

Quality, Safety & Experience Committee

Tue 23 September 2025, 09:00 - 12:00

Virtually via Teams



Agenda

09:00 - 09:05 1. PRELIMINARY MATTERS
5 min

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 - 09:05 2. CONSENT AGENDA BUSINESS
0 min

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

09:05 - 09:10 3. COMMITTEE GOVERNANCE ARRANGEMENTS
5 min

3.1. Action Log

Discussion Carolyn Donoghue, Independent Member/Committee Chair

📄 3.1 QSEC Action Log QSEC 23 September 2025.pdf (6 pages)

3.2. Matters Arising not contained within the Action Log

Discussion Carolyn Donoghue, Independent Member/Committee Chair

09:10 - 09:25 4. STAFF AND SERVICE USER EXPERIENCE
15 min

4.1. Shared Listening & Learning Story - Domestic Violence

Discussion Claire O Keefe, Head of Safeguarding

📄 4.1 Shared Listening & Learning Story-Domestic Violence v2.pdf (9 pages)

09:25 - 10:45 5. SETTING THE SCENE - SERVICE DELIVERY
80 min

5.1. Report from the Clinical Executives

Discussion Clinical Executives

📄 5.1 Clinical Exec Directors Update Report QSEC 23 September 2025.pdf (12 pages)

5.2. Care Group Highlight Reports

Discussion

5.2.1. Primary Care & Communities Care Group

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

 5.2.1 PCC highlight report QSEC 23rd Sept 2025.pdf (11 pages)

5.2.2. Diagnostics, Therapies, Pharmacy & Specialities

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

 5.2.2 Highlight Report DTPS QSEC 23 September 2025.pdf (15 pages)

5.2.3. Mental Health & Learning Disabilities Care Group

Discussion *Lloyd Griffiths, Head of Nursing*

 5.2.3 MHL D Highlight Report QSEC 23 September 2025.pdf (11 pages)

5.2.4. Planned Care Care Group

Discussion *Sharon O'Brien, Care Group Nurse Director*

 5.2.4 Highlight Report Planned Care QSEC 23 September 2025.pdf (10 pages)

5.2.5. Unscheduled Care Care Group

Discussion *Owen Weeks, Care Group Medical Director*

 5.2.5 USC QS Highlight Report QSEC 23 September 2025.pdf (14 pages)

5.2.6. Children & Families Care Group

Decision *Suzanne Hardacre, Care Group Nurse Director*

 5.2.6 Highlight Report Children & Families Care Group 23 September 2025.pdf (8 pages)

5.3. Reducing Health Inequalities

Discussion *Philip Daniels, Executive Director of Public Health*

 5.3 Inequalities presentation QSEC 23 Sept 2025.pdf (25 pages)

10:45 - 11:05

20 min

6. DELIVERING OUR PLAN

6.1. Patient Safety, Quality & Experience Dashboard

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

 6.1a Patient Safety and Quality Dashboard Report QSEC 23 September 2025.pdf (18 pages)

 6.1b Appendix 1 Patient Experience Report QSEC 23 September 2025.pdf (9 pages)

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

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

 6.2 Medical Negligence Claims QSEC 23 September 2025.pdf (6 pages)

11:05 - 11:50

45 min

7. GOVERNANCE, RISK AND ASSURANCE

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

Discussion Cally Hamblyn, Assistant Director of Governance & Risk

-  7.1a Org RR Sept 25 - QSEC 23 Sept 2025.pdf (7 pages)
-  7.1b App 1 - Org RR Sept 25 - QSEC 23 Sept 2025.pdf (7 pages)

7.2. Health Inspectorate Wales (HIW) Audit Tracker Report

Discussion Greg Dix, Executive Director of Nursing/Deputy CEO/Cally Hamblyn, Assistant Director of Governance & Risk

-  7.2a HIW Tracker Cover Report QSEC 23 September 2025.pdf (8 pages)
-  7.2b App 1 HIW Inspections Recommendations Tracker_QSEC 23.09.2025.pdf (10 pages)

7.3. Coroner's Inquest – Case Activity & Lessons Learned

Discussion Dom Hurford, Executive Medical Director & Greg Dix, Executive Director of Nursing/Deputy CEO

-  7.3 Coroner's Inquest – Case Activity and Lessons Learned 1 QSEC 23 Sept 2025.pdf (8 pages)

7.4. Internal Audit Review - Duty of Candour

Discussion Greg Dix, Executive Director of Nursing/Deputy CEO

-  7.4a Internal Audit Review Duty of Candour QSEC 23 September 2025.pdf (5 pages)
-  7.4b CTMUHB 2425-10 Duty of Candour Audit Report Final QSEC 23 September 2025.pdf (22 pages)

7.5. Health, Safety & Fire Sub Committee Highlight Report 4 September 2025

Discussion Carolyn Donoghue, Independent Member

-  7.5a HSFSC Highlight Report 4 September 2025 QSEC 23 Sept 2025.pdf (7 pages)
-  7.5b Appendix 1 - Terms of Reference QSEC 23 Sept 2025.pdf (9 pages)

7.6. Public Services Ombudsman for Wales Turning the Page Annual Report & Annual Letter

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

-  7.6a Annual Letter and Annual Report QSEC 23 September 2025.pdf (7 pages)
-  7.6b Annual Letter 2024-25 QSEC 23 September 2025.pdf (10 pages)
-  7.6c Llythyr Blynnyddol 2024-25 QSEC 23 September 2025.pdf (11 pages)

11:50 - 11:55
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

-  8.1.1 Unconfirmed Minutes QSEC 22 July 2025 QSEC 23 September 2025.pdf (18 pages)

8.1.1. Unconfirmed Minutes of the Meeting held on 22 July 2025

Decision Carolyn Donoghue, Independent Member/Committee Chair

-  8.1.1 Unconfirmed Minutes QSEC 22 July 2025 QSEC 23 September 2025.pdf (18 pages)

8.1.2. Unconfirmed Minutes of the In Committee Meeting held on 22 July 2025

Decision Carolyn Donoghue, Independent Member/Committee Chair

-  8.1.2 Unconfirmed Minutes IN-Committee QSEC 22 July 2025 QSEC 23 September 2025.pdf (3 pages)

8.1.3. Putting Things Right Annual Report

Decision Greg Dix, Executive Director of Nursing/Deputy CEO

-  8.1.3a PTR Annual Report 2024-2025 QSEC 23 September 2025.pdf (4 pages)
-  8.1.3b PTR Annual Report 2024-2025 QSEC 23 Sept 2025.pdf (15 pages)

8.1.4. Organ Donation Sub Committee Highlight Report and Terms of Reference

Decision Dom Hurford, Executive Medical Director

-  8.1.4a Organ Donation Committee Highlight Report QSEC 23 September 2025.pdf (6 pages)
-  8.1.4b Organ Donation TOR QSEC 23 September 2025.pdf (8 pages)

8.1.5. All Wales Individual Patient Funding Request (IPFR) Policy (2025)

Decision Philip Daniels, Executive Director o Public Health

-  8.1.5a IPFR policy update QSEC 23 September 2025.pdf (7 pages)
-  8.1.5b Appendix 1 NHS Wales IPFR Policy QSEC 23 Sept 2025.pdf (30 pages)

8.1.6. All Wales Prior Approval Policy (2025)

Decision Philip Daniels, Executive Director o Public Health

-  8.1.6a AW Prior Approval Policy QSEC 23 September 2025.pdf (5 pages)
-  8.1.6b Appendix 1 - NHS Wales Prior Approval Policy - FINAL July 2025.pdf (9 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 23 September 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 23 September 2025.pdf (5 pages)

8.2.3. Joint Commissioning Committee - Quality Safety and Outcomes Sub-Committee Highlight Report 31 March 2025

Information

-  8.2.3 QSO Highlight Report March 2025 QSEC 23 September 2025.pdf (8 pages)

8.2.4. Infection, Prevention & Control Annual Report 2024/2025

Information Greg Dix, Executive Director of Nursing/Deputy CEO

-  8.2.4a IPC Annual Report 2024-2025 QSEC 23 September 2025.pdf (5 pages)
-  8.2.4b IPC Annual Report 2024-2025 QSEC 23 Sept 2025.pdf (58 pages)

8.2.5. Research & Development, Innovation & Improvement Bi Annual Update

Information John Geen & Rhian Beynon, Research & Development

-  8.2.5 R&D Bi Annual Update QSEC 23 September 2025.pdf (15 pages)

8.2.6. Individual Patient Funding Request Annual Report

Information Philip Daniels, Executive Director of Public Health

-  8.2.6 IPFR Annual report 24-25 (FINAL) QSEC 23 September 2025.pdf (11 pages)

11:55 - 12:00 **9. CLOSE OUT BUSINESS**
5 min

9.1. Committee Highlight Report to the Board

Discussion Cally Hamblyn, Assistant Director of Governance & Risk

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

Discussion Carolyn Donoghue, Independent Member/Committee Chair

12:00 - 12:00 10. Private / Closed Session Business

0 min

Information Carolyn Donoghue, Independent Member/Committee Chair

The following items will be received In Committee:

- Maternity and Neonatal Leadership and Culture Plan
- Update on Special School Nursing (to include an update on timescales for achieving a solution)
- Organisational Risk Register - Closed Risks

12:00 - 12:00 11. Date & Time of the Next Meeting

0 min

Information Carolyn Donoghue, Independent Member/Committee Chair

The next meeting will take place on Tuesday 18 November at 9:00am

Committee Action Log

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	Propose to close In year delivery plans on estates performance will be presented to the Operational Delivery Committee along with any Estates Risks escalated to the Organisational Risk Register. Activity in relation to the development of an Estates Plan aligned to CTM2030 will be received at the Strategic Development Committee. It is recognised that there will be occasions depending on the nature of the topic being reported that there could be involvement from the Quality, Safety & Experience Committee and Health, Safety & Fire Sub Committee.
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.
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	Proposed for Closure Update included in the stroke service report presented to the meeting held on 22 July 2025
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	Proposed for Closure Update included in the stroke service report presented to the meeting held on 22 July 2025
25.03.2025	5.3b	7	Unscheduled Care Group Highlight Report	Spotlight presentation to be presented to a future meeting in relation to the positive experiences that had been achieved in regard to the opening of two wards at Ysbyty George Thomas during the critical incident at the Princess of Wales Hospital	Unscheduled Care Group Nurse Director	Unscheduled Care Group Nurse Director	30/07/2025 Now 23 September 2025	Open	Proposed for Closure An update has been included in the Care Group Highlight report being presented to the September 2025 meeting
25.03.2025	5.3f	9	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report	Further clarity to be provided in regard to the discrepancies highlighted in relation to the higher than average number of clinical incidents being reported within stroke services which did not correlate with the update provided on stroke services earlier in the meeting.	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20.05.2025	Open	Proposed for Closure Update included in the stroke service report presented to the meeting held on 22 July 2025

25.03.2025	6,1	10	Patient Safety, Quality & Experience Dashboard	Update to be provided at the next meeting which identifies whether the locally reportable incidents were now being picked up via the Duty of Candour. Ombudsman report to be shared with Committee Members for information and awareness.	Assistant Director of Quality & Safety	Assistant Director of Quality & Safety	20/05/2025 22/07/2025 Now 23 September 2025	Open	Proposed for Closure This detail will be included in the Duty of Candour section of the dashboard, which will be undertaken once the 2024/2025 annual report has been produced.
20.05.2025	4,1	3	Listening & Learning Story - Maternity Services	Update to be provided at a future meeting on the work being undertaken by the Team on how it was reaching the wider population via digital platforms.	Care Group Nurse Director, Children & Families	Care Group Nurse Director, Children & Families	TBC	Open	In progress Date to be agreed with Team
20.05.2025	4,2	4	Executive and Independent Member Walkaround Framework Cover Paper	Review of proposed frequency of walk rounds to be undertaken alongside a wider review of the new process once one round of walk rounds had been completed	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 Walk round per quarter, meaning that each Executive and IM will participate in four Walk rounds per year. Should an Executive or IM wish to conduct additional Walk rounds beyond this minimum, these will be arranged accordingly. Once a full cycle has been completed—allowing every Executive and IM to carry out a Walk round 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
22.07.2025	2,1	2	Consent Agenda Business	Internal Audit Review on the Duty of Candour to be deferred to the September 2025 meeting and placed on the main agenda for discussion	Executive Director of Nursing/Deputy CEO	Head of Corporate Governance & Board Business	23.09.2025	Open	Proposed for Closure Item placed on the main agenda for discussion at the September 2025 meeting
22.07.2025	4,1	4	Listening & Learning Story - Carers	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed, with further discussion required as to what could be done to address the issues	Head of Corporate Governance & Board Business	Executive Director of Nursing/Deputy CEO	20.01.2026	Open	In progress Item to be scheduled into the forward work programme for 2026
22.07.2025	5,1	4	Clinical Executives Report	Future reports to include more detail on the causes behind the increase in pressure ulcer incidents and the lessons that had been learnt	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	23.09.2025	Open	Proposed for Closure - Ongoing Regular updates will be provided to the Committee through the Harm Free Care Update reports being presented to the Committee in sequence, Falls, Nutrition & Hydration and Pressure Ulcer. Next report due in November 2025.

