (3). The highest number of incidents were reported as occurring in the Accident and Emergency department at the Royal Glamorgan Hospital (14).



3. Key Risks / Matters for Escalation

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

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

4. Assessment

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

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

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

5. Recommendation

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

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

6. Next Steps

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

Agenda Item
6.1 Appendix

Quality, Safety & Experience Committee

People's Experience Activity Report April – May 2025

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Becky Gammon, Assistant Director of Nursing & People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMU HB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advisory Liaison Service

1. Situation /Background

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

2. Specific Matters for Consideration

Engagement Opportunities

As the needs of our patients, families and carers change the People's Experience team continue to look at how they can reach out to the communities they support to ensure their voices are heard within the Health Board.

Date	Event	Attendance
11th April	CTM 2030 network, Bridgend	Head of People's Experience
28th April – 2nd May	Patient Experience Week – Ysbyty Cwm Cynon & Ysbyty Cwm Rhondda	Patient Experience Team & Value Based Healthcare

Planning is underway to plan the Armed Forces Health & Wellbeing Event on 26th June with third sector organisations to highlight the support that is available to them.

NHS Wales People's Experience Framework and Toolkit

Head of People's Experience Team has linked in with Care Group Senior Teams to look at how the Health Board can populate the self-assessment tool. Meetings are in place to discuss the work Maternity have underway and how the new Maternity Framework links in with this.

Ongoing Projects

Falls/Pressure Area review

A new draft leaflet has been populated with patient representative feedback to inform patients/families showing how they can support a person who has fallen or has a pressure area. This will also give preventative information that can be utilised once they are home and is being reviewed to ensure fit for purpose.

Lost Property Pilot

A container has been created and a pilot is underway on one site to understand if this supports patients in keeping their property (glasses, hearing aids etc) in one safe sustainable place and will be monitored accordingly.

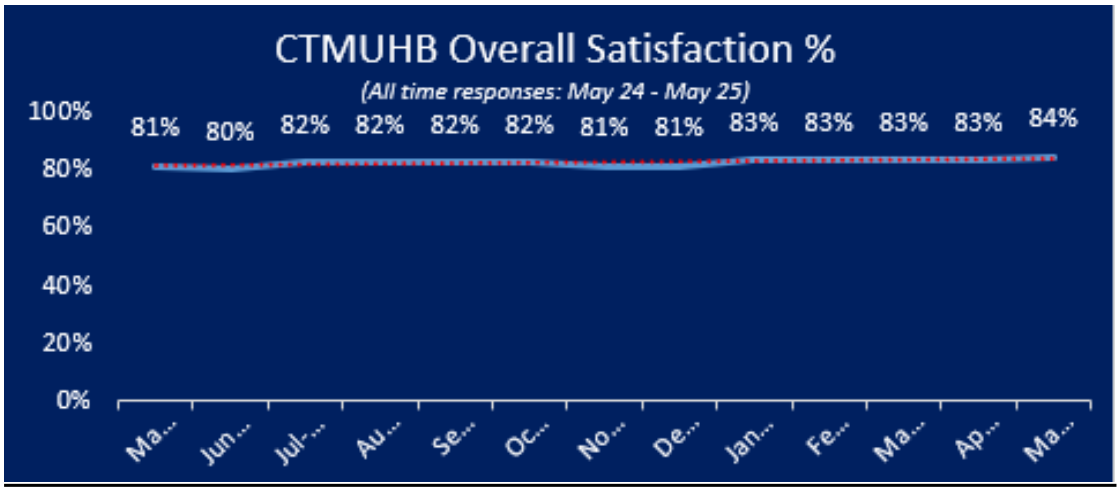
Patient Satisfaction Feedback

To ensure our services are meeting the needs of the community the need for feedback to inform this remains a high priority for the Health Board.

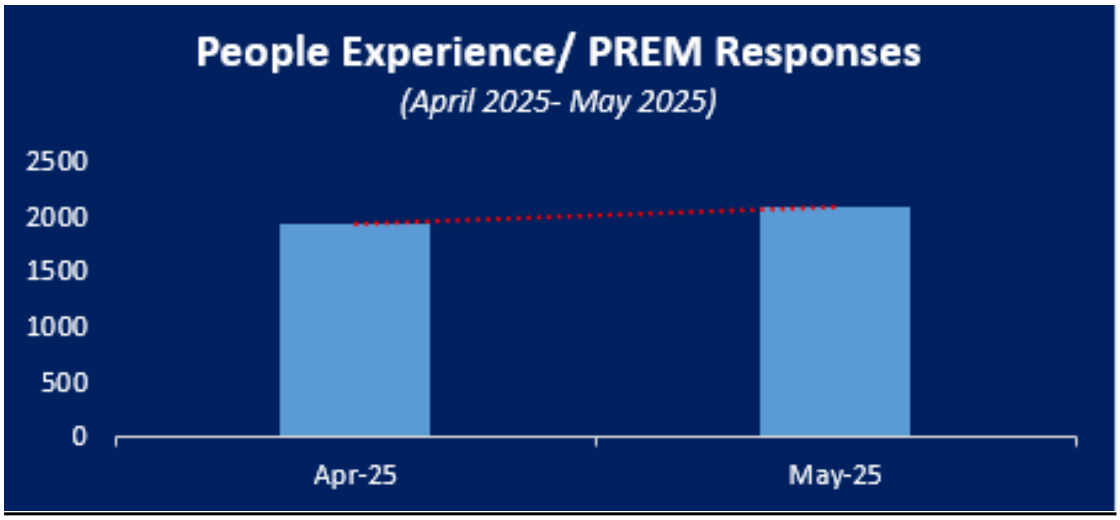
The new All Wales Survey is now being utilised across a number of services with more departments now coming on board. The team are also exploring the support of volunteers within the Health Board to enable more face-to-face feedback to be obtained, two volunteers have joined the team and will be supporting Princess of Wales from July 2025.

Reports showing comments from the public are fed through to the Care Groups via monthly reports and the Health Board are exploring how the actions taken from these are fed through to the public via 'you said, we did' formats.

Overview feedback satisfaction score for CTMU HB



Number of responses from the public





Chaplaincy

The chaplaincy teams work across the acute and community sites to support patients, families, carers and staff with their holistic care to understand what is important to them through their healthcare journey.

Number of People Supported with Significant Spiritual and Pastoral Care	
Patients	814
Relative's/carers	230
Staff	339

The Health Board has also recruited a Muslim Chaplain within our on-call service who has started working with us to look at how we can explore supporting our communities and staff here as well.

Bereavement

Work continues to explore how we can support our communities further when they lose a loved one with the Clinical Bereavement Lead:

- Provided Care After Death training for 30 students in University of South Wales.
- Creating a Paediatric Bereavement Booklet to ensure all the information needed is in one place to support families.
- Supported communal cremation services for pregnancy loss for over 50 families.

Volunteers

The team continue to look at how we can recruit more volunteers to support our patients and families:

- 33 volunteers joined us to support a number of different roles across the Health Board.

- Our volunteers have also supported further work across the Health Board to provide insight on slips, trips and falls and carers working groups.
- Manager has supported a process to look at third sector organisations to provide further holistic care with 'Pets as Therapy'.
- Joint working with Marie Curie to support a volunteer service in Prince Charles Hospital for patients and families.

Armed Forces/Veterans

Work to support our community and staff is being progressed within the Health Board and with third sector organisations.

- Staff Armed Forces Café took place in April and were able to signpost staff to different areas for support.
- Event has been planned with Valley Veterans Hub, Rhondda with over 30 stallholder's representing health and wellbeing, to be held during Armed Forces Week – 26th June 2025.
- Head of People's Experience is working with colleagues to explore how we can identify patients from the Armed Forces Family when utilising our services via an icon on the system for inpatient admissions.

PALS (Patient Advice Liaison Service)

The team continue to explore how they can engage further with patients, families and carers but also raise awareness of the service they provide within the community.

Number of PALS contacts	**Merthyr**	**Bridgend**	**Rhondda**
	59	128	55

Top Three Themes
Communication Issues
Clinical treatment/Assessment
Patient Care

- During Patient Experience week the team supported the gathering of feedback from patients, families and carers across the hospital community sites to inform service improvement and shared learning.
- Utilisation of the themes and trends the PALS see when working with families is being fed into different Forums to look at how we can proactively support shared learning and improvement across the Health Board.

Unpaid Carers

Support for unpaid carers to ensure their voice is heard and remains a focus when aiding those they care for are utilising services within the Health Board is being progressed.

To ensure we have feedback from unpaid carers themselves, a member of our volunteer team has gone across our hospital sites to gain feedback directly on their experience. This will inform the work the Health Board is looking to implement, with John's Campaign and an understanding of what further information and support is needed going forward.

Carer's co-ordinator has also supported 'Turning Pontypridd Blue' for dementia week, carer's meeting in Angelton and training for new staff starting in the Health Board.

A review of visiting hours is underway across the Health Board and the carer's co-ordinator has provided an insight to ensure that the role of a carer/cared for is considered within this. The utilization of the principles of John's campaign, the role the carer plays and the support they can provide within this has also been captured in the form of a 'carer's passport' to ensure a discussion takes place to inform the patients' journey and discharge process.

3. Key Risks / Matters for Escalation

Currently the PALS team is carrying a full-time vacancy as a member of the team is supporting the central concerns team and is looking to apply for a secondment here.

The Volunteer team is also carrying a full-time vacancy and are awaiting the outcome of a review as the proposed new roles have been pulled into the administration review. This has impacted on the number of areas we are able to support and how we can proactively bring more volunteers in to support the Health Board.

4. Assessment

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

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	

	Development of services aligned to communities is crucial ensuring their contribution to ensure their needs are met.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 The Committee is being asked to **NOTE** the report.

6. Next Steps

6.1 The People Experience team will continue the programmed activities of work and report to this committee as per the cycle of business.

Agenda Item
6.2

Quality, Safety & Experience Committee

Overview of the Development and Delivery of the Research & Development (R&D) Strategy

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Prof. John Geen, Assistant Director for R&D Mrs Rhian Beynon, R&D Manager
Cyflwynydd yr Adroddiad / Report Presenter	Mrs Rhian Beynon, R&D Manager Prof. John Geen, Assistant Director for R&D
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Prof. Greg Dix, Deputy Chief Executive / Executive Nurse Director, Executive Lead for Research & development

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**
R&D Group (Includes, all care group representation, Academic partners, Executive Directors and Independent member)	25/09/2024 20/11/2024 18/02/2025	Feedback incorporated
Health and Care Research Wales and Science, Research and Evidence Division- Welsh Gov't.	04/03/2025 22/05/2025	Feedback incorporated
Organisational Management Board	10/03/2025	Endorsement
Circulated electronically to Care Group Directors for cascade	27/05/2025	No comments received

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
HCRW	Health and Care Research Wales
R&D	Research and Development

1. Situation /Background

1.1 Research is central to the generation and delivery of the highest quality care, through access to new therapeutics, treatments, and technologies for patients and the development of a robust evidence base to inform and transform clinical service delivery.

1.2 It is well documented in the clinical and scientific literature that research active organisations provide better care and have better patient outcomes both morbidity, mortality and care satisfaction, than those NHS organisations that conduct less clinical research. In addition, there are many other benefits for an organisation to be research active to include workforce recruitment and retention, organisational development, reputational development and financial opportunities such as cost avoidance (research therapeutics) and the generation of income for further investment.

1.3 The Health and Care Research Wales NHS R&D Framework (2023) outlines ten factors deemed necessary for a research supportive NHS organisation to flourish. One of the factors is for the NHS organisation to have a current R&D Strategy aligned to organisational, national and UK wide clinical and research strategies.

1.4 CTMUHB's R&D Strategy 2025-30 provides the context, background and outlines a clear plan on how CTMUHB will meet its strategic vision to, *"To embed research as a core function in all that we do and harness the potential of research to address the health challenges of our population and the development of our workforce, to transform future clinical service delivery".*

1.5 The strategy was presented at the CTM UHB R&D Group and Organisational Management Board and shared with the UHB's Care Groups senior leadership teams for distribution for comment and Health and Care Research Wales as part of the comprehensive consultation process. The feedback and comments received have been incorporated into the final draft presented.

2. Specific Matters for Consideration

2.1 The strategy is aligned to key national policy documents to include, a Healthier Wales: Our Plan for Health and Social Care (and subsequent refresh), the Future of UK Clinical Research Delivery: Saving and Improving Lives and the NHS R&D Framework. The strategy also incorporates CTMUHB's strategic documents to include CTM 2030 Building Healthier Communities Together Strategy and CTMUHB's Quality Strategy.

2.2 7 strategic objectives (below) have been set across primary, secondary, community and social care and population health and is applicable to all specialties and professions (clinical and non-clinical):

- The Health Board will continue to develop a culture where research is recognised as a core aspect of its purpose and essential for clinical effectiveness, service redesign and improvement.
- The Health Board will provide and support the required infrastructure for the sustainable delivery of high-quality research activity and workforce development.
- The Health Board, with R&D departmental support, will maximise research related income and investment.
- Promote and optimise all opportunities for collaborative working with research partners and public involvement.
- Develop the commercial research portfolio of the Health Board and support the Local and National Life Sciences and Pharmaceutical Industry.
- Effective dissemination of research opportunities, findings, benefits and impact.
- Adopt novel research design, methodologies, digital technologies and advanced therapies to inform future clinical service delivery.

2.3 The R&D team continues to work towards delivering the strategic objectives and through endorsement of the 5-year R&D strategy, has the support of CTMUHB's Executive team, Independent members, Care Group Directors and Senior Leadership teams across all specialties and professions.

2.4 The successful delivery of this strategy will require partnership working between CTMUHB, Welsh Government, Health and Care Research Wales, academia, industry, third sector, local authority and the population.

3. Key Risks / Matters for Escalation

3.1 Strategic and departmental action plans for each of the strategic objectives have been developed to aid in monitoring and reporting on the delivery of the strategy to the R&D Group and Executive Management Board. Any risks associated with the delivery of the R&D strategy will also be identified and reported accordingly through the University Health Board's governance structures and processes.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Creating Health
	Inspiring People, Improving Care, Sustaining our Future
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Ageing Well
	Dying well, Growing Well, Living Well, Starting Well

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: To be completed once final draft confirmed.
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: R&D Strategy will be translated into Welsh once final draft confirmed.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	

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

5. Recommendation

5.1 The Quality, Safety and Experience Committee are asked to **Endorse for Board approval** the CTMUHB R&D Strategy 2025-30.

6. Next Steps

6.1 The Strategy will be presented to the Board for approval following feedback and endorsement from the Quality, Safety and Experience Committee and the final version will be widely promoted to staff, key stakeholders and the public.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



"View from the Bwlch, Rhondda" by Mal Durbin

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

RESEARCH & DEVELOPMENT STRATEGY

2025-2030

The landscape photographs included in this strategy were shortlisted as part of CTMUHB R&D's competition to commemorate the opening of the Clinical Research Centre in March 2021. The competition, in collaboration with Uprise Print, a digital printing company based in Llantrisant, invited staff and members of the public to submit images of "natural beauty" across the localities of Merthyr and Cynon, Rhondda and Taff Ely and Bridgend. Thanks go to all contributors for sharing their photography of the local landscapes across Cwm Taf Morgannwg University Health Board.



The Cwm Taf Morgannwg University Health Board R&D Strategic Vision

"To embed research as a core function in all that we do and harness the potential of research to address the health challenges of our population and the development of our workforce, to transform future clinical service delivery."

Foreword

Recent global events and increasing awareness of the dangers to population health have highlighted the importance of research in identifying cause and finding solutions to address these and reduce harm.

The NHS, through its access to the whole population and clinical and scientific expertise is central to generating, delivering and translating research to improve the health of the nation. Challenges such as increases in the older population will result in higher prevalence of age-related conditions and a subsequent increase in older people with care needs, estimated to be around 25% [1], requiring different approaches in health care delivery.

Change in health care delivery will require a robust evidence base to optimise new approaches, and implement new technologies and treatments, that are also aligned to value based health care principles. A focus on the prevention of ill health is also an important strategic aim of the NHS. Central to help gather and generate the evidence and implement change will be a workforce that has the skills to undertake research, deliver change and the opportunity to develop their research and health care careers. An ambitious research agenda will be essential in meeting these outcomes.

It is well established that wider health determinants contribute to and ultimately impact NHS service demand. Research plays a key role in removing the barriers and facilitating collaborative working with education, prison service and the environment. Research can help identify and address the inequalities recognised as contributory to the state of the populations' health and ensure inclusivity and access to all who can benefit from research. Factors already recognised in other national health strategies such as the ***Public Health Wales: Working together for a Healthier Wales.***[2] This strategy outlines how Cwm Taf Morgannwg University Health Board, as a key contributor to clinical service delivery in Wales, will maximise research opportunities for its population and beyond.



Professor Greg Dix
Executive Lead for Research & Development



Professor John Geen
Assistant Director for Research & Development

Introduction

What is Research?

Research is defined as ***"the mechanism to derive generalisable or transferable new knowledge to answer or refine relevant questions with scientifically sound methods"*** [3]. This requires robust and ethical data acquisition and analysis to answer the research question under investigation. Research in the NHS improves the knowledge base of healthcare, health disorders, their prevention and their safe and effective treatment. Research is also inextricably linked to the provision of value and evidence-based health care.


"River Cynon Autumn Colours" by Martin Agg

Research is central to the development and delivery of the highest quality care, through the provision of a robust evidence base to inform change and improvement. There are numerous well-established benefits to being a research active organisation. It is recognised that research active organisations provide better care and have better patient outcomes in terms of morbidity and mortality, than NHS organisations that conduct less clinical research[4]. Research ensures that patients are provided with access to new therapies, treatments and technologies not yet routinely available. Research is also essential for delivering the Duty of Quality agenda across NHS Wales. Research participants can benefit from enhanced monitoring, learn more about their condition and overall health and feel a sense of pride in helping others by contributing to research[5,6]. Organisational benefits include the recruitment and retention of high-quality staff, staff career development through research training and development and reduced level of burnout.

Furthermore, research builds partnerships between clinicians, academic partners, industry, third sector organisations and the public. Research, in conjunction with innovation and education, is a key pillar and essential criteria of maintaining university health board status.

Undertaking research provides financial benefits through the opportunity to recover costs and generate income to be re-invested in support of the research infra-structure, to further increase research capacity, in addition to the potential for cost avoidance / savings as a result of commercial companies providing medications for clinical trials. Research activity benefits the economy through the generation of jobs and



gross value added (GVA)[7]. Research can contribute to prosperity and where there are more prosperous communities there will be healthier communities. It is important that all the benefits of research are visible and communicated to our workforce, our patients and the wider population.

CTMUHB is situated in the Southeast of Wales and encompasses three local authorities namely, Merthyr Tydfil, Rhondda Cynon Taf & Bridgend. CTMUHB provides physical and mental health services to a population of 450,000 across primary, secondary and community care, in addition to supporting the work of public health and the prevention agenda. It is essential that CTMUHB provides equitable access to research that is of a high quality, safe, co-produced, inclusive, impactful and relevant to the local, national and global health needs and challenges. This will enable health inequalities to be reduced and benefits to the population to be realised.

Cwm Taf Morgannwg University Health Board's (CTMUHB) 5-year Research and Development Strategy 2025-2030, sets out how CTMUHB will further develop its vision, infrastructure, research culture and impact, to embed research as a core function of the organisation. The strategic aims and objectives outlined in this strategy are set across primary care, secondary care, population health, community and social care and are applicable to all specialties and professions, both clinical and non-clinical.

This R&D strategy is aligned to the CTMUHB's core values, described in the ***CTM 2030: Building Healthier Communities Together Strategy*** [8], with research and development strongly linked to each of the four strategic goals across the five key life stages, with prevention of ill health as a key objective. Furthermore, one of six quality ambitions outlined in ***CTMUHB's Quality Strategy 2022-25***[9] is for people to receive "effective care" that is appropriate and based on evidence obtained from high quality research. **Cwm Taf Morgannwg Regional Partnership Board's Population Needs Assessment 2022-2027**[10] identified the needs and demands of the CTMUHB population. Mental health (including CAMHS), population health and workforce support are already areas of focus for CTMUHB's research portfolio. Other priority areas for research identified include dementia, obesity, domestic violence, substance misuse, sensory loss, economic well-being, and safety and security. The recent success of the NHIR award for the Health Research Determinants Collaboration will foster and develop a partnership with the Rhondda-Cynon-Taf Local Authority to aid in the development of research at the interface of health and social care.

Figure 1: UK, Wales and UHB Strategic documents



The CTMUHB R&D strategy 2025-2030 has been developed aligned to key UK and Welsh Government policy and research focussed strategic documents to include the ***Well-being of Future Generations (Wales) Act 2015*** [11]and ***A Healthier Wales: our Plan for Health and Social Care (2018)***[12] and A Healthier Wales Actions Refresh 2024[13].

In 2022, Health and Care Research Wales published ***Research matters; our plan for improving health and care research in Wales 2022-25***[14] to be delivered in collaboration with the NHS, social care, higher education institutions, industry and funders. Four key aims are outlined in the plan: setting the agenda for health and social care research; funding and organising research; building capacity and capability in health and social care research; and using research to improve health and social care.



Other key strategies that have informed the CTMUHB R&D strategy include ***the Cancer Research Strategy for Wales*** [15] which aims to develop a collaborative, efficient, supported research community, to increase research grant income to improve prevention, diagnosis and treatment of cancer through delivery of six priority research themes. It is recognised that cancer patients in Wales miss out on opportunities to access new and novel cancer treatments or have to travel to England to access them. The **"Tackling Cancer Through Research"** [16] initiative sets out a plan to provide increased and inclusive access for Wales cancer patients to participate in commercial clinical studies.

The UK Governments ***Life Sciences Vision 2021***[17] states, "The collective ambition of the Government and the Life Sciences sector is for the UK to build on the scientific successes and ways of working adopted during Covid-19 and tackle future disease challenges – the silent pandemics – including cancer, obesity, dementia, ageing; securing jobs, investment and become the leading global hub for Life Sciences." The ABPI 10 Year Strategy states, "We want the UK to best place in the world to research, develop and use the medicines and vaccines of the future" [18].



Saving and improving Lives: Future of Research Delivery UK [19], developed by the UK Government and devolved nations sets out a 10-year vision "to create a world-leading UK clinical research environment which is more efficient, more effective and more resilient, with "**research delivery embedded across the NHS**". A study commissioned by Cancer Research UK, **Creating Time for Research**[20], examined the barriers to undertaking research and confirmed the importance of developing the capacity of healthcare staff to conduct research. The critical importance of research was demonstrated through the rapid development of treatments and vaccines undertaken during the Covid-19 pandemic. Despite this significant rise in the profile of research, participant enrolment onto commercial clinical trials has decreased in recent years.[21] ***The Lord O'Shaughnessy review*** into commercial trials in the UK[22] outlined regulatory, funding and policy recommendations to resolve key challenges in conducting commercial clinical trials in the UK. The UK Clinical Research Delivery programme is a UK wide programme of work has been established to create a more accessible and efficient clinical research delivery system, with a key priority being to streamline and reform the set up and delivery of clinical trials.

Delivering these strategies will ensure CTMUHB continues to make a significant contribution to the national and international research eco-system to improve patient and wider population health outcomes.

The Health and Care Research Wales NHS R&D Framework [23] has been co-produced by Health and Care Research Wales and NHS R&D Directors, with contributions from the academic sector and patient and public involvement. Published in July 2023, the framework details ten pillars outlining "what research excellence looks like within NHS Organisations in Wales and where research is embraced, integrated into clinical service, and is a core part of the organisation's culture". In delivering the NHS R&D framework, it is important to note that research is one of the four pillars of advanced clinical practice and as such embedding research is a key action outlined in multiple professional frameworks and research strategies; emphasising the importance of providing support and time to enable the workforce to undertake research and drive forward improvements in service delivery and support career development.

CTMUHB has a very active and varied commercial and non-commercial research portfolio supported by a dedicated research service, to include Clinical Trials Pharmacists and technical support, Pathology (Research Clinical Scientist), Radiology, Public Health and Therapy professionals all integral to the R&D team. CTMUHB researchers are represented across all professions, clinical and non-clinical specialties.

Key research strengths include Cardio-vascular (heart failure, Stroke, Pacing), Anaesthetics / Intensive Care Medicine, Public Health, CAMHS, Rheumatology, Gastroenterology, Biomarkers, Cancer,

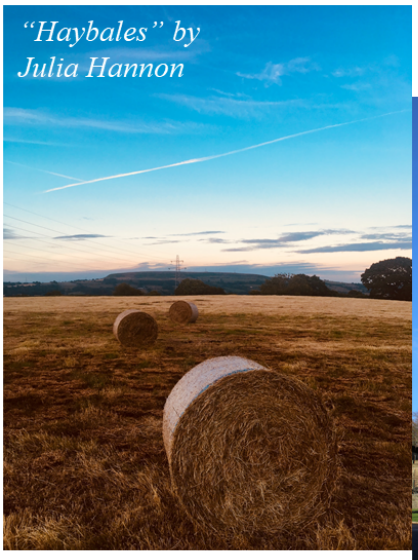
Obstetrics and Gynaecology, Maternity, Surgery, Endocrinology, Respiratory, Medical Devices, Dermatology, Physiotherapy, Sports Medicine, Podiatry, Dietetics and Workforce and Peoples Services.

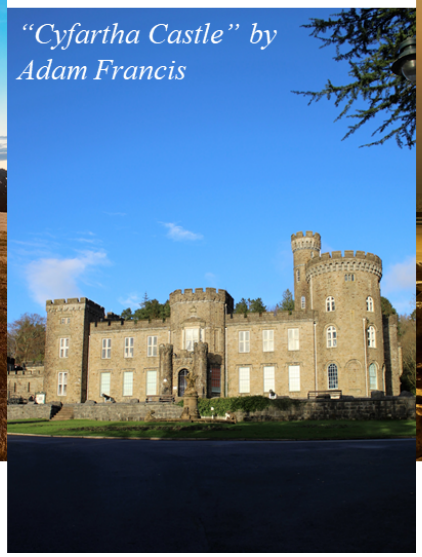
As a research active organisation CTMUHB are in a unique position of collaborating and sharing resources with several academic partners to include Cardiff, Swansea, Cardiff Metropolitan, Trinity St Davids, the Open Universities and the University of South Wales.

With a dedicated and fully equipped Clinical Research Centre at the Royal Glamorgan Hospital and access to patients across 3 acute sites, multiple community hospitals and 50 GP practices to include Keir Hardie Health Park, the opportunities for recruiting research participants are extensive. This is further enhanced by the opportunity to support research in care homes (ENRICH Cymru), prisons and other under-represented populations. The proposed development of the Llantrisant Health Park provides an exciting opportunity to ensure research is incorporated into the daily work of this centre.

The CTMUHB R&D strategy looks to build on previous collaborative research and development successes at CTMUHB and outlines the next steps CTMUHB will take to demonstrate the organisations commitment to driving forward the research agenda, ensuring that all available opportunities to increase the development and delivery of high-quality research are maximised. Through ratification of this strategy, CTMUHB will support the R&D department with the delivery of the strategic action plan (see page 16) and the implementation of the 10 pillars of the Welsh Government NHS R&D Framework.

CTMUHB will work with our partners in Welsh Government, Health and Care Research Wales, NHS organisations, academia, industry, third sector, local authority and the population to develop and increase the UHB's commercial and non-commercial research activity deliver the objectives detailed in this strategy.



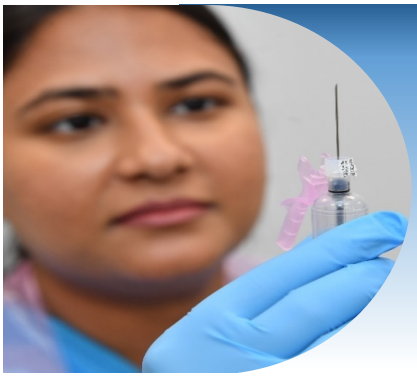






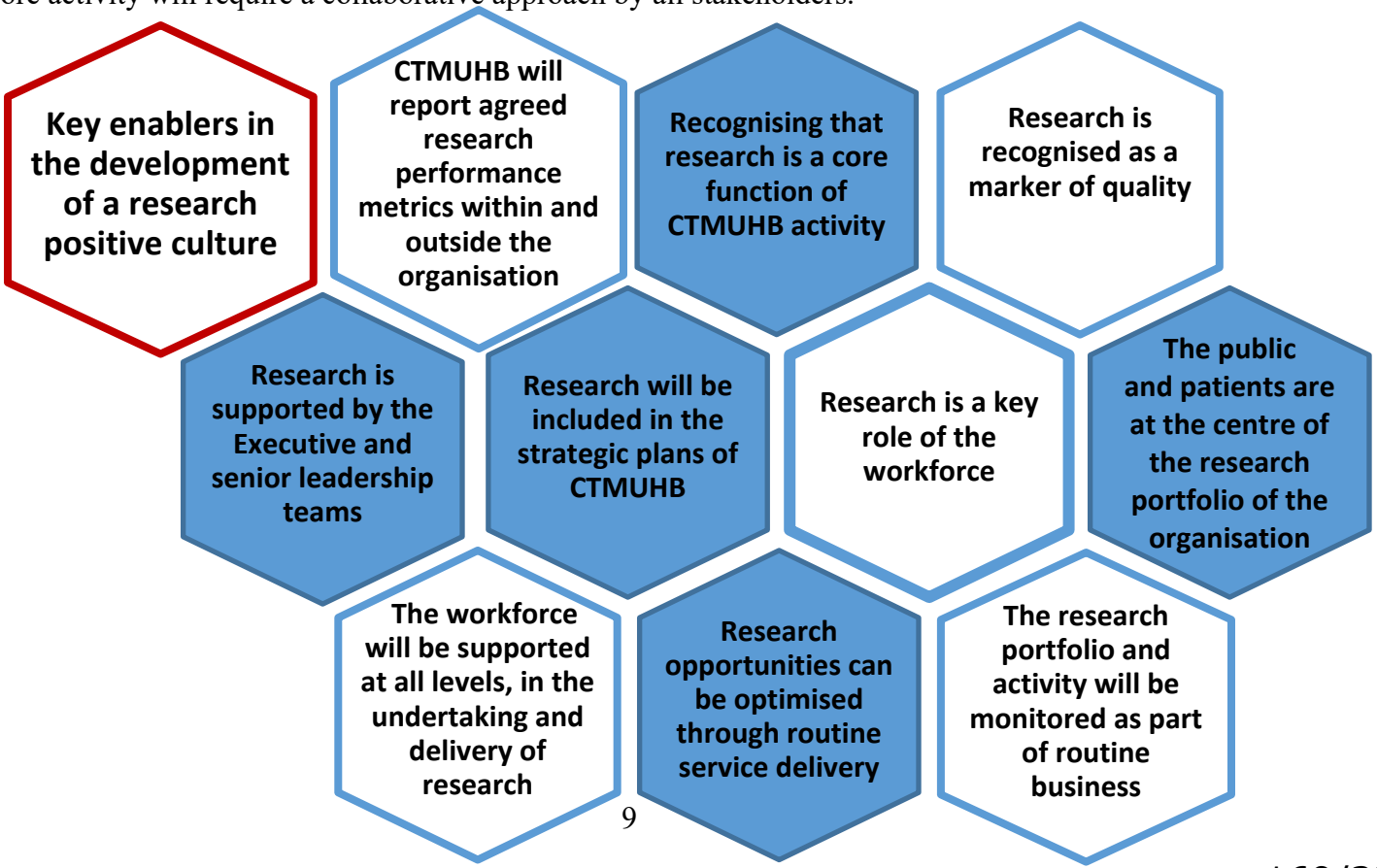
Setting the Strategic Objectives for CTMUHB R&D:

CTMUHB's R&D strategic objectives have been set being cognisant of the UK, Welsh Government and CTMUHB's strategic objectives for research and healthcare service delivery:
Action plans will outline the programme of work that needs to be undertaken across CTMUHB at departmental and strategic level to meet the strategic objectives and will aid in monitoring the delivery of this strategy.



The Health Board will continue to develop a culture where research is recognised as a core aspect of its purpose and essential for clinical effectiveness, service redesign and improvement.

Key to a pro-active research culture is the provision of an agreed strategy and shared ambition. This strategy sets the direction that will help support a positive research culture necessary to continue to develop the UHB's research portfolio. CTMUHB is committed to developing, promoting, supporting and facilitating an active, innovative, inclusive, ambitious and supportive research culture, to help deliver evidence-based patient care. One key objective is to embed research in the CTMUHB's service delivery, with the ultimate goal that all clinical and non-clinical services, ensure service delivery and research work hand in hand across the organisation. ***Every patient contact is an opportunity for research.*** The R&D department as a specialist service, has the skills, expertise and experience to support the strategic objectives and contribute to an active research culture. Promoting a culture where research is recognised as a core activity will require a collaborative approach by all stakeholders.





The Health Board will provide and support the required infrastructure for the sustainable delivery of high-quality research activity and workforce development.

The R&D Department provides a range of expert services enabling equitable access and support for research activity and workforce across the organisation. Continued R&D departmental workforce review ensures optimal research support for the organisation, providing career development opportunities and lifelong learning.