22.07.2025	5,1	5	Clinical Executives Report	Information to be shared with Members outside the meeting in relation to the consequences of the non agreement between Primary and Secondary Care in relation to preconception care and diabetes in pregnancy	Executive Director of Public Health	Executive Director of Public Health	23.09.2025	Open	Proposed for Closure Information shared by email with Members on 22 July 2025 by the Executive Director of Public Health
22.07.2025	5.2.1	6	Children & Families Care Group Highlight Report	Update to be included in September iteration of the report on the work being undertaken to address Special School Nursing issues	Director of Midwifery	Executive Director of Nursing/Deputy CEO	23.09.2025	Open	Proposed for Closure Brief update included in Care Group Highlight report for the September meeting. Detailed report to be received via September 2025 In Committee session
22.07.2025	5.2.3	8	Planned Care - Care Group Highlight Report	Update to be provided by G Hughes on what the impacts and expected outcomes were likely to be in relation to the developments within Gastroenterology and General Surgery, for example, reduction in waiting lists, patients having to spend less time in hospital	Chief Operating Officer	Chief Operating Officer	23.09.2025	Open	In progress Awaiting further update from Chief Operating Officer
22.07.2025	5.2.4	9	Mental Health & Learning Disabilities Care Group Highlight Report	Update to be presented to a future meeting on assurances being provided in relation to Learning Disability Services.	Care Group Nurse Director Mental Health & Learning Disabilities	Chief Operating Officer	23.09.2025	Open	Proposed for Closure Update included in Care Group Highlight report for the September 2025 meeting
22.07.2025	5.2.6	9	Primary Care & Community Care Group Highlight Report	Chief Operating Officer to provide an update on the plans in place to address the Paediatric General Anaesthetic Waiting list position given that this was largely dependent on Theatre List availability	Chief Operating Officer	Chief Operating Officer	23.09.2025	Open	Proposed for Closure Update provided to Board members at Board Briefing session held on 21 August 2025. Associated email shared with Board members by email on 16 September containing a further update on the mitigating actions being taken to reduce the Paediatric Dentistry GA Theatre List
22.07.2025	5,3	12	Stroke Services Report	Future reports to include focus on AHP and Therapies workforce availability to deliver a 7 day service, along with rehab goals and outcomes.	USC Care Group Service Director	Chief Operating Officer	20.01.2026	Open	In progress This will be included in the next scheduled substantive report which is due to be presented to Committee in January 2026
22.07.2025	6,1	13	Patient Safety, Quality & Experience Dashboard	Response to be provided outside the meeting regarding inconsistencies reported in figure contained in paragraph 2.2 regarding number of incidents reported compared to bar chart graph contained later in the report	Head of Concerns & Business Intelligence	Executive Director of Nursing/Deputy CEO	23.09.2025	Open	In Progress Deputy Director of Nursing plans to discuss the context of this action with Committee Chair
22.07/2025	6,1	13	Patient Safety, Quality & Experience Dashboard	Review to be undertaken of any themes and trends that needed to be highlighted to the Committee in relation to patient absconsions. Update to be included in Care Group Highlight report for the September 2025 meeting.	Head of Nursing, Mental Health & Learning Disabilities Care Group	Chief Operating Officer	23.09.2025	Open	Proposed for Closure An analysis of the review undertaken has been included in the September iteration of the Care Group Highlight report.

22.07.2025	6.1.1	14	Committee Referral - Details of the medical negligence claims from the losses and special payments report - Verbal Update	Detailed written update to be presented to the September 2025 meeting of the Quality, Safety & Experience Committee	Head of Concerns & Business Intelligence	Executive Director of Nursing/Deputy CEO	23.09.2025	Open	On agenda for September 2025 meeting
22.07.2025	6,2	14	Overview of the Development & Delivery of the Research & Development Strategy	Strategy on a page to be shared with Committee members following the meeting.	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	23.09.2025	Open	Proposed for Closure Strategy on a page was included with the Board papers published ahead of the July 2025 meeting
22.07.2025	6,4	14	People Experience Forum Update	Review the statement made within the report in relation to underfunding to better reflect the intended message, focusing on concerns rather than asserting underfunding as fact	Deputy Director of Nursing	Executive Director of Nursing/Deputy CEO	23.09.2025	Open	In progress Awaiting update from Patient Care & Safety
22.07.2025	6,4	14	People Experience Forum Update	For future meetings, there should be one agenda item on People's Experience, particularly when the update from the People's Experience Forum was due to be received	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	20.06.2026	Open	Proposed for Closure Head of Corporate Governance will ensure this is actioned for the next report which is due to be presented to Committee in January 2026
22.07.2025	7,2	16	Health Inspectorate Wales (HIW) Audit Tracker Report	Healthcare Inspectorate Wales Audit Tracker Report to be presented back to the September meeting on the main agenda for further discussion	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	23.09.2025	Open	Proposed for Closure Item added to the agenda for the September 2025 meeting
22.07.2025	9,1	18	Committee Highlight Report to Board	Concerns raised in relation to Paediatric General Anaesthetic Waiting Lists to be highlighted as an area for escalation within the Committee Highlight report to Board	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	25.09.2025	Open	Proposed for Closure This item has been included in the alert/escalate section of the Committee Highlight report being presented to the September 2025 Board

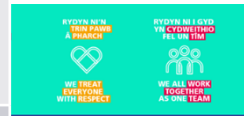
Committee Action Log

Committee
Member

the action originated from	reference	Reference Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
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	Completed Report received via the consent agenda for information at the 22 July 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 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 Report received and discussed at the In Committee session held on the 22 July 2025
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 Narrative explanation was included in the metrics received at the July 2025 meeting
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 Annual Report updated prior to submission to the Board for approval at the Board meeting on 29/05/2025
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 Improvement plan 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	Completed Included in highlight report which was 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 The policy has now been approved. The regulation 28 report has been drafted and has been reviewed by Counsel. It will be issued imminently.



4.1	23 rd of September 2025	Quality & Safety Committee	Shared Listening & Learning Story-Domestic Violence
Report Details:		Impact Assessment:	
FOI Status:	Please select: Open (Public)	Indicate the Quality / Safety / Patient Experience Implications:	
If closed please indicate reason:		Related Health and Care Standard	e.g. Governance, Leadership & Accountability
Prepared By: <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Claire O'Keefe – Head of Safeguarding	Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	No, not required for a patient story
Presented By: <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Claire O'Keefe – Head of Safeguarding	Are there any Legal Implications /Impact.	Consent has been obtained to share these stories.
Approving Executive Sponsor:	Greg Dix – Executive Director of Nursing	Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Report Purpose	For Noting	Link to Strategic Goals	Please Select: Sustaining Our Future Inspiring People Improving Care Creating Health



Health Independent Domestic Violence Advocate Service

Violence against women and girls has serious health and long-term psychological impacts. The Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) (Wales) Act 2015 requires health boards to develop and deliver local strategies to tackle VAWDASV and support victims and survivors. As many may not recognise the link between abuse and their health, timely access to support is vital to reduce harm and improve outcomes.

This work is also aligned with the NHS Wales Women's Health Plan (December 2024), which prioritises improving women's health outcomes and ensuring that services respond effectively to the wider determinants of health, including experiences of violence and abuse.



Evidence shows that women who experience domestic abuse and sexual violence:

- Present more frequently to health services.
- Have more admissions to hospital than non-abused women.
- Are issued with more prescriptions.

Key indicators of VAWDASV

- Symptoms of depression, anxiety, post traumatic stress, sleep disorders.
- Suicidal tendencies or self harming
- Alcohol or other substance misuse
- Unexplained gastrointestinal symptoms
- Unexplained gynaecological symptoms, including pelvic pain and sexual dysfunction.
- Adverse reproductive outcomes, including multiple unintended pregnancies and terminations
- Repeated health consultations with no clear diagnosis
- Delayed pregnancy care, miscarriage, premature labour and still birth or concealed pregnancy
- Genitourinary symptoms, including frequent bladder or kidney infections.
- Vaginal bleeding or sexually transmitted infections.
- Chronic unexplained pain
- Traumatic injury, particularly if repeated with vague implausible explanations.
- Problems with central nervous system – headaches, cognitive problems, hearing loss.
- Intrusive 'other person' in consultations, including partner, spouse, parent, grandparent or adult child (for elder abuse)

Staff Survivor Story

I was told by my ward manager and a nurse practitioner working in CTMUHB who is also a friend that there was an IDVA in the health board who could help me with what I was experiencing at home. The nurse practitioner was aware of my situation as a friend I confided in.

Initially I didn't know if I should meet with Kristy but both my friend and ward manager told me it was helpful and now I recognise that it was the right thing to do. My friend came into the IDVA's office and booked me an appointment and due to the advice given to my friend from the IDVA I contacted the Police in the meantime as things went beyond my control and I didn't feel safe

The IDVA has supported me from everything from A-Z. I always feel like I can call Kristy and have advice when I feel pressured or stress. I can communicate safely. It has been a really good support and helped me in a bad, hard time. She is the best like an angel. The support I was most grateful for was her attending the police station for me to give a video interview and the check in calls where I knew someone really cared and the risk assessments which helped to keep me safe.

The support helped me to stay in work. My work means a lot to me and having the support on site meant I was able to access when on shift which was supported by my managers and I am grateful for this

The life I have now is entirely different, me and my children are finally safe in our home and have a peaceful life. My children are happier and our house feels like a home.

I know support will continue when I have to give evidence in May where my husband has been charged with intentional strangulation, Coercive and Controlling behaviour, Stalking and other serious offences.

I just want to express how thankful I am for everything, and I don't think I would have got through it without the support. I recommend anyone going through difficulties at home should come and see the IDVA. There's in mixing personal and professional by getting the right support

Health IDVA Intervention

- Staff member experiencing domestic abuse in excess of 5 years, accessed the support of the health IDVA through her colleague and ward manager.
- She reported that the abuse had escalated in October 2023 when she experienced the first incidence of significant physical violence. Prior to this she had experienced emotional abuse, isolation and financial abuse.
- She presented to the GP and ED with a neck injury, however did not disclose the nature of how her injuries occurred.
- A colleague/friend who had been supporting the staff member approached the health IDVA in the first instance to discuss concerns she had for her friend. Following training with her was aware of the support available. Immediate safety advice was provided, which resulted in a police report and an appointment being made for confidential advice and support from the health IDVA to the staff member.
- The staff member has engaged with the health IDVA since April 24 – July 25 and will receive further support when the case is heard in court in May 26.
- A referral was made for the children to receive support, target hardening (security measures in home), referral to citizens advice, RCT domestic abuse services for education and recovery work and MARAC referrals when further risks were identified.
- Multi-agency working through MAPPA, MARAC arrangements to address risk.
- Onsite support, provide a safe space for the staff member to discuss her concerns and receive timely safety advice.

Patient Story

I originally met Kristy in A&E at the Royal Glamorgan Hospital who attended upon me following a domestic violence incident. Kristy spent time talking with me and asking questions and I felt supported. Following my initial meeting with Kristy, I had further meetings with her for some time and it felt like someone actually heard me and cared and I felt fully supported. Kristy also called to check in on me many times and I was aware that I could contact her if I needed to in between our meetings.

Unfortunately, 5 months after the domestic violence incident, I was involved in a further domestic violence incident and I was contacted by Kristy who had received a report of the assault. Again, Kristy gave her invaluable support. Kristy also assisted me with the police in providing a statement as the police hadn't acted properly at the outset. Following this incident, I was having meetings with Kristy and it really helped me and I feel that Kristy has really helped me emotionally throughout these incidents and that I couldn't have got through them without her.

I have not been in contact with Kristy for a while as we are currently waiting for the Court case although I know that if I am struggling or need help and support, I can contact Kristy for support. I cannot thank Kristy enough for her support during such difficult times.

Health IDVA Intervention

A 49 year old female, attended emergency department with abdominal and chest injuries. Bruising observed to limbs

This was the patients first presentation to an emergency department with an injury. She had disclosed to ED staff that her injuries were caused by her partner

A DASH/RIC was completed, an immediate safety plan put in place and a subsequent MARAC referral as she was identified as a high risk victim of domestic abuse. There was identified control, emotional abuse, financial abuse and escalating violence.

There were no further attendances to the emergency department with domestic related injuries

Due to the relationship and rapport built between the IDVA and patient, following an assault by her cousin she was able to confidently access further support

Outcome - Target hardening, childhood sexual abuse disclosure – referred to New Pathways. The patient reported this relationship was one that was on/off. As an outcome of the health IDVA intervention, the relationship never resumed. She attended the Freedom Programme (domestic abuse education) to enhance her understanding of risk.

The patient was supported to access BAROD, she had never previously engaged with alcohol services and is now 116 days sober.

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Specific Matters for Consideration:

The role of the health IDVA in CTMUHB assists the health board in meeting its statutory duties as set out in the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act.
The role also reflects the short term actions set out in the Women's 10 year health strategy.
Early identification of victims of domestic violence provides opportunities for early intervention and prevention.
Providing on site support to staff provides situational learning, training, education and most importantly a safe space for staff who are victims of domestic abuse to speak up safely.

Key Risks / Matters for Escalation:

The health IDVA role is not substantive and is funded by Value Based Health Care until March 2027.

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Recommendation

Next Steps

The Committee are asked to promote the service to colleagues across CTMUHB services to ensure they have access to timely support and advice.

Through Value Based Health Care the aim is to evidence the vital role the health IDVA can play in reducing inequalities, promoting good health and evidencing better health outcomes for those accessing CTMUHB services.



Agenda Item

5.1

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	1. Richard Hughes-Deputy Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	1. Greg Dix-Executive Director Nursing, Midwifery & Patient Care/Deputy CEO 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	1. Greg Dix-Executive Director Nursing, Midwifery & Patient Care/Deputy CEO 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health
Pwrpas yr Adroddiad / 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	
CEO	Chief Executive Officer
AHPs	Allied Health Professionals
CAG	Clinical Advisory Group
BMA	British Medical Association
HTA	Human Tissue Act
GMC	General Medical Council
CTM	Cwm Taf Morgannwg
DCMO	Deputy Chief Medical Officer
PAs	Physicians Associates
POW	Princess of Wales
RCSLT	Royal College of Speech and Language Therapists
MSc	Masters
AWDPP	All-Wales Diabetes Prevention Programme
WTE	Whole Time Equivalent
TIPSS	Trauma-Informed Practice in Secure Settings
OD	Organisational Development
CPD	Continued Practice Development
iCTM	Improvement in Cwm Taf Morgannwg
OT	Occupational Therapist
HEIW	Health Education and Improvement Wales
DTPS	Dietetics, Therapies, Pharmacy services
ICU	Intensive Care Unit
WPAS	Welsh Patient Administration Service
SBUHB	Swansea Bay University Health Board
LPMHSS	Local Primary Mental Health Support Services
T2DM	Type 2 Diabetes Mellitus
ELG	Executive Leadership Group
QSEC	Quality, Safety & Experience Committee
AMaT	Audit, Management & Tracking
HIW	Healthcare Inspectorate Wales
ESR	Electronic Staff Record

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 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 - Clinical Executive Director specific Updates:

2.1 Nursing & Midwifery-Greg Dix/Richard Hughes

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

Positives

External assurance from recent Healthcare Inspectorate Wales visits

Healthcare Inspectorate Wales (HIW) conducted recent visits to the Emergency Department at Royal Glamorgan Hospital (RGH) and to Maternity services at Princess of Wales Hospital (POW). The visits identified points for learning, which are being taken forward through established improvement mechanisms and monitored via the Health Board's HIW inspections tracker and committee routes.

No immediate assurances were required at the time of the visits, and the overall feedback reflects positively on the commitment and progress demonstrated by our clinical teams and partners across the system.

Oversight continues through routine reporting into ELG and QSEC, ensuring that learning is captured in AMaT and translated into sustained practice.

Strengthening of the Infection Prevention and Control (IPC) service model and availability

To enhance responsiveness and clinical support, the Health Board has implemented seven-day IPC cover, including launching a weekend/bank-holiday on-call advice service (08:00–13:00) and transitioning to a central, Health Board-wide IPC hub.

The hub became operational on 1 September 2025, and extended weekday availability (08:00–20:00) will commence from 1 October 2025, improving timely access to expert IPC advice, particularly for surge events and complex decision-making out of hours.

These changes are supported by a new IPC On-Call operating protocol and associated communications and are being cascaded through operational forums to ensure consistent adoption across sites.

Challenges

Band 2/3 Healthcare Support Workers (HCSWs)

Clarifying and implementing a sustainable approach for Band 2/3 HCSWs remains a key workforce priority.

CTM is actively engaged with the national programme and, in collaboration with the People Directorate, is developing the internal approach for CTM to ensure a safe scope of practice, consistency of roles and appropriate deployment in clinical settings.

Corporate Nursing continues to work with national teams on job profiling and job descriptions to align grading and duties with service needs.

Executive oversight of this work has been maintained through ELG (with recent planned updates), and CTM's workforce data improvement programme includes a pace-setter project covering Nursing, Midwifery and HCSWs, linking ESR and ledger to strengthen establishment control and underpin reliable planning.

2.2 Medical Directorate-Dom Hurford

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

Achievements

This section covers the following achievements:

1. Clinical Advisory Group New Chair
2. Fatigue and Facilities Charter Compliance
3. Human Tissue Act Inspection

Clinical Advisory Group New Chair

The Cabinet Secretary has elected Alex Brown as the new Chair of the Clinical Advisory Group (CAG). Alex works for CTM as a Respiratory Consultant and has previously held the role of Care Group Medical Director for Unscheduled Care.

Fatigue and Facilities Charter Compliance

We're pleased to announce that a new rest facility has been established at the Royal Glamorgan site. This gives resident doctors a quiet space to rest after a shift and has been developed in collaboration with the mess presidents and the BMA. It is hoped that this new facility will enhance well-being and safety for our resident doctors.

Human Tissue Act (HTA) Inspection

Following our first unannounced HTA visit there have been no significant findings within our service. The inspection was centred around interviews with our Designated Individual, Porter, Quality team and Mortuary staff and they had no concerns to raise.

The HTA commented that they were so impressed with the processes and ideas that our team have that they will be taking them away for future learning in Health Boards and Trusts. A truly outstanding service.

Areas of Focus

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

1. Appraiser Roles
2. Physician Associate Guidance

Appraiser Roles

Appraisal is compulsory for doctors, with failure to comply potentially leading to censure by the GMC and ultimately removal from the medical register. As such we are obliged to provide our workforce with the means to fulfil their requirements.

CTM currently has several areas where more appraisers are required. We will be recruiting early in the new year for more appraisers and have asked the Care Groups for support to ensure that appraisal provision remains consistent and effective across our services.

Physician Associate Guidance

There has been new National guidance released which outlines duties and expectations of Physician Associates (PAs). This new guidance will undoubtedly create uncertainty amongst CTM's PAs and their roles.

A Welsh Government (DCMO led) task & finish group is being set up to address the new guidance and medical leaders will be meeting with the PAs shortly to provide reassurance. CTM will then follow the all Wales agreed approach.

2.3 Allied Health Professions and Healthcare Science-Lauren Edwards

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

Successes

Recognition

Several Allied Health Professions and Health Sciences teams have been shortlisted for CTM Seren Awards 2025, which not only recognises the work of teams and individuals but also demonstrates the impact that these professions have within CTM.

The Cardiac Physiology Department at PoW has been nominated for both Department of the Year and Mentor of the Year Awards by students from Swansea University. A testament of the quality of training performed by those within the department whilst ensuring the readiness of future generations of the cardiac physiology workforce.

A member of the Occupational Therapy service has won the best dissertation prize on the Cardiff University MSc Advanced Practice course in 2025. The dissertation focused on evaluating the impact of Value-Based heart failure cardiac rehabilitation.

The Speech and Language Therapy Department hosted an event in partnership with the Royal College of Speech and Language Therapists (RCSLT) to celebrate the 80th anniversary of RCSLT. This was attended by the Minister for Children and Social Care, CTM's CEO, and a number of the CTM executive team.

Collaboration

In collaboration with Primary Care, the Department of Nutrition and Dietetics has expanded the roll out of the All-Wales Diabetes Prevention Programme (AWDPP) to 6 out of 8 clusters. The programme provides targeted support to people who are at an increased risk of Type 2 Diabetes, with the aim of preventing them from developing the condition.

The Dietetic PIPYN Team in Merthyr partnered with Merthyr Junior Parkrun, a free fun and friendly 2km event for juniors, to celebrate the end of Love Parks week, another example of how the PIPYN Programme supports children and their families to achieve healthy behaviours.

The psychology team across acute mental health services is now fully recruited (4.2wte). An initial schedule of TIPSS (Trauma-Informed Practice in Secure Settings) training has now been successfully completed, with all Health Care Assistants having participated. This training has significantly enhanced staff knowledge, skills, and confidence in delivering trauma-informed care to patients with complex needs. Feedback has been overwhelmingly positive, highlighting the value and relevance of the programme. Plans are now in place to extend TIPSS

training to nursing staff, ensuring a consistent and informed approach across the multidisciplinary team.

CTM Audiology Service continue to work with Workforce and OD colleagues in delivering the Affina Programme, designed to give insight on a team's performance. Feedback to date has been positive, with all of the senior leadership team engaged in the process, recognising the future benefits of having a greater insight into the team's preferences and areas of challenge.

Research/CPD

Recognising the importance of research and continuous professional development, the teams continue to present and share their work. Some of these are listed below:

- The AHP neonatal follow up service has been successful in providing an oral presentation at the British Association of Perinatal Medicine Conference. The dietitian from the service won Best Oral Presentation at this UK-wide annual conference.
- Dietetics and weight management staff submitted 2 posters to the iCTM conference in July 2025.
- A member of the physiotherapy service has recently had a study published in the Journal of Musculoskeletal Science and Practice.
- The OT service submitted 2 posters on the positive impact of the *Rapid Assessment & Prevention Occupational Therapy Service* and improving patient feedback to improve services in primary care.
- A member of the Speech and Language service presented at the HEIW Simulation Conference. The presentation demonstrated the impact of co-designing an interprofessional virtual reality simulation for community care.

Awareness

Following discussion and collaboration, the All-Wales Executive Directors of AHP and Health Science have confirmed their areas of priorities for 2025/26. High level deliverables have been identified for each of these areas and will now be progressed through workstreams, chaired by identified Executive leads. The Deputies peer group will drive forward the work through the workstreams, whilst engaging with their organisations through the established governance structures. Both of the all-Wales groups are chaired by either CTM's Executive or Deputy Director of AHPs and Health Science.

Alert

- **PIPYN Programme and the All-Wales Diabetes Prevention Programme (AWDPP)** – no sustainable funding has been identified for these services beyond March 2026. A partnership approach with colleagues in Public Health is ongoing with a paper on PIPYN summarising the

associated risks to be presented to the Executive Leadership Group for further discussion.

- **ICU Psychology Service** - Fixed term charitable funding ending Nov 2025. Business case with options appraisal is being finalised and a business continuity plan being developed.
- **Psychological Therapies** - There are 300 duplicate records on WPAS following the merge with SBUHB. Most of these have now been rectified with only a few queries outstanding. Review of longest waiters for LPMHSS Therapies shows extensive issues with Waiting List validation and business support processes as the care group has several administrative posts waiting for approval which is being addressed within the care group.

2.4 Public Health Update-Philip Daniels

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

CTM Diabetes programme update

- The 5-year diabetes strategic plan for CTM has been developed and signed off by the CTM diabetes programme board
- The 5 operational workstreams have developed their annual plans to operationalise the priorities within the 5-year strategic plan
- A CTM adult type 1 diabetes clinical pathway has been drafted – for programme board sign off
- A CTM adult type 2 diabetes clinical pathway is in development. Working with national and CTM community health pathways team to develop CTM T2DM community health pathway plus overview 'pathway on a page' summary for T2DM. Delayed waiting on publication new NICE T2DM management guidelines (in consultation until Oct 2025)
- Plan to review provision of structured diabetes education in CTM (children/adults) re access, equity, effectiveness and cost
- Options appraisal for CTM sustainable delivery of the All-Wales diabetes prevention programme is in development – will include follow up of women with gestational diabetes

Healthcare Inequalities:

The presentation delivered by the Executive Director of Public Health Philip Daniels in agenda item 5.3 outlines the imperative to reduce health inequalities across Cwm Taf Morgannwg University Health Board (CTM UHB), highlighting the moral, clinical, strategic, and financial reasons for action.

It defines health inequalities and presents local data showing significant disparities in life expectancy, healthy life expectancy, and the early onset of chronic conditions in more deprived communities within CTM.

Legislative frameworks including the Well-being of Future Generations Act and the Socio-economic Duty are identified as key enablers for change.

The presentation further explores healthcare inequalities through access, experience, and outcomes. In addition to inequalities among deprived population, it also examines the needs to consider inclusion health groups—such as homeless individuals, vulnerable migrants, and those with substance dependencies—who face compounded barriers to care.

The presentation concludes with a call to action for a paradigm shift: embedding equity into routine practice, proactively identifying solutions, and ensuring health inequalities are addressed across all programmes of work.

Children and Young People’s Weight Management

The All-Wales Weight Management Pathway for Children and Young People (CYP) describes three levels of weight management, from level one open access, early support and prevention through to level three specialist multi-disciplinary support.

Despite high levels of childhood obesity in Cwm Taf Morgannwg (CTM), there is currently no pan-CTM, all age approach to childhood obesity. The ongoing impact of childhood obesity is reflected on the corporate risk register. Work to reduce our levels of childhood obesity will require sustained, sustainable investment.

The Pipyn programme, a national pilot funded by Welsh Government and conceived by Public Health Wales in 2020/23 has been running in Merthyr Tydfil for the past four years, with promising short-term data. Funding is due to stop at the end of the 25/26 financial year, with uncertainty around Welsh Government’s longer-term position.

A business case for investing in healthy weight for CYP has been approved and prioritised for investment as part of the IMTP process for 25/26. However, delays in confirmation of investment have created uncertainty and instability in the Pipyn programme, and ongoing clinical risk for our most complicated cases of childhood obesity.