There is an opportunity to work smarter and optimise the support given by the R&D Department by utilising the available expertise and access to patients' healthcare professionals can provide, increasing the available research capacity and workforce development opportunities. A well-resourced infrastructure will also help maximise participant recruitment and retention.



Figure 2: Clinical Research Centre at Royal Glamorgan Hospital

Key enablers for a sustainable research infrastructure and workforce

- **R&D department and research support services have the workforce capacity and capability to set up and deliver research to optimise recruitment and retention of study participants.**
- **Joint clinical and research roles, notably in services critical for research delivery, to include Pharmacy, Pathology, Allied Health Professions, Healthcare Scientists, Nursing and Midwifery, Public Health, Imaging and Medicine.**
- **Time and resources for workforce development of research skills and knowledge.**
- **Access to research training and mentorship opportunities e.g. to include working with academia, industry, centres, units, networks and Health and Care Research Wales Faculty.**
- **Inclusion of research time and responsibilities in the organisation's workforce plans, job descriptions and job plans.**
- **Appropriately equipped research facilities and infra-structure to deliver all types of studies.**
- **Designated space at all key secondary care sites and primary care to host research governance and delivery workforce to provide a comfortable environment for research participants to attend appointments, at their convenience, and attracts research partners involved in high quality commercial and non-commercial research.**
- **Chief Investigators, Principal Investigators and profession / departmental research champions to include support for the National Institute of Health Research (NIHR) Associate Principal Investigator scheme.**
- **Success with personal awards and grant funding in support of staff time and backfill.**
- **Horizon scanning new clinical developments to include research capacity and opportunity (Llantrisant Health Park).**



The Health Board, with R&D departmental support, will maximise research related income and investment.

All Health Boards and NHS Trusts receive some of their funding for research delivery from Welsh Government, through Health and Care Research Wales Research Delivery funding. In addition to the core financial resources, there are a number of mechanisms by which other research funding streams can be secured in support of a sustainable research service, to include grant funding, commercial research cost recovery and capacity building income, charitable organisations and direct investment by the CTMUHB.





Promote and optimise all opportunities for collaborative working with research partners and public involvement.

Key enablers to optimize all opportunities for collaborative working

- **Shared organisational strategic aims, priorities, strengths, resources and expertise.**
- **Secure membership of research partners and the public on the Health Board's R&D Group.**
- **Clinical academic roles (all professions with academic partners, with clinical, education and research portfolios).**
- **Students and trainee access to NHS R&D as part of their educational qualification, vocational experience and clinical placements.**
- **Engagement events providing opportunities to facilitate research partnerships.**
- **Embedded advisory and leadership roles across partners.**
- **Equitable access to research for all participants which reflects the diverse population and ensures full inclusivity to include ethnicity, homelessness, rurality, rare diseases.**
- **Equitable support for all researchers and research partners.**
- **One Wales approach and "Once for Wales" to facilitate rapid study set up.**

CTMUHB's promotes and supports multi-disciplinary, multi-professional and multi-agency working across the health board. The R&D department facilitates and encourages collaborative projects with academic, industry and third sector partners. It is essential for these relationships to continuously develop the CTMUHB research portfolio.

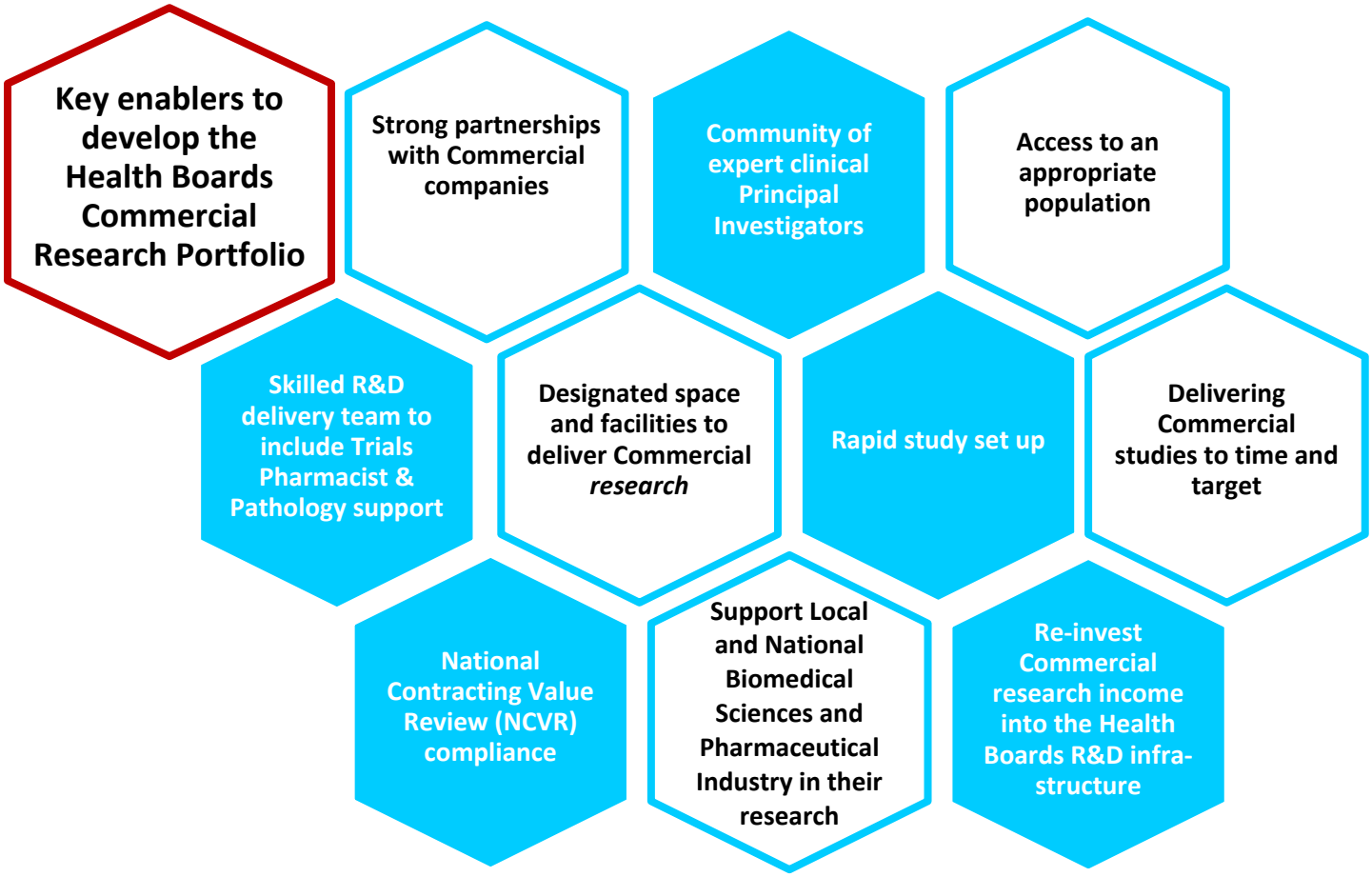
Building partnerships and strong connections through engagement with the public is also a key strategic aim. Establishing research priorities, contributing to study design, promoting research and dissemination of findings with shared recognition of their contribution are key areas where public involvement can support research across the organisation. Developing strategies to ensure the inclusion of the underserved communities and groups will also be important, to include digital literacy and access to digital technologies.

The Health and Care Research Wales "Discover Your Role in Health and Social Care Research Public Involvement Action Plan" [24] and "Inclusivity Action Plan 2025-2028"[25] will help provide guidance to progress the approach.



Develop the Commercial Research Portfolio of the Health Board and support the Local and National Life Sciences and Pharmaceutical Industry

Commercial research can provide the population with access to new and innovative medications, therapies and technologies, unavailable through routine care. In addition, Commercial research can provide an additional source of income that can be re-invested into the Health Boards research infra-structure and help with the provision of a sustainable research active organisation. Undertaking Commercial research is a key national objective to help improve patient care and maximise the benefits of a flourishing Pharmaceutical and life sciences industry across the UK. All of which can help support the organisation in delivering its corporate responsibilities over and above those solely related to health.





Effective dissemination of research opportunities, findings, benefits and impact.

Key enablers for the effective dissemination of research opportunities, findings, benefits and impact.

- **Patient, Public, Workforce and research partner awareness that CTMUHB is a research active organisation (through research specific or clinical interface communication opportunities).**
- **Communication strategy to share all research related information through multiple medias.**
- **Well established multiple routes and portals for sharing research information, outcomes and impact.**
- **Annual showcase to share the research undertaken its impact and successes, by the organisation's workforce and research partners.**

"Research is something that everyone can do, and everyone ought to do. It is simply collecting information and thinking systematically about it"

Prof Konrad Lorenz (Biologist)
Nobel Laureate

Knowledge mobilisation and translation of research findings into clinical practice is critical to the provision of evidence-based, high-quality care. It is vital therefore that mechanisms are in place to ensure that all research undertaken is disseminated in a timely manner to maximise research impact, patient outcomes, patient experience and share changes in evidence-based practice.

Dissemination of research findings also demonstrate the organisation's ability to set up and complete research studies, meeting the required recruitment target in the timeframe agreed under expert clinical oversight and study leadership. It is also an opportunity to recognise the researchers and the high-quality research they are undertaking.

Patient storytelling and case studies can also help highlight the impact research has on the patient and population from their perspective. It also provides an opportunity to recognise the essential role patients, and the population play in all stages of the research process.

Support and close working partnerships with CTMUHB and HCRW communications teams will be critical in developing an effective communications plan.



Adopt novel research design, methodologies, digital technologies and advanced therapies to inform future clinical service delivery.

Recent years have seen significant developments in research design and new technologies for use in the development and delivery of research. It will be important for CTMUHB to work with its partners to take full advantage of these emerging innovations in research design, data and technologies. This addresses the strategic objectives of the Delivery Plan for Advanced Therapies in Wales 2025-2029[26] and the Research Matters: A Genomics Research Strategy for Wales[27].

The Covid pandemic introduced innovative research design to manage the barriers to research delivery, implementing e-consent and virtual research visits, enabling the participant to stay in their own environment and reducing the need for hospital visits. The Covid vaccine registry also enabled research sites to approach a pool of patients that had already expressed an interest in participating in vaccine trials to enable an efficient screening and recruitment pathway, which CTMUHB utilised as part of the delivery of a Moderna vaccine trial.

Upcoming changes to the Good Clinical Practice (GCP) Regulations, UK Clinical Trials Regulations and the Declaration of Helsinki reflect these changes in practice and innovations in recent years. Updates to these regulations and policy statements account for technological innovations, introduce proportionality and a risk-based approach to governance and set-up, and reinforce the importance of principles such as research transparency, sustainability and patient and public involvement in research.



It will be important for CTMUHB to continue to embrace these new approaches, recommendations and pathways and explore and consider other mechanisms that can streamline the participant recruitment process, facilitate participant retention, utilise population health datasets, new technologies and diagnostics.

In alignment with the Health and Care Research Wales Data for Research programme, CTMUHB will also embrace the available data repositories for large scale data analysis studies through collaboration with SAIL and the Wales National Data repository currently under development



Undertaking large population-based studies employing central databases and health data repositories

Environmentally sustainable paperless research governance and archiving

Access to research opportunities and submission of expressions of interest.

Adopting digital solutions

Key enablers for ensuring research can support future clinical service delivery

Routine clinical / patient data, in full compliance with the statutory regulations, to support research recruitment and participation

Undertaking research in the field of machine learning and Artificial Intelligence

Precision Medicine

New Technologies (Virtual Reality, medical devices)

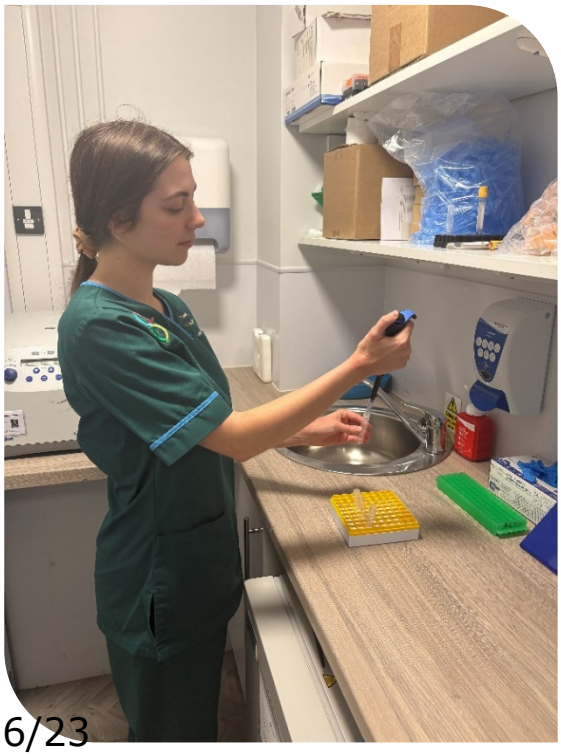
Advanced Therapies

Participation in developing fields of research includ

Biomarkers

Genomics and Bioinformatics

Imaging



CTMUHB R&D Strategic Action Plan 2025-30

The Health Board will continue to develop a culture where research is recognised as a core aspect of its purpose and essential for clinical effectiveness, service redesign and improvement.

	Action	Timescale for delivery	Key partner(s) to facilitate delivery
a	Inclusion of research as a regular agenda item at Health Board Executive level meetings within and outside the Health Board.	April 2025	Corporate services
b	Inclusion of research in all strategic documentation developed across CTMUHB to include the organisation's annual report.	March 2027	Strategic Planning, Corporate team, Care Group, Directorate and Senior Leaders
c	Development and reporting of R&D metrics at internal and external meetings (e.g. Executive - Care Group performance meetings) to include number of open studies, number of research participants, active researchers by profession, number of research active staff (e.g. Principal / Chief Investigators / Associate PI's), Number of sessions awarded for Research (SPA/ other HCP sessions) (not exhaustive).	October 2025	Executives, Care Group, Directorate and Senior Leaders
d	Inclusion of research plans in the IMTP for each Department and Care Group.	March 2026	Strategic Planning, Corporate team, Care Group, Directorate and Senior Leaders

The Health Board will provide and support the required infrastructure for the sustainable delivery of high-quality research activity and workforce development.

	Action	Timescale for delivery	Key partner(s) to facilitate delivery
a	Secure additional clinical and administrative space for research activities at Prince Charles and Princess of Wales Hospitals.	March 2027	Executive Directors, Strategic Planning, Senior Leaders, Facilities

b	Continue to review the R&D infrastructure to further develop research capacity and capability.	March 2026	Care Group, Directorate and Departmental Directors and Senior Leaders
c	Include R&D activity when assessing capacity required for service delivery when undertaking workforce planning.	March 2027	Workforce & OD, Care Group, Directorate, Departmental Directors and Senior Leaders
d	The R&D Department will facilitate an increase in the number of CTMUHB Chief Investigators, with the aim of having 10 Chief Investigators by March 2027 and 15 Chief Investigators per year by 2030.	March 2027 and March 2030	Clinical Researchers
e	Provide dedicated research time for medical staff through the provision of SPA for research. The UHB will have a target of 10% of SPA sessions providing support for research activity by 2026 and 15% by 2030. Research activity (e.g. Studies opened and supported) will be reviewed annually through the Job planning process.	March 2026 and March 2030	Workforce & OD, Medical Directors, Clinical Directors, Care Group Managers, Researchers
f	All Job Descriptions at Band 7 (and above) for Advanced Practice roles to include research with associated designated sessions. Research activity (e.g. Studies opened and supported and outputs) will be reviewed annually through the PDR process.	March 2027	Workforce & OD, Clinical Directors, Departmental, Directorate &Care Group Managers
g	Continue to develop joint clinical and research roles in services critical for research delivery include Pharmacy, Pathology, Allied Health Professions, Healthcare Scientists, Nursing and Midwifery, Public Health, Imaging and Medicine.	March 2027	Workforce & OD, Clinical Directors, Departmental, Directorate and Care Group Managers, Assistant Director for R&D

The Health Board, with R&D departmental support, will maximise research related income and investment.

	Action	Timescale for delivery	Key partner(s) to facilitate delivery
a	Continue to work with Health and Care Research Wales to maximise opportunities to secure additional NHS R&D funding.	Commencing May 2025	Health and Care Research Wales

b	Increase the number of grant applications submitted by CTMUHB researchers to 10 per year by 2030.	Commencing May 2025	Academic, Industry, Third Sector & Local Authority Partners, Researchers
c	Secure additional research funding from all non-commercial sources to £1 million to include cost recovery, excess treatment costs, grant funding, government funding schemes and third sector by 2028.	March 2028	Academic, Industry, Third Sector & Local Authority Partners

Promote and optimise all opportunities for collaborative working with research partners and public involvement.

	Action	Timescale for delivery	Key partner(s) to facilitate delivery
a	Increase the number of joint multi-professional and multi-disciplinary projects by 5% year on year with our academic, industry, third sector and local authority partners, signposting our partners to potential Chief Investigator and Principal Investigators.	May 2025	Academic, Industry, Third Sector & Local Authority Partners
b	CTMUHB will continue to provide financial support, through the R&D Department, to continue to run an annual research collaboration funding call to facilitate NHS-Academic partnership working.	May 2025	Finance team
c	CTMUHB will support the development of research partnerships with local businesses.	March 2026	Local Businesses
d	Develop training and work experience opportunities for all Health care professions seeking experience of research as part of their education and development.	May 2025	Academic and Educational Institutions and Organisations
e	The Health Board will work with Academic Partners to explore the development of Clinical Academic roles with a clinical, education and research portfolios.	March 2030	Academic and Educational Institutions and CTM Clinical Education Department
f	Work with Patient and Public Involvement (PPI) networks to ensure the representation, involvement and engagement of patients and the public in the establishment of research priorities and the design, delivery and dissemination of research. This will include the involvement and recruitment of underserved populations.	May 2026	CTMUHB's Research Active Professionals Patient Experience Team, Patients, Health and Care Research Wales
g	Continue to work with Health and Care Research Wales towards a Once for Wales and One Site Wales approach, where appropriate.	Commencing May 2025	Health and Care Research Wales, NHS Organisations

Develop the Commercial Research Portfolio of the Health Board and support the Local and National Life Sciences and Pharmaceutical Industry

	Action	Timescale for delivery	Key partner(s) to facilitate delivery
a	Support the implementation of the UK wide commercial Site ID system, to include the development of a marketing profile to promote CTMUHB and maximise commercial research opportunities.	July 2025	Health and Care Research Wales, CTMUHB Communications, CTMUHB ICT Service
b	Increase the number of Commercial research studies to 15 per year by 2030.	April 2030	Industry, Health and Care Research Wales, Clinical Researchers, Academic Partners
c	Increase the number of participants recruited to commercial research studies to 100 per year by 2030.	April 2030	Industry, Health and Care Research Wales, Clinical Researchers, Academic Partners
d	Increase the UHB's generation of commercial research income by 50% by 2030.	April 2030	Industry, Health and Care Research Wales, Clinical Researchers, Academic Partners

Effective dissemination of research opportunities, findings, benefits and impact.

	Action	Timescale for delivery	Key partner(s) to facilitate delivery
a	The R&D Department will work with all services to raise patient and population awareness of research activity across the Health Board and utilise their stories and experiences of research participation.	March 2026	Clinical Services, Medical appointments, Communications / ICT Patient Experience team and Patients
b	The R&D Department will develop a publicly accessible internet page to promote, support and disseminate the scope of research being undertaken across CTMUHB and the resultant outputs and impact to the NHS.	July 2025	CTMUHB Communications, CTMUHB ICT Service
c	The R&D Department will further develop its communications plan and work with the communications teams from CTMUHB and Health and Care Research Wales to promote research and research studies across the UHB and partners.	January 2026	Health and Care Research Wales & CTMUHB Communications

d	Develop mechanisms for recording, documenting and sharing the impact of research.	April 2026	CTMUHB Communications

Adopt novel research design, methodologies, digital technologies and advanced therapies to inform future clinical service delivery.

	Action	Timescale for delivery	Key partner(s) to facilitate delivery
a	Embrace emerging design and technologies for use in the efficient delivery of research (e.g. research registries, recruitment applications and QR codes, virtual research visits, electronic site file platforms, research registries), in accordance with relevant data protection requirements.	May 2025	ICT Service
b	Support the development and delivery of research involving the use of routine health data and facilitate access to internal data sources and external repositories e.g. SAIL.	March 2026	Information / Analyst Team
c	Support the development and delivery of research evaluating the use of applications, digital tools, Artificial Intelligence (AI), Genomics and Advanced Therapies, maximising access to innovative treatments, personalised medicine and care pathways for CTMUHB's population.	May 2025	Clinical Researchers, Research Partners

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Agenda Item
6.3

Quality, Safety & Experience Committee

Annual Duty of Quality Report 2025

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Deputy Executive Director of Nursing. Patient Care and Safety Team.
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

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

Acronyms / Glossary of Terms	
CMTUHB	Cwm Taf Morgannwg University Health Board
RTT	Referral to treatment time

1. Situation /Background

1.1 The attached report is the second of its kind, following the first report issued last year in accordance with the new guidance established by NHS Performance and Improvement. Throughout the past year, the Health Board engaged in several sessions and discussions to better understand how organisations can tailor their reports to meet the needs of our community citizens effectively.

1.2 This year's report, reflecting the financial year 2024/25, has been developed as an interactive resource for our patients and community members to understand better the work being carried out by CTMUHB in accordance with our legislative duties. This report marks a significant change, addressing some criticisms of previous iterations that highlighted the report's format as inaccessible to several end readers.

2. Specific Matters for Consideration

2.1 The annual report sets out to capture key initiatives and pieces of work carried out across CTMUHB throughout 2024/25, providing an overview of activity across the corporate and clinical service portfolio.

2.2 In addition, the report has also set out key areas for future or ongoing work throughout 2025/26 that are aligned with national, regional, and local priorities.

3. Key Risks / Matters for Escalation

3.1 Committee is asked to note and welcome some additions to the report ahead of Board approval in September, namely an outline of our six goals work and referral to treatment operational data to understand the work attending to the timeliness of care.

3.2 The committee is also asked to welcome the addition of a forward message to be provided by the Quality, Safety, and Experience Chair ahead of the September Board once it has been discussed by committee members in this upcoming committee session.

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
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below: Ageing well, dying well, growing well and starting well.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below: Culture and Valuing People, Data to knowledge, whole systems.
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)	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: Reporting existing activity.
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: It is full expected that the version approved by Board will have both English and Welsh translations.

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 endorse this report for Board **Approval**.

6. Next Steps

6.1 If agreed, the report will be submitted to Board approval with the described additions and any further committee recommendations to the Board in September 2025.

6.2 To access the Annual Duty of Quality Report, please click the link below:
https://www.canva.com/design/DAGn-mmejt0/K3oTNprHKx-Ztncdf7wQ9Q/view?utm_content=DAGn-mmejt0&utm_campaign=designshare&utm_medium=link2&utm_source=uniquelinks&utlId=h2bbccb92f6

Agenda Item
6.4

Quality, Safety & Experience Committee

Highlight Report for People Experience Forum

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Jenny Oliver, Head of People's Experience & Richard Hughes, Deputy Executive Director of Nursing.
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Richard Hughes, Deputy Executive Director of Nursing.
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Peoples Experience Forum	20/05/2025	To inform committee report

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
VBHC	Value Based Health Care
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
CTM	Cwm Taf Morgannwg University Health Board
ED	Emergency Department
ICU	Intensive Care Unit

1. Introduction

In light of the changes to the Health Board's Care Group and Corporate structures, a need arose to reinstate a comprehensive forum. This forum would integrate both qualitative and quantitative data from an experiential standpoint while also facilitating a continuous exchange of the various quality, safety, and risk experience meetings led by the care groups.

Purpose of this Meeting

This Forum facilitates a strategic dialogue centred on enhancing People's Experience within the Health Board. It focuses on identifying key themes and trends and developing actionable improvement initiatives, which are conducted quarterly. The objective is to critically assess and refine various aspects of the healthcare experience through targeted recommendations and collaborative efforts.

2. Highlight Report

Alert / Escalate	This Forum provides the Corporate Team with a comprehensive overview of the initiatives to enhance and celebrate the care and support offered to our patients, families, carers, and staff. The Forum's representation is diverse, reflecting contributions from Care Groups, Corporate entities, and People's Experience support services, including bereavement, chaplaincy, carer support, engagement and planning, workforce development, and strategic planning. Additionally, Llais provides an independent perspective and assurance in this context. **Key areas of discussion:** a. Concerns about pain management, hygiene, and communication during ED care. Suggestions included environmental reviews, improved communications messaging, and targeted patient surveys. The VBHC team proposed adapting national PREMs to capture site-specific issues better. b. Members engaged in a productive discussion about the challenges posed by underfunding and its impact on nurses. The group suggested utilising storytelling and digital evidence gathering as effective tools to advocate for increased investment in healthcare. While there is some provision for psychological therapies, the current offerings fall short of providing comprehensive service support. We aim to highlight these needs to foster improvements in the system. Registered nurses are actively providing support in areas where services are currently unavailable. In

	addition to storytelling and data collection, the forum intends to recommend that the care group commission a comprehensive review of psychological therapy services within the critical care sector. This recommendation should be aligned with strategic decisions pertaining to critical care service delivery across the CTM region. c. There is ongoing confusion among families regarding pathways and access to services that support neurodiversity. Insights gathered from a significant engagement exercise with 500 families indicated a need for clearer communication and support. The forum agreed to reach out to the Children and Families Care Group to determine if targeted support from the forum could enhance communication and engagement with families.
Advise	• Slide decks are populated quarterly, utilising data from Datix and Civica (patient feedback system) to provide a baseline of concerns and patient feedback data for the Care Group to provide further detail on and advise on key issues for escalation/discussion. • This data enables a triangulated viewpoint to inform issues pertinent to Care Groups individually and those that cross all services. It also allows shared learning and the ability to celebrate the positive work carried out in different specialities. • Enables a broader insight into ongoing work that staff may not be able to see due to the breadth of services the Health Board supports, and opportunities for collaborative working. **Key areas of discussion:** a. The Lead Chaplain delivered a presentation on the importance of spiritual care beyond religion, emphasising holistic support for patients and staff. Spiritual care will continue to be a significant aspect of our people's experience. b. Mental Health and Learning Disability Care Group colleagues discussed the complexity of managing restrictive practices and the importance of lived experience in shaping services. The forum agreed to continue monitoring at this stage, with the potential for future support where commissioned by the care group. c. Sexual safety has been identified as a priority across the organisation. In collaboration with NHS Performance and Improvement, formal representation from the forum to the Executive Nurse Director's team has resulted in a detailed discussion. Consequently, the decision has been made for the Director of Nursing for Mental Health and Learning

	Disabilities to initiate and lead a CTM approach that aligns the relevant issues with the Health Board's direction. d. Updates from care group representatives highlighted significant challenges in both unscheduled and planned care arising from infrastructure issues at POW, coupled with an increased demand at RGH. Key concerns identified included staff morale, patient communication, and the fragmentation of services. The forum acknowledged the efforts undertaken by members and colleagues across the organisation during the emergency transfer and recommended that a similar approach be considered for the repatriation process once initiated. Additionally, the forum agreed to explore potential future work aimed at providing broader support to care groups in seeking opportunities to enhance the experiences of staff, visitors, and patients.

Assure	• Each Care Group submits a populated slide to inform discussions in the Forum. The slide builds on the baseline data they are provided with, enabling informed discussions to take place.
	• Llais is also represented in this Forum to bring in an independent viewpoint from our community.
	• Following the forum, an action log is created with agreed-upon points that are escalated within the respective meetings/senior teams to proceed.
	• This Forum demonstrates a:
	  ○ Commitment to person-centred care.
	  ○ Targeted support and intervention when needed.
	  ○ Use of patient feedback to inform services at local and service-led levels.
	• Diversity of representation provides a broader perspective that facilitates the sharing of information and allows for the consideration of varied opinions and viewpoints, thereby enriching discussions and informing actions.
	• Improvement of communication and collaboration by facilitating better understanding through direct interaction.

Inform	• In conjunction with this Forum, the Value People's Experience Operational Working Group facilitates the alignment of various workstreams that enhance the collection, processing, and analysis of People's Experience data across all formats. a. This enables the data that informs the People's Experience Forum to be used strategically to compare data to relevant Groups / Clinical Teams. b. Enable & support improved data quality, accuracy and consistency. c. To identify early issues and trends.

	d. To share good practice actions in response to people's experience data. ▪ The Forum's structure allows us to adapt to our community's evolving needs and the data that informs our discussions. **Key areas of discussion** a. A proposal has been put forth to conduct a comprehensive environmental review of emergency department waiting areas, with an emphasis on comfort, access to water and food, and the availability of communications support such as charging stations. Both VBHC and Communications have endorsed this initiative by providing relevant examples and communication strategies. The purpose of the forum is to draft a letter to the Unscheduled Care Group, outlining the offer for a program of work scheduled for the autumn of 2025.
Appendices	None identified.

3. 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:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /*	Person Centred
	If more than one applies please list below:

Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reuse
	If more than one applies please list below:

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

4. Recommendation

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

4.2 The Quality, Safety, and Experience Committee might consider **APPROVING** the following two questions in forthcoming reports involving the experiences of patients, visitors and staff and future documents produced by the People's Experience Forum:

4.2.1 How are services ensuring that patient and family voices are embedded early in the design and transition of services, particularly for vulnerable groups (e.g. paediatrics to adult care, neurodivergent pathways)?

4.2.2 What mechanisms are in place for services to monitor and respond to patient experience feedback in high-pressure environments like ED and ICU, and how are these insights shaping service improvements?

Agenda Item
7.1

Quality, Safety & Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	22 July 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	June / July 2025	RISKS REVIEWED
Executive Leadership Group	14 July 2025	REVIEWED & 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.

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 4 July 2025.

Training

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

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

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

2.8 To date **792** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2.

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

2.10 109 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 4.80 out of a maximum score of 5.

2.11 100% of the 109 attendees providing formal feedback found that:
- The session provided the right amount of information.
- They gained more confidence and knowledge in risk management having attended.
- They would recommend this training to a colleague.

2.12 98% of the 109 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

2.13 Some of the recent comments from the session, received through evaluation, have been included below:
- *"I feel confident in doing a risk management review but still need some more guidance in doing it. Familiarity with the Datix system for risk will improve much of our knowledge on how to do a report".*
- *"I found it very useful to see the practical demonstration of the Datix system. The presenter was very knowledgeable and explained things really well have a much better understanding of the difference between the BAF and Organisational Risk Register. Finally makes sense!"*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Patient Care and Safety Directorate
- Datix Risk ID 6228 - Effective and efficient management of requests from the HM Coroner. New risk escalated with a risk score of 16.
- Datix Risk ID 6229 - Timely development of, management and response to Learning from Event Reports (LFERs). New risk escalated with a risk score of 16.
- Datix Risk ID 6230 - Proactive management and compliance with Medical Negligence or Personal Injury claims at Pre-Action Protocol stages. New risk escalated with a risk score of 16.
- Datix Risk ID 6231 - Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. New risk escalated with a risk score of 16.
- Datix Risk ID 6232 - Stability of the Legal Services Function. New risk escalated with a risk score of 15.

Diagnostics, Therapies, Pharmacy & Sciences Care Group
- Datix Risk ID 5304 - The Air Handling Unit (AHU) for the pharmacy aseptic production suite. New risk escalated with a risk score of 16.

Children & Family Care Group

- Datix Risk ID 6217 - A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity. New risk escalated with a score of 15.

3.2 CHANGES TO RISKS

Risk Score Increased

Children and Family Care Group

- Datix Risk ID 5753 – Inadequate Special School Nurse Provision. The risk score increased from a 16 to a 20 in July 2025 due to ongoing capacity challenges.

Risk Score Decreased

No risks were decreased in terms of risk score in the July 2025 iteration of the Organisational Risk Register.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Children and Family Care Group

- Datix Risk ID 5903 - Unfunded Continuing Care Packages / unfilled packages. This risk was closed in July 2025 due to improvements in workforce provision. Care Group have advised that this risk can now be closed as following review of continuing care new staff training and packages then within the next 6 weeks (from 1 July) the service will be totally removing New Cross agency from the remaining package, the service have put in place regular oversight during this period from the CCN key workers.

Capital and Estates Directorate

- Datix Risk ID 5932 - 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. This risk has been removed as the roof and battens have been competed above patient areas in Phase 1, only plant rooms remain.
- Datix Risk ID 5961 - Remedial roof works to resolve the water ingress at POWH. this risk has been removed as has been significantly reduced for the Phase 1 roof that this refers to as the roof has been replaced as in risk 5932 above. Risk likelihood score reduced as only leak on Phase 1 recently was above ITU and the flashing was identified as the problem and subsequently corrected so this should not reoccur.

Patient Care and Safety Directorate

- Datix Risk ID 4908 - Failure to manage Legal cases efficiently and effectively. This risk has been closed as it has been superseded by the new risks under the Patient Care and Safety Directorate identified on page 3 of this report.

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

Consequence							
	5			3337 6217	5276 6053 6102		
	4			5820	4885 5576 5821 6229 6228 6230 5304	5646 5579 5761 5691 5045 4973 3567 6231	4491 3826 4632 5417 6111 6179 5753
	3						4691 6232
	2						
	1						
CxL		1	2	3	4		5
		Likelihood					

3.5 EMERGING RISKS

Identified in the May 2025 Organisational Risk Register Cover Report:

3.5.1 **The Diagnostics, Therapies, Pharmacy and Sciences Care Group** are reviewing the following risk for escalation to the Organisational Risk Register in July 2025:

- Datix Risk ID 5304 – Air Handling Unit for the Pharmacy Aseptic Production Suite – Medicines Management.

This risk has now been escalated in the July 2025 iteration of the Organisational Risk Register as identified in section 3.1.

3.5.2 **The Primary, Care & Community Care Group** are assessing a risk in relation to the Welsh General Optometry Service (WGOS), with a few to escalating to the Organisational Risk Register in July 2025. Any escalation has been deferred as discussions are underway in July and August with Welsh Government. A more robust update as to whether this is a risk that requires escalation to the Organisational Risk Register will be shared in the next iteration of the Organisational Risk Register in September 2025.

3.5.3 **Finance Directorate –** following closure of Risk ID 5765, captured in section 3.3, a new risk for the financial year 2025-2026 was being developed with a view to escalating to the Organisational Risk Register in July 2025. Two new financial risks have now been escalated in the July iteration of the Organisational Risk Register as identified in section 3.1.

Emerging risks identified whilst drafting the July 2025 iteration of the Organisational Risk Register are identified below:

3.5.4 **Children & Family Care Group** are considering the escalation of a risk regarding the extensive wait times for paediatric patients to have an Electroencephalogram (EEG) investigations (Datix Risk ID 6187) once a review of the demand management plan has been further considered with the Chief Operating Officer.

3.5.5 **Primary Care & Community Care Group** – are considering the escalation of a risk around the Lymphoedema Service (Datix Risk ID 6107) once the service review plan with district nursing has further been considered with the Chief Operating Officer.

3.5.6 **Unscheduled Care – Care Group** – are currently reviewing the mitigation relating to the "Lack of Resuscitaire in Princess of Wales Hospital Emergency Department" (Datix Risk ID 6152). This risk at the time of finalising the Organisational Risk Register was scoring at a risk score of 20, however, the current control measure is that there is an interim measure to enable access to a Resuscitaire when required as the Emergency Department will be able to access the Resuscitaire located in paediatrics for neonatal patients who come into Emergency Department. Furthermore, agreement and approval to purchase Resuscitaire for the Emergency Department has been agreed and an order placed for delivery. As a result of these mitigations the risk score is under review and therefore at the time of submitting this report it is uncertain whether it will still require escalation to the Organisational Risk Register, however it has been referenced here to ensure visibility.

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

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score
1.	Improving Care, Sustaining our Future 	**a) Enough capacity to meet elective demand**	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4)
		b) Enough capacity to meet emergency demand			20 (C4xL5)

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

4. Assessment

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

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required 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
4	6179	Executive Director of Public Health	Public Health - Health Protection	Executive Director of Public Health	Creating Health & Improving Care	Quality / Complaints / Assurance / Patient Outcomes Impact on the safety – Physical and/or Psychological harm	High and increasing prevalence of overweight and obesity in children and adults.	**If** there is insufficient preventative activity to reduce rates of overweight and obesity **Then** rates of obesity will remain high in CTM . **Resulting in** increased activity/acuity/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents.	A range of work is currently under way in response to high levels of obesity in CTM including: 1)Grant funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment 2)Adult Weight Management Service – the scale of this is vastly insufficient to make a difference to population level rates of obesity 3)Children and Young People's weight management service – current time-limited funding for Pipyn, preventative family based intervention, ongoing development work to maximise population impact, scale remains small. Proposed future development of a service in line with level 3 of the All-Wales Weight Management Pathway. 4)Healthy pre- and health schools programmes – working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: -healthy environments -healthy settings, -healthy people, -leadership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	The Healthy Weight Steering Group is currently developing a healthy weight road map for CTMUHB, outlining actions and strategic direction over the short, medium and long term. This will be in line with Healthy Weight: Healthy Wales, and take into consideration health board actions under the new national action plan. The Healthy Weight roadmap is under development and due at Board for approval in November 2025 There is a business case in place for sustainability and increased capacity for Pipyn (level1+), and a CYP level 3 weight management service. A level 3 weight management service will help improve outcomes for some our most disadvantaged children. Update 7.7.2025 - Confirmation being sought as to whether this was approved as part of the IMTP process - update from finance awaited.	Quality, Safety & Experience Committee. Strategic Development Committee.	20	C4xL5	9 C3xL3	↔	06.05.2025	09.05.2025	08.07.2025
5	6111	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Medical Examiner Delays	**If:** there continues to be delays in length of time for scrutiny of deaths by the Medical Examiner Service **Then:** death certification will not be completed in a timely manner and so increasing the length of stay of the deceased **Resulting in:** complaints from bereaved relatives due to delayed funerals, inability to view loved ones, and deterioration in condition due to delay and inability to comply with WG bereavement framework and mortuary capacity being overwhelmed	Bereavement database updated to track cases and ensure timely attendance by doctors following scrutiny. Bereavement teams to provide estimated timescales for scrutiny based on database. Daily monitoring of daily occupancy. Funeral directors to be contacted by mortuary teams. All contingency capacity HB wide activated in line with mortuary escalation action card. Use of contracted funeral director staircase if required. Use of medilink sessions to manage post mortem demand.	Plan to improve timely death certification by CTMUHB specific QR code to alert wider staff and reduce delays and education videos from MES to improve accuracy. Continue to improve on communication with families around delays and estimated timescales. Update End of June 2025 - Communications ongoing with ICT colleagues around a data sharing risk using MS Office. Current work ongoing to implement this. Current work-around is in place to take data into a spreadsheet then delete the forms after a certain period of time. Discussions with ICT also in place in terms of solution to implement QR Code.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C4xL5	12 (C4xL3)	↔	05.03.2025	30.06.2025	31.8.2025
6	6053	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Service / Business interruption	Failure to secure an alternative Clinical System for GP practices on Vision	**If:** a new supplier is not secured. **Then** there will be a significant risk to the availability of a clinical system/solution to support General Practice service delivery for our GP practices yet to transfer to an alternative provide (EMIS). **Resulting in** GP service delivery and patient care being significantly impacted and further impacting on other healthcare services.	Digital Health Care Wales (DHCW) Task force with 4 workstreams set up to manage the incident: Comms & engagement. The company is currently seeking a buyer, process started on Friday, December 13th. DHCW will work with the administrator on the next steps, whatever the outcome of the marketing process. The administrator has advised they are planning to maintain a full service to minimise disruption to practices. Health Boards are working together with DHCW to produce business continuity plans for both HBs and for practices.	Collaboration with DHCE and other Health Boards for Business Continuity Plans - timeframe 27.3.2025. Securing a new Clinical System Provider - timeframe 30.06.2025. Update May 2025 - Digital Health Care Wales (DHCW) are still in negotiations with interested / preferred buyer of the Cededim clinical system. In the meantime HOPC/DHCW and Health Board Digital Leads working on mitigation and business continuity plans. Update 24 June 2025 - new provider secured and Novation Agreement for the transfer of the contract has been received by CTM to sign. Returned to Digital HealthCare Wales. This will secure the clinical services for practice and part of the contract is to expedite the migration to EMIS earlier in 2025. Next review	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	CSxL4	5 (CSxL1)	↔	15.01.2025	24.06.2025	1.8.2025
7	6102	Director of Digital	Central Corporate - Digital & Data	Head of Clinical Admin Transformation	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patient Pathways - Working in WPAS Instances.	**If**: A patient is moved between Swansea Bay University Health Board WPAS and Cwm Taf WPAS and their pathway is closed in one before it is opened in the other. **Then:** The pathway will not be automatically re-opened by the systems (this must be manually transacted) and the pathway will remain closed. **Resulting in:** The incorrect ending of the patient pathway, as they will not be visible on the system, which could lead to possible patient harm/ death.	Monitor records/ processes through agreed Standard Operating Procedure's and ensure corrective actions are taken until mitigation is successful. Flagging to users/ management where examples of this not being followed are identified.	Review current business processes and Standard Operating Procedures to clarify the importance of opening the CTM record before closing the Swansea Bay University Health Board record. This process prevents delays in urgent pathway management, as highlighted by flagged dermatology cancer referrals that were discharged on WPAS but not set up on another system at the time of checking. It is anticipated that the target score will not be achieved until CTMUHB have a fully migrated PAS systems and the whole organisation is using a singular PAS system for patient pathways. Update July 2025 - Whilst the PAS disaggregation has completed, Care Groups now need to work with operational managers and clinicians to aggress Health Board wide ways of working and Standard Operationing Procedures to manage patient pathways in a consistent ways across CTMUHB.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	CSxL4	5 (CSxL1)	↔	19.02.2025	3.7.2025	31.08.2025
8	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update July 2025 Unscheduled Care - Rapid Improvement Action Plan in development to achieve Ministerial Advisory Group target of 45 minutes for handover for Ambulance Internal action plan in development to achieve a reduction in 12 Hour Emergency Department performance. Formulations of ED Rapid Improvement Plan and Improvement Targets, including: •The above improvements will be aligned against the following assumptions: •Single Point of Access (scheduling unscheduled care) – November 2025 •All GP / 111 / NHSGW calls to be triaged by the Nav Hub •Zero tolerance to any GP expected patients (off pre-alerts) being seen first in ED – November 2025 •'Ticket to ride' for all WAST non-red Care Home attendances – implementation aligned with national work •Additional hospital at home (HbH) and clinically optimised for discharge (COFD) capacity within Primary and Community Care •20 additional bds from August 2025 •60 additional beds from November 2025 •60-minute specialty in reach – August 2025 •Sign off Internal Professional Standards Substantive consultant recruited June. Start date in Jan '26. 1 Stroke Consultant 6 month phased return. Single Point of Access Board to be established. Planned Care Update: •Progress made on >104 week •8 theatres across CTMUHB remain closed •Endoscopy moved back to Princess of Wales Hospital in June 2025. •2 mobile endoscopy treatment rooms opened 4th March 2025 •4 Mobile theatres opened Mid-April •2 Prince Charles Hospital (PCH) theatres opened end of April 2025 •1 Theatre and Ward at PCH dedicated to Orthopaedic Inpatient surgery from May – July 2025	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 C4 x L3	↔	13.7.2023	01.07.2025	31.08.2025
9	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update July 2025 - Consultant medical workforce remains fragile • Substantive consultant recruited June with an anticipated start date in January 2026. • 1 stroke consultant has RTW on phased return over a 6-month period. • 2 x agency locums remain in place and secured until December 2025	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4 x L3)	↔	11.05.2021	20.06.2025	31.07.2025
10	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 May 2025 - Phase 1 UAT has now been completed by Digital Health Care Wales (DHCW). They are working with University Health Boards to understand any issues or critical blockers from testing. Replanning options are also being currently looked at e.g. should migration be based on individual specialities/discipline rather than at an individual University Health Board level. DHCW are currently undertaking a procurement activity reviewing the use of Citrix, which is used to deploy LIMS, so activity to explore the mitigation of a potential Citrix contract termination in December is underway. Update July 2025 - Rather than a whole Health Board migration approach, the national programme have proposed that individual pathology disciplines are migrated across Wales. Each University Health Board has been asked to approve that approach and any associated costs. Clarity is being sort on the appropriate governance to approve the additional costs.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CSxL4	5 (CSxL1)	↔	26.10.2022	3.7.2025	31.08.2025
12	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update 20.06.2025 - The emergency departments across CTM remain overcrowded. There are many internal actions being undertaken within Care Group to reduce attendances, improve flow and reduce overcrowding: • CTM UHB Development of Urgent & Emergency Care Rapid Improvement Plan (45 minute ambulance handover and 90-day ED performance) • TRUE Rapid Improvement Plan through 6 Goals Programme - SRO - Deputy Exec Med Director and Deputy COO • USC CG Formalise and sign off 30/60/90-day improvement plan • Acute Medicine Transformation Programme (STAMP) - POW – 2 workshops complete – 3 further planned June/early July • New investment agreed for x3 Consultant Acute Physician posts. Targeted recruitment drive currently underway. • Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established. • Targeted recruitment of Acute Medicine Consultants following new investment to provide 7/7	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	20.06.2025	31.08.2025

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
13	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 May 2025 - Prince Charles Hospital (PCH) has confirmed a GA session will run every Friday, this will enable up to 7 patients to be seen p/w dependent on complexity. Still exploring possible use of Vanguard, waiting for the theatres to be utilized by adults patients from the 10 April to understand suitability if theatres are safe for Paediatric use. CDS have started to assess 30 patients p/w in readiness for the Saturday list however will pull down additional assessment clinics in the next few weeks if there is a delay in use of the Vanguard Theatres Confirmation is required as soon as possible due to children can only be assessed 9-10 weeks prior to treatment, additionally other CDS patient lists are currently being cancelled to ensure there is an appropriate cohort for treatment on the Vanguard lists. Currently waiting for secondary care staffing costs to be shared with Service Director to enable costs to be reviewed/signed off. Update July 2025 - Since the previous update, the service has been informed that the Vanguard theatres are unsuitable for the delivery of paediatric lists on the weekend. Therefore, the service was offered the opportunity to explore Saturday lists at Princess of Wales Hospital (POWH). However, other specialities have also been considering the use of POWH and as a result, CDS have been asked to scope Sunday availability of staff instead. In addition, the service has now also been informed that weekend lists could be run from the main site of Royal Glamorgan Hospital (RGH) on the weekend, using the Paediatrics Assessment Unit. This option will be explored over the coming weeks. Next review end of July 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	9 C3xL3	↔	20.04.2023	25.06.2025	31.07.2025
14	5753	Executive Nurse Director / Deputy Chief Executive	Children & Family Care Group	Care Group Service Director	Improving Care	Workforce / Organisational Development / Staffing / Competence	Inadequate Special School Nurse Provision	**If** the Health offer towards the current Special Schools Nursing Model is not increased and Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools **Then t**he Community Children's Nursing (CCN) Service are unable to meet their obligations across the five special schools in CTM and be unable to fulfil their obligation to Rhondda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA **Resulting in**, Dissatisfaction and fractured relationships within RCT and Merthyr LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), impact on Consultant Led clinics, inability of special school nurse to deliver on School Nursing Framework in Wales part 2 - Nursing in Special Schools and Healthy Child Wales (HCW) part 2, lack of access to continual professional development and peer support for the nurses based in Special Schools, continued issues with recruitment and retention of nursing staff into Special Schools	Mitigation – reviewing SLA at pace with LA, high level meetings with EDON, Nursing Director and Directors of education. Supporting staff, sharing risk across SSN schools. During periods of absence or vacancies; access to a school nurse will not be available in person 5 days per week. However, telephone advice and support will be available. These control measures do not meet expectations of Local Authority. Meetings have been held between Directors of education and Director and Executive Nurse. SBAR has been escalated to Care Group OMB but needs to be escalated to HB OMB (19/02/2025) Engagement between senior nurse and head teachers and support for special school nurses has been given.	Update May 2025 - Special school nursing team remains fragile, 1 LTS ongoing from September, 1 Maternity Leave unsuccessful backfill, 1 staff member just returned from LTS. Increasing demands from schools and uncertainty of agreed roles and responsibilities heighten this fragility. Discussion scheduled for May with Chief Operating Officer (COO) and Executive Director of Nursing and Care Group. Update July 2025 - Meeting held 3 June 2025 with Chief Operating Officer and Executive Director of Nursing / Deputy CEO to provide them with an update and risks raised and capacity challenges. As at 4 July 2025 there are two vacant posts now 'live' on the Trac recruitment system following notification of staff departures. At present risk score remains unchanged.	Quality, Safety & Experience Committee Operational Delivery Committee	20 Risk Score increased from a 16 to a 20 in July Iteration of Organisational Risk Register	C4xL5	8 (C4xL2)	↑	16.04.2024	04.07.2025	31.07.2025
15	6228	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Effective and efficient management of requests from the HM Coroner	**If:** the Health Board fails to effectively respond and manage requests from the HM Coroners Office in a timely manner. **Then:** there is a risk that the Health Board will breach 'The Coroners (Investigations) Regulations 2013' in failing to provide documentation on time and take required action in a timely manner to ensure lessons have been learned. **Resulting in:** poor experience and the wellbeing impact for the families and staff members involved in inquests, reputational impact of the Health Board in terms of trust and confidence in the service, an increase in the number of Regulation 28 / 29 reports on actions to prevent future deaths, an increase in potential enactment of the Coroners powers, including under Schedule 5 - "Power to require evidence to be given or produced".	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Review and remap internal processes in the management of inquest cases within the organisation. Weekly coronial meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage inquests effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: cases reviewed in partnership with Senior Coroner's Officer, resulting in case reduction from >350 to 191 cases. Weekly panel meetings are now in place to review new inquest notifications, to align already received evidence, and to ensure appropriate allocation of care groups and witnesses. Organisational Change Process of Patient, Care & Safety team near completion ensuring appropriate allocation of resources.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
16	6229	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Timely development of, management and response to Learning From Event Reports (LFERs)	**If:** the Health Board fails to achieve timely completion of LFERs, respond promptly to the questions from the Welsh Risk Pool Learning Advisory Panel and provide assurance that learning has been implemented and shared. **Then:** there is a risk that improvement to quality and safety in healthcare aligned to learning which flows from case investigations, and the LFER (Learning From Event Report)s is not acted upon. **Resulting in:** reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned. Missed opportunities to improve patient care and safety following identification of areas for improvement. Financial penalties if the Welsh Risk Pool consider withholding reimbursements due to being dissatisfied with the learning and actions taken in a case.	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Incident Management Framework and Toolkit. Incident Investigation Training Visibility of data using the Datix System. Listening and Learning Framework	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: Cases are reviewed in partnership with the Head of Safety at Welsh Risk Pool, with plans for approved extensions on current cases and WRP support on case management. Weekly data meetings are in place to review current cases, align already received evidence, and ensure appropriate allocation of care groups and teams. WRP to support on the development of an internal CTMUHB Learning From Events Report Panel. Organisational Change Process of Patient, Care & Safety team near completion ensuring appropriate allocation of resources.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
17	6230	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future???	Standard Duty, regulation, mandatory requirements.	Proactive management and compliance with Medical Negligence or Personal Injury claims at Pre Action Protocol stages.	**If**: the Health Board fails to comply with the Personal Injury or Medical Negligence Pre Action Protocol stages of a case. **Then:** there is a risk of breaching practice direction / pre action conduct. **Resulting in:** avoidable delays to the litigation process being incurred including the wellbeing impact on family's and staff involved. Reputational impact in terms of compliance failings. The court initiating a range of penalties due to no compliance, proceedings being commenced unnecessarily or where additional costs have been incurred.	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Claims Management Procedure Engagement with Legal & Risk Services. Experienced Claims Handlers in post.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: Cases are reviewed in partnership with the Assistant Director for Health & Safety, resulting in a review and streamlining of current case activity. Weekly data meetings are in place to review current cases, align already received evidence, and ensure appropriate case management. The Organisational Change Process of the Patient Care & Safety team is near completion, ensuring appropriate allocation of resources. The Deputy Executive Director of Nursing and the Assistant Director for Corporate Governance & Risk have met with Legal & Risk leads to review options on case management of current cases and substantive measures to streamline current processes.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
18	6231	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future???	Standard Duty, regulation, mandatory requirements.	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	**If:** the Health Board fails to comply and proactively manage cases that qualify for consideration under NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. **Then:** there will be a missed opportunity to deal with concerns under a single and consistent method for grading, investigating and to actively involve the person raising the concern in an open and engaged manner to put things right. **Resulting in:** Delays in improving patient safety and experience as a result of identifying how services may have improved as a result of concerns notified and dealt with under these arrangements. Early resolution of cases which provide an opportunity for closure for families and staff as well as effective and efficient learning to be implemented. Avoidable costs should a case proceed to litigation due to failure to comply proactively with the arrangements. Reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Putting Things Right - Handling Concerns Procedures Engagement with Legal & Risk Services. Experienced Concerns Handlers in post.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: Performance reviewed on a twice weekly basis focusing on KPI/standards in responses within 30 working days, acknowledgement within 2 working days and overall management of early resolutions. Current performance indicates improvement with 30 working day target above 75% and acknowledgement standard at 64% compliance. Additional work in partnership with the CEO's team to review management of MP/MS concerns has resulted in improved communication and streamlining of case management (under regular review).	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
21	5304	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Sustaining Our Future	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU at the Royal Glamorgan hospital (RGH) is 25 years old, therefore is at higher risk of failing to meet the required standards due to its age and design, with four recent incidents occurring. **If** the AHU is not maintained to the required standard this could **then** lead to further closures at short notice or production being halted. **Resulting in:** •Patient Safety and Quality: Delays in supplying treatments, particularly for cancer patients, which could compromise patient outcomes. There is also a risk of severe patient harm if regulatory compliance cannot be maintained. •Complaints and Patient Experience: Increased waits to start treatment or delays in treatment, leading to poor patient satisfaction and an increased number of complaints. •Reputational Risk: Negative publicity due to increased waiting times for cancer treatments or the inability to provide certain treatments, resulting in reduced patient and clinician confidence. •Financial Risk: Increased medicines expenditure and wastage from having to outsource aseptically prepared products from external suppliers. •Research and Innovation: No opportunity to conduct clinical trials involving aseptically prepared products.	The output from the AHU is continuously monitored internally & externally The estates department maintain the AHU regularly here are contingency plans in place to outsource products from elsewhere.	Capital resource approved and the service is working with project manager on timelines which will then initiate a review of the risk to see if mitigations are successful and risk score can be reduced.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	4 (C4xL1)	New risk escalated to Organisational Risk Register in July 2025	29.11.2022	27.06.2025	30.09.2025
22	3567	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	Capacity of Cellular Pathology Service - Space	**If:** there is not enough laboratory and office space for Cellular Pathology to operate the core service safely or support increasing demand, service disaggregation and future Health board changes; **Then:** the service will be unable to work effectively and efficiently in line with Duty of Quality guidance and recognised Health board standards for IPAC, H&S etc. **Resulting in:** - Inability to meet increasing demand - increase in staff stress and compromised well being due to working in suboptimal conditions. - Poor cancer performance and inability to meet expected turnaround times, impacting on Health Board cancer performance - poor quality patient care due to delays in diagnosis or misdiagnosis - Increase in clinical incidents, complaints and potential for reputational damage. - Inability to effectively disaggregate the current SLA with Swansea Bay and repatriate services from Bridgend impacting clinical services across CTM. - inability to support full digital rollout and support regional reporting in line with WG strategic direction - delayed development of advanced scientist dissection to support increasing reporting capacity and delivery of workforce modernisation - loss of tissue leading to Serious incidents and Regulatory non-compliance with HTA and potential compromise of HTA license. - financial risk of outsourcing - threat to strategic regionalisation project due to the scale of the lack of capacity in CTM	SOPs are in place to standardise practice and mitigate risk of variation in practice caused by limitations of the laboratory environment. Controls to reduce the use of reception/dissection as a thoroughfare including signage and demarcation belt. Workflows established to maximize efficiency of limited space. Block and slide filing removed from laboratory area where possible. System of work including check established in dissection to minimize risk of error. IPC and H&S environment inspections undertaken to assess impact of laboratory environment on clinical effectiveness and risk to patients and staff.	Mitigating Action Plan includes: Engagement with estates to review small scale projects to increase laboratory space. Engagement and participation in Regional Scoping group to scope options including estates to look at long term solutions. Update July 2025 - Initial meeting held 10/06/25 to discuss options for progress. Follow up meeting scheduled to finalise what options meet future requirements and look to understand feasibility. Discussed plans with COO and Planned care colleagues around options within RGH. No change to risk at present.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	C3xL2 6	↔	28.05.2019	27.06.2025	31.07.2025

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
23	5045	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Access to Neurology Inpatient and Outpatient Services for CTM Residents	**If:** there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of RTE; **Then**: existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue; **RESULTING IN**: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients.	An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint x3 consultant neurologists within CTM as part of the Neurology Liaison Plan.	Update May 2025 - Neurology capacity pressures remain across CTM and limited access to neurophysiology testing is also an issue. A locum consultant neurologist started in Royal Glamorgan Hospital (RGH) in December 24 and is currently providing inpatient support to RGH and 4 OP clinics per week. This is supporting reducing the OP backlog and improving inpatient support, however, as at end of March 25 there are 1782 patients waiting over 26 weeks for a first op appointment. IMTP bid for neurology consultant posts submitted and awaiting a decision. Update July 2025 - Agreement to progress CTM Neurology Liaison service through support the recruitment of 2 x Consultant Neurologists posts. These posts are being advertised as part of a targeted recruitment campaign. Date to be confirmed.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	09.3.2022	20.06.2025	31.08.2025
24	5576	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Palliative Medicine Staffing	**If** the Health Board are unable to recruit to the vacant Palliative Medicine Consultant post in Ysbyty Cwm Cynon (YCC) for Merthyr/Cynon. **Then**., there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant compliment. **Resulting In**., a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status.	Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant. Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards	Update July 2025 - Care Group update as at 24.06.25 - meeting arranged with COO and CEO on 26.06.2025 to agree engagement plan as part of wider system changes with view to commence process. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	11.10.2023	25.06.2025	31.08.2025
25	4973	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical Medical Cover within CTM Adult Mental Health Services	**If:** CTM Mental Health Service fails to implement adequate senior medical cover across adult in-patient and CMHT services **Then:** the Health Board's ability to provide quality care, a safe environment for patients and a good standard of training for junior doctors will be reduced and potentially compromise the safety of patients and staff **Resulting in**: sub-optimal care to patients, inability to discharge its legal duties under the Mental Health Act, due to insufficient numbers of suitably skilled and experienced Approved Clinicians. Junior doctor supervision will be reduced which may affect future recruitment, patient safety/experience compromised and staff well being will be poor.	Functional inpatient model in place with 3 consultants to cover. Redeployment out of the service and resignation has led to a further depleted workforce and cover will reduce to two consultants from January 2025 with additional middle grade support. Rehabilitation service is at a critically low level with urgent closure of one service needed. Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients. Difficulty recruiting to locum posts due to introduction of rate card and need to have Welsh AC approval. Permission to go out to non-DE has been provided. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements. Two PAs recruited to Rehab and IP in Jan/March 2025 which will free up senior time The Adult Directorate is managing medical staffing through "escalated action" procedures with daily scrutiny and communication pressures and counter measures to release the Consultant body. Daily reviews with Retinue on the availability of staff	Substantive jobs which are new posts are being developed and advertised. Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025. Update July 2025 - The control measures in place are themselves fragile and the implications of them being ineffective are major. The control measures are having to be reviewed on a daily basis to ensure their remain effective. No change to risk at present.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4xL3)	↔	06.01.2022	25.06.2025	31.07.2025
26	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 17.04.2025 - agreement with North Bristol NHS Trust extended to 30/4/25 to all North Bristol Trust to schedule all the new out patient appointments. Wash up meeting planned for May to discuss progress and whether it is something that could be repeated in 25/26 (subject to funding). Funding discussions ongoing. Welsh Government have commenced scoping exercise and has met with all University Health Board commissioning leads in March and will meet with clinical leads this month. Draft report to be submitted to Welsh Government by scoping lead in April. Update 26 June 2025 - wash up meeting between CTMUHB and North Bristol Trust has been held. 59 urgent referrals were triaged and 45 of these were offered an outpatient appointment. Majority of those seen were discharged back to GP with management advice. Looking to secure funding to support an additional 40 urgent referrals but not yet confirmed. Meeting again in July to explore option of longer term solution. This cannot happen at the moment due to CTMUHB awaiting the outcome of a Welsh Government scoping exercise.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL5	4 (C4xL1)	⇔	08.07.2024	26.06.2025	29.08.2025
29	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 12.6.2025 - Progress against the timeframes outlined in the Project Initiation Document for the Policy Review programme are being met. There are some delays in gathering the baseline information status for all Non Clinical Policies and Procedures, which at this stage this is not causing concern in terms of implementation date, however, this will be raised with the Executive Management Board via a progress update being shared with them on the 30 June 2025. At this stage the mitigating actions are yet to positively impact the risk so the risk score remains unchanged. Next risk review scheduled for end of August 2025	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	⇔	26.10.2021	12.06.2025	31.08.2025
30	5691 Closed Session due to business sensitivities	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The details of this risk is captured in the closed session of the Committee due to business sensitivities.											
31	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. Update May 2025 - No change to risk score or mitigation this period. Executive Medical Director to raise risk again at next All Wales Medical Director meeting. Update 23 June 2025 – Still no movement here. Its within the discussion of Digital HealthCare Wales provider status and open sharing of data between Health Boards. The current proposal has not been agreed between ABUHB and DHCW. CTMUHB are asking and raising the concern, however, cannot directly resolve.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	23.06.2025	01.09.2025
32	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 July 2025 - MHLD Care Group update 17.6.2025 - Risk reviewed, no change at present however in the Right Care Right Person meeting on 13/06/25 it was agreed to reduce the Likelihood from Highly likely to Likely which would reduce the over score from 16 to 12 and lead to a de-escalation from the Organisational Risk Register, however this decision needs to be ratified through the Care Group's internal Operational Management Board prior to taking effect.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	17.06.2025	31.07.2025
33	5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PSYN continues to be delivered in Merthyr (PHW funding until 26) and Taff Ely and Rhondda (Cluster funding until 26) 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3)Business case developed submitted and submitted for IMTP consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Finance-dependant controls: 1)Set up service if funding identified via IMTP process.	Update July 2025 - Awaiting formal notification of IMTP investment which will reduce this risk.	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	20.06.2025	18.08.2025

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
37	6232	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future???	Safety & Wellbeing Patients / Staff and Public	Stability of the Legal Services Function	**If:** the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. **Then**: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. **Resulting in:** an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: The Organisational Change Process is near completion, with feedback from team members now catalogued. The benchmarking exercise is complete, and the senior leadership team is reviewing the structure against known demand. Additional workforce in place through recruitment and redeployment to support immediate service needs and overall recovery.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C3xL5	C3xL2 = 6	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
38	6217	Executive Medical Director	Children & Family Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity	IF the safeguards and quality systems and processes are not robust Then: - mothers and babies may not receive the best evidence based care Resulting in - Potential for patients to have poor outcomes and experience within the service.	Rapid reviews have been undertaken on all cases with findings and learning from each. Meetings held with Care Group and executive team to decide on way forward. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan).	External review commissioned on Nationally Reported Incidents. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) - the action plan and risk will be further reviewed once external report received.	Quality, Safety & Experience Committee.	15	C5xL3	10 (C5xL2)	New risk escalated to Organisational Risk Register in July 2025	14.05.2025	04.07.2025	31.07.2025
41	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central 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 July 2025 -The Care Group are currently in the third week of the procurement process which has allowed suppliers to bid. This is scheduled to finish on 5th July when the Care Group should be in a position to know how many suppliers are in the procurement activity.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	25.06.2025	31.07.2025
42	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update July 2025 - MHLD Care Group Director update 30.06.2025 - 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 now that the capital teams capacity has become available since the initial Princess of Wales Hospital critical incident. No change to risk score at this stage.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	30.06.2025	31.08.2025
43	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	**IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. **THEN** there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. **RESULTING in** avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update July 2025 - Local Public Health Team Strategic Development meeting are scheduled to meet on the 8th July 2025 to review the risk and consider if risk score can be reduced or whether it remains at a score of 12. Review date end of July.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	7.7.2025	31.07.2025

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
Nil on this occasion											

	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	5903	Chief Operating Officer	Improving Care	Statutory Duty, Regulation, Mandatory Requirements.	Unfunded Continuing Care Packages / unfilled packages	**If** the budget is not allocated, to employ additional staff within Children's Continuing Care **Then** agreed packages of care which have clearly identified an unmet need, will remain unfilled **Resulting in** impacts of child and family wellbeing, risk to the child, risk of the unmet need continuing, children with packages for school being prevented from attending. Not meeting health boards obligation against Welsh Government Continuing Care Guidance.	Recruitment activity underway. Temporary posts advertised for Health Care Support Worker - partially successful Risk remains high as staff need to be recruited, inducted and trained SBAR for permanent recruitment escalated to Operational Management Board - no decision to date.	Update May 2025 - Financial allocation being discussed with Care Group which is likely to reduce / remove this risk. Update July 2025 - 4 new starters will complete initial training by end of July to manage the package (2nd person) currently being managed by new cross agency, rotas from mid august move to health board staffing, therefore risk can be closed	Quality, Safety & Experience Committee Operational Delivery Committee	jul-25	Update July 2025 - Care Group have advised that this risk can now be closed as following review of continuing care new staff training and packages then within the next 6 weeks (from 1 July) the service will be totally removing New Cross agency from the remaining package, the service have put in place regular oversight during this period from the CCN key workers.
3	5932	Executive Director of Finance Executive Lead for Estates	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 July 2025 - This risk has been removed as the roof and battens have been competed above patient areas in Phase 1, only plant rooms remain. Risk score revised to a likelihood of 2 as it could be on a very small scale/localised area compared to the whole Phase 2 roof.	Operational Delivery Committee Quality, Safety & Experience Committee Health, Safety & Fire Sub Committee	jul-25	Capital & Estates Directorate have removed this risk as the roof and battens have been competed above patient areas in Phase 1, only plant rooms remain. Risk score revised to a likelihood of 2 as it could be on a very small scale/localised area compared to the whole Phase 2 roof. Target score of 10 was reached.
4	5961	Executive Director of Finance Executive Lead for Estates	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 July 2025 - risk of water ingress – this risk has been significantly reduced for the Phase 1 roof that this refers to as the roof has been replaced as in risk 5932 above. Risk likelihood score reduced as only leak on Phase 1 recently was above ITU and the flashing was identified as the problem and subsequently corrected so this should not reoccur.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	jul-25	Capital & Estates Directorate have removed this risk as it has been significantly reduced for the Phase 1 roof that this refers to as the roof has been replaced as in risk 5932 above. Risk likelihood score reduced as only leak on Phase 1 recently was above ITU and the flashing was identified as the problem and subsequently corrected so this should not reoccur. Target score reached.