The programme is fully subscribed until the end of the current funding period (March 31st, 2026) and places offered beyond this are at risk of being cancelled, with associated negative reputational risk.

There is also an immediate impact on current staffing given the uncertainty past March 2026, with five staff from the establishment of 10 having left posts seeking more sustainable employment elsewhere. The remaining five are on fixed term contracts. Delays in confirmation of funding are leading to heightened concern among these staff for their future employment, and increased risk to staff retention.



A paper to summarise these risks will be reviewed by the Executive Leadership Group for onward escalation to the next QSEC in November as necessary.

3 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Creating Health Inspiring People Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below: Ageing Well Dying Well Growing Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies please list below: 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Quality of patient care is at the forefront of



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

4 Recommendation

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

5 Next Steps

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



Agenda Item

5.2.1

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities
Care Group

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Nurse Director, Primary Care & Communities
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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

CAVUHB	Cardiff and Vale University Health Board
CTM	Cwm Taf Morgannwg
CVC	Community Vaccination Centre
DN	District Nursing
DNA	Did not attend
GA	General Anaesthetic
GP	General Practitioner
HMPPS	His Majesty's Prison and Probation Service
IPC	Infection Prevention control
MCN	Managed Clinical Network
PCH	Prince Charles Hospital
QI	Quality Improvement
QSRE	Quality, Safety, Risk and Experience
RGH	Royal Glamorgan Hospital
SDS	Standard Determinate Sentences
SLA	Service Level agreement
WG	Welsh Government
YCC	Ysbyty Cwm Cynon Hospital
YCR	Ysbyty Cwm Rhondda Hospital

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 18th August 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 Committee 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 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	Comprehensive Care for Paediatrics within Dental Services At present, children are referred to CAVUHB for treatment under an existing service level agreement. However, at the Paediatric MCN meeting held on 7th May 2025, CAVUHB informed the service that they have not been accepting these referrals. There is no capacity within CTM for these patients to be seen so this has been escalated to the planning team to address this with CAVUHB to enable formal processes to be followed. A meeting was held between Cardiff & Vale UHB and CTM on 24th July 2025 to discuss the repatriation of these lists. A further meeting is required to discuss the detail but CTM will need to find capacity for these patients within the current list allocation which could impact on the service's ability to achieve previously reported recovery trajectories and will need to be re-forecasted. In addition to this, the throughput of routine patients is less than anticipated as the service anticipated seeing 11 patients per all day list but the hospital team have requested that only 9 patients are seen.
Advise	CVCs Following a recent IPC and Health and Safety assessment across the 6 vaccination centres in June, the overall conclusion is the centres are not fit for purpose. The key areas identified in the report are: 1. Unsuitable or Unfit Clinical Space, areas are repurposed from non-clinical or multipurpose rooms. 2. Hand Washing and Infection Prevention and Control Compliance 3. Poor Ventilation and Air Quality 4. Patient Privacy and Confidentiality Recommendations have been made under each of the key findings. In response to this a full review of the delivery model will be undertaken and proposals will take into consideration the recommendations. Paediatric GA List There are currently 555 children on the waiting list (a decrease from 667 in June) on the waiting list for a General Anaesthetic Assessment and a further 440 318 children (an increase from 318 in June) on the waiting list for Prevention



and Behavioural Management Assessment which could lead to treatment under general anaesthetic. Confirmation can be provided that from September, a sufficient number of lists have been allocated to the service to enable the backlog to be reduced and manage ongoing demand within the service. Lists will operate from all 3 acute hospital sites. Additional assessments sessions will be put in place with community dental to ensure full utilisation of the lists.

There have been some positive developments in relation to the number of lists proposed for the service with 1.5 lists per week being allocated in PCH and 2 lists per week in RGH. However, the theatre timetable still requires final sign off so this could be subject to change.

General Dental Services at Parc Prison A reduced service is operating within the prison due to capacity issues; the current service provision is for urgent treatment only. This is a risk to patients not receiving access to full courses of treatment.

Short term mitigation is additional session on weekends – provider has sent update costs for weekend working, scope of service for weekend working to be agreed; i.e., routine access appointments. Long term mitigation is for an additional capacity to go into the prison, this is on the refurbishment plan.

However, there were no improvements in the appointment utilisation rate; 65% in June. 94 missed appointments in June out of a total of 171 appointments booked. 53 of missed appointments were DNAs.

Medication incident increase at YCR hospital Due to the increase of incidents, there has been numerous meetings undertaken with nursing and pharmacy to investigate and to identify any gaps in processes. There are now new increased monitoring in place for all wards across YCC and YCR Hospital. The impact of these changes is being monitored via the care groups QSRE meeting, incidents and staff concerns.

Lymphoedema Service Current risk is due to change of non-recurrent funding for the service. A full-service review is required for this team. Awaiting outcome in relation to interim funding solution required to review the service.

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. Awaiting



outcome in relation to interim funding solution required to review the service.

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

Estate limitations, particularly space constraints and inadequate IT infrastructure, remain barriers to service expansion and team efficiency. Office space continues to be a challenge however improved with the introduction of a Senior Leadership Team office.

G4S has recently identified a Healthcare Liaison Manager as part of their senior leadership team, who will work collaboratively with CTM to address these issues. Progress will be monitored through the CTM Prison assurance Board.

Women's Health Hub A Ministerial priority is for all Health Hubs to establish a pathfinder Women's Health Hub by February 2026. Funding has been granted until the end of March mainly to support the planning and preparation of the Hubs but no recurrent funding is available from 1st March 2026 onwards. The National Women's Health Team have submitted a proposal on Friday 29th August for further funding. This programme involves collaborative work between Children and Families and Primary and Community Care Groups. The focus will be on how to utilise existing resources and shift pathways and resources left from secondary care into an 'intermediate care' / community service.

Prison Expansion Plan HMPPS and G4S have secured planning permission to expand the prison capacity by an additional 345 individuals by October 2028. The approved plans also include the construction of a new kitchen and dining block, alongside a gym, multi-faith facility, education building, and a redesigned visitor/staff entrance with increased car parking and supporting infrastructure.

Initial discussions have taken place between the Care Group and G4S regarding the expansion. However, we are currently awaiting further detail, as G4S is in the process of engaging with building and design contractors to determine the specifications—particularly the allocation of space for healthcare services that meet operational requirements. To ensure ongoing oversight and coordination, the Prison Expansion Plans will remain a standing



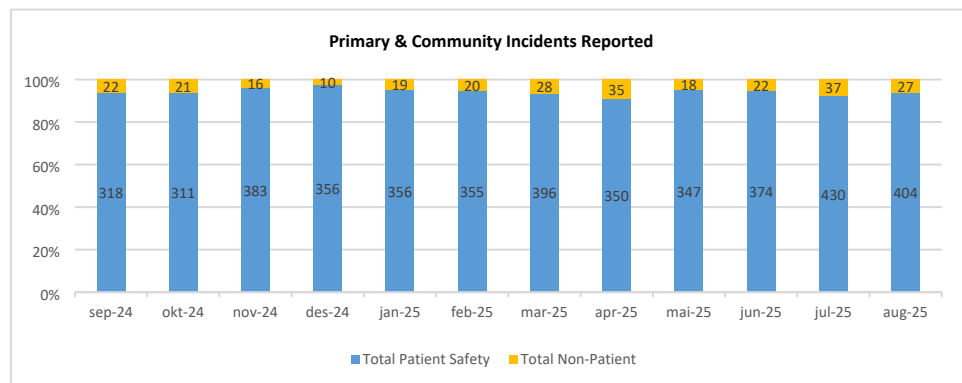
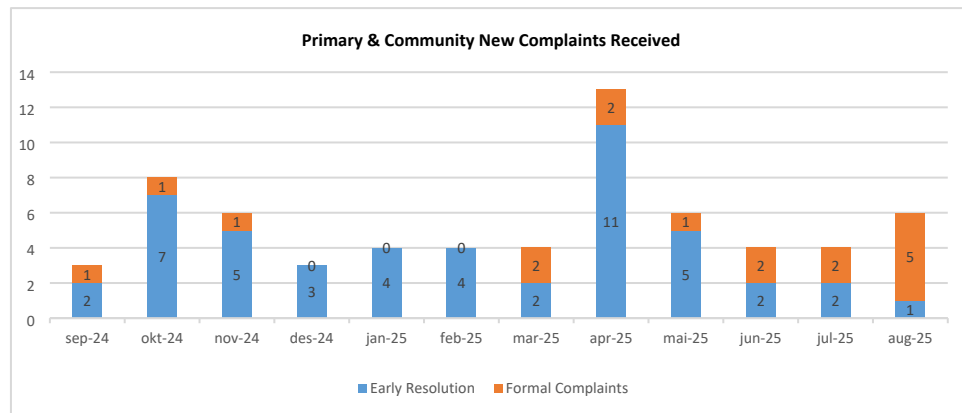
agenda item on both the Prison Assurance Board and the Healthcare Partnership Board.

Parc Prison Optician's service is delivering well within the prison. Provider has introduced a new triaging process, and this has reduced the waiting list by 13 patients between May & June in addition to 89 patients being added to the waiting list between May & June). Additional session will commence in August, it is expected when this is introduced, we expect to see a further reduction in the waiting list. Activity and utilisation will be monitored on a monthly basis to identify effectiveness of additional session, and potential for this to be a longer-term arrangement if there is demand.

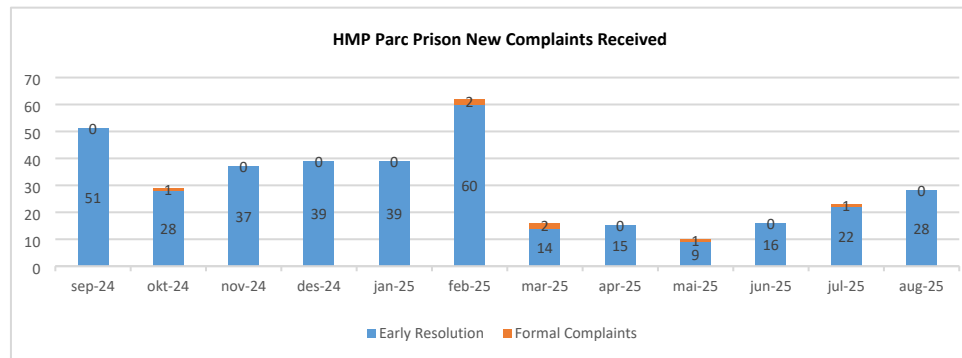


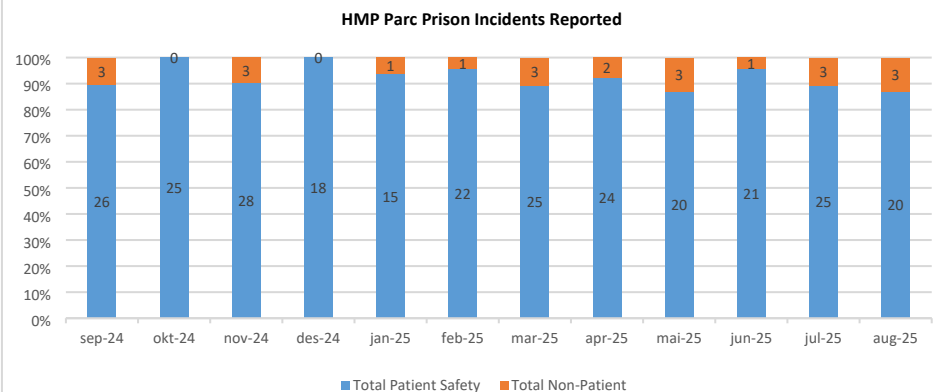
Assure

Concerns and incidents (excluding Parc Prison)



HMP Parc Prison concerns and incidents





PALs Enquiries

Please see slides within the appendix (available on request)

Inform

Community Nursing specification The DN call centre is now in operation for the whole HB. In line with the nursing specification which outlined one telephone contact number for all patients and referrers.

New Dental Contracts - Consultation for the new dental contract has now closed. Responses currently being analysed by Welsh Government. It is expected an update will be issued in September 2025 providing further detail on areas that required clarification and details of any changes that have been made as a result of the consultation. Final contract anticipated to be issued in February 2026

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

District Nursing Service Bridgend Manual handling has been removed off the risk register as the compliance is now at 91%.

CTM presented at the Primary Care and Community Strategic Event in July 25; the **Peer Nurse Advocacy Team** showcased posters in relation to the benefits of restorative clinical supervision.

Bladder and Bowel Lead Nurse to meet with Swansea Bay HB regarding a review of the continence service and look at QI improvements for CTM.

Parc Prison Healthcare - Criminal Justice Act 2003 (Suitability for Fixed Term Recall) Order 2025. The introduction of fixed term recall for most SDS offenders, limiting recall periods to 28 days,

is expected to reduce prison overcrowding but will increase prison turnover and churn. The implications for the Prison Healthcare Directorate will mean more frequent transitions between custody and community, requiring stronger discharge planning, continuity of care, and coordination with external health services to manage medication, mental health, and follow-up care effectively.

Stroke Pathway Collaborative work continues with colleagues in Therapies and Unscheduled Care in respect of the new stroke model. Community pathway had been drafted and bed modelling is being revisited with Digital and performance teams.

2024-27 Hepatitis B and C Elimination Plan the Health Board submitted an update to the above plan which was assessed by the WG Elimination Oversight Group in July. In their response letter to the Health Board, they highlighted the rapid increase in testing at HMP Parc. 99% of men were offered a test in the previous 12 months (target for elimination 100%) and 94.4% of men had taken up that offer and been screened in the previous 12 months (target 90%).

Parc Prison Health & Safety General Audit. The 2025 Health & Safety General Audit was undertaken by CTMs Health & Safety Coordinator on 4th August demonstrated a high level of compliance across all assessed domains, achieving an overall compliance rating of 98%.

Key strengths included robust waste management, effective incident reporting and learning processes, and comprehensive local induction procedures. Minor areas for improvement were identified in manual handling training and centralised access to maintenance documentation.

Parc Prison Team's Success, members of the team have been recognised with CTM wide Seren Awards for both April and May – a recognition to the dedication, kindness and hard work that the team bring to their roles every day. These awards are a recognition of the outstanding work being carried out within the prison to improve services and outcomes for our patients.

April Award; this was awarded for the excellent progress made by the Clinical Lead Manager, and the team in working towards elimination status for hepatitis, reflecting the team's commitment to public health and preventative care. May Award; nominated by a G4S Senior Operational Managers, this award recognised the collaborative work undertaken by Registered Learning Disability



	Nurse, to improve neurodiversity services at HMP Parc, which is a great example of partnership working at its best.
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:
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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Learning, Improvement & Research
	If more than one applies, please list below: Culture and valuing people Leadership
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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



Agenda Item

5.2.2

Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
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
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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 1st September 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: The LIMS Programme remains in RAG status RED. The Deployment Plan, agreed to at the 12th August Programme Board, has changed twice since acceptance. This is primarily due to: the incomplete configuration of the LIMS system, the number of Severity 1 & 2 defects outstanding, delivery of National Interfaces, completion of Data Migration and Legacy Data. this has been escalated via operational routes.

Increased Blood Transfusion Risk:

Nine clinical incidents have been reported in relation to Blood Transfusion 07/07/2025 – 20/08/2025. Six of these incidents are the result of errors that have originated in Blood Bank. This represents an increase in the reporting trend for Blood Bank.

Where appropriate, incidents have been reported externally to the Medicines and Healthcare Products Regulatory Agency and/or have been subject to a RAPID review. Review has identified that system functionality (Telepath) and staff resource are contributory factors in the increase in incidents. There is a long-standing risk on the Pathology risk register in relation to staff resource in Blood Bank & Haematology (apart from senior staff, blood bank and Haematology staff are shared and cover both departments). In order to mitigate this risk, various measures have been taken to stabilise the service including the use of locum Biomedical Scientists (BMS), Organisational Change Process (OCP) and acting down of staff in senior positions. Additional measures have been introduced to reduce the risk of human error when issuing blood products.

The increased incidents in the Blood Transfusion Service have been escalated via the Clinical Director of Health Science, with a recent assurance paper being presented to the Executive Leadership Group.

Healthcare Science

Cardiac Physiology

There remains a sustained demand-capacity gap within the Echocardiography service. This gap is further exacerbated by both planned and unplanned long-term sickness and maternity leave. Current mitigation includes partial support through bank staff and overtime, managed within the existing budget.

Waiting lists continue to rise. To address this, non-recurrent short-term funding has been secured to deliver an additional 300 weekend appointments. Scheduling and staff rotas are in development, with the aim of reducing the waiting list by December 2025.

A longer-term workforce plan is being developed to support sustainable service delivery. Initial engagement has commenced



for a demand and capacity review of Echo resources across CTM, with the objective of ensuring equitable access, consistent service provision, and improved operational efficiency. Challenges with effective patient contact processes are presenting an additional challenge.

Neurophysiology

Deficit continues between demand and capacity with backlogs continuing to rise for both testing and reporting, which will be further exacerbated by plans to increase neurology consultant capacity.

Mitigations are being explored through dialogue with neighbouring Health Boards regarding physiologist and consultant capacity, along with any ideas regarding alternative ways of working. Discussions are underway regarding a recovery plan.

Radiology

Staffing challenges, particularly in relation to out of hours cover, continue to impact service resilience and staff wellbeing. These concerns were identified during the PCH IR(ME)R inspection as an area requiring improvement. Monitoring and workforce planning are ongoing to mitigate risks to safe and effective service delivery.

A number of sonographers across the health board have been affected by work-related musculoskeletal disorders (WRMSKD), resulting in a critical workforce issue that is directly impacting the department's ability to deliver NOUS services. Risk assessments have been completed in collaboration with the Manual Handling Advisor and the Health and Safety Radiographer. Findings and recommendations of the report are awaiting to determine the most appropriate course of action.

Radiology-supported endoscopy services at RGH have been temporarily suspended following the identification of critical faults in the endoscopic equipment. As a result, the service has undergone reconfiguration, with procedures being redirected to other sites. This has led to a decrease in overall service capacity, which may affect access to the service and contribute towards longer waiting times.

A backlog in image reporting persists. While temporary non-recurrent schemes have boosted capacity, they are unsustainable and once they end, the waiting times for reports increases as demand exceeds capacity.

Medicines Management



	- Risks of privately prescribed GLP-RA agonists (e.g. Mounjaro) being continued on GP repeat medication due to system issues. Vigilance needed <u>Dietetics</u> - PIPYN aims to support children (aged 3-7 years) and their families make healthy choices and build healthy family habits. The programme offers family-based support sessions embedded within plans to build healthy environments around the family. There is no sustainable funding identified for PIPYN beyond March 26. The service will remain open to new referrals whilst options are being considered. Capacity until March 26 now full. Staff who are on fixed-term contracts are likely to start looking for alternative employment which will further impact capacity of service. Business case for Children's Weight Management Service submitted as part of Integrated Medium Term Plan (IMTP) process. All Wales Diabetes Prevention Programme (AWDPP) Service currently funded by the Strategic Programme of Primary Care (SPPC) and Welsh Government, no budget identified from March 26 onwards. Fixed term staff likely to start looking for alternative employment risking in-year delivery. Options appraisal being developed via workstream 1, as part of Diabetes Operational Group. <u>Intensive Care Unit (ICU) Psychology Service</u> - Fixed term charitable funding for 8a 0.6wte and 3.0wte Assistant Psychologists funding ending Nov 25. Options appraisal being finalised and business continuity plan being developed.
Advise	<u>AHPs</u> - Increase in incidents reported across AHPs services: 23 in June and 33 in July 25. The average number of incidents per month has risen to 19, where this was previously 14. The increase in incident reporting related to lack of POW ICU dietetic service (risk ID: 5658), delay in access to services, and delay in clinical assessment. POW ICU dietetic service (risk ID: 5658) mitigations in place, SBAR has been shared with Planned Care. Professional leads are working to identify any possible mitigations. - Continued delay in the funding for AHP neonatal workforce being allocated to AHP budget is resulting in continued resource gap in meeting British Association of Perinatal Medicine (BAPM) standards, as the service is not staffed to



meet the clinical needs of neonates. The proposal submitted as part of the IMTP has not been supported, therefore further work between DTSP and Children and Families care groups is required to identify a funding solution.

- **Occupational Therapy (OT)** – continued pressure across acute physical inpatient services, caused by high demand, peak annual leave and ongoing Long Term (LT) sickness. OT management monitoring and moving resource as able to mitigate the risk on flow and patients' functional recovery.
- **OT** - There is no Therapy cover at Ysbyty George Thomas (YGT). Patients have been transferred to YGT when they continue to have ongoing OT needs. Due to functional deterioration in YGT, patients have required referral to OT for updated assessments, ADL/manual handling equipment and there have been failed discharges in the community. This is putting additional pressure on the OT in-patient service and impacting negatively on patient care, discharge and staff wellbeing. Meeting held between YGT and OT service to review issues and Standard Operating Procedure (SOP) to be updated with improved patient selection.

Radiology

Following feedback from the PCH IR(ME)R inspection, actions have been identified to further enhance service delivery, particularly around the entitlement process. Audit tracking will be improved through consistent use of AMaT, aiming for 100% compliance on all observational IR(ME)R audits. Staff engagement will be supported through improved appraisal processes and wellbeing initiatives. Additionally, bilingual materials and feedback boards will be introduced into waiting areas to enhance patient experience.

Pathology

Cellular Pathology – Transfer of reports from outsourcing: currently all reports received from the outsourcing company are manually transferred from the results portal to the Pathology system. This has resulted in several incidents where reports have been incorrectly transcribed, and the risk has been increased to reflect this. Cellular Pathology is currently working with the outsourcing company to implement an automated solution which will enable results to be electronically transmitted directly to the pathology system. A statement of need has been submitted to progress this; now on the Capital priorities list awaiting consideration.



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 increasing; to operate effectively there will be a requirement for additional equipment, improved workflows, and adoption of Digital Pathology. This is not possible within the current space constraints. The 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). In terms of progress, work is underway to support conversion of office space for increase of one Pathologist and associated workload. A SON for feasibility study of medium-term option to expand estate has been submitted and is progressing through approval routes.

Biochemistry analyser upgrade: The Biochemistry Department at Royal Glamorgan Hospital is currently in the process of implementing new analysers. As a result, the department will operate with one analyser until end of October 2025. This poses a potential risk if the remaining analyser fails. There is an established contingency plan which includes support from the PCH site to mitigate this risk. This contingency plan triggered over the Bank Holiday weekend where the operating Biochemistry analyser failed. Samples were transported to PCH for analysis as per contingency plan, however some patient samples did not arrive at PCH promptly. The Biochemistry department is currently working with Facilities to establish how this happened.

Possible Nationally Reportable Incident (NRI) due to delay in Cellular Pathology reporting:

Incident involving a patient with suspected cancer. A biopsy was taken on the 22nd July and sent to the Cellular Pathology outsourcing provider as per contract, for processing and reporting in Cellular Pathology. The sample was received by outsourcing on the 25th July, the pathology report was not received until 18th August (longer than the agreed 14 day turnaround). A RAPID review meeting has been held to discuss the incident, learning and required actions.

Health Science

Audiology

Rise in equipment failure in adult services (pan-CTM), despite recent calibration due to the age of the equipment. A SON has been submitted.



	Staff survey showed some stress and burnout in work. Well-being lead has had update training and is implementing an action plan to support the service. Onboarding in Ear, Nose & Throat (ENT) will lead to approx. 750 new adult hearing aid pathways. We already have 850 new adult hearing patients breaching. No current funding for overtime, consideration is being given to how roles can be changed to include audiologists where required. Evacuation risk at Keir Hardie Health Park (KHHP) for patients in wheelchair on floor 1 has been identified. Floor 1, staff are liaising with estates colleagues to work through risk and mitigations. Cardiac Physiology Since the merger in May, WPAS issues continue with a more complex, time- consuming pathway now in place. Ongoing discussions with IT are taking place to resolve issues which are currently having an effect on pathways and staff morale. Clinical Engineering The service is currently unable to progress Quality Management System implementation to regain ISO 9001:2015 and technologist training plans due to service pressures and continual demand on time to beds service. Consideration is being given to how these areas can be progressed to avoid any impacts in the future. Medicines Management School vaccine programme includes nursery Fluenz® programme this year. Additional funding secured from Health Protection Board for courier service to accelerate deliveries to schools. PCH also funded for over time to cover early opening for vaccine collection at 8.15am during campaign
Assure	Medicines Management CD audits: Target= 100% Current figures for completion of CD audits are: • RGH: 81% [Previous Quarter 100%] • PCH: 100% [Previous Quarter 100%] • POW: 84% [Previous Quarter 81%] • YCR: 100% [Previous Quarter 100%] • YCC: 100% [Previous Quarter 80%] Local sites have plan in place to achieve 100% for the quarter (attending Theatres audit day). In future, Amat team looking to build dashboard to assist with planning and reporting on compliance



Parc Pharmacy risks have now been added to the HMP/YOI Parc risk register

A homecare provider company, have launched a new clinical portal to allow the homecare team to access patient information from an online gateway. Homecare team working with information governance to complete Data Protection Impact Assessment (DPIA) for new portal access. This allows the team to maximise digital tools and create efficient ways of working.

New Ustekinumab biosimilar SteQeyma® offer free faecal-calprotectin tests for patients receiving treatment via homecare. Homecare team approached by gastro consultant to explore home testing to reduce burden on CTMUHB pathology services and current 8-week turnaround time.

Pathology

Unannounced Human Tissue Authority (HTA) /Inspection:

An unannounced HTA inspection took place in CTM on 3rd and 4th September. This was the first unannounced HTA visit in CTM, and there were no significant findings within the service. This is an excellent achievement.

The HTA inspection was carried out across RGH, PCH and POWH sites, with one recommendation which has already been actioned with Estates. HTA will be drafting some advice/guidance for the future in relation to our Mortuary estate and facilities in RGH, which was expected. Whilst there were no concerns with the paper-based system currently in use for tracking patients between sites, HTA did recommend the use of a digital solution to avoid transcription error.