	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
7	4908	Executive Nurse Director / Deputy Chief Executive	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update July 2025 - this risk has been superceded by new risks	Quality, Safety & Experience Committee Operational Delivery Committee	jul-25	Update July 2025 - this risk has been superceded by new risks

Agenda Item
7.2

Quality, Safety & Experience Committee

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

Dyddiad y Cyfarfod / Date of Meeting	22nd July 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

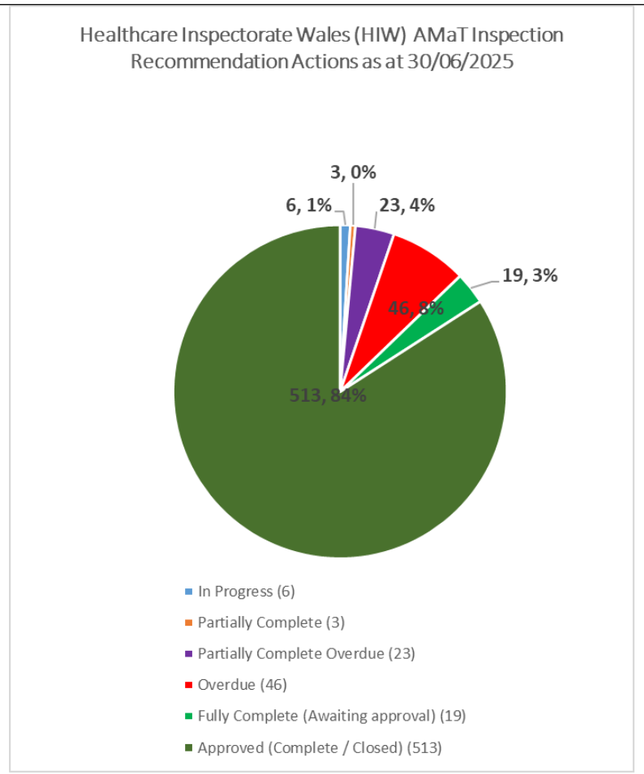
Pwrpas yr Adroddiad / Report Purpose	For Noting

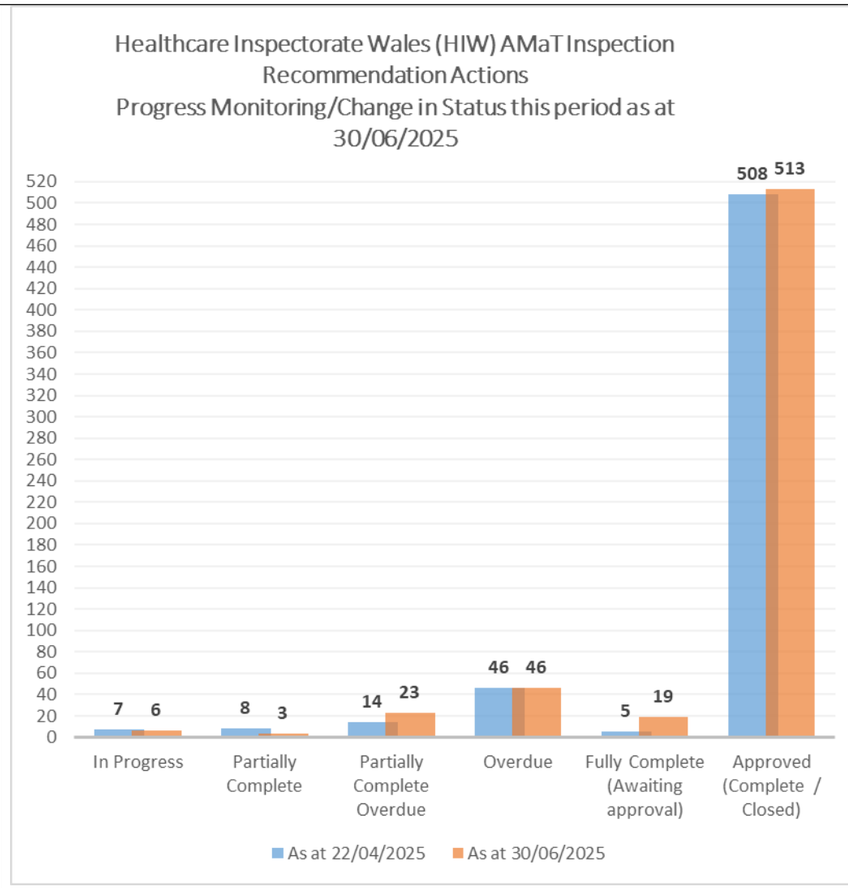
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

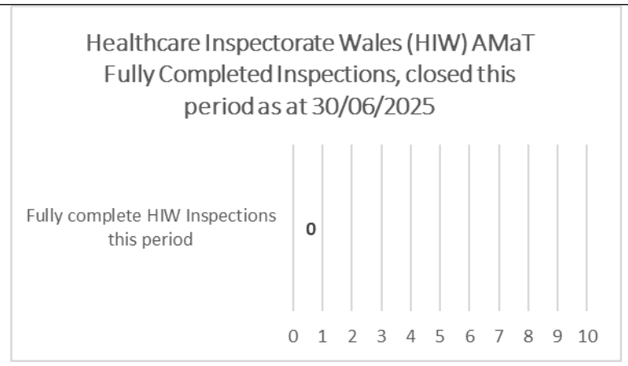
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales

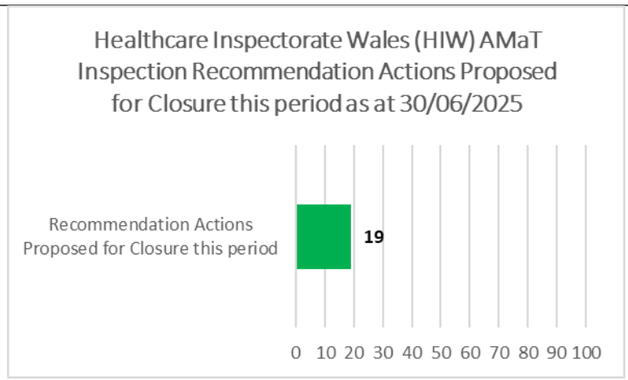
AMaT	Audit Management and Tracking

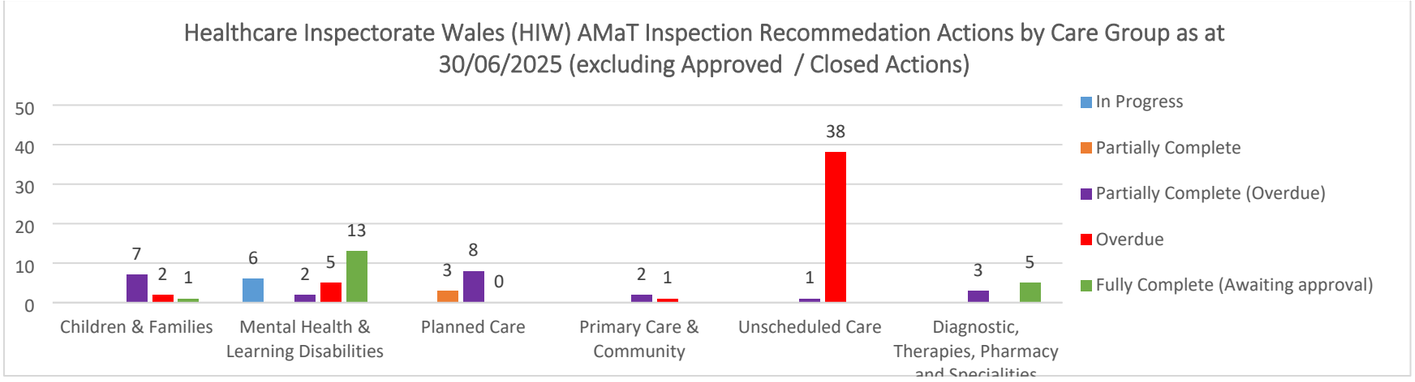
Compliance Dashboard











1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker of the accepted Improvement Plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 3rd March to 1st July 2025.

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 All open and live HIW inspection improvement plans continue to be recorded on AMaT. Since the last report, a review management and tracking process of the Death in Custody reports concluded that these would no longer be included in this report and would be reported on separately.

2.3 Requested system developments with AMaT remain in progress with the continued requirement for the team to manually compile data to analyse and report on.

2.4 The response rate in terms of providing updates to inspection actions this month has been particularly low. Where there are also concerns in terms of actions not having been updated for consecutive months then escalation and follow up has been undertaken, please see paragraph 3.1.

2.5 Care Groups are responsible for providing regular updates on the improvement plans within their care group portfolios in order that the tracker can remain live and up to date ensuring all actions are completed in a timely manner. Reminders are sent out in advance via AMaT of reporting deadlines to encourage and request further updates from Care Groups. An engagement session in the Executive Nurse Director huddle was informative and helpful and escalation is ongoing.

2.5 A breakdown of the status position with regards to all actions up to the 30th June 2025 is detailed below.

- A total of **610 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.

- **513** Actions were Fully complete, approved and closed with a further **19** actions fully complete and awaiting approval.

2.6 **New Inspections / Actions**

- There were **2** new Improvement Plans and **22** actions added this period.

2.7 Please note that Death in Custody reports and data are no longer included in this data as they are outside the scope of this process and have other monitoring and reporting arrangements in place.

3. Key Risks / Matters for Escalation

3.1 The HIW actions tracker will continue to be updated with a targeted focus on actions where the action agreed due by date has passed or no update has been received. Where updates have not been received more than twice this has been flagged on the tracker. A separate report will be produced and provided to the Deputy Executive Director of Nursing in order to facilitate planned focus work with Care Groups to improve the position.

3.2 Ongoing AMaT system developments and requests are continuing in order to deliver a system and process that is required for improved governance. The Head of Quality Assurance and Compliance continues to liaise with other Health Boards in Wales to gather support and share experiences on the use of AMaT for this purpose.

3.3 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. Continued engagement is required from Care Groups to continue to update and cleanse the current and historic Inspection actions to make analysis more meaningful.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies, please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol –	A Healthier Wales

Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-acten.pdf (futuregenerations.wales)*	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	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.

HIW Inspection Recommendations Tracker
Leads as at 01/07/2025

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	22	22	**Planned Care** Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	2	2	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	17	18	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22/03/2022	7	7	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07/03/2023	39	180	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	2	2	**Unscheduled Care** Sarah Follows, Unscheduled Care Group - Service Director (awaiting new DoN to be appointed)
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	7	7	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	50	50	**Unscheduled Care** Sarah Follows, Unscheduled Care Group - Service Director (awaiting new DoN to be appointed)
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13/11/2023	25	26	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	31	36	**Unscheduled Care** Sarah Follows, Unscheduled Care Group - Service Director (awaiting new DoN to be appointed)
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	09/01/2024	2	27	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	14	36	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13.11.2024	27	46	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	27.01.2025	13	14	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	20.05.2025	4	8	**Diagnostic, Therapies, Pharmacy and Specialities** Carl Verrecchia, Service Director

AMaT Recommendation Actions - Status Key

In progress	**Inspection action is in the process of being completed and has not yet reached the deadline.**
Partially complete	**Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.**
Partially complete (Overdue)	**Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.**
Overdue	**Inspection action deadline has been reached and no recommendations have been completed.**
Fully complete (Awaiting approval)	**Inspection actions have been fully completed and are waiting to be approved to be closed.**
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.

HIW Inspections Recommendation Actions Tracker as at 01/07/2025
(for Quality, Safety and Experience Committee 22/07/2025)

Inspection Code	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	31.12.2025	Partially complete	April, June 2025 Update - No update against this recommendation action has been received on these occasions. February 2025 Update - No further development to what already implemented within primary care. 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 clinician/consultant Ophthalmology SRO to help drive this, need to identify HB/Digital representation on DHCW national EPR/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 RGH to receive urgent referrals (from primary care [GP & optometry] & A and E) launching Jan 2025 (fax line being discontinued) 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.
Healthcare Inspectorate Wales (HIW)/2017/141	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	April, June 2025 Update - No update against this recommendation action has been received on these occasions. February 2025 Update - No further update from secondary care December 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.
Healthcare Inspectorate Wales (HIW)/2017/141	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)	April, June 2025 Update - No update against this recommendation action has been received on these occasions. February 2025 Update - All clinicians aware of FUNB and discussed collectively at weekly RTT meetings. Health Board strategy being developed to manage patients backlog. KJ 27/2/25 December 2024 Update - Service Manager continuing with regular FUNB updates at weekly RTT meetings. Approval for closure to be reviewed at Care Group SMT 23/12/24.
Healthcare Inspectorate Wales (HIW)/2017/141	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 (Overdue)	April, June 2025 Update - No update against this recommendation action has been received on these occasions. February 2025 Update - All Medical Retina injection FUp's are given dates before leaving clinic to eliminate this high risk cohort of patients (None of this cohort will go on a FUNB). Health Board Strategy being developed to manage backlog KJ 27/2/25 December 2024 Update - Glaucoma 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 longterm 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.
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Healthcare Inspectorate Wales (HIW)/2017/141/MD12/1	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A Significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	April, June 2025 Update - No update against this recommendation action has been received on these occasions. February 2025 Update - Outcome forms established and if not completed correctly in clinic are sent directly back to clinician to complete. All patients that require a FU appointment under 6 weeks are booked before the patient leaves clinic. All patients over 6/52 are currently on FUNB with target date determined. Health Board strategy being developed to address and manage backlog KJ 27/2/25 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.
Healthcare Inspectorate Wales (HIW)/2017/141	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)	April, June 2025 Update - No update against this recommendation action has been received on these occasions. February 2025 - Historic harm review on going to complete all outstanding NRI's by end of March 25. Health Board strategy being developed to address backlog of FUNB patients KJ 27/2/25 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.
Healthcare Inspectorate Wales (HIW)/2017/141	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 (Overdue)	April, June 2025 Update - No update against this recommendation action has been received on these occasions. February 2025 Update - Currently shortlisting for Head of Optometry and Head of Orthoptics posts. Anticipating start date by end of April 25 KJ 27/2/25 December 2024 Update - Optometry-led laser pathway successfully implemented >12/12 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.
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HIW)/2017/141/MD15/1	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CARRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete	February, April, June 2025 Update - No update against this recommendation action has been received on these occasions. December 2024 Update - External funding (£26k) 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 WGDS (primary care optometry contract) rollout of new pathways - glaucoma and AMD filtering (referral refinement) pathways now fully WGDS-compliant (autonomous in primary care). WG Transformation Funds (£57k) secured to support primary care optometry contract implementation (admin & clinician resources). ECCG 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.
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/141/MD17/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	February, April, June 2025 Update - No update against this recommendation action has been received on these occasions. 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.
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	February, April, June 2025 Update - No update against this recommendation action has been received on these occasions. 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 (WGDS) continues to progress. In light of head of service vacancy, a revised implementation date of 01/06/2025.

HIW Inspections Recommendation Actions Tracker as at 01/07/2025
(for Quality, Safety and Experience Committee 22/07/2025)

Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HIW)/2017/141/MD21/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	**Partially complete (Overdue)**	February, April, June 2025 Update - No update against this recommendation action has been received on these occasions. 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 01/06/2025 is required.
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda (Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030))	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HIW)/2020/139/MD2/1	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care & Community	01.10.2020	01.10.2020	**Overdue**	June 2025 Update - Email sent from head of Nursing to Assistant Director of Transformation requesting an update on the outstanding action. No response received currently. December 2024, February, April 2025 Update - An update against this recommendation has not been provided on these occasions. 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)/2021/137	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MD3/1	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	**Partially complete (Overdue)**	June 2025 Update - after discussion at QSE it was felt more evidence was required to meet the recommendation estimated date July 2025. April 2025 Update- evidence added to be signed off in May QSRE, delayed due to shortage of representatives at the last QSRE. February 2025 Update (26-02-25) - being presented at QSRE on 12th March with a view to close. December 2024 Update - Plan to complete TOR within the physical health improvement focus group and to then close by Feb 2025.
Healthcare Inspectorate Wales (HIW)/2022/131	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**	June 2025 Update - Maternity services returned to the POW site mid February and have been experiencing acuity pressures since the return. Operational availability challenges have been experienced. Business case in draft discussion arranged with C&F operational leads end August 2025. December 2024, February, April 2025 Update - No update against this recommendation action has been received on these occasions. 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	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, February, April, June 2025 Update - No update against this recommendation action has been received on these occasions. 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	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Additional welfare support is available for KIT staff.	Healthcare Inspectorate Wales (HIW)/2022/131/MD6/1	Workforce team asked for specific resources for KIT staff going forward.	Children & Families	01.06.2022	01.10.2023	**Fully complete (Awaiting approval)**	June 2025 Update - KIT days fully supported with the maternity services across CTM. this includes max of 10days where staff can lead on KIT requirements before returning back to their role following their period of maternity leave. December 2024, February, April 2025 Update - No update against this recommendation action has been received on these occasions. August 2024 Update - KIT update to be taken to next Care Group Workforce meeting on the 28th August and the Local Partnership Forum.
Healthcare Inspectorate Wales (HIW)/2022/131	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, February, April, June 2025 Update - No update against this recommendation action has been received on these occasions. 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)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MD18/1	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	**Overdue**	June 2025 Update - Closure of the pre-engagement, undertaken with both suppliers. ITT issued 7th May and closed on 5th June 2025. Evaluation and supplier responses are now underway of all the system requirements so that scoring can be awarded. Attendance has been good from all service areas within the evaluation sessions. Evaluation sessions will end 26th June 2025. Recruitment, shortlisting and interviews for relevant roles is ongoing April 2025 Update - process has been made in the journey towards achieving the single clinical record that has allowed 3 Health Board's to come together in a collaborative cluster in the discovery of the single care record for Mental Health. It is likely that we will know who the supplier of our digital system will be towards the end of September 2025 into October 2025. An implementation date is yet to be confirmed but anticipated Dec 25 / Jan 26 February 2025 Update (26-02-25) - Letter from WG allowing us now to complete all the job descriptions, and get them on TRACS •Pre engagement session with 2 suppliers are ongoing they are RIO and TPP with engagement extended as we have a new supplier •Full procurement is likely to be around Autumn •Still at risk as we still do not have a definitive date for a single patient record. •Clare Williams appointed as Senior Responsible Officer for this program December 2024 Update - progress is being made, remains ongoing at this time
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)	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 of all existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review Following agreement of ToR at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	**Overdue**	June 2025 Update - • Total MH/LD policies – 64 • In date – 55 • Under review – 7 (In patient SOP, PICU SOP, CRHTT SOP, On Call, Rehab inpatient SOP, Transition, refeeding) • Pending ratification – 2 (on agenda for OMB July 2025) April 2025 Update - As of 1st April 2025 Total number of MHLD policies / procedures – 65 Actual position: In date – Target – 65, Actual – 55 Out of date – 0 Pending ratification/under review – 10 (7 on target for ratification in May 25, 3 of which are currently out for comment to QSRE Board. Awaiting confirmation of Mental Health Measure Policy, Refeeding Policy being discussed at CTM Nutrition Group, awaiting feedback) February 2025 Update (26-02-25) - MH and LD policies remain at 66 •46 are currently in date •9 policies under review. This will reduce to 8 as 2 communities polices are merging into one •11 Pending ratifications. These should have agreed at OMB but due to Business Continuity issues OMB was cancelled for 2 months. •All MH Policies are in date. •MH Policy page on the intranet has been updated making it simpler and easy to navigate December 2024 Update - currently 16 polices to update
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)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/2	Mental health policies will follow the agreed organisational process for ratification. All NH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 In date and approved 13 Expired 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" (recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	**Overdue**	February, April, June 2025 Update- No update against this recommendation action has been received on these occasions. December 2024 Update - 16 policies remain to be updated
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)	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, February, April, June 2025 Update- No update against this recommendation action has been received on these occasions. August 2024 Update - CDU BLS - 94%, ILS 40%. ED BLS - 80% ALS 65% (CDU- Clinical Decisions Unit- (BLS) Basic Life support (ILS) Immediate Life Support (ED) Emergency Department (BLS) Basic Life support (ALS) Advanced Life Support.)
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken . To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023	31.08.2023	**Partially complete (Overdue)**	December 2024, February, April, June 2025 - No update against this recommendation action has been received on these occasions. 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	HMP Parc	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MD7/1	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include- flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care & Community	31.08.2023	31.08.2023	**Partially complete (Overdue)**	December 2024, February, April, June 2025 - No update against this recommendation action has been received on these occasions. August 2024 Update - Ongoing with Pharmacy lead and GP in HMP parc.
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - This work is ongoing and forms part of long term engagement and partnership working via the stroke programme board.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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.

Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - "CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan."
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - this action is not being progressed as - Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD8/1	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cymru. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS Exec colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our speciality demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	Healthcare Inspectorate Wales (HIW)/2023/155/MD9/1	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD10/1	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within work stream 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams having direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon Safe2Start site based meeting. This piece of work is Optimise and focuses of value added care. This work is ongoing and is large scale transformation with a detailed project plan and times lines for implementation that are monitored via 6goals Board.	Unscheduled Care	01.04.2024	01.04.2024	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - a proposal has been shared with the board for extension of the CNS workforce with Senior nurse oversight. this requires resource allocation.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - this work remains a focus and is part of ongoing discussions as programme board - Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.
Healthcare Inspectorate Wales (HIW)/2023/155	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	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - collaborative work with WAST in relation to patient pathways is ongoing.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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.
Healthcare Inspectorate Wales (HIW)/2023/155	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	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - Case submitted to Board in January 2024 and rejected - Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	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	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - remains ongoing with digital team - Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.
Healthcare Inspectorate Wales (HIW)/2023/155	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	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - this work is continuous - The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - USC Care Group continue to explore regional solutions however this remains multifaceted and complex - Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - this work is ongoing as was a focus as part of the recent 'reset fortnight' - As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - this remains ongoing - CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the D2RA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	**Overdue**	December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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).

HIW Inspections Recommendation Actions Tracker as at 01/07/2025
(for Quality, Safety and Experience Committee 22/07/2025)

Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. 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	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update -As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.
Healthcare Inspectorate Wales (HIW)/2023/155	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, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. August 2024 Update - this work is ongoing with digital colleagues - The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.
Healthcare Inspectorate Wales (HIW)/2023/157	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/MD24/1	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	June 2025 Update - An update against this recommendation action has not been provided on this occasion. April 2025 Update- Awaiting dashboards to be disseminated , once this is completed we can take to QSRE for sign off and provide evidence February 205 Update (26-02-25) - Lloyd Griffiths has been working with the Business Intelligence Manager in the Patient Care and Safety team to move the structure of Datix to reflect the Care Groups functional model which went live 27th February 2025. This will now enable the development of a Quality Dashboard and allow the Care Group, directorates and all group of wards and teams to easily identify themes and trends. December 2024 Update - remains ongoing has been escalated to Nigel Downs and Greg Dix
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)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	Overdue	June 2025 Update - capital work is still ongoing and PCH major construction works are continuing. Welsh Government funding continues to be explored, which will facilitate improved patient clinical areas allowing for improved patient and staff experience. April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - capital work is still ongoing and PCH major construction works are continuing. Welsh Government funding continues to be explored, which will facilitate improved patient clinical areas allowing for improved patient and staff experience. August 2024 Update - capital work ongoing - PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/6	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	June 2025 Update - pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care has been implemented. This reinforces that patient flow is a team approach across the site. The plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area are ongoing. Capital environmental works remain ongoing across the site. April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - this remains in progress, work ongoing
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)	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	June 2025 Update - part of ongoing capital plans - We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety. April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - capital plans and work remain ongoing at the PCH site, when completed the Ambulatory Care Area will be able to implements to plan to facilitate improved observations of patients within that area. Whist awaiting this work make safes are in place including regular timed routine checks of all areas including the waiting room to identify any changes in patients condition whilst awaiting clinical assessment. There is also increased monitoring of the patients vital signs for early recognition of any clinical changes. 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	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DoLS (CDU) training.	Healthcare Inspectorate Wales (HIW)/2023/167/MD29/1	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug'23 fire training for staff is as follows:- ED-RN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April, June 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - The 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%. Ongoing Fire Training continues. CDU (now named AMU) Fire Training compliance is 92% to date. ED Fire Training compliance is 64% this is lower due the recruitment drive which has resulted in new Registered Nurses and Health Care Support Workers, this is being managed by the Senior Nurse for Professional Development and is being closed monitored by the Senior Nurse for ED. 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	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD30/1	Monthly mandatory training study days and reports now include V & A, DoLs, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April, June 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - The 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% continue. ED compliance has been reduced due to a recruitment drive which has resulted in a number of new Registered Nurses and Health Care Support Workers who are booked for, or awaiting training dates. Violence and aggression training compliance CDU (now named AMU) is 94% Violence and aggression training compliance is 77% MCA training compliance AMU is 79% MCA training compliance ED is 64% Safeguarding training compliance AMU is 90% Safeguarding training compliance ED is 78% 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	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)	February, April, June 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024 Update: due to the current pressure at Princess of Wales site in relation to the roof repairs - theatre workforce has been on hold. Plans to re-instate the finance meeting is due February 2025
Healthcare Inspectorate Wales (HIW)/2024/165	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)	February, April, June 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024 Update: New qualified midwives are now in post with an additional 3 NQM due to date early 2025. Additional posts have been advertised and a further 5 WTE were appointed and due to be in post early March 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	June 2025 Update - An update against this recommendation action has not been provided on this occasion. March 2025 Update - Meetings planned to revisit this work for PCH and PoW in March 2025. December 2024, February 2025 - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits of attracting staff to CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	June 2025 Update - An update against this recommendation action has not been provided on this occasion. March 2025 Update - Mat-Neo services in PoW has now re-opened - Will revisit this work, contact made with recruitment to meet in April 2025. December 2024, February 2025 - An update against this recommendation action has not been provided on these occasions. Update 11/09/2024 - Filming of staff has commenced, currently on hold due to pressures due to PoW temporary closure.
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	June 2025 Update - An update against this recommendation action has not been provided on this occasion. March 2025 Update - There have been challenges with attendance in Safe to Start meetings during the PoW temp closure due to the acuity and timing of the sessions which clash with handover and essential safety briefings in maternity. This will be revisited in a meeting arranged for 25th 2025, Senior on-call midwifery managers attend daily and weekend site escalation meetings. December 2024, February 2025 - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Datix reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	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)	June 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February, April 2025 - An update against this recommendation action has not been provided on these occasions. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	5. The health board must develop a policy in line with best practice guidelines that ensures the safety, privacy, dignity and rights of patients can be maintained throughout the mixed gender wards as well as keeping patients of the same gender safe in dormitories.	Healthcare Inspectorate Wales (HIW)/2024/235/MD5/2	The Health Board has developed a Single Sex accommodation policy. The draft version is currently going through the Health Board's ratification process.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Overdue	June 2025 Update - The Health Board has developed a Single Sex accommodation policy. The draft version is currently going through the Health Board's ratification process. Going to OMB next month for sign off. April 2025 Update - In progress, Estimated date for completion 30/04/2025 Added to tracker February 2025
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	7. The health board must develop a policy to provide guidance to staff regarding patients' use of electronic equipment, mobile phone devices and access to the internet.	Healthcare Inspectorate Wales (HIW)/2024/235/MD7/1	There is an all Wales Social Media Policy and a Health Board policy that supports use of mobile phones within hospital settings. Both policies are out of date. A request has been made to update the Health Boards policy.	Mental Health & Learning Disabilities	30.06.2025	30.06.2025	In progress	June 2025 Update - Unfortunately as it has passed its review by some time, there is now suggestion that this should be split into two separate policies one covering the technical and physical safety elements, the other on the use of devices for recovering capturing photos etc. This is being taken for discussion to Executive colleagues to agree this and who will lead it. This is being captured in our policy programme of work. April 2025 Update -In progress, Estimated date for completion 30/06/2025 Added to the tracker February 2025.
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	12. The health board must: • Provide an update in relation to the Section 136 process in terms of staffing and outcome of the review into a centralised Section 136 suite. • Provide assurance on what actions will be taken in the meantime to meet the guidance for standards of the Section 136 assessment facility and outline how individuals will be kept safe while under their care.	Healthcare Inspectorate Wales (HIW)/2024/235/MD12/1	Prior to the inspection, a capital bid had been approved for a centralised Section 136 suite within the RGH, and a specific ward had been allocated for this purpose. However, due to unforeseen circumstances at the Princess of Wales Hospital (POWH), many wards needed to be relocated, including the designated ward for the Section 136 suite. This work is part of a Health Board improvement plan and requires a substantial programme of repair. Until further notice, Section 136 assessments will be conducted within the mental health suites across the Health Board. At Coity Clinic, the Crisis Resolution Home Treatment Team (CRHT) now coordinate all Section 136 assessments. They are a dedicated team who specialise in crisis assessments to ensure continuity of care for patients during this time. This approach aligns with the process across the Health Board. The CRHT Operational Policy is being reviewed as part of the improvement work to align all 3 CRHTs.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Fully complete (Awaiting approval)	June 25 Update - The HB is now progressing plans to create a new purpose built Section 136 suite in POW. With the aid of capital planning colleagues the HB has engaged a Consultant Architect to initiate a feasibility study of areas we in and around Ward 14, POW. Action completed signed of at QSE. April 2025 Update -In progress. Estimated date for completion 30/04/2025 Added to tracker February 2025.
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13. The health board must: • Ensure all hospital areas are effectively cleaned. • Ensure patients on both wards have access to a working washing machine and tumble dryer. • Ensure staff have access to a working sink in the clinic room on Ward 14. • Strengthen the audit and oversight process to identify and action IPC issues. • Review the cleaning roles and responsibilities of nursing and domestic staff to ensure all areas of the wards are covered. • Update and review the Cleanliness Standard Roles, Responsibilities and Audit Tool Procedure policy and Housekeeping Standard Operating Procedure.	Healthcare Inspectorate Wales (HIW)/2024/235/MD13/3	The washing machine and tumble dryer will be replaced as part of the Capital scheme.	Mental Health & Learning Disabilities	31.08.2025	31.08.2025	In progress	June 2025 Update - Remains estimated date for completed 31/08/25 April 2025 Update - In progress. Estimated date for completion 31/08/2025 Added to tracker February 2025.
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	15. The health board must update the Medical Gas Cylinder policy, ensure that warning signs are displayed and review its current arrangements in terms of emergency equipment stock and oversight to ensure it is in line with guidance from the Resuscitation Council UK.	Healthcare Inspectorate Wales (HIW)/2024/235/MD15/3	The Medical Gas Cylinder policy has recently undergone a thorough review and refresh through the Medical Gases Advisory Group and is currently awaiting final sign-off stages this is expected to be completed by April 2025.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Fully complete (Awaiting approval)	June 2025 Update - Fully complete, evidence attached signed of QSE May 2025. April 2025 - In progress. Estimated date for completion 31/04/2025 Added to tracker February 2025
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	16. The health board must ensure the daily stock checks undertaken against the controlled drug logbook are recorded appropriately on Ward 14.	Healthcare Inspectorate Wales (HIW)/2024/235/MD16/1	The Health Board Control Drug (CD) policy is due for ratification which will align monitoring across all directorates.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Fully complete (Awaiting approval)	June 2025 Update - Fully complete, signed of at QSE in May 2025. April 25 -In progress. Estimated date for completion30/04/2025 Added to tracker February 2025

Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	18. The health board must review the seclusion arrangements in place on the PICU and make improvements to ensure they adhere to the health board policy and best practice standards.	Healthcare Inspectorate Wales (HIW)/2024/235/MD19/1	The National Association of PICUs (NAPICU) standards outline best practice standards and minimum requirements. The Directorate will review the seclusion arrangements against the NAPICU standards and bench mark against the current provision the directorate have, outline areas of improvement and share within the Care Group QSRE meeting	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Fully complete (Awaiting approval)	June 2025 Update - Fully complete. The National Association of PICUs (NAPICU) standards outline best practice standards and minimum requirements. The Directorate will review the seclusion arrangements against the NAPICU standards and bench mark against the current provision the directorate have, outline areas of improvement and share within the Care Group QSRE meeting in May 2025. April 2025 Update - In progress. Estimated date for completion 30/04/2025 Added to tracker February 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	1. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD1/1	Vents to be cleaned by estates team.	Mental Health & Learning Disabilities	01.05.2025	01.05.2025	Fully complete (Awaiting approval)	Added to tracker May 2025; this action is marked as Completed as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	1. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD1/2	A new estates reporting and monitoring system is currently being piloted, the roll out of this on all Older Adult Mental Health Inpatient wards will be completed by 30/04/2025. This reporting system will generate outstanding estate issues for escalation. This will feed into Quarterly Health and Safety Directorate meetings.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Partially complete (Overdue)	June 2025 Update - completed ,evidence attached, needs to go to QSE in July for sign off. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	2. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD2/1	Contractors have revisited the site since the inspection and agreed that floor needs to be completely replaced.	Mental Health & Learning Disabilities	30.06.2025	30.06.2025	Fully complete (Awaiting approval)	June 2025 Update - completed, evidence attached signed QSE May 2025. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	3. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD3/1	Plug socket replaced.	Mental Health & Learning Disabilities	01.05.2025	01.05.2025	Fully complete (Awaiting approval)	Added to tracker May 2025; this action is marked as Completed as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	4. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD4/1	Exposed wires to be covered as much as possible. Wires covered but there remains a small area of exposure which has been escalated to estates.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Fully complete (Awaiting approval)	June 2025 Update - fully completed, signed off May 2025 QS; awaiting upload of another piece(s) of evidence. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	5. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD5/1	Sharp edges in the corridor need to be fixed. The part remains on order.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Fully complete (Awaiting approval)	June 2025 Update - Fully completed signed off May 2025 QSE. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	6. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD6/1	Light to be fixed.	Mental Health & Learning Disabilities	01.05.2025	01.05.2025	Fully complete (Awaiting approval)	Added to tracker May 2025; this action is marked as Completed as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	7. The health board must address this environmental issue and resolve it in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2025/241/MD7/1	All doors to be lockable.	Mental Health & Learning Disabilities	01.05.2025	01.05.2025	Fully complete (Awaiting approval)	Added to tracker May 2025; this action is marked as Completed as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	8. The health board must ensure that the controlled drug cupboard is monitored and organised to ensure all drugs are properly accounted for and that presence of other medication and items that are not controlled drugs are not stored in controlled drug cupboard.	Healthcare Inspectorate Wales (HIW)/2025/241/MD8/1	Pharmacy to collect vial from Ward 7. Daily CD checks are now being completed to ensure monitoring of controlled drugs is in place Any issues will be reported through Quality, Safety, Risk, Experience (QSRE) meetings.	Mental Health & Learning Disabilities	01.05.2025	01.05.2025	Fully complete (Awaiting approval)	Added to tracker May 2025; this action is marked as Completed as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	9. The health board must ensure that a mental health pharmacist is allocated to the ward to support staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD9/1	Pharmacy provision to form part of the wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. The mitigation includes; Ysbyty Cwm Cynon pharmacy teams screen medication charts and supply medication to the wards and the Principle Pharmacist for Mental Health supports the ward on an adhoc basic with reviewing medication incidences.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	June 2025 Update - Pharmacy provision to form part of the wider strategic programme on Older Adult inpatient redesign work. Estimated 31/12/25. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	10. The health board must ensure that appropriate physical intervention training is provided to bank staff who work on the ward to ensure the safety of staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD10/1	Compliance to reach 85% or more by 31.03.2025. Evidence attached, training compliance at 92% in March. Bank staff have the responsibility of booking onto PMVA training themselves. As mitigation, staff ensure they roster a minimum of 3 staff per shift who are trained appropriately.	Mental Health & Learning Disabilities	01.05.2025	01.05.2025	Fully complete (Awaiting approval)	Added to tracker May 2025; this action is marked as Completed as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	11. The health board must ensure that a dietician is allocated to the ward to support staff and meet the needs of the patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD11/1	Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. Mitigation includes; all patients have a risk assessment which determines the level of risk. There is a scoring mechanism in place from 0-7+ based on nutritional risk. If the score is 7+ then the patient requires referral to Dietetic service. In this scenario the Advanced Nurse Practitioner (ANP) or Doctor also prescribe supplements, advise on diet plan and nursing staff would complete weekly weights.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	June 2025 Update - Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. Estimated 31/12/25. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	12. The health board must ensure that policies are reviewed to ensure they are current.	Healthcare Inspectorate Wales (HIW)/2025/241/MD12/1	The policies identified within the inspection that were; Mental Health policies • Management of violence and behaviours that challenge, no review date (this has been completed) Corporate / Health Board policies • Health and safety policy, review date August 2024 • Consent to examination or treatment, review May 2024 • Policy for safe support and supervision of patients, review date October 2018 • PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents, however, at appropriate intervals there will be engagement with the Assistant Medical Director Quality & Clinical Effectiveness, who leads on Clinical Written Control Documents to ensure consistency and flow. Project Objectives: 1. To establish a baseline compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. 4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents. To review the "Policy on Policies" and develop a simplified document supported with clear process maps.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	June 2025 Update - The policies identified within the inspection that were; Mental Health policies • Management of violence and behaviours that challenge, no review date (this has been completed) • Corporate / Health Board policies • Health and safety policy, review date August 2024 • Consent to examination or treatment, review May 2024 • Policy for safe support and supervision of patients, review date October 2018 • PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents estimated 31/12/25. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	13. The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HIW)/2025/241/MD13/1	It has been agreed that a priority for the Older Adult Mental Health Directorate is to complete a pan CTM inpatient redesign review which will scope a widespread multi-disciplinary establishment review.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	June 2025 Update - Estimated completion 31/12/25. Added to tracker May 2025
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	The employer must ensure that: •The ratification process for DRLs is robust and clearly outlined in the employer's procedure.	Healthcare Inspectorate Wales (HIW)/2025/261/MD1/1	Amend EP6 Schedule 2, 1 (f) Procedure for the use and review of diagnostic reference level and dose reference levels to ensure the ratification process for DRLs is robust.	Diagnostic, Therapies, Pharmacy and Specialities	22.05.2025	22.05.2025	Fully complete (Awaiting approval)	Added to tracker June 2025; this action is marked as Complete 22/05/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	The employer must ensure that: •The ratification process for DRLs is robust and clearly outlined in the employer's procedure.	Healthcare Inspectorate Wales (HIW)/2025/261/MD1/2	Amended EP to be shared with the chair of the Radiation Safety Committee for ratification prior to the next meeting (October 2025).	Diagnostic, Therapies, Pharmacy and Specialities	29.05.2025	29.05.2025	Fully complete (Awaiting approval)	Added to tracker June 2025; this action is marked as Complete 29/05/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/1	Current DRLs reviewed and cross referenced with Radiation Protection Service Cardiff's dose audit 1 December 2021 and 31 May 2022. No Local DRLs exceed National DRLs.	Diagnostic, Therapies, Pharmacy and Specialities	22.05.2025	22.05.2025	Fully complete (Awaiting approval)	Added to tracker June 2025; this action is marked as Complete 22/05/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/2	Current DRLs removed, National DRLs displayed until local DRLs ratified.	Diagnostic, Therapies, Pharmacy and Specialities	02.06.2025	02.06.2025	Fully complete (Awaiting approval)	Added to tracker June 2025; this action is marked as Complete 02/06/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/3	CTM DRL group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRLs. The DRL group will feed into CTM image optimisation team and radiation safety committee.	Diagnostic, Therapies, Pharmacy and Specialities	05.06.2025	05.06.2025	Partially complete (Overdue)	June 2025 Update (05/06/2025) - The inaugural meeting took place, and the terms of reference were agreed upon. 22/07/2025- The next meeting is scheduled to take place following the DRL audit conducted by RPS Cardiff.
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	If local DRLs exceed national DRLs, the decision is justified by the Employer and evidenced, with consideration for optimisation or further investigation.	Healthcare Inspectorate Wales (HIW)/2025/261/MD3/1	It is not expected that CTM;HB local DRLs will exceed national DRLs. However, EP6 Schedule 2, 1 (f) Procedure for the use and review of diagnostic reference level and dose reference levels has been amended to include that if local DRLs exceed national DRLs, the decision is justified and documented by the Head of Radiography and Medical Physics Expert, with evidence of consideration/completion of optimisation or further investigation.	Diagnostic, Therapies, Pharmacy and Specialities	29.05.2025	29.05.2025	Fully complete (Awaiting approval)	Added to tracker June 2025; this action is marked as Complete 29/05/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd July 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	Any changes to DRLs are communicated to staff and staff read and comply with the employer's procedure in relation to the use and review of DRLs.	Healthcare Inspectorate Wales (HIW)/2025/261/MD4/1	Following ratification, the updated DRLs and EP6 Schedule 2, 1 (f) Procedure for the use and review of diagnostic reference level and dose reference levels will be emailed to all staff. These will be made available on SharePoint. These will be discussed and confirmed in relevant modality user group, CTM Image Optimisation Team, Radiology Clinical Governance and Radiation Safety Committee. A read and sign confirmation will be sent to staff via Microsoft forms to provide evidence of receipt.	Diagnostic, Therapies, Pharmacy and Specialities	02.06.2025	02.06.2025	Partially complete (Overdue)	June 2025 Update (30/05/2025) - EPs and DRLs were ratified outside of committee by RPC chair. 02/06/2025 Electronic notification sent to all relevant staff Please see below a summary of the email sent on 2nd June 2025 to all relevant staff in PCH and RGH (attached for reference): Updated CT Diagnostic Reference Levels (DRLs) for both PCH and RGH have been made available. All previous versions of the DRLs will be removed with immediate effect. The EP6 documentation has been updated to include additional required information. Changes are highlighted in yellow in the attached document. The most up-to-date version is also available on SharePoint. All staff are required to acknowledge the update by completing the Read and Receipt form via Microsoft Forms.
Healthcare Inspectorate Wales (HIW)/2025/261	Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900)	Any changes to DRLs are communicated to staff and staff read and comply with the employer's procedure in relation to the use and review of DRLs.	Healthcare Inspectorate Wales (HIW)/2025/261/MD4/2	Compliance will continue to be monitored via the 'DRL Exceeded Logbook' audit	Diagnostic, Therapies, Pharmacy and Specialities	02.06.2025	02.06.2025	Partially complete (Overdue)	June 2025 Update (05/06/2025) - Audit from QA Superintendent radiographer stating No recorded exceeded LDRL for May 2025. 22/07/2025 - DRL group meeting to discuss themes and trends from audit reports.

Agenda Item	8.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 20 May 2025 at 9:00am
Venue	Virtually via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Dilys Jouvenat	Independent Member
	Patsy Roseblade	Independent Member
In Attendance	Greg Dix	Executive Director of Nursing/Deputy CEO
	Lauren Edwards	Executive Director of Allied Health Professionals & Health Sciences (In part)
	Philip Daniels	Executive Director of Public Health
	Hywel Daniel	Executive Director for People (In part)
	Dom Hurford	Executive Medical Director
	Gethin Hughes	Chief Operating Officer
	Richard Hughes	Deputy Director of Nursing
	Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
	Kim Dunn	Directorate Manager – Primary Care (In part)
	Owen Weeks	Medical Director - Unscheduled Care
	Debbie Jones	Head of Midwifery, Gynaecology, Integrated Sexual Health and Neonates
	Sharon O'Brien	Care Group Nurse Director – Planned Care
	Ana Llewellyn	Care Group Nurse Director – Mental Health & Learning Disabilities
	Lucie Owen	Care Group Nurse Director – Primary Care & Community
	Hannah Wilton	Chief Pharmacist
	Carl Verrecchia	Care Group Service Director – Children & Families
	Kelly Godwin-Francis	Lead Midwife for Women's Experience
	Becky Gammon	Assistant Director of Nursing

	Claire Taylor	Action Regional Director, Llais Cymru
	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business (Secretariat)
Meeting Observers	Rhiannon Dubberley	Graduate Trainee Manager

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	C Donoghue welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its 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 were received from: • Kath Palmer, Vice Chair. • Hayley Proctor, Independent Member • Suzanne Hardacre, Director of Midwifery • Gaynor Jones, Staff Side Representative
1.3	**Declarations of Interest**
	P Daniels declared that he was Chair of the Area Planning Board which was a dual role as opposed to a conflict of interest. Members noted that the Area Planning Board was referenced within the Clinical Executives report in regard to recommissioning of services.
2.	**CONSENT AGENDA BUSINESS**
2.1	C Donoghue advised that she felt that there were a couple of items within the consent agenda section that may require further discussion at a future meeting, which she would explore further with members towards the end of the meeting.
3.	**COMMITTEE GOVERNANCE ARRANGEMENTS**
3.1	**Action Log**
	The action log was received and noted. Members supported the actions proposed for closure.
3.2	**Matters Arising Not Captured on the Action Log**
	There were no matters arising.
3.3	**Committee Annual Report 2024-2025**
	C Donoghue presented Members with the Committee Annual Report for 2024/2025 and advised that this had been placed on the main agenda for greater visibility given that it had been identified within the Committee Annual Self Effectiveness survey that some Members/Attendees were not aware that an Annual Report was produced.

	P Roseblade requested that the date identified for N Milligan in regard to her tenure as a Committee Member was checked as it currently stated her tenure ended July 2025 when it should read July 2024.
Resolution:	The Annual Report for 2024/2025 was ENDORSED for Board Approval
Action:	Annual Report to be amended prior to Board approval to reflect that N Milligan's tenure as Committee Member ended in July 2024 as opposed to July 2025.
4.	**STAFF AND SERVICE USER EXPERIENCE**
4.1	**Shared Listening & Learning Story – Maternity Services**
	K. Godwin-Francis shared a presentation which outlined the care received by a Patient within Maternity Services C Donoghue extended her thanks to K Godwin-Francis for sharing the story and advised that she was pleased to see that the learning identified had been put into action. D Jouvenat sought clarity as to whether the Induction of Labour service referred to within the presentation was offered to every new mother or only offered to mother's who had experienced difficulties during birth. K Godwin-Francis advised that the service was offered to every family at numerous points during the stages of pregnancy and following birth. Members noted that families were also offered the option to self-refer into the service and noted that positive feedback had been received from families regarding the service and the care provided. D Hurford welcomed the presentation, and the lessons learnt that had been identified within it and sought clarity as to whether there was a policy in place that enables the baby to be brought into the theatre whilst the mother was being sutured. K Godwin-Francis confirmed that this had been included within the policy and added that babies were always welcomed into the theatre environment to limit the separation of families, and added in this particular case, suturing had been undertaken in the labour room as opposed to a theatre setting which caused a delay in the baby being given to the mother to hold. G Hughes also welcomed the presentation and noted the news that whilst 250 families had accessed this service, there were still a large number of families who were not getting support from other places and queried whether there were forums and avenues available where awareness of this service could be increased and shared. K Godwin-Francis advised that the team were exploring ways in which the service could be promoted and added that families who had used the service had been asked for their views on how they would like to be provided with updates and information on services moving forwards. Members noted that the team are encouraging Community Midwifes to raise awareness of the service with families during their first few visits. D Jones advised that the team were undertaking fantastic work with limited resource and added that a project was being undertaken in regard to reigniting antenatal education and improving the assertiveness of service users so that they feel confident enough to ask questions on their care. G Hughes advised that he would be happy to explore possible funding opportunities with the team

	so that they could take forward key pieces of work, for example, a request for charitable funds if appropriate. D Jones advised that she would be happy to provide an update to Committee Members at a future meeting on the work being undertaken by the team on how it was reaching the wider population via digital platforms. This was welcomed by the Committee. C Donoghue once again extended her thanks to K Godwin-Francis for presenting the story and to the patient for allowing their story to be shared. C Donoghue added that she was pleased to see the learning that had been identified and how this was now making a difference to empowering patients to speak up in clinical settings.
Resolution:	The Listening & Learning story was **NOTED.**
Action:	Update to be provided at a future meeting on the work being undertaken by the Team on how it was reaching the wider population via digital platforms.
4.2	**Executive and Independent Member Walkaround Framework**
	A Llewellyn presented members with the report and highlighted the key matters for Members attention. Members noted they were being asked to approve the revised framework. P Roseblade advised that she felt on the whole the document was a positive addition to this activity, and whilst she felt some of the suggested questions/prompts for Independent Members/Executive Directors to raise during visits could be perceived as negative, she reflected that there were also positive questions included which she found to be helpful. P Roseblade highlighted that there appeared to be no questions in relation to 'speaking up safely' and queried what would happen if a junior member of the team approached one of the senior members to express some concerns. P Roseblade also commented on the recommendation made regarding one walkround per quarter which she felt was too much, given that Independent Members already commit to more than their four allocated days per month and was also a significant commitment for the Executive Team and the organisation. A Llewellyn advised that in relation to the comment made by P Roseblade on the suggested prompt questions, that these were a guide to support discussions, however, a natural two-way conversation with staff is encouraged to gain their valuable feedback on working for the organisation and to try and amplify great practice. G Dix suggested that he reviews the proposed frequency alongside a wider review of the new process once one round of walkrounds had been completed. G Dix extended his thanks to A Llewellyn for leading on this work which had not been easy given the differing views expressed as to how walkrounds should be delivered. G Dix advised that general themes highlighted from the walkrounds would be presented to the Committee on a bi-annual basis. P Daniels advised Members that in addition to clinical sites, visits were also being undertaken to other areas, for example, Valleys Veterans, and as a

	consequence of a visit undertaken by himself and the Chair, an event had been organised with Valleys Veterans which would focus on smoking, mental health, vaccinations, plus other matters, which would enable the Health Board to engage with its population and meet the needs of groups who might not normally be included in the Health Board's decision making on a regular basis. P Daniels welcomed the report that had been produced by A Llewellyn and felt it was a fantastic way to engage with people. D Jouvenat made reference to the prompt questions and recognised that whilst some Independent Members welcomed the prompt questions, she would prefer to focus on a general topic area and added that she would not feel comfortable asking staff some questions, for example, had there been any incidents occurring recently. D Jouvenat added that she fully appreciated the significant work undertaken in pulling the proposal together. D Hurford advised that he felt it would be the role of the Executive Directors to ask the questions highlighted, even if the questions were asked after rather than during the walkround. D Hurford advised that whilst he recognised the desire for visits to be undertaken across all sites, he felt that there needed to be some degree in flexibility of approach. C Donoghue recognised that Independent Members would have different views and approaches to walkrounds and added that personally she felt the most benefit from having an informal chat with a patient or member of staff which tended to generate a rich conversation. C Donoghue advised that she thought this was a positive piece of work and added that having the evidence in place as to what works well was important.
Resolution:	The Committee **APPROVED** the revised Executive and Independent Member Walkaround Framework.
Action:	Review of proposed frequency of walk rounds to be undertaken alongside a wider review of the new process once one round of walk rounds had been completed.
5.	**SETTING THE SCENE – SERVICE DELIVERY**
5.1	**Spotlight Report Update on cluster of incidents within maternity services at the Princess of Wales Hospital (March – May 2025).** C Verrecchia presented the report and outlined the key matters for Members attention and the actions that had been taken following the incidents that had occurred. C Donoghue extended her thanks to C Verrecchia for presenting the report and added that the Committee would be looking for assurance on the actions taken and whether the investigations were highlighting any specific trends, which had been clearly outlined within the report. C Donoghue advised that it was clear from reading the report that a comprehensive review had been undertaken by the Team and that steps had been taken to address the immediate make safes and associated learning. C Donoghue recognised the impact to families and staff involved in the incidents.

	G Dix outlined the support provided to families following these incidents and added that the mothers and babies involved were either near full recovery or fully recovered. G Dix added that it was hoped that the external review of all cases would be completed by the end of June, with any next steps being dependent on the outcome of the reviews. D Jones advised that it was important to recognise that families had been fully supported following these incidents and also added that the workforce involved had been through a period of significant change during the last year, particularly in relation to the changes within the senior leadership structure, and added that every effort was being made to ensure the team was being supported, with support also in place from the Wellbeing Team. D Jones confirmed that the Team were progressing at pace with some of the actions identified. C Donoghue noted that this matter would be included within the alert/escalate section of the Highlight report and noted that a further update would be presented to the July meeting of the Committee.
Resolution:	The Report was **NOTED.**
Actions:	Further update on progress to be presented to the July meeting of the Committee.
5.2	**Report from the Clinical Executives**
	G. Dix and Clinical Executive colleagues presented the report and highlighted the key matters for Members attention. D Jouvenat asked for her thanks to be recorded for those staff who had either received awards or had been nominated to recognise their positive achievements. P Roseblade made reference to the recruitment of a new Nurse Director for Unscheduled Care and sought clarity as to whether the reappointment process began as soon as the previous post holder resigned or whether there was a gap, and if there was a gap, how this would be addressed. G Dix advised that given that the role was pivotal, a decision was made to use a recruitment agency which has lengthened the recruitment process. Members noted that interviews were planned for 16 July 2025 and that an interim plan had been put into place, with the professional nursing role being supported by the Nurse Director for Planned Care, with the Deputy Director of Nursing and Heads of Quality supporting the quality governance remit. G Dix added that recruitment would also be undertaken to appoint a Head of Quality Governance for the Care Group. P Roseblade made reference to revalidation and the achievement of 95.95% engagement with annual appraisals which was significant, and sought clarity as to the process for follow up where an annual appraisal had not been completed either as a one-off or repeatedly. D Hurford advised that there was a robust revalidation process in place supported by a Revalidation Team and added that for the staff who are still yet to complete an annual appraisal, they were given three months to catch up in regard to engaging in the process.

	Members noted that if staff continue to not engage, a General Medical Council notice is then served, which could result in them being removed from the register, which is an exceptionally rare circumstance. C Donoghue advised that she found the report to be helpful and succinct and welcomed the positive performance regarding revalidation and annual appraisals and welcomed the research efforts within the Allied Health Professionals section of the report. C Donoghue also recognised the awards and recognition achieved by staff.
Resolution:	The report was **NOTED.**
5.3.	**Care Group Highlight Reports** The Chair invited the Care Group Leads to present their respective reports, requesting them to focus on the areas highlighted in the alert/escalate section.
5.3.1	**Children & Families Care Group Highlight Report**
	C Verrecchia presented the report and highlighted the key matters for Members' attention. P Roseblade referred to special school nursing and sought clarity as to why there had been a request for investment in the highlight report when there are funded vacancies. G Dix added that there were two things driving this, the first being the acuity of children in special schools and the second being the Healthy Child Wales Part 2 Programme which places more pressure on Health in relation to provision of care delivery for children in specialist schools. Members noted that there is a sixth school that would be coming into the Health Board locality and noted that the Team were undertaking a demand and capacity exercise, recognising that the children within the special schools within the locality of the Health Board were of poorer health. P Roseblade advised that whilst she understood the update provided by G Dix, she felt that the report did not reflect the update provided in the meeting and suggested this is reflected more accurately in the next report.
Resolution:	The report was NOTED.
5.3.2	**Unscheduled Care Group Highlight Report**
	O Weeks presented the report and highlighted the key matters for Members attention which included a detailed update on Stroke Services. In response to a query raised by P Roseblade, O Weeks confirmed that Stroke Consultant interviews would be taking place in June and not January as stated within his earlier update. P Roseblade made reference to the unannounced internal ward assurance visits conducted on Wards 3 and 20 and queried if issues had been highlighted on these wards, how do we know that we have not got the same infection, prevention and control issues prevalent on other wards. G Dix advised that the Team undertake monthly Infection, Prevention & Control and environmental audits across all wards and departments across the Health Board, which would

	identify any particular issues and trends. Members noted that Ward Assurance visits also take place in ward areas where there are concerns regarding some of the quality indicators, with any issues identified being reported into the Infection, Prevention & Control Committee. In response to a further question raised by P Roseblade as to whether these audits should have picked up the issues on Wards 3 and 20, G Dix explained that the ward assurance audits had not picked up the issues regarding Infection Prevention and Control (IP&C) because the audits were part of a broader set of quality metrics. Members noted that while the IP&C audits alone did not indicate significant issues, when combined with other quality metrics, a fuller picture emerged. This comprehensive view, which included various aggregated quality metrics, highlighted the concerns on Ward 3 and Ward 20. C Donoghue highlighted the significant amount of learning identified in this report and concurred with the points raised by P Roseblade. G Dix further clarified that whilst the review had not picked up these issues, the Team had identified the issues and subsequently invited the Corporate Nursing Multi-Disciplinary Team in to undertake an inspection. C Donoghue thanked G Dix for this point of clarification. C Donoghue advised that she had undertaken a second visit to the Stroke Unit with H Daniel and it was evident that a significant amount of work had been undertaken, with a significant improvement in atmosphere, and recognised the efforts leading to the improvements that had been made. C Donoghue advised that she did feel concerned for the staff members on the unit who were the only permanent trained members of staff on duty in areas which are physically and mentally challenging and recognised that mechanisms had been put into place to support these staff. C Donoghue advised she felt that there was significant learning to be gained from the rapid move of this service.
Resolution:	The report was NOTED.
5.3.3	**Planned Care Group Highlight Report**
	S O Brien presented the report and highlighted the key matters for Members attention. D Jouvenat made reference to the update provided in the report in relation to lack of provision of Manual Handling and Violence & Aggression training and advised that as Chair of the Health, Safety & Fire Sub Committee, access to training was discussed regularly and it had been highlighted that there was a large number of 'Did Not Attends' being reported to the Sub Committee, which needed to be looked at and addressed. S O Brien advised she would be happy to discuss this further with Ward Managers and ask them to ensure that staff attended training, whilst recognising the day-to-day pressures in covering staffing gaps. C Donoghue recognised the fantastic achievement on the rapid establishment of the Vanguard theatre. She also recognised that the number of 'did not attends' at training sessions was an ongoing risk that needs to be considered

	further. C Donoghue suggested that this is clearly highlighted as an area of concern within the highlight report.
Resolution:	The report was NOTED.
Action:	Highlight report to reflect the concerns raised regarding the number of did not attends being reported into Health, Safety & Fire Safety Committee for Manual Handling and Violence & Aggression training.
5.3.4	**Mental Health & Learning Disabilities Care Group Highlight Report**
	A Llewellyn presented the report and highlighted the key matters for Members attention. C Donoghue extended her thanks to A Llewellyn for presenting the report and welcomed the update that the Team now had a Quality Dashboard in place.
Resolution:	The report was NOTED.
5.3.5	**Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report**
	H Wilton presented the report and highlighted the key matters for Members attention. C Donoghue referred to the Cellular Pathology space risk and queried whether this was a new issue. C Verrecchia advised that this had been an ongoing concern, exacerbated by the need to manage sample pathways effectively. Members noted that the challenge had been highlighted by the need to transport samples from Princess of Wales Hospital to Swansea Bay University Health Board (SBUHB), which has added complexity to the process. Members noted that the issue has become more pressing due to the disaggregation of the service level agreement with SBUHB and noted that internally, efforts had been made to find more space, particularly for sample preparation, however, additional space is required to handle the workload effectively. Members noted that the team is working on an options appraisal to address the space constraints and ensure the service can meet demand, which includes considering the necessary equipment and infrastructure to support the increased workload. G Hughes added that the Health Board was currently outsourcing a significant proportion of pathology activity at a premium cost and addressing the space issues would allow the Health Board to bring all of its pathology work back.
Resolution:	The report was NOTED.
5.3.6	**Primary & Community Care Group Highlight Report**
	L Owen presented the report and highlighted the key matters for Committee attention. Members noted that the main item for escalation was in relation to Dental Services and noted the separate report which had been prepared on this matter which was presented by K Dunn. C Donoghue welcomed the report on Dental Services and advised that this had been an area of concern for the Committee for some time. C Donoghue added that she had recently visited Community Dental Services where she was

	pleased to see the variety of approaches being taken to address the capacity and demand issues. P Roseblade advised that she found the report to be very informative and sought clarity on the next steps included in the report at section 5.2 which refers to where Community Dental should sit within the organisation. P Roseblade advised that the report reads as if there is a feeling that this should not sit within Primary Care and Community Services and queried how this was being addressed. L Owen advised that this was more around the ownership of the General Anaesthetic list, which is where Community Dental Services were experiencing difficulties given that it was difficult to put demand into the lists when they were not owned by the service. C Donoghue advised that historically, it had been difficult for dental services to get priority in regard to surgical lists and added that this had been an issue for some time and noted the commitment made by G Hughes that he would address the matter outside the meeting to identify and explore solutions with the relevant teams. C Donoghue advised that she found the paper helpful and added that Committee Members were mindful of the harm coming to patients and their families whilst waiting for treatment on a waiting list and potentially needing continuous medication. G Hughes made reference to the point made by K Dunn in her presentation relating to the opportunity to offer an alternative treatment to General Anaesthetic, and advised that the challenge he would put back to the service would be whether they were confident that the current pathways are correct and that only those that genuinely needed general anaesthetic were being listed. G Hughes advised he would discuss further with the Team outside the meeting.
Resolution:	The report was NOTED.
6.	**DELIVERING OUR PLAN**
6.1	**Patient Safety, Quality and Experience Dashboard**
	K Jenkins-Forrester presented the report and highlighted the key matters for Members attention. P Roseblade requested clarification on the patient falls incident data, specifically noting a discrepancy in the report, and pointed out that the report mentioned 27 incidents of moderate harm and one incident of severe harm but then stated that no incidents related to patient falls resulted in severe harm or catastrophic harm. K Jenkins-Forrester confirmed that this was an error and advised that the report should read that no incidents were reported as catastrophic or death during that time period.

	In response to a query raised by C Donoghue regarding the Failed Discharge Policy, K Jenkins-Forrester advised that she does not have a timescale for completion but would seek an update outside the meeting. C Donoghue noted that Nationally Reportable Incidents appeared to mainly relate to Maternity and Pressure Damage. In response to a query raised by C Donoghue regarding the paragraphs relating to closed Clinical Negligence Claims which she felt read the same, K Jenkins-Forrester clarified the difference between "triggered for settlement" and "closed claims." K Jenkins-Forrester explained that "triggered for settlement" refers to the point at which liability is admitted, and damages are offered, while "closed claims" refers to the final closure of the claim after all processes are completed. This distinction was made to ensure understanding of the stages involved in the legal process of settling and closing clinical negligence claims.
Resolution:	The report was **NOTED.**
Actions:	Update to be provided outside of meeting as to the timescale for completion of the development of the Failed Discharge Policy.
7.	**GOVERNANCE, RISK AND ASSURANCE**
7.1	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee**
	C Hamblyn presented the report and highlighted the key matters for Members attention. In response to a query raised by P Roseblade as to whether the air handling unit risk was the same unit that had been on and off the risk register for some time, H Wilton clarified that the risk mentioned pertains to the aseptic preparation unit at Royal Glamorgan Hospital, which was on the same circuit as the theatres. Members noted this risk is related to the upcoming Transforming Access to Medicines (TRAMS) project, with a business case expected to be presented to Board at the end of July.
Resolution:	The report was REVIEWED and CONSIDERED.
7.2	**Highlight Report from the Harm Free Care Agenda** R Hughes present the report and highlighted the key matters for Members attention. C Donoghue advised she found the report incredibly useful and emphasised the importance of identifying problems, accountability, and the impact of actions taken. C Donoghue advised she agreed with the questions posed at the end of the report, stating they were exactly what the Committee needed to see and highlighted the need for managing expectations regarding the impact of actions and maintaining a strategic focus. R Hughes provided assurance that the scrutiny and important questions related to the harm-free care agenda were being addressed through the Improving

	Care Board and added that Executive colleagues, had requested specific metrics around falls and pressure ulcers to better gauge information and identify hotspots for focused improvement efforts. G Dix advised that he was pleased to see this work now being taken forward, given that the Committee had previously raised concerns in relation to these quality metrics. In response to a query raised by C Donoghue, G Hughes confirmed that the Improving Care Board reported into the Executive Management Board. C Donoghue supported the idea of biannual reporting for the harm free care agenda into this Committee.
Resolution:	The report was NOTED.
7.3	**Annual Assurance Report on Compliance with the Nurse Staffing Level (Wales) Act** G Dix presented the report and highlighted the matters contained within the alert/escalate section of the report. C Donoghue recognised the significant amount of complex information included within the report and extended her thanks to the officers that had collated the information for inclusion within the report.
Resolution	The Committee NOTED the report.
8.	**CONSENT AGENDA**
	C Donoghue queried whether Members had any concerns surrounding the volume of items on the consent agenda and sought assurance as to whether they were receiving adequate scrutiny, with specific reference to the Continuing Healthcare (CHC) report as potentially requiring more detailed discussion. Whilst A Llewellyn advised that the (CHC) report had previously generated significant discussion and may warrant more scrutiny, P Roseblade advised that she felt that the balance in the CHC report had been achieved, which was an initial concern of the Committee and noted that the level of information was robust. Following discussion, it was agreed that further consideration would be given to this at agenda planning. R Hughes made reference to the Medical Gases Management Policy and confirmed that his concerns had now been addressed, and the policy had been updated to relfect the comments he had made.
8.1	**FOR APPROVAL**
8.1.1	**Unconfirmed Minutes of the meeting held on 25 March 2025** The Minutes were APPROVED

8.1.2	**Unconfirmed Minutes of the In Committee meeting held on 25 March 2025** The Minutes were APPROVED
8.1.3	**Ratification of Chairs Urgent action Medical Gases Management Policy** The Chairs Urgent Action was RATIFIED.
8.2	**FOR NOTING**
8.2.1	**Non-Routine Committee Business (Forward Plan)** The Committee NOTED the forward plan.
8.2.2	**Committee Annual Cycle of Business 2025** The Annual Cycle of Business was NOTED.
8.2.3	**Clinical Policies Highlight Report** The report was NOTED.
8.2.4	**Cancer Services Annual Report** The report was NOTED.
8.2.5	**Bi-Annual Report CTM Radiation Safety Committee** The report was NOTED.
8.2.6	**Antimicrobial Stewardship Report – May 2025** The report was NOTED.
8.2.7	**Outcome Report – Quality, Safety & Experience Committee Effectiveness Survey** The report was **NOTED**
8.2.8	**Healthcare Inspectorate Wales Improvement Plan Tracker Report** The report was NOTED
8.2.9	**Continuing Healthcare** The report was NOTED
8.2.10	**Infection, Prevention & Control** The report was NOTED.
8.2.11	**Health, Safety & Fire Sub Committee Highlight Report from the meeting held on 1 April 2025** The report was NOTED
8.2.12	**Joint Commissioning Committee Quality, Safety & Outcomes Sub Committee Highlight Report** The report was NOTED
9.	**CLOSE OUT BUSINESS**
9.1	**Committee Highlight Report to Board - Verbal** C Hamblyn provided an update on the items she had been capturing throughout the meeting and advised that she would share the draft report outside the meeting with Members for review and comment.
9.2	**Meeting Feedback** The Committee Chair advised that she would welcome feedback from colleagues outside the meeting. D Hurford advised that he felt that all of the items discussed at the meeting today had been appropriate and felt the balance of topics discussed was also appropriate.
9.3	**Any Other Business**

	There was no other business to report.
10.	**Private / Closed Session Business** The following items would be discussed at the In-Committee session immediately following the meeting: • Organisational Risk Register Held in closed session due to business sensitive risks included. • Controlled Drug Accountable Officer (CDAO) Report: April 2024 – March 2025 – Held in closed session due to business sensitive matters included within the report. • Update on cluster of incidents within maternity services at the Princess of Wales Hospital - Verbal update. Held in closed session as detail could include potentially idenfiable detail.
11.	**DATE AND TIME OF NEXT MEETING** The next meeting takes place on Tuesday 22 July 2025 at 9:00am as an in-person meeting at the Hub, Royal Glamorgan Hospital.