There is still some paperwork to submit as supporting evidence and HTA will arrange a formal closing meeting in the coming 2 weeks. Some very positive feedback was received from the HTA in relation to the operation of the CTM mortuary service, and they will be taking some ideas away for future learning in other Health Boards and Trusts.

Health Science

Audiology

The air conditioning issue at POW is now resolved. New units fitted in 2 x test rooms, which has improved quality of the environment, improved safety, and boosted staff morale.

Hearing aid repair service 'open access' shortlisted for the annual Seren award for Respect and Inclusion.



	Clinical Engineering Anaesthetics/Ventilation Technologist now in post and training up to re-establish this cover at RGH and PCH and remove the requirement for a service contract. This will reduce costs and improve on site responsiveness to any issues, improving patient experience and safety. Due to a failure to appoint into a B5 vacancy discussions are taking place with the Apprenticeship team and Coleg Y Cymoedd to appoint via apprenticeship route and Annex 21. <u>Radiology</u> An internal audit of access to diagnostics within Radiology found that comprehensive referral guidelines were in place within the Radiology directorate. While referral details were consistently and correctly recorded on request forms, the audit identified gaps in the documentation of additional examination-related information. ID verification and the operator's name were either not consistently completed or were difficult to read. A downward trend in the number of radiation incidents has been observed, with only two incidents reported in July, below the monthly average of six. This reduction may indicate early signs of improvement as a result of additional staff training.
Inform	<u>Radiology</u> Recruitment has progressed well, with all Band 5 radiographer vacancies now filled. Safety huddles are embedded across sites and are proving effective in promoting communication and incident awareness. Weekly DATIX drop-in sessions have reduced the number of open incidents and modality user groups are helping to standardise imaging protocols. Radiology continues to receive positive feedback from patients across CTM, particularly in the quality of care delivered in ultrasound. Comments consistently highlight staff professionalism, communication and reassurance during examinations. <u>Medicines Management</u> • Architect visits for dispensary re-design and robot underway. Survey work completed. New procurement schedule drafted. • PCH ED Mediwell (automated dispensing cabinet) on order awaiting Delivery. The previous equipment was damaged as the result of a leak and highlighted in a previous report. This is to assure the committee that the issue is close to

being resolved, and alternative medicines storage remain in place.

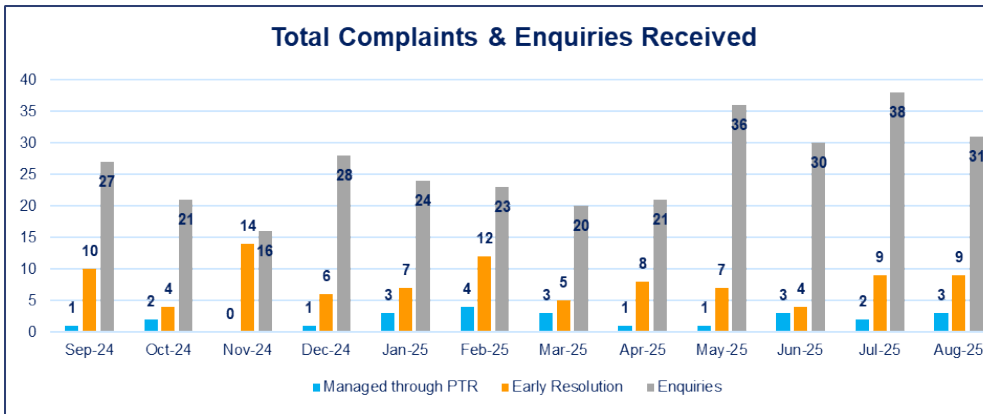
- HMP Parc: Discussions regarding expansion plan and proposed space for new pharmacy dispensary ongoing with G4S and Galliford Try
- Community Pharmacy: Concerns and complaints (2) raised for repeated temporary closures across branches of a multiple pharmacy provider (a “chain”). Often notified after the event with limited detail. Care agencies report distress due to uncertainty, though supervised administration patients and deliveries were reportedly managed appropriately. Team continuing to work with the contractor to support service stability and minimise disruption to care.
- An electronic non-formulary form is being developed to ensure prescribing is in line with our local formulary and promoting equity of care across the HB.
- Nintedanib service being withdrawn from current homecare provider from Oct25; planning complete to transfer patients to another provider and minimise/eliminate disruption to their treatment.

Pathology:

UKAS Inspection: UKAS inspection took place during the first week of July. Minor findings were received for each department, with most findings already cleared by UKAS. Feedback awaited for Microbiology and one Biochemistry finding. The final report is yet to be received.

DTPS Complaints Received and Compliance

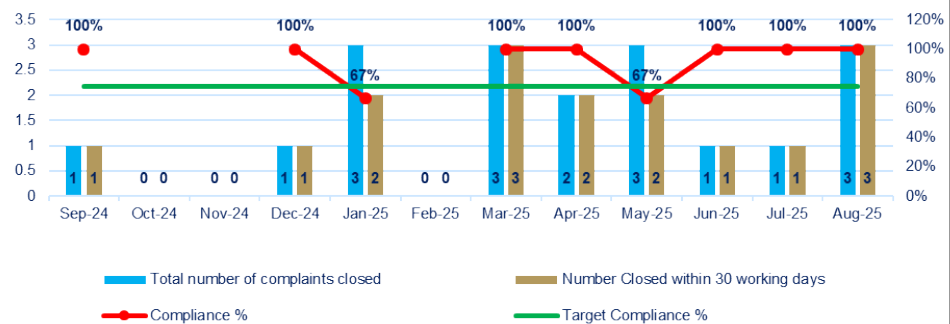
Total Complaints & Enquiries Received



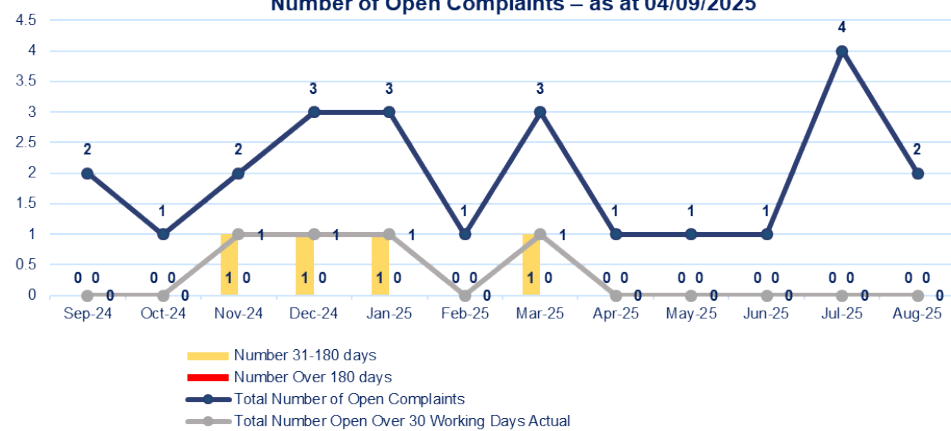
Month	Managed through PTR	Early Resolution	Enquiries
Sep-24	1	10	27
Oct-24	2	4	21
Nov-24	0	14	16
Dec-24	1	6	28
Jan-25	3	7	24
Feb-25	4	12	23
Mar-25	3	5	20
Apr-25	1	8	21
May-25	1	7	36
Jun-25	3	4	30
Jul-25	2	9	38
Aug-25	3	9	31

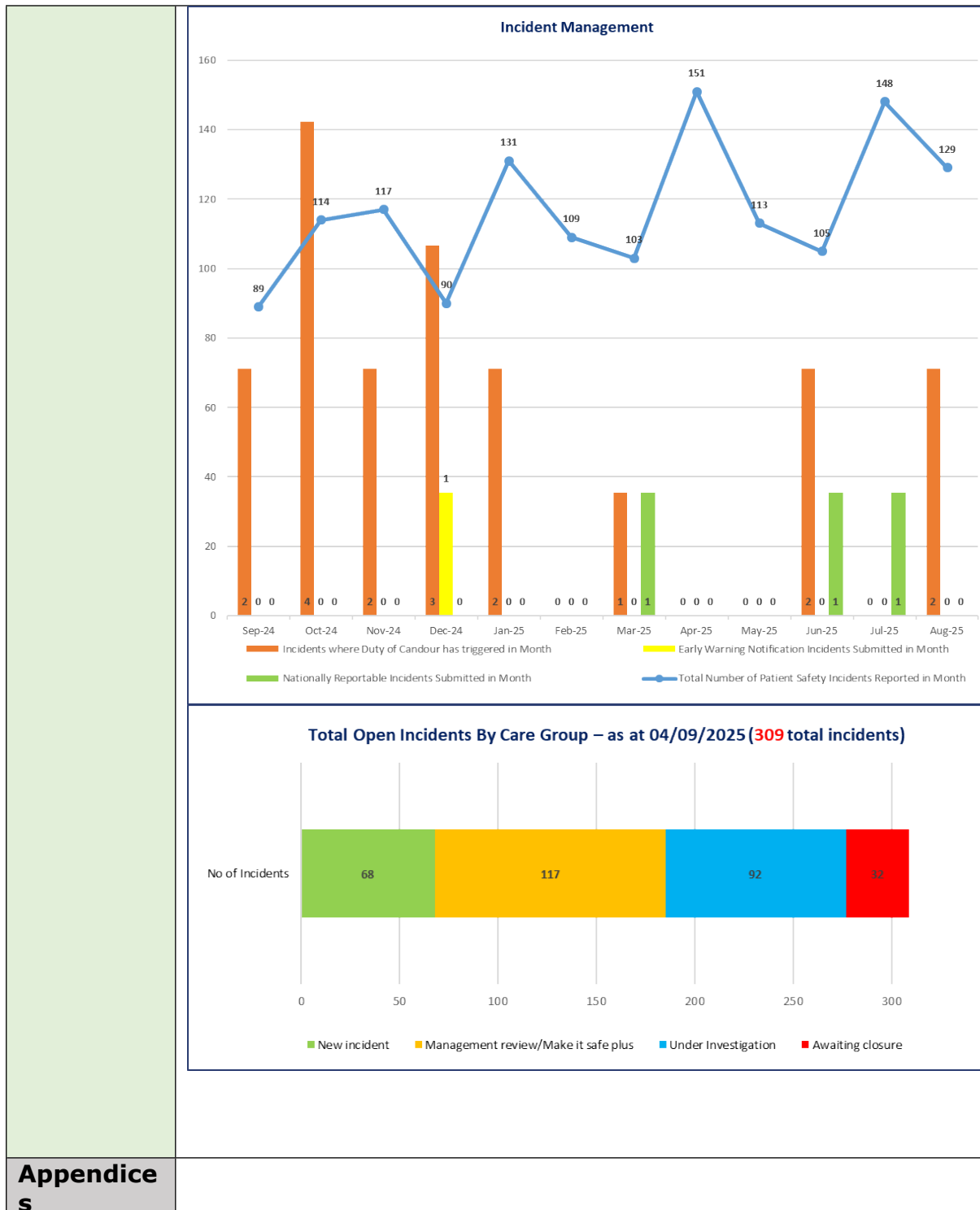


% Compliance for Closed Formal Complaints



Number of Open Complaints – as at 04/09/2025







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 <i>150623-guide-to-the-fg-act-en.pdf</i> <i>(futuregenerations.wales)</i>	A Healthier Wales
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	Data to Knowledge
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

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



<i>Have you undertaken a Quality Impact Assessment Screening?</i>		Not required at this point
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐ Outcome for Equality: NEUTRAL Outcome for Welsh Language: NEUTRAL/	No: ☒ 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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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

5.2.3

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning
Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Lloyd Griffiths, Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Lloyd Griffiths, Head 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
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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
AWOL	Absence Without Leave
CTM	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
CVUHB	Cardiff and Vale University Health Board
ED	Emergency Dept
HMP	His Majesty's Prison
IMTP	Integrated Medium Term Plan
IT	Information Technology
LD	Learning Disability
LTA	Long Term Agreement
MHA	Mental Health Act
MH	Mental Health
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
PICU	Psychiatric Intensive Care Unit
PMVA	Prevention and Management of Violence and Aggression
POW	Princess of Wales Hospital, Bridgend
QSE	Quality Safety Experience
RN	Registered Nurse
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
RCN	Royal College of Nursing
RCRP	Right Care Right Person
RGH	Royal Glamorgan Hospital
SBUHB	Swansea Bay University Health Board
SRU	Supported Recovery Unit (Rehab Ward)
SSP	Student Streamlining Project
WTE	Whole Time Equivalent



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 13/08/2025.
- 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

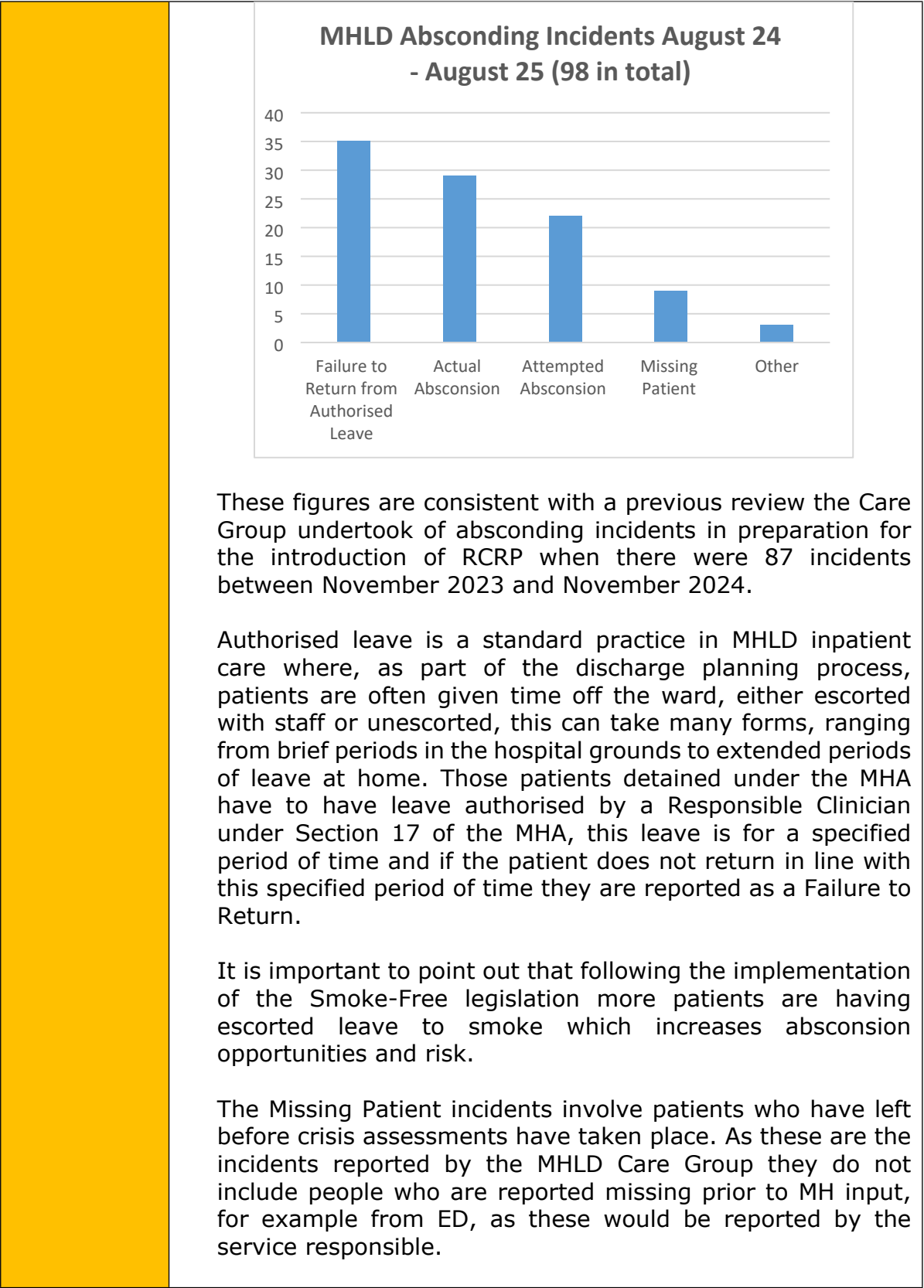
- The 111 Press 2 service offers urgent assessment and signposting advice for anyone experiencing a mental health crisis or requiring support to manage their symptoms. The service has recently seen an increase in demand which, coupled with sickness and vacancies, have stretched the service. Limited bank staff are available to cover shifts due to access to the IT systems.

The Adult Community Directorate Senior Leadership team have implemented immediate contingency plans to ensure the staff and service are supported and sustainable as longer-term staffing, location and management solutions are explored.

- 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



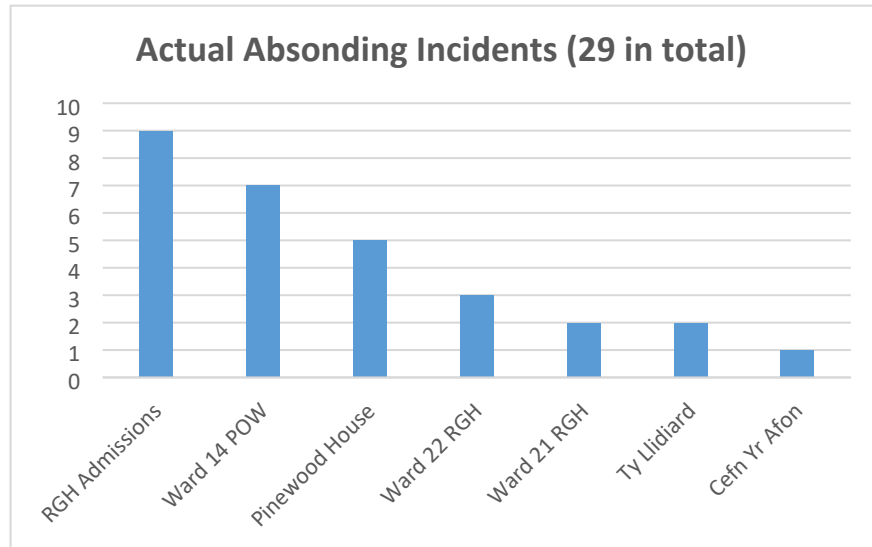
	train the trainer model was unsustainable and the only viable option was to commission an external provider to deliver Module D. Funding has been secured through the IMTP process but as yet a private provider has not been commissioned. The in-house training ended in March 2025 meaning there is a risk that training compliance could fall. There are 23 newly qualified RNs starting in September/October across the MHL D wards who will all need 4 days PMVA training. To mitigate against this the Care Group is spot purchasing individual courses to maintain compliance until a longer-term programme of training is procured. • Ligature risk on Older Adult admission wards remain high, with mitigation and actions reviewed monthly on the risk attached to the Risk Register. Risk assessments are closely monitored and due to review in line with the developing strategic inpatient work.
Advise	• Review of Patient Absconsions The Care Group has reviewed incidents where patients have absconded to identify any themes and trends. From August 2024 to August 2025 there were a total of 98 incidents reported by the Care Group through Datix under the Category "Absconding or missing patient/service user". This Category is made up of 5 subcategories; ○ Failure to Return from Authorised Leave. ○ Actual Absconsion. ○ Attempted Absconsion. ○ Missing Patient. ○ Other.





Following investigation 72 (73%) were assessed as resulting in no harm, 26 (27%) were assessed as being low harm, no incidents were assessed as being moderate or severe harm.

The 29 Actual Absconson incidents were all from MH Wards.



RGH Admissions and Ward 14 POW are the adult acute admission wards and it is be expected that they would have the highest number of Actual Absconson and Failure to Return from Authorised Leave incidents. It is important to highlight that both wards have recently had replacement doors installed to improve security, the Care Group will monitor the impact of this on Actual Absconson incidents through QSE meetings.

There were no Actual Absconson incidents from the PICUs or any of the OPMHS wards.

Phase 2 of RCRP which was implemented in September 2024 relates to AWOL and missing patients. There have been no significant concerns relating to phase 2 of RCRP escalated from the Care Group which is consistent with the fact that none of the incidents has resulted in moderate or severe harm.

- Medical staffing remains fragile across the Care Group. 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.



• LD Update

Specialist Learning Disability health services are commissioned via an LTA with SBUHB and these arrangements are reviewed through a Regional Performance and Commissioning Governance structure.

The MHL D Care Group is responsible for CHC arrangements for its population with a LD. The Care Group also employs a Quality Lead Nurse for LD whose role is focussed on improving the health outcomes for people with a LD.

Welsh Government has announced its four priorities for LD, 2025/2026 – 'In determining funding availability to continue delivering strategic priorities in the final year of the Learning Disability Strategic Action Plan (2025-2026) the Minister has provided clarity on her four priority areas, against which she would like to see demonstrable and measurable action.' They are:

1. Increasing access to and uptake of Annual Health Checks (AHC) for people with learning disabilities (main priority)
2. Adult specialist services (Improving learning disability community and inpatient services, including reducing admissions, length of stay, and care pathway delays)
3. Enhancing data quality and standards
4. Reducing restrictive practices

Each Health Board had an opportunity to submit a bid to access a total of £110,000 to support these priorities over the next twelve months.

CTMUHB submitted a bid to access the funding under two of the priorities, increasing access to and the uptake of annual health checks and supported a shared bid with SBUHB and CVUHB in relation to Reducing Restrictive Practices. The Care Group submits quarterly performance reports to WG on the progress of LD health checks.

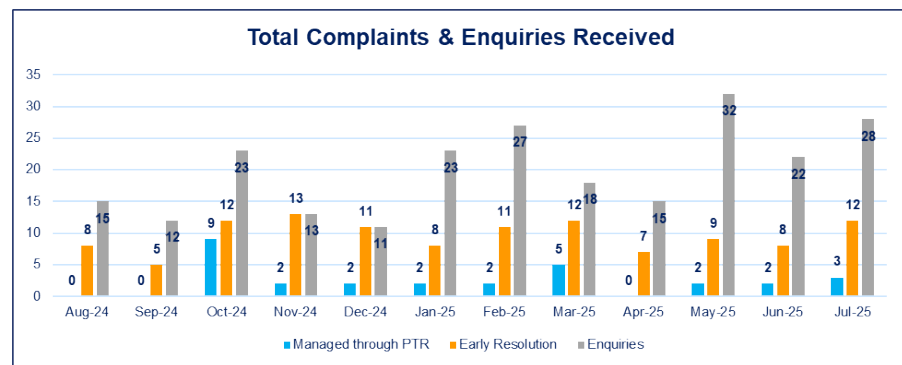
There are currently 3 WTE Acute Learning Disability Liaison Nurses employed by SBUHB operating across the 3 Acute Hospitals within CTMUHB. The Liaison Nurses deliver training on CTMUHB's induction programme and a training day on the deteriorating LD patient as well as Monthly champion training/champion training updates.

A comprehensive LD report is presented to the MHL D QSE meeting bi-annually.



Assure

- The number of complaints received by the Care Group during this reporting period (10 in June and 15 in July) was lower than the 2 year monthly mean of 18. The number of formal complaints received in June and July was 5 which is consistent with the monthly mean.

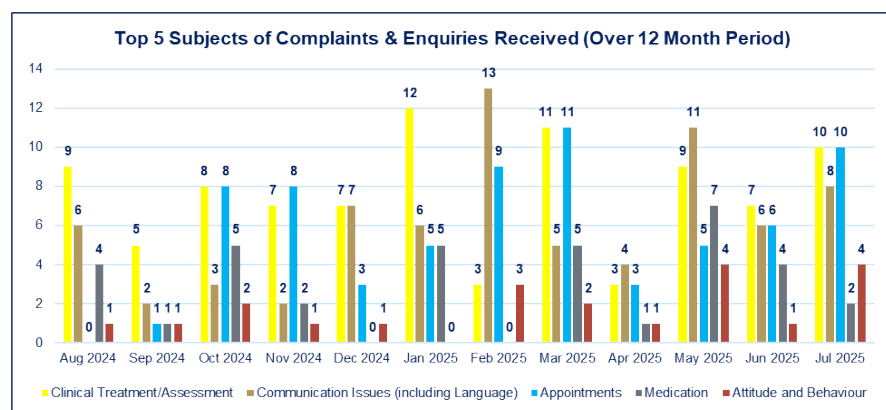


Complaint closure compliance in the Care Group was 50% in June and 60% in July, however, the low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.

The Care Group has been focussing on the closure of Early resolution complaints, closing a substantial proportion and ensuring that all complaints sit with the correct service and are resolved in a timely manner.

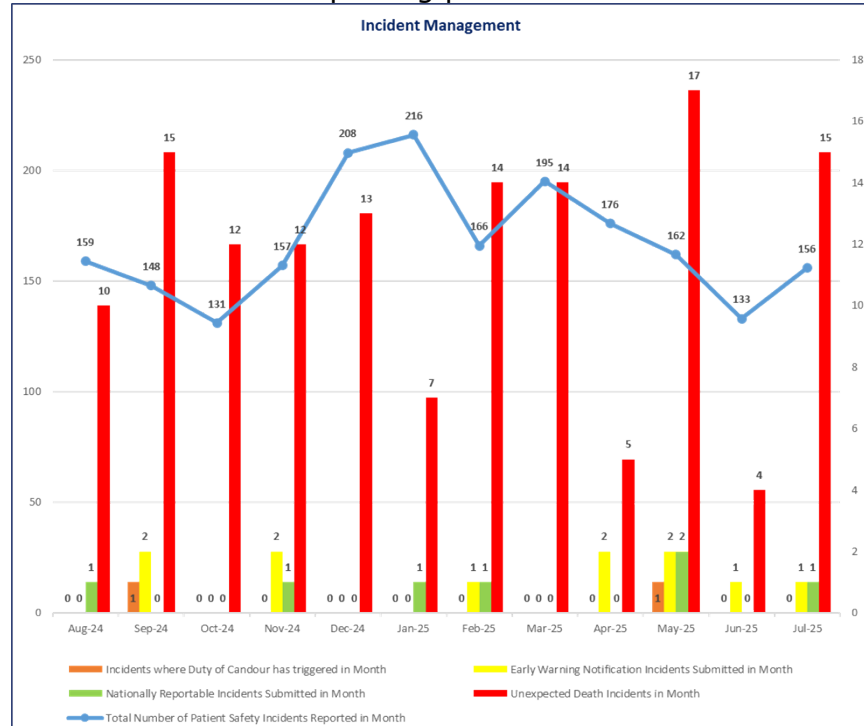
Enquiries returned to within the 2-year mean following a spike in May, the themes are consistent with previous periods and are spread across all areas. The Care Group will continue to monitor complaints and enquiries for themes and trends.