Agenda Item	8.1.2

Unapproved Minutes of the In Committee Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 20 May 2025 at 12:00pm
Venue	Virtually via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Patsy Roseblade	Independent Member
	Dilys Jouvenat	Independent Member
In attendance	Greg Dix	Executive Director of Nursing/Deputy CEO
	Lauren Edwards	Executive Director of Allied Health Professionals & Health Sciences
	Philip Daniels	Executive Director of Public Health
	Gethin Hughes	Chief Operating Officer
	Dom Hurford	Executive Medical Director
	Richard Hughes	Deputy Director of Nursing
	Carl Verrecchia	Care Group Service Director – Children & Families
	Debbie Jones	Head of Midwifery, Gynaecology, Integrated Sexual Health and Neonates
	Kelly Godwin-Francis	Lead Midwife for Women's Experience
	Hannah Wilton	Chief Pharmacist
	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business (Secretariat)

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**
	Apologies were received from: • Kath Palmer, Vice Chair; • Hayley Proctor, Independent Member • Suzanne Hardacre, Director of Midwifery
1.3	**Declarations of Interest**
	There were no interests declared.

2.	**MAIN AGENDA**
2.1	**Organisational Risk Register – CLOSED RISKS** C Hamblyn presented the report and highlighted the key matters for Members' attention. D Jouvenat drew attention to Risk ID 5691 "CCTV System Failure in Prince Charles Hospital and Princess of Wales Hospital captured in the Organisational Risk Register and queried the sentence '*Contractors need to be procured and appointed. The contractor has commenced the system install and it is anticipated that it will be completed in June 25*'. C Hamblyn agreed to provide a response outside the meeting to confirm the position.
Resolution:	The report was NOTED.
Action:	Response to be provided outside the meeting in relation to the query raised regarding approval of contractors.
2.2	**Controlled Drug Accountable Officer (CDAO) Report: April 2024 – March 2025** H Wilton presented the report and highlighted the key matters for Members attention. In response to a comment made by P Roseblade as to whether a workforce representative needed to sit on this group given that discussions were being held in relation to individual staff members, H Wilton clarified that the role of the group was to share anonymised intelligence, with separate discussions being held with Care Groups and workforce colleagues regarding detailed intelligence. H Wilton provided assurance to P Roseblade that it was her responsibility, as the accountable officer, to detect diversions, and added that issues identified across Health Boards were being shared more widely via the Controlled Drug Local Intelligence Network.
Resolution:	The report was NOTED
2.3	**Cluster of Maternity Incident at Princess of Wales Hospital** G Dix presented Members with a verbal update. Members noted the work being undertaken to strengthen leadership in this service, improve staff engagement and development a culture programme. Members welcomed the work being undertaken to address the position.
Resolution:	The update was NOTED.
3.	**ANY OTHER BUSINESS**
3.1	There was no other business discussed.
4.	**DATE AND TIME OF NEXT IN COMMITTEE SESSION - TO BE CONFIRMED**

Agenda Item
8.1.3

Quality, Safety & Experience Committee

Terms of Reference – Quality, Safety & Experience Committee

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

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**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Good Governance & Probity Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Health Board members and officers must be aware of the SOs and, where appropriate, should be familiar with their detailed content.

1.3 The Quality, Safety & Experience Committee Terms of Reference form schedule 3.5 of the Standing Orders and the purpose of the paper is to seek endorsement from Members regarding an amendment that needs to be made.

2. Specific Matters for Consideration

2.1 The Terms of Reference have been amended to reflect an update that has been made to the In Attendance section, in which the Assistant Director of Health, Safety & Fire has been added as an attendee. The Terms of Reference can be made available to Members on request.

3. Key Risks / Matters for Escalation

3.1 The Standing Orders will be further strengthened in year as and when required.

4. Assessment

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

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

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

5. Recommendation

5.1 The Committee are being asked to **ENDORSE** the amendment made to Terms of Reference as outlined in section 2 for Board Approval.

6. Next Steps

6.1 The Terms of Reference will be submitted to the September 2025 Public Board for final approval.

Agenda Item
8.1.4

Quality, Safety & Experience Committee

Highlight Report from the Health, Safety & Fire Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dilys Jouvenat, Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Approval

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

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its meeting on 5 June 2025.

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

2. Purpose of this Meeting

2.1 The purpose of this Sub-Committee is to:

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

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

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

Highlight Report

Alert / Escalate	There were no matters to escalate on this occasion.

Advise	• The **Outcome of the Sub Committee Self Assessment** was received. Members noted that a discussion would be held between the Executive Director for People and the Director of Corporate Governance in relation to the role and purpose of the Sub Committee; • The **Assistant Director of Health, Safety & Fire report** was received and discussed; • The **Fire Safety report** was received. Members noted that whilst issues continued to be encountered in relation to equipment blocking corridors, assurance was provided that steps were being taken to address the position, which included consideration being given to the introduction of a stock control co-ordinator to improve stock ordering and management, which would be piloted at Prince Charles Hospital in the first instance; • The **Overarching Care Group Health, Safety & Fire Highlight report** was received and noted; • The **Children & Families Care Group Health, Safety & Fire Highlight report** was received. A discussion was held on the need to address the ongoing issue of medical and dental staff not completing mandatory training and Members were provided with assurance that the Care Group had made significant progress in addressing compliance in this area, with matters being escalated to the Executive Medical Director as and when required; • The **Diagnostics, Therapies, Pharmacy & Sciences Care Group Health, Safety & Fire Highlight Report** was received and noted; • The **Facilities Health, Safety & Fire Highlight report** was received. Members noted the issues with car parking on the Royal Glamorgan site had recently improved and noted the constraints being experienced within Facilities in regard to staff being able to access ICT systems to complete statutory and mandatory training; • The **Estates – Ventilation System Compliance Report** was received. Members noted the significant recruitment challenges faced by the NHS in Wales, particularly for mechanical and electrical staff, which stem from a national shortage of 60,000 workers and the higher salaries being offered within the private sector; • The **Organisational Risk Register report** was received and noted both in public and private session;

Assure	• A **Listening & Learning story relating to Manual Handling** was received. Members noted the significant progress made in supporting bariatric patients effectively within the bariatric facility at Dewi Sant Hospital. Members acknowledged the congratulations extended to the Face Fit team for their achievements.
Inform	• The **Health, Safety & Fire Sub Committee Annual Report** was received and endorsed for Committee approval (appendix 1) • The Unconfirmed Minutes of the meeting held on 1 April 2025 were received and approved; • The Annual Cycle of Business was received and noted.
Appendices	•

3. Assessment

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

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

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

4. Recommendation

4.1 The Quality, Safety & Experience Committee is asked to **NOTE** the highlights outlined in section 3 of this report and **APPROVE** the Health, Safety & Fire Sub Committee Annual Report attached as appendix 1.

Appendix 1

Cwm Taf Morgannwg University Health Board

Annual Report 2024-2025

Health, Safety and Fire Sub Committee

Date:

June 2025

HEALTH, SAFETY & FIRE SUB COMMITTEE
ANNUAL REPORT 2024-2025

1. FOREWORD

As Chair of the Health, Safety and Fire Sub Committee, I am pleased to present our Annual Report for 2024-2025. This report highlights the significant progress and achievements we have made in ensuring the health, safety, and fire compliance within our organisation.

Over the past year, our Sub Committee has worked diligently to advise and assure the Board and the Quality, Safety & Experience Committee on the effectiveness of our health and safety arrangements.

The Sub Committee has met quarterly, providing robust scrutiny on behalf of the Quality & Safety Committee on all matters relating to health, safety, and fire 4. Our membership, comprising four independent members, has ensured that we provide thorough scrutiny and assurances to the Board.

As we move forward, we remain committed to enhancing our health, safety, and fire management practices. We will continue to collaborate closely with other Committees of the Board, particularly the Quality, Safety & Experience, to share risks and support each other's work

Dilys Jouvenat,
Chair of the Health, Safety & Fire Sub Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

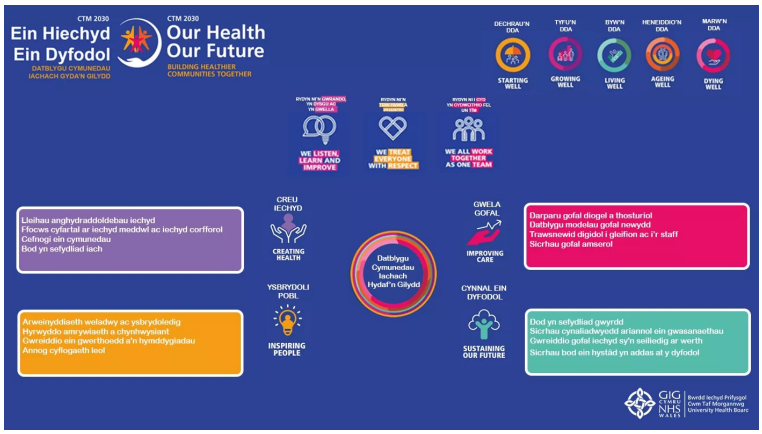
The purpose of the Health, Safety & Fire Sub Committee "the Sub Committee" is to:

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

- Encourage strong leadership in health, safety and fire, championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the sub-committee will advise the Board and the accountable officer on where and how its health, safety and fire management may be strengthened and developed further.

The Sub-Committee has embraced the new Strategic Goals in how it manages its agenda to ensure that its activity supports the **'CTM2030: Our Health, Our Future'** Strategy and the **Values and Behaviours** of the Health Board.



The Sub-Committee meets quarterly, with the key function to provide scrutiny on behalf of the Quality, Safety & Experience Committee on all matters relating to Health, Safety and Fire.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Sub-Committee is to support the Board through the Quality, Safety & Experience Committee with regard to its responsibilities for health, safety and fire:

- approve and monitor implementation of the annual health, safety and fire action

plan.

- review the comprehensiveness of assurances in meeting the Board and accountable officers' assurance needs across the whole of the health Board's activities, both clinical and non-clinical.
- the consideration of relevant CTMUHB policies for approval by the Quality, Safety & Experience Committee.

3.2 MEMBERSHIP

The membership of the Health, Safety & Fire Sub-Committee comprises of four independent members, enabling the Sub-Committee to provide robust scrutiny and assurances to the Board as appropriate through the Quality, Safety & Experience Committee.

A summary of the independent membership during 2024-2025 is outlined in table 1 below:

Table 1 – Composition & Membership of the Health, Safety & Fire Sub- Committee April 2024-March 2025

Name	Period
Members	
Dilys Jouvenat	April 2023 –
Geraint Hopkins	November 2023 -
Helen Lentle	March 2024 – January 2025
Carolyn Donoghue	September 2024 -
Hayley Proctor	January 2025 -
Nicola Milligan	April 2023 – June 2024

3.3 ATTENDANCE AT HEALTH, SAFETY & FIRE COMMITTEE 2024-2025

During the year, the Sub-Committee met on three occasions. All meetings held during 2024-2025 were quorate as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

	19th June 2024	5 September 2024	January 2025
Dilys Jouvenat	✓	✓	✓ (Chair)
Geraint Hopkins	✓	✓ (Chair)	✓
Helen Lentle	✓	X	
Carolyn Donoghue		✓ (Additional Attendee)	✓
Hayley Proctor			X
Nicola Milligan	✓		

3.4 ATTENDEES

The Sub-Committee's work is informed by reports provided by leads within CTMUHB, colleagues from these areas are invited to attend each meeting of the Health, Safety & Fire Sub-Committee. Invitations to attend the Sub-Committee meetings are also extended, where appropriate and on an 'ad-hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. HEALTH, SAFETY & FIRE SUB COMMITTEE BUSINESS

The Health, Safety & Fire Sub-Committee provides an essential element of the Health Board's overall assurance framework.

Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports.

All reports included on the Main Agenda were discussed during each meeting. The Health, Safety & Fire Sub Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2024/2025 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Health, Safety & Fire Sub-Committee are highlighted at the Quality, Safety & Experience Committee by the Sub-Committee Chair via a highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Sub-Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Sub-Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Sub-Committee and from the Sub-Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference;
- Committee Annual Report;
- Highlight Reports from the Sub-Committee to the Quality, Safety & Experience Committee meetings;
- Forward Work Programme.

The Corporate Governance Team maintain a "Committee Effectiveness Tracker" to ensure the above activity is undertaken at the appropriate times during the year.

7. ASSURANCE TO THE BOARD/QUALITY, SAFETY & EXPERIENCE COMMITTEE

The Health, Safety & Fire Sub Committee considers, that on the basis of the work completed by the Sub-Committee during 2024 - 2025, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2024-2025 and beyond ensures that the Sub Committee retains scrutiny on key areas of activity.

The Forward Work Programme has continued to be presented to each meeting of the Sub-Committee during 2024/2025. This supports and helps identify the key areas of focus for the Sub-Committee and is one of the key components in ensuring that the Sub-Committee is effectively carrying out its role. It also facilitates the management of agendas and Sub-Committee business.

8. LINKS WITH OTHER COMMITTEES

The Health, Safety & Fire Sub-Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Quality, Safety & Experience Committee and Audit & Risk Committee.

As a Sub Committee of the Quality, Safety & Experience Committee, regular highlight reports are presented to the Quality, Safety & Experience Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

APPENDIX 1

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda

During 2024 – 2025 the following items were received on the Consent Agenda for Approval/Endorsement:

- Unconfirmed minutes;
- Sub Committee Terms of Reference.
- Sub committee Annual Report

During 2024-2025 the following items were received on the Consent Agenda for Noting/Information

- Forward Work Programme.

3. Main Agenda

During 2024-2025 the following items were received on the Main Agenda:

- Action Log & Matters Arising not Contained within the Action Log
- Shared Listening & Learning Story – Violence & Aggression
- Assistant Director of Health, Safety & Fire Report
- Health, Safety & Fire Performance Report
- Fire Safety Report
- Estate Safety & Compliance Reports
  - Low Voltage Electrical system compliance
  - Annual Report High Voltage Electricity
  - Annual Report Medical Gasses
- Organisational Risk Register
- Overarching Care Group Health, Safety & Fire Highlight Reports
  - Planned Care & Unscheduled Care Health, Safety & Fire Reports
  - Children & Families and Diagnostics Therapies, Pharmacy and Sciences Health, Safety & Fire Reports
  - Primary Care & Community Group and Mental Health & Learning Disabilities Care Group, Health Safety & Fire Report

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

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

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

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
16 May 2024	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	20 May 2025 – **Now 22 July 2025**	**In progress** Was due to be presented to the May 2025 meeting of the Committee. This will now be presented to the meeting taking place on the 22 July 2025
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 **late 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** Consideration being given to governance reporting routes for RADAR. In this respect this item may be removed from to forward plan for Quality, Safety & Experience Committee
18 February 2025	Committee referral made by the Audit, Risk & Assurance Committee at its meeting on 13 February 2025	Executive Medical Director	Details of the medical negligence claims from the losses and special payments report	A detailed discussion required on the reasons for the increases in medical negligence claims with the appropriate execs all being present to answer questions and provide assurance to the committee.	Assistant Director of Quality & Safety	Executive Director of Nursing	20 May 2025 – **Now 22 July 2025**	**In progress** Was due to be presented to the May 2025 meeting of the Committee. This will now be presented to the July meeting.
11 March 2025	Request made by an Independent Member at the January 2025 QSEC for this report to added to future meeting agenda's	Executive Director of Nursing	WAST Produced Quality Report	USC Care Group to provide a report on the joint working with WAST looking at the People's Experience and Quality of care as this is work that is	USC Care Group Nurse Director	Executive Director of Nursing	20 May 2025 22 July 2025 **Now November 2025**	**In progress** Agreed that this agenda item is put on hold until the new USC DoN is appointed. Agreed that

				undertaken jointly with the central team and sits within USC portfolio.				this item will be deferred until July QSEC with any urgent issues being provided through the USC Care Group highlight report; Matter will be kept under review regarding frequency of reporting and the report requirements will be made to allow for regular updates to be provided by the Care Group in respect of the joint working with WAST looking at the People's Experience and Quality of Care **Update as at July 2025 - the Care Group Nurse Director unlikely to be in post until October 2025. Discussion to be held at next agenda planning session as to whether this should be scheduled in for a discussion at the November 2025 meeting.**
10 April 2025	Request made at the agenda planning session held on 10 April 2025	Committee Chair	Stroke Services Progress Report	Stroke Services report to be presented to the July meeting of the Committee	Executive Director of Allied Health Professionals & Healthcare Sciences	Allied Health Professionals & Healthcare Sciences	22 July 2025	**In progress** Report on agenda for discussion at the July meeting
Completed Items								
	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	**Completed** The summary of the Annual Quality Work Plan will be provided in the forthcoming July Quality and Safety Executive (QSE) meeting. The objective is to align this component with the forthcoming Duty of Quality Annual Report. Additionally, the Quality Strategy is scheduled for revision during the current financial year,

								and efforts will be made to ensure that the reporting for Duty of Quality is integrated with the Quality Strategy, facilitating ongoing reporting and assurance.
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	Assistant Head of Assets Governance and Technical Services	Executive Director of Finance	19 November 2024	**Completed** All policies now approved by the Committee
21 January 2025	Item identified as future report at the meeting held on 21 January 2025	Primary Care & Community Care Group Nurse Director	Progress report on Dental Services	To be presented to the Committee for information and awareness	Primary Care & Community Care Group Nurse Director	Chief Operating Officer	20 May 2025	**Completed** Report received and discussed at the May meeting of the Committee

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					✓ Defer to Sept 25				✓				X	✓

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Staff and Service User Experience																
8. Shared Listening & Learning Story	Executive Director of Nursing / Deputy CEO	All Regular Meetings													X	
9. Outcome reports - Executive and Independent Member Patient Safety Walkabouts	Executive Director of Nursing / Deputy CEO	Twice per annum.			To be deferred to the May meeting											
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/Care Group Medical 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 – it has been agreed that updates on Stroke Services can now be included in the Unscheduled Care Group Highlight Report moving forwards with no separate report required)*	Executive Director of Therapies & Health Science / Chief Operating Officer	Twice per annum													X	
Governance, Risk and Assurance																
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	**(consent)**		**(consent)**		**(consent)**		**(main)**		**(consent)**		**(main)**			**(to be added to the main agenda on a 6 monthly basis)**

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Governance, Risk and Assurance Contd.																
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. (to be placed on main agenda for 2026)	Executive Nurse Director / Deputy Chief Executive	Annually			To be deferred to the May meeting										X	
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													X	
22. Putting Things Right Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually							Defer to Sept							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					Defer to July									

29. Cancer Services Annual Report	Executive Medical Director	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.																
30. RADAR Committee Highlight Annual Report	Executive Medical Director	Annually plus exception reporting			Removed from the March agenda whilst reporting arrangements are being finalised											X
31. Clinical Audit Quarterly Report	Executive Medical Director	Quarterly														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			To be deferred to the May meeting											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
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					Defer to July 25									X
41. Organ Donation Sub Committee Highlight Reports	Executive Medical Director	All meetings following a Sub Committee					Defer to July 25								Unless there is an area for escalation	X

42. Organ Donation Sub Committee Annual Committee Report	Executive Medical Director	Annually					Defer to July 25		Defer to Sept 25							X
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**
Governance, Risk and Assurance Contd.																
43. 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														
45. Harm Free Care Update	Executive Director of Nursing	Twice Per Annum													**X**	
46. Annual Duty of Quality Report	Executive Director of Nursing	Annually					Defer to July								**X**	
47. Research & Development, Innovation & Improvement	Executive Director of Nursing	Bi Annually													**X**	
48. People Experience Forum Update	Executive Director of Nursing	Bi Annually													**X**	

Agenda Item
8.2.3

Quality, Safety & Experience Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME QUARTER 1 UPDATE 2025-2026

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit & Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
NMTR	National Major Trauma Registry
CA&QI	Clinical Audit & Quality Informatics Department
NEIAA	National Early Inflammatory Arthritis Audit
SWTN	South Wales Trauma Network
PWH	Princess of Wales Hospital

PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
AMaT	Audit Management and Tracking
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NICE	National Institute for Health and Care Excellence
HQIP	Healthcare Quality Improvement Partnership
WG	Welsh Government
NCA&ORP	National Clinical Audit and Outcome Review Plan
CEC	Clinical Effectiveness Committee
LFER	Learning From Events Reports
BI	Business Intelligence
NAIF	National Audit of Inpatient Falls
NHFD	National Hip Fracture Database
NJR	National Joint Registry
HTW	Health Technology Wales
DVT	Deep Vein Thrombosis

1. Situation /Background

1.1 The purpose of this report is to provide an update for the Quality, Safety & Experience Committee on progress against the CTMUHB Clinical Audit Forward Plan 2025-2026. The CTMUHB plan based on information from the HQIP directory of United Kingdom wide agreed audits and reviewed against the NCA&ORP for Wales (2025/26) published 17 June 2025.

1.2 **39** out of 41 national audits (tier 1) are green fully compliant and 2 amber (NMTR / TARN and NEIAA (PWH) where the audits are delayed, a backlog exists work is ongoing to partially or fully comply with the national audit deadlines.

1.3 CEC meetings have taken place for Falls, Frailty & Orthopaedics / Trauma, and Children and Young People. The main purpose of the CEC is to use national audit data to monitor quality of care across CTMUHB using evidence-based approaches.

1.4 The AMaT system continues to be extensively used across CTMUHB with significant work being undertaken to develop BI dashboards based on a number of ward audits routinely undertaken for medicines management, falls and pressure ulcer monitoring.

2. Specific Matters for Consideration

2.1 NCA&ORP for Wales (2025/26)

The CTMUHB Clinical Audit Forward Plan 2025-2026, released in March 2025 has been reviewed to ensure alignment with the NCA&ORP for Wales (2025/26) published on the 17 June 2025. The following amendments have been made:

- Removal of the proposed COPD Primary Care (Wales) audit
- Removal of the following Clinical Outcome Reviews:
  - Rehabilitation after critical illness
  - Blood Sodium
  - Acute Limb Ischaemia
- Addition of the following Clinical Outcome Reviews:
  - Emergency Surgical Procedures

2.2 Clinical Audit Forward Plan 2025-2026 Current Position

Two audits have been highlighted as amber:

NEIAA due to clinical pressures and limited administration resources to support the service in the PWH. This resulted in case ascertainment falling below the minimum requirement for the 2024/25, work is ongoing to improve compliance for 2025/26.

TARN / NMTR new data collection platform is now in place and has extensively used, but there is a backlog for 2024/25 cases. However, agreement has been sought from the SWTN for CTMUHB to focus data input for quarter 1 2025/26, to enable the provision of information for the newly established Trauma Centre at the RGH.

2.3 Clinical Effectiveness Committee findings and actions

The Falls, Frailty & Orthopaedics / Trauma CEC meetings was held on the 1 April 2025. This included a review of findings from the following national audits:

NAIF

Successes:

1. Newly established Falls Prevention Steering Group, with specific task and finish groups to target priorities (training and education, patient safety and lifting equipment.
2. Falls collaborative (with Improvement CTMUHB), ward-based audit and improvement activity, dashboard development to review falls activity and share learning.
3. New CTMUHB Inpatient Falls policy.

Challenges:

1. Improved data completeness of multi-factorial risk assessments (Lying, Standing Blood Pressure, vision assessments, delirium assessments)

Improvement actions:

1. Work with QI team to expand use of Falls audit that includes BP monitoring

NHFD

Findings (Position at 6 June 2025):

KPI	Description	PWH	PCH	RGH	NHFD Average
0	Admitted to specialist ward - With nerve-block within 4 hours	31%	35%	10%	**9%**
1	Prompt orthogeriatric assessment - Assessed by a senior geriatrician (ST3+) within 72 hours of presentation	48%	0%	0%	**89%**
2	Prompt surgery - Surgery by the day following presentation with hip fracture	82%	70%	55%	**58%**
3	Prompt surgery - Surgery by the day following presentation with hip fracture	57%	53%	66%	**71%**
4	Prompt Mobilisation after surgery - Mobilised out of bed (standing or hoisted) by the day after operation	77%	63%	57%	**82%**
5	Not delirious when tested - Not delirious (<4 on 4AT test) when tested in the week after operation	80%	0%	1%	**67%**
6	Return to original residence - Discharged back to original residence, or in that residence at 120 day follow-up	74%	70%	67%	**74%**
7	Return to original residence - Discharged back to original residence, or in that residence at 120 day follow-up	51%	1%	15%	**54%**

Challenges:

1. Requirement for orthogeriatricians in PCH and RGH
2. Limited theatre and ward space in RGH due to transfer of activity and wards from PWH

3. Combined PWH and RGH activity being undertaken in RGH
4. There is no lead for POW as Trauma service including NOF transferred to RGH in October 2024

Improvement actions:

1. Funding for Orthogeriatricians and recruitment. Business case developed with CTMUHB planning team.
2. Running all day trauma list six days a week and most bank holidays. This has improved efficiency in getting patients to theatre quickly.
3. Change from use of uncemented hemiarthroplasties for hip fractures to a cemented version, as per NICE recommendations.
4. Maintain a dedicated hip fracture bed on our orthopaedic ward. Once a hip fracture is diagnosed the patient can be 'fast tracked' to a bed on the orthopaedic ward.

NJR

Successes:

5. MDT meeting established for complex primaries and revision arthroplasty
6. Standardisation of antibiotic and DVT prophylaxis
7. Standardisation of physiotherapy protocol

Challenges:

2. Need to improve patient consenting to share data for NJR
3. Lack of ring-fenced beds

Improvement actions:

8. Consent to share data for NJR to be included in trauma booklets and undertake a review of process for patients unable to give consent (Consent form 4 process). To be discussed in directorate governance meeting
9. Plan to re-start arthroplasty procedures with ring-fenced beds

The outcome of the Children and Young People CEC meeting held on the 24 June 2025 will be included in the September 2025 quarterly report.

The forward plan of themed CEC meetings includes the following 4 themed meetings:

September

Respiratory and Diabetes

October

Cancer and Cardiology

2.4 Clinical Audit Training

To date over 749 Health Board staff have received training on the ward and area module.

2.5 AMaT Implementation

A number of BI dashboards have been released this quarter based on AMaT ward and area audit data to support data analysis for improvement for medicines management, falls and outreach services.

2.6 NICE Compliance Programme of work

HTW is a national body working to improve the quality of care in Wales. They assess non-medicine health and social care technologies and models of care and support, and issue independent, authoritative guidance based on the best available evidence and expertise.

In quarter 1, 2025/26 CTMUHB participated in an annual review of HTW adoption audits reviewing 9 pieces of guidance to note their applicability or not for CTMUHB population. The results were as follows:

- Multi-grip myoelectric upper-limb prosthetics **(not applicable).** Cardiff and Vale provide prosthetic services
- Photobiomodulation for the prevention and treatment of oral mucositis associated with cancer treatment **(applicable).** Evidence / guidance from HTW was not to adopt the technology.
- Wearable cardioverter defibrillators for people at risk of cardiac death **(not applicable).** Device extraction undertaken at tertiary centres only currently. Use of this equipment would be driven and on direction of tertiary centres.
- Myopia-control contact lenses and spectacles to slow the progression of myopia in children and adolescents **(applicable).** Not available on the NHS at present. Patients are not referred elsewhere for it but they are informed about it.
- Solution-focused assessment tools for improving the treatment of people with severe mental illness within secondary mental health services **(applicable).** This technology is in routine use in one team, but is not used with most of the patients who would meet criteria for involvement.
- Percutaneous implantation of pulmonary artery pressure sensors for monitoring treatment of chronic heart failure **(not applicable).** From discussion with clinical leads at all 3 sites implanted PAP sensors are not being used currently at CTM.
- Artificial intelligence (AI)-derived software to help clinical decision making in stroke **(applicable).** e-stroke commissioned for use within CTMUHB.
- UrgoStart for treating diabetic foot ulcers and leg ulcers **(applicable).**

- KardiaMobile for detecting atrial fibrillation **(applicable).** PWH was involved in research study ('Rehearse-AF').

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB is the responsibility of the care groups.

3. Key Risks / Matters for Escalation

No key risks or concerns to note for quarter 1, 2025/26.

4. Assessment

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

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

5. Recommendation

5.1 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB.

6. Next Steps

6.1 To ensure completion of the full CTMUHB Clinical Audit Forward Plan 2025-2026, by the end of March 2026.

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	22/07/2025
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	26/06/2025	Approved

Acronyms / Glossary of Terms	
HTA	Human Tissue Act
DI	Designated Individual
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
DTPS	Diagnostics, Therapies, Pharmacy & Specialities

1. Situation /Background

1.1 The Health Board is licensed by the HTAuth through compliance inspections which are undertaken every three years or unannounced inspections as required.
1.2 No inspections by the HTAuth have been undertaken since last reporting to the Quality, Safety & Experience Committee in January 2025.
1.3 This report presents an updated status since January 2025.

2. Specific Matters for Consideration

Quality Control

2.1 The Quality Control Department within Pathology conduct a cyclic audit programme around the specific standards within the HTAuth Codes, predominantly items regarding consent, tissue traceability, governance, quality control, protection, environment and facilities.
2.2 This quality system is augmented through 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 and this continues into 2025.
2.4 The quality assurance of security arrangements is supported through monthly CCTV audit of Mortuary Departments and unauthorised swipe card attempts out of hours.
2.5 All non-conformance is followed up by the Quality Department and DI.
2.6 There are currently no significant shortfall in standards to report from the three HTA licensed Mortuary Departments.

Legal Compliance

2.7 The Health Board is 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 potentially in mid-2025.
2.8 The DI has put in place a number of continual actions to ensure the service maintains its compliance including on-going audit, local inspections, incident analysis and *Deep Dive* exercises.
2.9 The DI reports quarterly to the HTA Board in terms of compliance and this serves to ensure robust 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).
2.10 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 upon their arrival.

2.11 The Medical Examiner (Wales) Regulations came into force on 9th September 2024. From that date all deaths in England and Wales are reviewed, without exception, either by a medical examiner or a coroner.

2.12 The introduction of the new Medical Examiner service initially led to an adverse impact upon the time of death to Death Certification resulting in an increase in the length of stay within the Mortuary for the deceased.

2.13 This resulted in increased pressure upon Mortuary capacity over an already busy winter period.

2.14 Over the last few months there has been steady progress in reducing the time period for Death Certification, led by senior clinicians with input from the Executive Medical Director.

2.15 The current length of stay is now approaching accepted norms and the capacity of the three Mortuary Departments is improving. However, the Pathology Directorate assess the service capacity will remain fragile over the forthcoming winter period without further investment.

2.16 A new satellite Post Mortem HTA Licence was granted for the Princess of Wales Hospital Mortuary Department by the HTAuth to assist Cardiff an Vale University Health Board in their Forensic Post Mortem activity whilst refurbishment work is undertaken at their Mortuary Department.

2.17 This arrangement has now ceased and has been repatriated to Cardiff and Vale University Health Board.

2.18 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.

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

2.20 This arrangement continues and supports capacity over long Bank Holiday periods between winter periods.

Incident Analysis

2.21 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 from April 2023 to March 2025 (Appendix 1).

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

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

2.24 Since the last progress report there have been no HTARI or near-miss HTARI reports.

2.25 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.

2.26 In relation to type of incidents the leading two categories are reports regarding the adult deceased, followed by PLRs.

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

2.28 On-going training, feedback and awareness raising by the DI and Mortuary Manager continues to ensure lessons are learnt and implemented from the analysis of reported HTA related incidents.

Welsh Government Guidelines for Community Body Stores

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

2.30 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 into Mortuary services was recommended by the Welsh Government for all Health Boards.

2.31 Both YCC and YCR do not require a HTA Licence as there is no scheduled activity as defined by the HTA (2004), however it is important that these body stores are maintained to a high standard.

2.32 To ensure high standards at these community hospital body stores a plan is in place via a Memorandum of Understanding between Pathology, Facilities, Nursing and Hospital Management.

2.33 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 that the recommendations are met.

2.34 It is proposed that 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.

2.35 **At present the Memorandum of Understanding remains outstanding as a decision from Corporate Nursing has been awaiting since June 2024 regarding the involvement of Health Care Support Workers 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 an urgent 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 Health Care Support Workers 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** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: 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**	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate):	If no, please include rationale below:

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	NEUTRAL	
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 Health Care Support Workers for safe deceased person release to Funeral Directors.

APPENDIX 1

Table 1: HTAct Related Datix incidents reported from April 2023 to March 2025 by Incident Type and Hospital site (n = 58)

		PLR	Deceased	Equipment	Security	PCH	RGH	POW	Other	TOTAL	HTARI	Near-Miss
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
	Q4	4	2	0	0	4	2	0	0	6	0	0
		25	**30**	**1**	**2**	**25**	**13**	**18**	**2**	**58**	**1**	**5**

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
8.2.5

Quality, Safety & Experience Committee

Highlight Report from the Organ Donation Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Corinna McNeil & Victoria Hughes, Specialist Nurses Organ Donation David Deekollu, AMD (Q & S)
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
SNOD	Specialist Nurse Organ Donation

CLOD	Clinical Lead Organ Donation
NHSBT	NHS Blood & Transplant
WTE	Whole Time Equivalent
SIGNET	Statins for Improving Organ outcome in Transplantation

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety and Experience Committee with details of the key issues considered by the Organ Donation Sub Committee at its last meeting.

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

2. Purpose of this Meeting

2.1 The purpose of the Organ Donation Sub Committee is to influence policy and practice to ensure that Organ Donation is considered in all appropriate situations, and to identify and resolve any obstacles to this.

2.2 The Organ Donation Sub Committee will:
Ensure that a discussion about organ donation features in all end of life care, wherever located and whenever appropriate, recognising and respecting the wishes of the individuals.
Maximise the overall number of organs donated, through better support to potential donors and their families. (From Terms of Reference).

3. Highlight Report

Alert / Escalate	• No red alerts but please note 'Advise' section
Advise	• Our Health Board has relatively lower numbers of Organ Donor Registrations in the UK. Opt-in Registrations help to reduce the uncertainties and improve the rates of consent. Our health board is asked to promote the visibility of NHSBT Organ Donor Register to our population. One idea is to Link any patient facing digital solutions with the NHSBT Organ Donor Register to provide an opportunity for public to register their decisions when engaging with the Health Board. • Programme Director at PCH and Head of CTM Charity and income generation have supported the Donor Recognition

	Artwork to be installed at PCH in August. The artwork will feature a QR code and web address for members of the public in the Out-Patients Department to register their organ donation decision. NHSBT would support/part-fund opportunities like this across each acute site within the HB but will require project management support. • CTM Comms team are supporting to create a digital package of local donor stories, recipient stories and organ donation key messaging that can be shared across platforms within the HB and into the communities we serve. Innovative strategies are required to enhance public awareness, engagement and educational activities related to organ donation
Assure	• CTM UHB has a well-attended Organ Donation Committee (ODC), which has representation from all relevant internal and external stakeholders, including patient and family representatives. The ODC is the forum in which Health Board performance is reported, missed opportunities discussed, a communication strategy developed, and education sessions are planned. • NHSBT Data from the year 2024- 25; Our Health Board referred 88 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate). When compared to national data, our Health Board was in line with the national average for Specialist Nurse presence when approaching families to discuss organ donation • CTM Comms Team continue to support the Organ Donation service with community engagement opportunities and outreach into local 3rd sector businesses. Our Comms team are aiming to create a digital package of local donor stories, recipient stories and organ donation key messaging that can be shared across platforms within the HB and in to the communities we serve. • A continued effort by clinicians, clinical staff and support workers to ensure that organ and tissue donation is a positive end of life opportunity that is offered to families of anyone meeting donation criteria. Early recognition of potential donors aids SNOD workforce planning to ensure that we are present to assess donation potential before offering it to a family, and being present for conversations to ensure families give informed consent/decline.

	• CTM and South Wales Regional ODC Chair and CTM COO have kindly lobbied for additional hours for the CTM SNOD workforce in November 2024. Recognising that operating at a 1.8FTE was having a detrimental impact on our hospital engagement, embedded time and ability to provide oversight of services and education across 3 acute hospitals. In April 2025 this was actioned and the CTM SNOD workforce now consists of 2 full-time SNODs.
Inform	• NHSBT is currently in the interview phase of appointing a CLOD for the Princess of Wales hospital, improving equity and consistency in organ donation activity across all 3 sites. Current CLODs in PCH and RGH continue in their roles. • Due to on-call SNOD requirements (1 shift in 4) and an incredible year across South Wales in 2024-25 where donation activity has been consistently high (as a region we were over target for proceeding organ donors), SNOD embedded time within HBs has suffered across the region. Felt more within HBs that operate across multiple sites like CTMUHB. In order to maintain donation education, awareness and early recognition of potential donors, Link Nurses have been appointed and trained by embedded SNODs to champion donation within their ICUs. Further development of this role into Emergency Departments and Theatres relies on SNOD workforce capacity but is a vision for the future and will require expressions of interest and support from those Departments. • Organ Donation policies on our HB intranet are currently being reviewed and updated
Appendices	

4. Assessment

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

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A 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))*	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**	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	
Cyfreithiol / Legal	Yes (Include further detail below)	
	All practices are performed in-line with the Human Tissue Act and Welsh "Deemed Consent" law.	
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 is asked to **NOTE** the highlights outlined in section 3 of this report.

Duty of Candour
Final Internal Audit Report

March 2025

Cwm Taf Morgannwg University Health Board

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Review reference:	CTMUHB-2324-10
Report status:	Final
Fieldwork commencement:	July 2024
Fieldwork completion:	January 2025
Debrief meeting:	January 2025
Draft report issued:	January 2025
Management response received:	March 2025
Final report issued:	March 2025
Auditors:	John Cundy, Lead Auditor Emma Samways, Deputy Head of Internal Audit Paul Dalton, Head of Internal Audit
Executive sign-off:	Greg Dix, Executive Director of Nursing, Midwifery & Patient Care
Distribution:	Kellie Jenkins-Forrester, Head of Concerns and Business Intelligence
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Risk Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cwm Taf Morgannwg University Health Board. Work performed by internal audit should not be relied upon to identify all

strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

Our review considered the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.

Overview

We have issued reasonable assurance on this area.

Our key finding relates to the need for Datix to be fully completed and completed with a consistent approach. To aid this, guidance needs to be in place and available to staff.

More accurate data captured will lead to better monitoring in relation to compliance with the Duty.

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Process and procedures	Reasonable
2	Training and support	Reasonable
3	Operation and compliance	Limited
4	Monitoring and reporting	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Amendments to the assessment of level of harm	3	Operation	Medium
3	Completion of Datix records	1,2 & 3	Operation	High
4	Following the Duty of Candour process	3	Operation	Medium
6	Accuracy of monitoring data	4	Operation	Medium

1. Introduction

1.1 Our audit review in relation to the Duty of Candour arrangements was completed in line with the 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Duty of Candour legislation was introduced in April 2023 as part of the Health & Social Care (Quality and Engagement) (Wales) Act 2020 along with the Duty of Quality.

1.3 Duty of Candour (the 'Duty') means that NHS organisations have a duty to be open and honest with the service users for which they are providing healthcare. If things go wrong, and harm has occurred, organisations must recognise this and communicate with the service user. This builds upon the principles of the 'Putting Things Right Regulations' already in place within NHS Wales, with an overall objective of ensuring that when a person receives healthcare services, they are dealt with in an open an honest way by their care provider. The Duty ensures that NHS organisations are clear about avoiding any potential culture of blame and supports those where mistakes and errors have been made.

1.4 Where Duty of Candour incidents are identified they should be investigated by the relevant NHS organisation within the required timeframe. This helps to understand what happened, to provide the service user with truthful information and an apology, and to identify areas for improvement and lessons to be learnt.

1.5 This review has links to strategic risk two of the Health Board's strategic risk register: Ability to deliver improvements which transform care and enhance outcomes'.

1.6 The risk considered during our review include:

- Non-compliance with legislation if guidance is unclear and staff are unaware of their responsibilities.
- Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt.
- Reputational damage with decreased public confidence.

1.7 The relevant lead for this review is the Executive Director of Nursing, Midwifery and Patient Care.

2. Detailed Audit Findings

Objective 1: Clearly defined procedures are in place for the management of Duty of Candour cases, which are in line with Welsh Government guidance and include the roles and responsibilities for identifying, investigating and monitoring cases.

2.1 In April 2023 the Welsh Government (WG) published their 'Duty of Candour Statutory Guidance', which details the necessary information to allow NHS organisations to deliver the requirements of the Duty of Candour. The Health Board has chosen not to produce a standalone Duty of Candour policy, as it is an integral part of the incident management process. In February 2024 the Health Board's Incident Management Framework was updated to incorporate information in relation to the Duty. The Health Board's concerns policy and procedure has also been updated to include reference to the Duty.

2.2 We have confirmed that the Incident Management Framework contains a Duty of Candour section, which includes the requirements in relation to contacting patients should a Duty of Candour matter arise. As the Duty is an integral part of the incident management processes, details about the roles and responsibilities for investigation and monitoring cases are included in that wider incident management context.

2.3 Whilst the Incident Management Framework provides high level guidance, there are no detailed operating procedures or guidance documents is in place. Our testing under objective 3 identified discrepancies in the interpretation of information and the completion of the Datix system, which is used to record and capture incident information and determine if a Duty of Candour matter has been triggered. We saw that information fields were not always completed, and the information required to be included in date fields had been interpreted differently by different staff. We understand that there is an intention to develop action cards that sit beneath the incident framework, to guide staff on the correct process to follow. **(See Matter Arising 3)**

Conclusion:

2.4 The Health Board's incident management framework has relevant information that aligns to the Welsh Government guidance, which includes roles and responsibilities and identifying, investigating and monitoring cases. However, there are no detailed operating procedures in place to guide staff. We have provided **Reasonable Assurance** for this objective.

Objective 2: Health Board wide training and ongoing support is in place to help staff meet their Duty of Candour responsibilities.

2.5 We understand that a number of events and activities took place within the Health Board to inform staff before the Duty came into effect. For example, presentations to care groups. In addition, the Health Board's staff newsletter contained an overview about the implementation of the Duty and contained links to the Duty of Candour information pages on the intranet. We also saw that the Primary Care internet pages contained a section on the Duty of Candour, and a link to a series

of fifteen virtual drop-in clinics being run across the year that primary care providers could attend.

2.6 We note that Duty of Candour awareness training is available for NHS staff via e-learning accessed through ESR. We understand that staff were made aware of the training module at the launch events. The Health Board has not made training on the Duty mandatory, and we have not seen monitoring of training uptake. We obtained information from the Learning & Development team and identified that since launching in March 2023, 434 staff had enrolled on the e-learning package up to the end of September 2024. Whilst most of those have viewed the training material, only 145 had completed the training package. Information on the training module is not identified on the Duty of Candour intranet pages. **(Matter Arising 1)**

2.7 No other specialist training on the Duty has been created or delivered for incident managers and reviewers. However, we acknowledge that any investigation required if a Duty of Candour is triggered forms part of the wider incident investigation process, for which training is provided.

2.8 From our fieldwork, it was clear that quality and safety teams have a leading role in relation to the Duty of Candour process and act as local support for staff that may have queries. However, through our testing we have identified numerous issues relating to the completion of Duty of Candour details in Datix and therefore the potential need for training in relation to this. **(see Matter Arising 3)**

Conclusion:

2.9 General information about the Duty has been made available to staff via the Health Board's intranet, and the quality and safety leads within care groups are able to provide more detailed, Health Board specific, guidance. Awareness could be enhanced further through promotion of the ESR training and monitoring of uptake. We have provided **Reasonable Assurance** for this objective.

Objective 3: Robust processes are in place to ensure the Health Board complies with the Duty of Candour.

2.10 The Duty requires the Health Board to follow a process when a service user suffers an adverse outcome, which has, or could result in unexpected or unintended harm that is more than minimal, and the provision of health care was, or may have been, a factor. As such, a Duty of Candour matter is triggered when the level of harm is assessed by a manager as 'moderate or above' and an answer of 'yes' is given against the question on whether healthcare provision was a contributing factor. Once the Health Board becomes aware that a Duty has been triggered, the statutory guidance sets out a series of actions to be taken including, initial 'in person' contact with the patient or their representative, a follow-up written notification, and a final letter following completion of the investigation.

2.11 Care group Quality & Patient Safety (Q&PS) teams oversee the incident management process for their areas, and the Duty of Candour is integrated into this process. A duty is triggered by the Q&PS team following the completion of an

incident 'triage' process where the team review the initial level of harm allocated by the incident reporter and attribute a 'manager's harm' assessment level.

2.12 We obtained a report from the Datix system showing the changes in harm level between the reporter's initial assessment, the manager's triaged assessment, and the post investigation assessment. Our analysis showed that in 60% of cases the level of harm attributed by the manager differed to that attributed by the reporter. While the assessed level of harm was increased in some cases, most were decreased. We understand that the reporter's initial harm assessment is often based on the incident outcome which can be more severe, as opposed to an assessment of the harm caused at that time, hence the level is often overstated.

2.13 However, we also identified that all cases that had a harm level of low or none following manager assessment, went on to be upgraded to moderate harm or above following investigation. Whilst these cases would have still been investigated using the incident management framework, the Duty of Candour element of that process would not have been instigated as the low or no harm manager assessment meant the Duty had not triggered. Furthermore, given that all cases downgraded to low or no harm at manager assessment stage were subsequently upgraded to moderate and above, would indicate additional training and guidance is needed for managers. **(Matter Arising 2)**

2.14 We reviewed data from cases recorded in Datix between April and July 2024. We identified cases where information relevant to the Duty had not been populated. This included instances where the manager's harm assessment was not recorded, and instances where the answer to the healthcare factor question had not been populated. Some of these cases had already been closed, which could mean that a potential Duty of Candour matter may have been missed. **(Matter Arising 3)**

2.15 We also saw cases where information was captured in these key fields and a Duty of Candour matter was triggered, but the 'date the health board became aware' field was blank. We are aware that a key report generated from the Datix system uses the 'date the health board became aware' as part of its criteria. As such, reports generated of cases that have triggered a Duty of Candour matter may not be accurate. **(Matter Arising 3)**

2.16 We undertook more detailed testing on a sample of cases where a Duty of Candour matter had been triggered. In the majority of cases we could evidence that the correct process had been followed. We did note some cases where required information had not been captured, key documents such as copies of letters had not been saved to Datix, or the dates recorded in Datix did not correspond to the dates on the letters. Also, many of the initial letters and final letters had not been sent within the required timeframes. **(Matter Arising 4)**

2.17 A small number of more complex cases that were likely to trigger a Duty of Candour matter were identified during out fieldwork. These cases involved other NHS bodies. There appeared to be some delays in instigating the Duty of Candour process while it was determined where responsibility lay. While the WG statutory guidance provides direction on the process to follow in complex cases, there are

no detailed procedures in place to support the application of the statutory guidance. **(Matter Arising 5)**

Conclusion:

2.18 Our review of reports generated from the Datix system and our testing of a sample of cases has identified gaps in the information that should be captured in relation to the Duty of Candour and inaccuracies where data is recorded. There are currently no operating procedures in place to guide staff. We have provided **Limited Assurance** against this objective.

Objective 4: Timely monitoring and reporting arrangements are in place at appropriate levels within the Health Board, which include lessons learnt and contribute to a system of continuous improvement.

2.19 In the care groups that we sampled, we saw evidence of spreadsheet trackers of Duty of Candour cases. We also saw dashboards within Datix to facilitate monitoring.

2.20 At the weekly Executive team meeting an incident management update report is provided. This incorporates monthly data on the number of incidents where a Duty of Candour matter has been triggered, and a brief overview of the cases that have triggered since the previous meeting.

2.21 Since its launch in April 2023, Duty of Candour data and information has been included in the patient safety, quality and experience dashboard that is presented at each Quality & Safety Committee meeting.

2.22 While we saw reporting and monitoring in relation to the Duty of Candour at various levels within the Health Board we identified instances where the data appeared to be incomplete. **(Matter Arising 6)**

2.23 In addition, in March 2024 there was an all-Wales update to the Datix system. A question was added to help determine if a Duty of Candour matter had occurred which identified if healthcare provision was a factor in the patient suffering harm. Previously, a nursing care question was used to inform if an incident should be considered a Duty of Candour matter. The new question was retrospectively added to cases already in Datix and a 'yes' answer applied in cases where the manager's assessment of the level of harm was 'moderate or above'. This amendment to 2023/24 data may have affected the accuracy of reported Duty of Candour cases for the year, as it appears that more cases have triggered a Duty of Candour matter but were not treated as such. **(Matter Arising 6)**

2.24 The WG statutory guidance requires the Health Board to produce an annual report in relation to the Duty, which is to be published at the end of October each year, in line with the 'Putting Things Right' annual report. As such, at the time of our fieldwork, the Health Board's first annual report in relation to the Duty was being prepared.

2.25 The Duty is embedded within the incident management process, so lessons learnt are recorded and disseminated as part of this process. Our testing has confirmed

that for all cases in our sample, the lessons learned sections in Datix had been appropriately completed.

Conclusion:

2.26 Since the Duty of Candour was launched an established reporting and monitoring routine has been established. However, our testing has identified some instances where the information is not complete or accurate for some elements of the data. We have provided **Reasonable Assurance** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Duty of Candour awareness training (Operation)	**Potential Impact**
NHS staff should have an awareness of the Duty of Candour and understand the requirements of the Act. At the time the Duty came into effect, an all-Wales e-learning module was made available to staff via ESR. Staff were made aware of the training module when it was launched, but we have not seen further communication to encourage participation. We also note that there is no reference or link to the training module on the Duty of Candour intranet pages. The Health Board has not mandated completion of the training and to date there does not appear to have been any monitoring of uptake. Our review of data provided by the Learning & Development team identified that 434 staff enrolled on the on-line course between March 2023 and September 2024. Most have started to view the course content, but only 145 have completed the course.	Incorrect application of the Duty of Candour.

	Recommendations	**Priority**
1	Information and a link to the ESR Duty of Candour training module should be included on the Duty of Candour intranet pages. Consideration should be given to identifying those staff that would most benefit from attending Duty of Candour training and direct communications to encourage participation. Periodic monitoring on training uptake should take place. If necessary, reminders about the duty and the availability of training should be issued via Health Board wide communication channels.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1	a) Duty of Candour Intranet pages to be updated to include links to training programmes. b) Consideration of Duty of Candour training to be included in training plan for implementation of revised Putting Things Right regulations.	31.03.25 31.10.25	Head of Concerns & Business Intelligence Assistant Director for Quality & Safety /Head of Concerns and Business Intelligence

Matter Arising 2: Amendments to the assessment of level of harm (Operation)	**Potential Impact**
We obtained a report from the Datix system showing the changes in harm level between the reporter's initial assessment, the manager's triaged assessment, and the post investigation review assessment. The report contained 528 incidents from 2023/24. Following the manager assessment, 261/528 cases had their harm level reduced to none or low, meaning they did not trigger the Duty of Candour at that time. However, following completion of the incident investigation, all 261 cases had the harm level increased back up to moderate or above. We acknowledge that the manager level of harm assessment is based on the limited information they have at that time, whereas the final level of harm assessment is based on information following investigation. However, as all 261 cases where the harm level was lowered at management review stage, were then increased, would suggest further guidance or training may be needed.	Duty of Candour not recognised and acted up where inaccurate harm assessments are made.

Recommendations		**Priority**
2.1a 2.1b	Regular analysis of data on the variations in harm levels at the various stages in the incident process should be undertaken to look for any trends or patterns. For example, if the under or overstating of harm levels is predominately linked to certain care groups or departments. Training should be provided in relation to assessing the level of harm, with a focus on those areas where analysis may have shown higher numbers of variations.	**Medium**
2.2	To encourage a consistent and more accurate assessment of harm levels at the various incident stages, information and guidance should be incorporated into any operating procedures that are developed. (see Matter Arising 3)	

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1a	Monthly assessment of variations in harm levels to be undertaken and feedback provided monthly Care Group reports	30.06.25	Head of Concerns & Business Intelligence

2.1b	Training in relation to assessment of harm to be included in training programme for implementation of revised Putting Things Right Regulations.	31.10.25	Assistant Director of Quality & Safety / Head of Concerns & Business Intelligence
2.2	The Incident Management Framework to be updated to include information and guidance in relation to harm assessment and its application to Duty of Candour.	31.05.25	Head of Concerns & Business Intelligence

Matter Arising 3: Completion of Datix records (Operation)	**Potential Impact**
A report from the Datix system for the period April to end July 2024 records 8,080 incidents. Our review of the data identified instances where information relevant to the Duty of Candour process had not been input. The manager's assessment of the level of harm, takes place following the reporter assessment of harm, and is required to determine if a Duty of Candour matter has been triggered. Our analysis of the 8,080 incidents in the report identified that: • For 1,239 incidents the manager harm assessment was not recorded, and of these 35% had already been closed or were awaiting closure within Datix. • Of the incidents closed or awaiting closure, 42 had been initially assessed by the reporter as having a harm level of 'moderate or above', indicating a Duty of Candour may have triggered. In addition, the question on whether 'healthcare was a factor in the patient suffering harm', had also not been answered meaning that these incidents may not have been considered for Duty of Candour despite the initial reporter assessment meeting the threshold. • For 308 incidents the managers assessment of harm was recorded as 'moderate or above'. However, in 123 of these incidents the healthcare factor question had not been completed, meaning a Duty of Candour matter had not been triggered. We tested a sample of 15 of these cases, five should have triggered a Duty of Candour as a 'yes' answer had been input against the previously used question relating to nursing care being a factor. • For 50 incidents a Duty of Candour matter was triggered as the manager harm assessment had been recorded as 'moderate or above' and healthcare had been a determining factor in the patient suffering harm. However, no information was recorded in the 'date became aware' field in 22/50 (44%) of cases, which is a criteria for identifying Duty of Candour matters in some Datix reports. (see matter arising 6) We understand that the Workstream forms set up within Datix Cymru had mandated fields that would prevent a case being closed if key information was missing. However, it appears that some users within the Health Board were not using the approved form. This has allowed the mandatory controls in-built not to be completed. As such, information in relation to key stages can be left unpopulated, meaning incidents can be closed without answers to the Duty of Candour trigger questions being completed, or with key information missing where a Duty of Candour matter has been triggered.	Failure to properly identify and act upon Duty of Candour cases. Failure to declare Duty of Candour incidents correctly and within timescales.

Furthermore, there are no supporting operating procedures or guidance notes to aid staff on matters such as how to interpret key dates including 'date first became aware a DOC was triggered', or the capturing of information in Datix.		
Recommendations		**Priority**
3.1a 3.1b	Detailed operating procedures should be developed to aid staff in ensuring the correct application of the Duty of Candour and the capture of essential information within the Datix system. Once produced, the procedures should be made accessible to staff via the Duty of Candour intranet pages.	**High**
3.2	A review of the current forms used within Datix Cymru by the Health Board should take place with a view to reinstating the workstream approved form in the system that have mandatory elements in-built and prevent fields being left unpopulated.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	The Incident Management Framework to be updated to include flow charts as appendices to support the implementation of Duty of Candour and accurate completion of Datix Cymru.	31.05.25	Head of Concerns & Business Intelligence
3.1b	The Incident Management Framework Health Board Intranet Pages to be updated to include all supporting documentation relating to the implementation of Duty of Candour and the accurate completion of Datix.	31.05.25	Head of Concerns & Business Intelligence
3.2	Review of Datix Cymru forms allocated to be undertaken and updated as required.	30.04.25	Head of Concerns & Business Intelligence

Matter Arising 4: Following the Duty of Candour process (Operation)	**Potential Impact**
The WG statutory guidance states that on first becoming aware that a Duty of Candour is triggered, the patient or person acting on their behalf should be notified 'in person' (telephone, video call, face to face) and an initial apology and explanation provided. This should be followed up with a written notification within five working days. Reference is then made to the 'Putting Things Right' (PTR) guidance and the need for a final letter to be sent within 30 working days, (upon completion of the investigation). The Datix Cymru system has been set up to capture this information. We undertook testing in relation to a sample of 24 cases where the 'date became aware' field had been populated, meaning a Duty of Candour matter had been triggered. We identified: • In two cases, the date the initial letter was sent was not captured and we could not see a copy of the letter saved to Datix. Where date information was captured, there were only eight cases where the initial letter was sent within the target 5-working days after the initial notification. However, our review of the data suggests staff are not clear on the date to be recorded in this field. In many cases other dates such as when the final letter was sent, or the case closed date had been input in this field. • The system requires the manual calculation and input of a date 30-working days after the initial written notification. This is the target date for the final response letter to be sent. 7 cases had no date captured of when the final letter was due to be sent by. Of the closed cases, only two were sent within the 30-day target. We also noted some cases where the 'sent date' in Datix was not accurate when compared to the date recorded on the final letter. Again, it appears there is a confusion as to what information is required.	Failure to comply with requirements and timescales set out in the statutory guidance. Inaccurate reporting where data is incomplete or incorrectly captured.

	Recommendations	**Priority**
4.1	As part of the development of an SOP to provide clarity to staff on the capture of information, staff should be remined of the importance of comprehensively and accurately completing the required fields in Datix and saving copies of relevant documents to the Datix record. Staff should also be remined of the timeframes of when key letters should be issued. (Though we appreciate achievement of the 30-day timeframe in complex investigations is difficult).	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
4.1	The Incident Management Framework to be updated to include flow charts as appendices to support the implementation of Duty of Candour and accurate completion of Datix Cymru.	31.05.25	Head of Concerns & Business Intelligence

Matter Arising 5: Complex case guidance (Design)			**Potential Impact**
During our testing we identified a small number of cases that involved other health boards or trusts. In such cases, determination of who is responsible for the incident can delay the actions required under the Duty of Candour. The WG statutory guidance includes a chapter on complex cases including where more than one NHS body is involved, or the NHS and other organisations. However, in the absence of detailed guidance notes or operating procedures, it is not clear to staff the process that should be followed.			Failure to declare candour correctly and within timescales.
Recommendations			**Priority**
5.1	The Health Board should consult with the Candour network to ensure a consistent and unified approach to dealing with complex cases involving other health boards or trusts is set out and prevent possible delays.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Consult with Duty of Candour Network to identify best practice for management of complex cases and incorporate into Standard Operating Procedure.	30.06.25	Assistant Director of Quality & Safety / Head of Concerns & Business Intelligence

Matter Arising 6: Accuracy of data used for monitoring (Operation)	**Potential Impact**
Our testing has identified instances where data is not captured consistently within Datix Cymru. As such, there is a risk that Datix reports used for monitoring are inaccurate and incomplete. For example, if reports on the number of Duty of Candour cases are generated using 'date became aware', this is a risk of under-reporting. It appears that the standard reports built into the system have not been utilised and as alternative reports have been put in place, this creates the risk of inconsistency. Furthermore, an all-Wales Datix update in April 2024 may also be having an impact on the accuracy of the number of 2023/24 cases being reported. The system update saw the addition of a key question relating to whether the healthcare provided was a factor in the patient suffering harm. This question was also retrospectively added to cases already captured in Datix Cymru, and an automatic answer of 'yes' applied in cases where the manager's level of harm assessment was moderate or above. As part of the update, a validation exercise should have been carried out by the Health Board to identify any records where healthcare was not actually a factor. This exercise does not appear to have been carried out and has resulted in records being closed with a harm grading of moderate or above and no rationale in place while the Duty of Candour does not apply.	Inaccurate reporting of Duty of Candour cases.

Recommendations		**Priority**
6.1	The Health Board should ensure the reports it utilises for monitoring of Duty of Candour are in line with the standard reports produced by the OfW Central Team.	**Medium**
6.2	The Health Board should undertake a review of 2023/2024 data to validate all matters which are closed with a harm grading of moderate or greater. Assistance for this task can be obtained from the OfW Central Team. A regular review/audit of closed records should be undertaken to identify which have a closed status, a harm grading of moderate or greater and insufficient clarification regarding Duty of Candour status.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
6.1	Review all reports produced in relation to Duty of Candour are in line with Once for Wales templates and reports.	31.03.25	Head of Concerns & Business Intelligence
6.2	Review of 2023 / 2024 data to be completed and learning identified to inform improvement action. Weekly review of closed records to be implemented and monitored via the weekly Quality & Safety data meeting.	31.03.25	Head of Concerns & Business Intelligence

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Service User Experience

Final Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



Substantial Assurance

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Review Reference	CTM-2425-13
Fieldwork	February to April 2025
Executive Sign Off	09 May 2025
Audit Committee	May 2025
Executive Lead	Greg Dix, Executive Director of Nursing, Midwifery & Patient Care
Audit Team	Paul Dalton, Head of Internal Audit
	Emma Samways, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Our review of service user experience has been undertaken in line with the 2024/25 Internal Audit Plan for the Cwm Taf Morgannwg University Health Board ('CTMUHB' or the 'Health Board').

Service users have the right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected, and dignity maintained. A high-quality experience should be fundamental, underpinned by appropriate standards, whatever and wherever the setting of care and treatment.

The Welsh Government framework for assuring service user experience was first introduced in 2013 and then updated in 2015. It describes the evidence based key determinants of a good service user experience, identifies the key attributes, and uses of a range of feedback methods. The Framework was further updated in 2018 to reflect a set of eleven validated questions to be used by all NHS Wales organisations to obtain real time feedback.

The Health Board currently uses the CIVICA system for service users to feedback on their experience via a Short Messaging Service (SMS), text service, paper, and quick reader (QR) codes, while generating reports from the data provided.

During 2024, CTMUHB participated in the national procurement exercise for a new Patient Reported Outcome Measures (PROMs) digital system to meet the national PROMs Standard Operating Model (PSOM) guidance, and procured a system called 'Promptly'. Implementation is currently underway, and work is being undertaken to migrate service user data collected as Patient Reported Experience Measures (PREMs – linked to healthcare interventions) and 'Have Your Say' (completed by anyone interacting with the Health Board) to the Promptly system, supporting the vision of one integrated system which will enable the use of patient experience data in person with patients, as well as supporting aggregated analysis and improvement action.

Overview

We have concluded substantial assurance on this area. The matter requiring management attention relates to:

- The identification and analysis of the effects of under-representation of certain patient groups in service user feedback processes.

Full details of the matter arising are detailed within the Findings & Agreed Action Plan. We also identified the following opportunities for enhancement that do not impact the overall opinion and are highlighted for management information:

- Due to delays in the publication of the Welsh Government's service user experience framework, production of a patient experience strategy has been postponed. The framework was released in April 2025 as our fieldwork concluded. This now enables the Health Board to progress with drafting its strategy.
- 'Have Your Say', PROM and PREM surveys are not available in languages other than English and Welsh, although a multi-lingual functionality can be incorporated into the Promptly system, and translations efforts are ongoing. Progress in relation to the publication of surveys in alternative languages should continue to be monitored.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Health Board has a patient experience strategy/ plan in place detailing its commitment and approach to listening and learning from patient's experience.	-	**Reasonable**
2	Appropriate mechanisms and resources (including the use of technology and Patient Advice and Liaison Service (PALS) officers), are in place for the collation and analysis of patient feedback.	1	**Reasonable**
3	Feedback is used to inform and drive improvement throughout the Health Board, with evidence of action taken to address identified issues and share good practice.	-	**Substantial**
4	Patient experience is monitored and reported to the Board (or an appropriate committee of the Board), to provide assurance that the key components of the service user experience are being assessed, and that action is taken to deliver improvements.	-	**Substantial**

Management Actions

-	1
High Priority	Medium Priority

Themes



Information, Data Quality & Data Accuracy

Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The Health Board has a patient experience strategy/ plan in place detailing its commitment and approach to listening and learning from patient's experience.	**Reasonable**

The Health Board is in the process of developing a patient experience strategy. However, production of the document had been paused as the Health Board waits for the Welsh Government (WG) to release the people's experience toolkit, which includes an updated service user experience framework. During our fieldwork, the framework was released by WG and we understand that work in relation to the strategy has now resumed.

We established that although work on the strategy document is ongoing, activities and initiatives detailed in the planning document are already being acted upon.

The various approaches taken by the Health Board to capture service user experience and listening and learning, are referenced in the strategy planning document. We understand that these areas will be more detailed in the final strategy document.

Objective 2: Appropriate mechanisms and resources (including the use of technology and Patient Advice and Liaison Service (PALS) officers), are in place for the collation and analysis of patient feedback.	**Reasonable**

Several feedback mechanisms are in operation throughout the Health Board and incorporate various innovations to ensure feedback is sought from as many service users as possible. For example, the 'Have Your Say' survey is available to all service users in multiple formats, PREMs are incorporated into clinical processes, and patient engagement with these surveys is strongly encouraged. PREM SMS surveys are also used. Robust procedures exist to ensure the accuracy of data collected via the feedback systems.

We saw that significant effort is made to promote inclusivity in the feedback processes and to ensure feedback is obtained from a diverse range of service users. The Patient Experience and Value-Based Health Care (VBHC) teams work independently and collaboratively on initiatives intended to address health inequalities within specific groups of service users.

We saw evidence that a proactive approach is taken to obtaining feedback, and a comprehensive Patient Advice and Liaison Service (PALS) provides individualised assistance to service users when required. Resources have been enhanced as PALS officers now operate from all three of the main Health Board sites. Their presence ensures that individuals belonging to potentially under-represented groups are given the opportunity to provide feedback on a more equal basis and mitigates some of the risks surrounding non-response bias that are inherent to feedback processes.

However, we note that the Health Board does not identify and evaluate potential sources of bias in the patient feedback mechanisms, or under-representation in the feedback results. As such, no work has been done to quantify or explain the effects that bias and under-representation could have on the feedback data.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Bias and under-representation** Processes are in place to ensure feedback mechanisms are made available to all service users on an equal basis and incorporate inclusivity. A wide range of targeted engagement activities are supported by the People's Experience and Value Based Healthcare teams. The specific needs of groups that are identified as potentially being vulnerable to experiencing access or engagement issues with Health Board services are being addressed by this work. Notwithstanding these efforts, systems to identify and quantify under-represented groups in service user feedback data are yet to be established.	Harm to patients where issues are not identified in underrepresented groups.	**Suggested Action:** Feedback data analysis processes will be revised and refined in order to incorporate procedures to assess the potential effects of under-representation and bias in feedback results. Observations derived from the operation of these procedures will be utilised in efforts to reduce bias and under-representation where possible. Furthermore, information on this will be disseminated to managers, and included in the narrative of feedback reports in order to provide additional context to the data contained therein.
			Expected Evidence of Implementation: Analysis results. Demographics data reports.
		Medium Priority	**Responsible Officers:** Denise Lowry Head of VBHC and Jenny Oliver Head of People's Experience **Target Implementation Date:** 29 December 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Feedback is used to inform and drive improvement throughout the Health Board, with evidence of action taken to address identified issues and share good practice.	**Substantial**

Management reporting arrangements in relation to patient feedback and the activities of the People's Experience and VBHC teams appear to be well established and operating effectively.

There are various means by which feedback themes and trends are identified. The same categories of themes are used across the different feedback systems to allow data to be combined and be more meaningful. Common themes are then identified and reported upon with trends in themes included in management reports. We saw evidence that suitable processes were in place to ensure remedial actions are implemented in response to themes and trends in patient feedback.

Mechanisms have been implemented to ensure actions are taken in response to individual instances of feedback where appropriate. Responses may be directly co-ordinated by the PALS team or reported to management by various means which include the People's Experience Forum and the care group Quality, Safety, Risk and Experience group meetings.

The work of the People's Experience and VBHC teams contribute to the Health Board's compliance with the Duty of Quality standards. Particular emphasis is placed on the work of the People's Experience team in the Health Board's most recent Annual Duty of Quality Report.

Objective 4: Patient experience is monitored and reported to the Board (or an appropriate Committee of the Board), to provide assurance that the key components of the service user experience are being assessed, and that action is taken to deliver improvements.	**Substantial**

Appropriate management and reporting arrangements in relation to patient experience and associated feedback processes have been established, and monitoring processes are in place.

The Health Board's Quality, Safety and Experience (QSE) Committee provides oversight of patient feedback systems, and some information relating to the activities of the VBHC team are reported to the Strategic Development Committee.

Regular 'People's Experience Activity Reports' are presented to each QSE Committee meeting, which provide a summary of the Health Board's activities in relation to patient feedback. We also saw additional information presented via the individual care group highlight reports that are reported to the QSE Committee.

Performance monitoring processes are incorporated into patient feedback systems. Performance information is reported through various channels to stakeholders across the Health Board, and externally where required.

Appendix A

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Cwm Taf Morgannwg University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Agenda Item
8.2.8

Quality, Safety & Experience Committee

Annual Unpaid Carer's Report

Dyddiad y Cyfarfod / Date of Meeting	22/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	David Watkins – Corporate Carers Lead.
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	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**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
RP	Regional Partnership
WG	Welsh Government
RIF	Regional Integrated Fund
CTM RP	Cwm Taf Morgannwg Regional Partnership

1. Situation /Background

1.1 The Cwm Taf Morgannwg (CTM) Carers Partnership Group, established in 2019, continues to provide oversight and strategic direction for the region's work with unpaid carers. The group brings together key partners across the local authorities, the Health Board, and third sector organisations to support the implementation of the CTM Carers Statement of Intent, which outlines five key aims designed to improve the identification, recognition, and support of carers across the region.

Funding for regional carers programmes continues to be held within the RP to support a consistent and equitable offer across the Cwm Taf Morgannwg University Health Board (CTMUHB) footprint.

The five aims set out in the Carers Statement of Intent are:

- Aim 1: Identify carers of all ages and acknowledge their contributions.
- Aim 2: Provide up-to-date, relevant, and timely information, advice, and assistance.
- Aim 3: Offer support, services, and training to meet carers' diverse needs.
- Aim 4: Empower carers by giving them a voice and greater control over their lives.
- Aim 5: Collaborate to maximise available resources for carers' benefit.

These aims remain under review through an ongoing planning and engagement process led by the Cwm Taf Morgannwg Regional Partnership (CTM RP), which also considers alignment with the Welsh Government's (WG) national priorities for unpaid carers.

In response to evolving engagement needs, the former Carers Steering Group was stood down in 2024. Instead, carer issues are now embedded as standing agenda items across three existing RP strategic domains: Dementia, Learning Disability, and Children and Young People, providing a more integrated approach to participation and accountability.

Work to identify and support staff who are also unpaid carers has continued to progress through the CTMUHB's Corporate Carers Lead. This includes ongoing partnership with the People Directorate, with the aim of improving carer visibility, support in the workplace, and improved retention of staff balancing work and care.

2. Specific Matters for Consideration

2.1 Carers Grant and Regional Integration
Historically, CTM's carers programme was supported through the Welsh Government Carers Grant. From 2023 onwards, this funding has been integrated into the Regional Integrated Fund (RIF) and is now managed via the CTM RP. This enables a more coordinated regional approach across local

authorities, health, and third sector services. Funding continues to support a regional carers programme and the Corporate Unpaid Carers Coordinator role within CTMUHB.

2.2 Corporate Unpaid Carers Coordinator Role

The coordinator has focused on embedding a whole-system approach to identifying, recognising, and supporting unpaid carers within acute and community settings. This includes building partnerships with local authorities, third sector organisations, and health board departments to improve carer support during hospital admission, care planning, and discharge.

2.3 Carers Passport and John's Campaign Principles

During 2024–25, work progressed on introducing a Carers Passport and embedding the principles of John's Campaign across inpatient settings. These initiatives aim to improve consistency in how carers are welcomed, informed, and supported during hospital stays.

The passport provides carers with an opportunity to be part of a discussion how involved they would like to be in the care of their loved one while they are in hospital.

John's Campaign principles promote inclusion of carers in care decisions and planning, particularly for those with cognitive or communication impairments. It allows carers to support the person they care for outside of normal visiting hours.

Training will be launched alongside both tools, forming part of a wider programme on patient-centred visiting practices.

2.4 Staff Carers Café

The Staff Carers Café has grown in strength over the past year, creating a safe space for employees who have unpaid caring responsibilities. Sessions have included peer discussions, access to Human Resources policies, and signposting to support services. Plans are underway to expand the offer, including thematic sessions and closer alignment with the broader CTMUHB staff wellbeing programme.

2.5 Short Breaks Fund

In 2024/25, the RIF approved £ 194,255.27 for delivery of the Short Breaks Fund across CTM. This provided flexible and personalised respite opportunities for unpaid carers, contributing to their mental and physical wellbeing. The fund supported a wide range of provision, from activity-based breaks to practical respite services. (Appendix 1)

2.6 Carer Awareness Training

Targeted carer awareness training was delivered to:

- Band 6 and 7 community nurses
- Newly qualified nurses
- 'New to Trust' nurses

The training raised awareness of carers' rights, explored practical strategies for recognising carers during care planning, and introduced the forthcoming carers passport. To date approximately 200 staff members, have been trained.

2.7 Additional Engagement and Collaborative Workstreams

Digital Integration: Work is ongoing to develop a carer icon on digital ward whiteboards to prompt early recognition of carers.

Age Connects Morgannwg: Continued partnership with trusted assessors to identify and support carers on wards.

Community Outreach: Attendance at multiple community events to raise awareness of carer support and strengthen referral pathways.

CTM2030: Ongoing collaboration with the Head of Engagement and Involvement to ensure carers remain visible within the Health Board's future strategy.

People Experience Team: Continued partnership to include carers' perspectives in patient experience reporting.

Third Sector and CVCs: Working closely with carer organisations and voluntary sector partners to improve signposting and support for carers.

3. Key Risks / Matters for Escalation

3.1 Ongoing Funding Uncertainty
The Corporate Unpaid Carers Coordinator role continues to be funded annually through the RIF. While CTMUHB recognises the value this role brings in progressing the carer agenda, the temporary nature of the funding poses a significant risk to the sustainability and continuity of the programme. As the WG undertakes a review of the national Carers Strategy, there is potential for shifts in strategic priorities and resource allocation, which may impact future funding arrangements across the region.

3.2 Strategic Alignment During National Review
There is a degree of uncertainty regarding how current local and regional priorities will align with the revised national direction once the updated strategy is published. While CTMUHB remains committed to embedding carer support into everyday practice, changes in policy focus or delivery expectations could necessitate a shift in planned activity or governance structures.

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: 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: A resilient Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People If more than one applies please list below:
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: This is not a policy or service review.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No change to service provision

	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 Committee members are asked to accept this report and NOTE the breadth of work undertaken to strengthen support for unpaid carers across the Health Board footprint. This includes ongoing collaboration with local authority and third sector partners, the development of the Carers Passport, application of John's Campaign principles, enhanced support for staff carers, and insight gained through regional survey activity. These efforts collectively demonstrate CTMUHB's continued commitment to improving outcomes for carers through integrated and person-centred approaches.

6. Next Steps

6.1 To continue collaborative coproduction with CTM RP and third sector partners, ensuring unpaid carers remain central to service design and delivery. Key next steps include the rollout of the Carers Passport and John's Campaign Principle's training, expansion of the Staff Carers Café model, integration of carer representation within strategic workstreams, and strengthened use of carer insight—such as survey findings and lived experience input—to inform improvements across hospital and community settings.

Cwm Taf Morgannwg
Partneriaeth Rhanbarthol | Regional Partnership

Prosiectau Seibiau Byrion wedi'u Hariannu Cwm Taf Morgannwg 2025/26

Short Break Funded Projects Cwm Taf Morgannwg 2025/26





Rhondda Cynon Taf

Prosiect: **Seibiau Byrion Cymuned Gofalwyr**

Mae'r gwasanaeth hwn ar gyfer:

- Oedolion a Phobl Hŷn
- Plant a Phobl Ifanc

Y cynnig:

- Taleb rhodd (gall gofalwyr ddewis eu gweithgareddau eu hunain, fel aros dros nos, diwrnodau sba, neu brofiadau te prynhawn)
- Taleb Ystafell Ddianc Rhondda (i 2 berson, dewiswch rhwng 5 ystafell wahanol)
- Cerdyn rhodd 'Bwyta Allan' (i'w fwynhau mewn nifer o fwytai stryd fawr blaenllaw)
- Taleb theatr y New Theatre (gellir defnyddio hwn tuag at brynu sioe o'ch dewis)
- Cerdyn rhodd 'Bwyta gartref' (e-daleb Just Eat i chi ei harchebu a'i mwynhau pan fyddwch chi eisiau)
- 'Ditectif am Ddiwrnod' (wedi'i ddanfon i'ch drws, popeth sydd ei angen arnoch i ddatrys 'llofruddiaeth y cwch hwylio moethus' – yr holl dystiolaeth ynddo, a gallwch ei ddatrys yn eich amser hamdden gyda'ch ffrindiau, teulu – perffaith ar gyfer noson wych i mewn!)

Project: **Carer Community Short Breaks**

This service is for:

- Adults and Older people
- Children and Young People

The offer:

- A gift voucher (carers can choose their own activities, such as overnight stays, spa days, or afternoon tea experiences
- Rhondda Escape Room voucher (for 2 people, choose between 5 different rooms)
- 'Dining Out' gift card (to enjoy at a number of leading high street eateries)
- New Theatre voucher (this can be used towards a purchase of a show of your choice)
- 'Dining in' gift card (a Just Eat e-voucher for you to order and enjoy at your own convenience)
- Detective for a Day (delivered to your door,

  everything you need to solve 'murder of the luxury yacht' – all evidence within and solve it at your leisure with your friends, family – perfect for a great night in!)



Sut i ymgeisio / How to apply:

Ffoniwch / Please call:
01443 281463

Merthyr Tudful
Merthyr Tydfil

Cancer Aid

Y cynnig:

Mae seibiannau byr Cancer Aid yn darparu'r gwasanaethau canlynol i ofalwyr gan ganolbwyntio ar hunanofal, ymlacio, a gwella llesiant. Bydd hyn yn helpu i feithrin cysylltiadau cymunedol i leihau unigrwydd cymdeithasol ac i gysylltu ag eraill sydd mewn sefyllfaoedd tebyg.

Gall gofalwyr ddewis o blith:

- Sesiynau therapi cyflenwol
- Gwasanaethau salon gwallt
- Mynychu caffi cysylltu gofalwyr – grŵp cymorth / cyfarfodydd cinio wythnosol i ofalwyr
- Mynediad at drafnidiaeth os yw trafnidiaeth yn rhwystr i gael mynediad at unrhyw gymorth
- Diwrnodau antur – tripiau undydd teuluol, tripiau theatr, tripiau undydd

Cancer Aid

The offer:

Cancer Aid's short breaks will provide the following services for carers focusing on self-care, relaxation, improving wellbeing. This will help build community connections to reduce social isolation and connect with others who are in similar situations.

Carers can choose from:

- Complementary therapy sessions
- Hair salon services
- Attending a carers connection café – a weekly carers support group / lunch meets
- Access to transport if transport is a barrier to accessing any support
- Adventure days – family day trips, theatre trips, day trips

Sut i ymgeisio / How to apply:

Gall gofalwyr gysylltu â Cancer Aid drwy ffonio **01685 379633,** neu alw heibio i'w canolfan ar Upper Union Street, Dowlais, CF48 3LE.

Maen nhw hefyd yn derbyn atgyfeiriadau gan ymarferwyr gofal iechyd neu weithwyr gofal cymdeithasol ar yr amod y gellir dangos fod cydsyniad wedi'i roi.

Os oes angen unrhyw beth pellach arnoch, mae croeso i chi gysylltu â'r tîm ar **01685379633.**

Carers can contact Cancer Aid by phoning **01685 379633**, or call into their centre on Upper Union Street, Dowlais, CF48 3LE.

They also accept referrals from health care practitioners or social care workers provided you can provide consent.

If you need anything further please don't hesitate to contact the team on **01685 379633.**

Rhanbarthol / Regional

Gwasanaeth Hamdden Halo

Y cynnig:

Mae prosiect Llesiant Gofalwyr Halo yn rhoi cyfle i ofalwyr gymryd rhan mewn gweithgareddau ymarfer corff a llesiant wythnosol naill ai am ddim neu fel treial.

Bydd y prosiect yn talu am ofal amgen er mwyn i ofalwyr di-dâl allu mynychu sesiynau, gan ei gwneud hi'n haws iddyn nhw gymryd seibiant.

Gallwch gofrestru ar raglen chwe wythnos sy'n cynnwys:

- **Gweithgareddau ymarfer corff a llesiant** a gynigir am ddim neu fel treial. Cynhelir y sesiynau hyn mewn cyd-destun a gynlluniwyd i leihau pryder ac annog cyfranogiad ymhlith gofalwyr di-dâl.
- **Canllawiau deiet a maeth a ddarperir gan ddeietegydd Lefel 4.** Yn ogystal, bydd cyngor arbenigol ar gyfer cefnogi unigolion â dementia ar gael trwy Ddeietegydd Iechyd Meddwl Pobl Hŷn Bwrdd Iechyd Prifysgol CTM.
- **Gweithdai therapi cyfannol,** gan gynnwys sesiynau ymwybyddiaeth ofalgar, gyda'r nod o ddysgu technegau lleddfu straen y gellir eu hintegreiddio i fywydau prysur gofalwyr. Dangoswyd bod y dulliau hyn yn lleddfu iselder a phryder, yn ogystal â chynorthwyo i brosesu a derbyn emosiynau anodd.
- **Gofal amgen i oedolion hŷn** pan fydd gofalwyr yn cymryd rhan yng ngweithgareddau'r rhaglen. Drwy gydweithio â Chymdeithas Alzheimer gellir sicrhau gweithgareddau cyfoethog i dderbynwyr gofal, fel defnyddio'r Ystafell Synhwyraidd yng Nghanolfan Bywyd Pen-y-bont ar Ogwr.
- **Gwybodaeth, Cyngor a Chymorth (IAA):** Ymweliadau rheolaidd gan sefydliadau sy'n darparu gwasanaethau ehangach i atgoffa gofalwyr am eu hawliau, beth y mae ganddynt hawl iddo, a'r gefnogaeth sydd ar gael. Mae hyn yn cynnwys gwybodaeth am sut mae system gofal a chymorth yr awdurdod lleol yn gweithredu, y mathau o wasanaethau sydd ar gael, gan gynnwys asesiadau gofalwyr, a sut i gael mynediad atynt.
- **Mynediad parhaus** at weithgareddau hamdden y fwrdeistref sirol trwy aelodaeth 3 mis i ofalwyr ar ddiwedd 6 wythnos y sesiynau llesiant cychwynnol. Cynlluniwyd y parhad hwn i'ch helpu i barhau â ffyrdd iach o fyw a mabwysiadu hynny'n hirdymor. Bydd gweithio'n agosach gyda rhaglen CRISP Cymdeithas Alzheimer yn helpu i greu system gymorth lyfnach a mwy cydgysylltiedig i ofalwyr. Bydd cydweithio ychwanegol â Chydlynwyr Cymunedol Lleol yn anelu at wella gwytnwch grwpiau cyfoedion, o bosibl trwy gronni taliadau uniongyrchol i ffurfio grwpiau parhaus ac opsiynau gofal amgen.

Halo Leisure Service

The offer:

The Halo Carer Well-being project provides carers with the opportunity to participate in weekly exercise and well-being activities on a complimentary or trial basis.

This project will pay for replacement care so unpaid carers can attend sessions, making it easier for them to take a break.

You can enrol onto a six week programme that includes:

- **Exercise and well-being activities** offered on a complimentary or trial basis. These sessions are conducted in environments designed to reduce anxiety and encourage participation among unpaid carers.
- **Diet and nutrition guidance provided by a Level 4 dietician.** Additionally, specialised advice for supporting individuals with dementia will be available through "CTM University Health Board's Older Persons' Mental Health Dietitian."
- **Holistic therapy workshops,** including mindfulness sessions, aimed at teaching stress-relief techniques that can be integrated into the busy lives of carers. These methods have been shown to alleviate depression and anxiety, as well as assist in processing and accepting difficult emotions.
- **Replacement care for older adults** while carers are engaged in programme activities. Collaboration with the Alzheimer's Society ensures enriching activities for care recipients, such as utilising the sensory room at Bridgend Life Centre.
- **Information, Advice, and Assistance (IAA):** Regular visits from organisations providing wider services to keep carers informed about their rights, entitlements, and available support. This includes information on how the local authority's care and support system operates, the types of services available, including carers' assessments, and how to access them.
- **Ongoing access** to county borough leisure activities through a 3-month membership for carers, once the initial six week wellbeing session has finished. This continuation is designed to help you maintain healthy lifestyles and adopt a long-term approach. Working more closely with the Alzheimer's Society's CRISP programme will help create a smoother and more joined-up support system for carers. Additional collaboration with Local Community Coordinators will aim to enhance peer group resilience, potentially through pooled direct payments to form continuous groups and replacement care options.



Bydd sesiynau grŵp yn darparu ar gyfer tua 10-15 o ofalwyr, gan feithrin datblygu rhwydwaith cymorth cyfoedion a lleihau teimladau o unigrwydd ac arwahanrwydd.

Gellir efelychu'r rhaglen hon ar gyfer mathau eraill o ofalwyr, gan gynnwys rhieni sy'n ofalwyr.

Group sessions will accommodate approximately 10-15 carers, fostering the development of a peer support network and reducing feelings of loneliness and isolation.

This programme can be replicated for other types of carers, including parent carers.

Sut i ymgeisio / How to apply:

I gael mwy o wybodaeth am y rhaglen, neu i gymryd rhan, cysyllwch â Jess ar: **jess.jaques@haloleisure.org.uk** neu **07812496038**

https://haloleisure.org.uk/community/carers-respite-programme

Cofrestrwch eich diddordeb ar gyfer **Rhaglen Seibiant Rhiant-ofalwyr Halo yma**

I gael mwy o wybodaeth am y rhaglen, neu i gymryd rhan, cysyllwch â Terri ar: **terri.llewellyn@haloleisure.org.uk**

For more information on the programme or to get involved, please contact Jess on: **jess.jaques@haloleisure.org.uk** or **07812496038**

https://haloleisure.org.uk/community/carers-respite-programme

Please register your interest for **Halo's Parent Carers Respite Programme here**

For more information on the programme or to get involved, please contact Terri at: **terri.llewellyn@haloleisure.org.uk**

Y Bont – Cwtch

Mae'r gwasanaeth hwn ar gyfer:

- Oedolion a Phobl Hŷn
- Plant a Phobl Ifanc

Y cynnig:

Y Bont yw'r unig wasanaeth yng Nghymru sy'n cynnig gofal a chefnogaeth arbenigol cyn oedran ysgol i blant a chyflyrau meddygol cymhleth, anableddau ac anghenion cymhleth sy'n ymddangos. Bydd y gweithgareddau'n cwmpasu'r uned deuluol gyfan gan ddarparu:

- Digwyddiadau a gweithgareddau fel diwrnodau llesiant, gweithdai ymwybyddiaeth ofalgar, gweithdai crefft, digwyddiadau golff, digwyddiadau cymdeithasol i'r gofalwyr wrth i ofal gael ei ddarparu ar gyfer y plentyn / plant.
- **Digwyddiadau teuluol –** dengys adborth gan deuluoedd y mae Y Bont yn gweithio'n agos iawn gyda nhw nad oes llawer o leoedd sy'n darparu ar gyfer teulu plentyn ag anghenion cymhleth 'mond i 'fod' gyda'i gilydd fel teulu. Nod y sefydliad yw cynnal digwyddiadau teuluol gyda gweithdai ar gyfer gofalwyr ifanc, ble bydd staff wrth law i gefnogi'r plant ag anghenion cymhleth i ymuno ag unrhyw weithgareddau gyda'u brodyr a chwiorydd, a ble gall rhieni a'r gofalwyr ymuno os ydynt yn dymuno, neu gallan nhw gwrdd a siarad â'i gilydd tra byddwn ni'n gofalu am y plant ac yn eu diddanu.
- Cyfle i deuluoedd fwynhau gweithgareddau gyda'i gilydd fel uned deuluol gyda'r sefydliad wrth law i'w cefnogi ac i hwyluso hynny ar eu cyfer.
- Gall rhieni / gofalwyr plant ag anghenion ychwanegol deimlo'n ynysig. Mae'r sefydliad yn cynnig digwyddiadau cymdeithasol, boreau coffi neu'r cyfle i gerdded gydag eraill a allai fod yn wynebu anawsterau tebyg. Dyma bobl a allai ddeall, sydd angen rhywun i siarad ag ef, neu a hoffai gwrdd ag eraill sydd â phlant mewn sefyllfaoedd tebyg i'w rhai hwy.
- Seibiant i brif ofalwyr y plentyn, fel mynd i gyngherddau brodyr a chwiorydd, cael coffi, hyd yn oed gwneud y siopa wythnosol.

This service is for:

- Adults and Older people
- Children and Young People

The offer:

Y Bont is the only service in Wales that offers specialist pre-school care and support for children with complex medical conditions, disabilities and complex emerging needs. The activities will encompass the whole family unit providing:

- Events and activities such as wellness days, mindfulness workshops, craft workshops, golf events, social events for the carers whilst care is provided for the child / children.
- **Family events –** feedback from families Y Bont work very closely with is that there are not many places that will cater for a family of a child with complex needs to just 'be together' as a family. The organisation look to put on family events with workshops on for young carers, staff on hand to support the children with complex needs to join in any activities with their siblings, for the parents and carers to join in if they wish or for them just to meet and talk to each other whilst we look after and entertain the children.
- For families to enjoy activities together as a family unit with the organisation on hand for support and to facilitate that for them.
- Parents / carers of children with additional needs can feel isolated. The organisation offers social events, coffee mornings or a walk with others who may have similar battles to face. These are people who may understand, need someone to talk to, or just would like to meet others with children in similar situations to their own.
- Respite for the child's main carers such as going to a siblings' concerts, having a coffee, or even doing the weekly shop.







Bydd Y Bont yn cynnal digwyddiadau misol i roi cyfle i rieni a gofalwyr gymryd seibiant o'u rwtîn arferol a gwneud rhywbeth drostynt eu hunain. Bydd cyfarfodydd coffi cymdeithasol wythnosol – a gynhelir yn y bore, y prynhawn, neu gyda'r nos – yn cynnig opsiynau hyblyg ar gyfer cysylltu a chefnogi. Gan gydnabod anghenion penodol gofalwyr gwrywaidd, bydd Y Bont hefyd yn trefnu sesiynau pwrpasol ar gyfer tadau. Yn ogystal, cynhelir digwyddiad teuluol bob tymor, gan roi lle i deuluoedd ddod at ei gilydd, dathlu, chwarae, a mwynhau amser o safon fel uned.

Y Bont will host monthly events to give parents and carers an opportunity to take a break from their routine and do something for themselves. Weekly social coffee gatherings—held in the morning, afternoon, or evening—will offer flexible options for connection and support. Recognising the specific needs of male carers, Y Bont will also organise dedicated sessions for dads. Additionally, a family event will be held each term, providing a space for families to come together, celebrate, play, and enjoy quality time as a unit.

Sut i ymgeisio / How to apply:

E-bost / Email: **sarah@ybont.com**

Ffôn / Telephone: **01656 646 013**

Merthyr a Rhondda Cynon Taf
Merthyr and Rhondda Cynon Taf

Pobl yn Gyntaf Cwm Taf

Mae'r gwasanaeth hwn ar gyfer:

- Oedolion ag anabledd dysgu / eu gofalwyr

Y cynnig:

Mae Pobl yn Gyntaf Cwm Taf yn cynnig cynnig tri seibiant byr ¬– un ymhob chwarter o'r flwyddyn – a thri diwrnod profiad. Bydd y diwrnodau profiad hyn yn digwydd gyda'r nos neu ar benwythno-sau, heb aros dros nos, er mwyn rhoi cyfle i ofalwyr di-dâl a'r bobl maen nhw'n eu cefnogi orffwys y tu allan i oriau arferol yr wythnos.

Bydd pob seibiant neu brofiad yn cefnogi 8 i 12 o gyfranogwyr, yn dibynnu ar anghenion unigol a chostau fel llety a gweithgareddau. Bydd manylion pob digwyddiad yn cael eu cynllunio ar y cyd gyda'r grŵp i wneud yn siŵr bod y gweithgareddau'n ystyrlon ac yn bleserus.

Mae'r dull hwn yn rhoi mwy o gyfleoedd i ofalwyr di-dâl a'r rhai sy'n derbyn gofal ganddynt i gymryd rhan mewn gweithgareddau maen nhw'n eu dewis – rhywbeth sy'n aml yn anodd oherwydd eu cyfrifoldebau gofalu.

Cwm Taf People First

This service is for:

- Adults with a learning disability / their carers

The offer:

Cwm Taf People First proposes offering three short breaks—one in each quarter of the year—and three experience days. These experience days will take place in the evening or on weekends, without overnight stays, to give both unpaid carers and the people they support a chance to rest outside of typical week day hours.

Each break or experience will support 8 to 12 participants, depending on individual needs and costs such as accommodation and activities. The details of each event will be planned together with the group to make sure the activities are meaningful and enjoyable.

This approach gives unpaid carers and those they care for more chances to take part in activities they choose—something that is often difficult due to their caring responsibilities.

Sut i ymgeisio / How to apply:

E-bost / Email: **leejones@rctpeoplefirst.org.uk**

Ffôn / Telephone: **07496883553**

Pen-y-bont ar Ogwr

Bridgend

Ymddiriedolaeth Ddiwylliannol Awen – Gofalu am Gymunedau

Mae'r gwasanaeth hwn ar gyfer:

- Oedolion a Phobl Hŷn

Y cynnig:

Digwyddiadau wedi'u cynllunio ar gyfer gofalwyr

- **Misol:**

  Cyngherddau Be Hear Now yn Neuadd Tref Maesteg
  Cynhwysir te a theisen ar gyfer hyd at 100 o ofalwyr

- **Gydol y flwyddyn:**

  Cinio dydd Sul yn Nhŷ Bryngarw
  Ar gyfer 20 pâr

- **Ionawr / Chwefror:**

  Digwyddiad Dydd Santes Dwynwen / Dydd Sant Ffolant
  Swper rhamantus gyda cherddoriaeth fyw yn Nhŷ Bryngarw ar gyfer hyd at 40 o ofalwyr

- **Mawrth:**

  Digwyddiad Dydd Gŵyl Dewi
  Te prynhawn gyda pherfformiad ar y delyn yn Nhŷ Bryngarw ar gyfer hyd at 40 o ofalwyr

- **Mai:**

  - **Opera Abertawe** yn Neuadd Tref Maesteg
    Ar gyfer 20 o ofalwyr
  - **Sioe Gomedi Stand-yp** yn Neuadd Tref Maesteg
    Ar gyfer 20 o ofalwyr

- **Mehefin:**

  Ballet Cymru yn Neuadd Tref Maesteg
  Ar gyfer 20 o ofalwyr

- **Awst:**

  Outdoor Theatr Awyr Agored ym Mharc Bryngarw
  Tair sioe ar gyfer 40 o ofalwyr

Awen Cultural Trust – Caring for Communities

This service is for:

- Adults and Older People

The offer:

Planned events for carers

- **Monthly:**

  Be Hear Now Concerts at Maesteg Town Hall
  Includes tea and cake for up to 100 carers

- **Year-Round:**

  Sunday Lunches at Bryngarw House
  For 20 couples

- **January/February:**

  St Dwynwen's Day / Valentine's Day Event
  Romantic dinner with live music at Bryngarw House for up to 40 carers

- **March:**

  St David's Day Event
  Afternoon tea with harp performance at Bryngarw House for up to 40 carers

- **May:**

  - **Swansea Opera** at Maesteg Town Hall
    For 20 carers
  - **Stand-Up Comedy Show** at Maesteg Town Hall
    For 20 carers

- **June:**

  Ballet Cymru at Maesteg Town Hall
  For 20 carers

- **August:**

  Outdoor Theatre at Bryngarw Park
  Three shows for 40 carers

Prosiectau Seibiau Byrion wedi'u Hariannu



Y cynnig:

Digwyddiadau wedi'u cynllunio ar gyfer gofalwyr

- **Hydref:**
  - **Made in Tennessee** (Sioe Canu Gwlad) yn Neuadd Tref Maesteg
    Ar gyfer 20 o ofalwyr
  - **Lipstick on Your Collar** (Sioe gerdd 1950au / 60au) yn Neuadd Tref Maesteg
    Ar gyfer 20 o ofalwyr
- **Rhagfyr:**

  Groto Siôn Corn Hamddenol aym Mharc Gwledig Bryngarw
  Ar gyfer dros 60 o deuluoedd, yn cynnwys addurniadau, crefft, bwyd, diod ac anrhegion. Daw'r digwyddiad hwn, sy'n ystyriol o'r synhwyrau, â llawenydd a seibiant i gyfranogwyr.

The offer:

Planned events for carers

- **October:**
  - **Made in Tennessee** (Country Music Show) at Maesteg Town Hall
    For 20 carers
  - **Lipstick on Your Collar** (1950s / 60s Music Show) at Maesteg Town Hall
    For 20 carers
- **December:**

  Relaxed Santa Grotto at Bryngarw Country Park
  For over 60 families. Includes decorations, crafts, food, drinks, and presents. This sensory-friendly event brings joy and respite to participants.

Sut i ymgeisio / How to apply:

E-bost / Email: **claire.cressey@awen-wales.com**

Ffôn / Telephone: **01656 754825**

Os oes gennych unrhyw gwestiynau pellach, anfonwch e-bost at leah.morgan@rctcbc.gov.uk

If you have any further questions, please email leah.morgan@rctcbc.gov.uk

Cwm Taf Morgannwg
Partneriaeth Rhanbarthol | Regional Partnership

ctmregionalpartnershipboard.co.uk