At the end of July there were 3 open formal complaints (the 2-year mean is 7).





- The Datix incidents reported this period, 133 in June and 156 in July are lower than the 2-year mean of 198 per month and lower than the last reporting period.



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

There was 1 new NRIs reported during this period.

- All the MHL D 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	37.8%		0
Infection Control	16	96.8%		11
Medicines Management	2	86.7%		7
Patient Safety	26	91.1%		24

Patient safety compliance has gone up from 89% to 91%. Of the 28 overdue actions, 25 are RAG rated green with 3 RAG rated as amber, these relate to estates issues in SRU which have been escalated and to the newly added CTP audits. No actions are rated as red. Performance against these audits is monitored in the individual directorate's QSE meetings.



Inform	- The young people at Ty Llidiard have created sketches for the design of a future 'tuck shop' and digital designs regarding a beauty salon. All ideas have been handed over to a local kitchen design company who have kindly agreed to provide and install the equipment necessary. - William Turner, Dementia Nurse in HMP Parc and Nicola Cowan, Clinical Nurse Specialist for Memory Services have been shortlisted for the RCN Nurse of the Year Awards for 2025. This is the 2nd year in a row that OPMHS have had 2 shortlisted nurses and all 4 are from our developing and improving Memory Service. - A Carers Cafe launched at the end of August 2025 as a pilot on Ward 22, RGH, with plans for a phased rollout across all inpatient sites. The café aims to offer support, compassion and clear information to families and carers, helping to reassure and guide them during challenging and emotionally difficult times. It reflects our commitment to inclusive, person-centred care that recognises the vital role carers play their loved one's recovery.
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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 (<i>Pobl / Ariannol</i>) / Resource Impact (<i>People / Financial</i>)	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

5.2.4

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
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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	
ACCTT&O	Anaesthetics, Critical Care, Theatres, Trauma & Orthopaedics
SDEC	Same Day Emergency Care
DTPS	Diagnostics, Therapies, Pharmacy & Scientists



ERCP	Endoscopic Retrograde Cholangiopancreatography Procedure
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
GIRFT	Getting it Right First Time
ANTT	Aseptic Non Touch Technique
IPC	Infection, Prevention & Control

1. Introduction

- 1.1 This report has 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 18th August 2025.
- 1.2 Key highlights from the meeting are reported in section 3.

2. 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. Highlight Report

Alert / Escalate

General Surgery & Gastro-intestinal (GSGI) Services

- Temporary ceasing of ERCP procedures being carried out in PCH due to equipment concerns. All patients are currently transferred to RGH and POW increasing bed demand on these 2 other sites.
- Plan in place with DTPS to purchase new scopes to enable the service in PCH to recommence.



	RGH Surgical Assessment Unit (SAU) – increased demand and frequent overcrowding in waiting room to support front door surgical demand. Mitigation. • SDEC area within SAU (Surgery, ENT, Urology, T&O and Ophthalmology) had 1166 patient attendances in June & July. Combination of new patients and SDEC follow ups including virtual follow ups. • Extra space acquired in the main ward corridor to create an SDEC assessment and treatment area. • Nursing establishment review to ensure right workforce with right skills. • CTM UHB Surgical Pathways being scoped to define the Surgical Clinical Model for CTM UHB.
Advise	ACCTTO • Creation of 2 separate Directorates from August to create: Anaesthetics, Critical Care & Theatres Directorate Trauma & Orthopaedics Directorate Each Directorate will have a Directorate Manager and a Lead Nurse • Reopening of the Theatre & recovery Suite at POW beginning of September has led to reproducing an up to date theatre utilisation plan to ensure maximum theatre efficiency. • Staff Survey into Culture in Critical Care pan CTM UHB. Staff feedback sessions arranged for September. Specialist Services • Ophthalmology, cataract surgery move from RGH to POW Ophthalmology Centre beginning of September using 'Surgicube' to increase theatre capacity and reduce waiting list time. Llantrisant Health Park (LL.H.P) & Arthroplasty • Planned Care and LL.H.P clinical and operational teams produced a proposed Clinical Model and Nursing Workforce required for the Arthroplasty Centre. • New In-patient Arthroplasty patient pathway aligned to GIRFT process will be piloted in POW from September as part of transformation in preparation for LL.H.P General Surgery • Combined Ward 21 and Bridgend Clinic to create single acute surgical ward in POW.

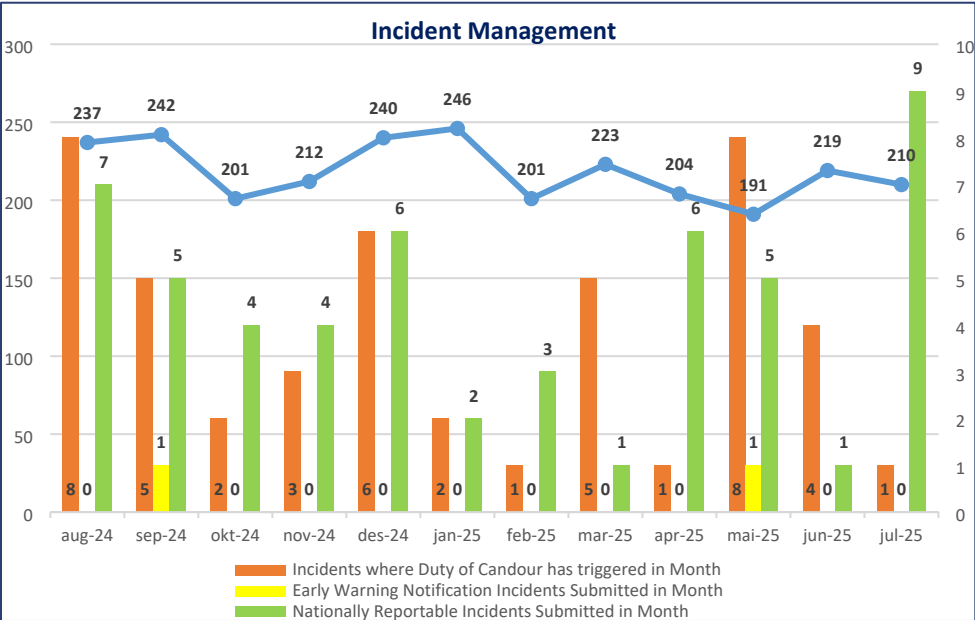
- Created a dedicated Gynae Assessment Unit attached to this ward.

Paediatric Dental Surgery

Paediatric Dental Recovery Plan agreed between Community Dental and RGH Theatre Service to increase theatre capacity to clear all patients waiting by December 2025.

Concerns & Incidents

Incidents



Outstanding Cancer Harm review incidents volume and mitigation process in place.



Falls Scrutiny Panels (August)

No avoidable falls across Planned Care July 25.

Key Themes	Actions
• Patient requires consultant review in terms of falls and medication noting postural drop. • Drug chart to be uploaded to datix • No medical proforma for review post falls • Lying and standing (L&S) Blood Pressure (BP) needs completion on and acted upon. • No physio review post falls • Medication review not undertaken • Documentation to reflect what action has been taken to assess and implement relevant measures to reduce falls risk	❑ Key themes to be shared and discussed in Professional Focus Group for shared learning ❑ WM and Senior Nurses monitoring ESR Care Fall training compliance as a priority ❑ L & S blood pressure prompt on ward handovers and SN to discuss at board rounds when identifying new admissions ❑ Reinforcing need for enhanced supervision paperwork review daily in Safe2Start ❑ Robust Senior Nurse staffing scrutiny to support ward acuity levels – Safe Care review to be undertaken daily ❑ Intentional rounding promoted ❑ Staff rotation during shift encouraged ❑ Falls champions attending falls collaborative sessions to share wider learning



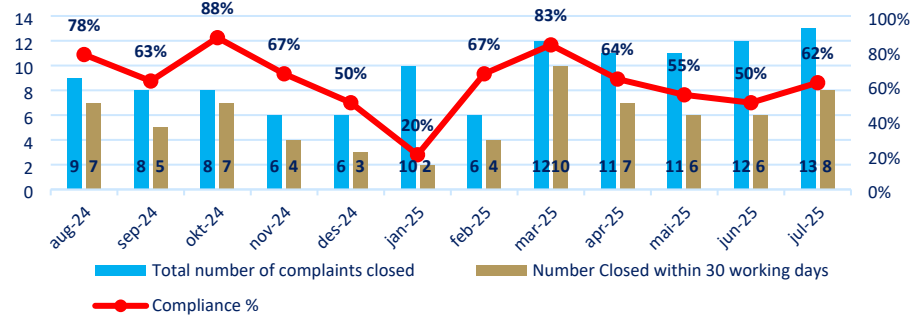
	Pressure Damage Scrutiny Panels (August)	
	Key Themes	Actions
	• Purpose T not completed correctly with enough clinical info • Failed to upgrade equipment • Leaflet regarding risk not given to patient with capacity that was declining care • Care plan with insufficient info • No wound chart • No images obtained (out of hours camera) • Inconsistency of mattress choice • To ensure ears are fully inspected at initial review Noted Reduction of avoidable pressure damage on ACCTTO wards	❑ Key themes have been shared and discussed at Professional Focus Group ❑ Avoidable PU cases added to PFG monthly for wider discussion and learning ❑ WM and Senior Nurses working to improve PU training compliance as a priority ❑ Ward Managers & Senior Nurses focusing on areas of improvement and regular audits ❑ High risk patients to be alerted to WM and included on ward handovers ❑ Pressure relieving oxygen tubing available in all clinical areas
	Concerns	
	Themes • Communication with Multi Disciplinary Team (MDT) - Most common theme • Waiting list (T&O) • Pain Assessments & delays in administering pain control • Discharge Planning • Clinical issues	



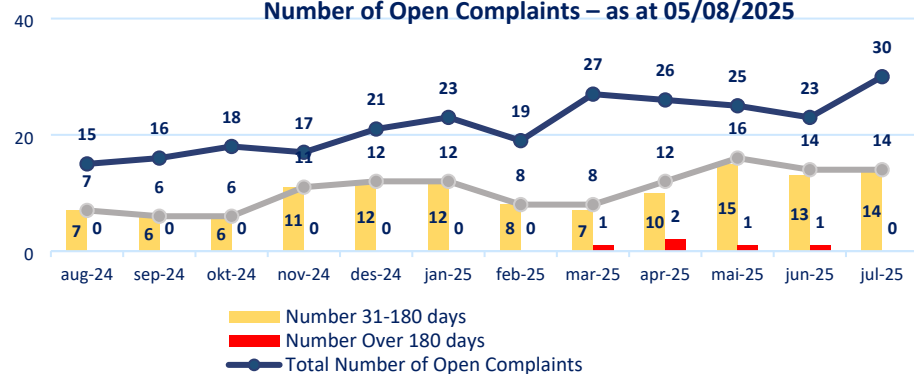
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

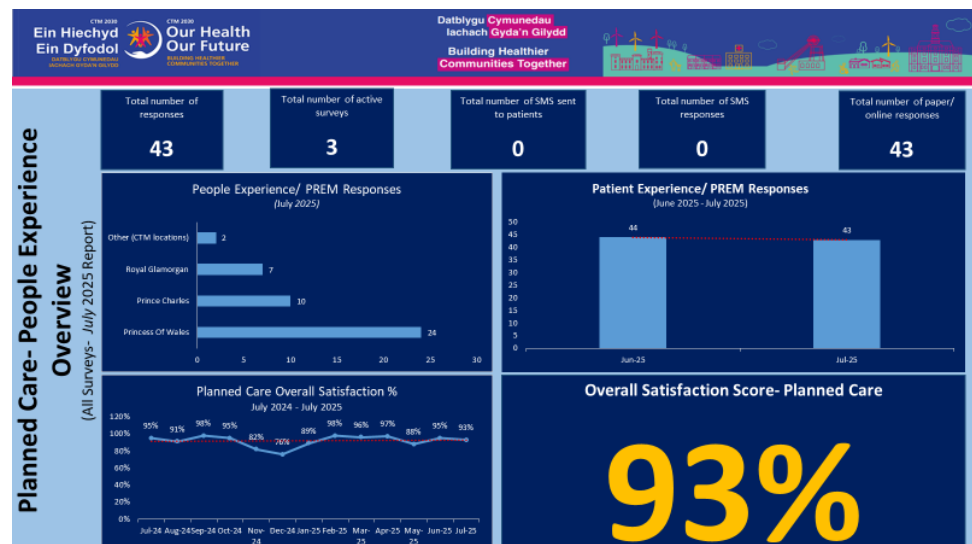
% Compliance for Closed Formal Complaints



Number of Open Complaints – as at 05/08/2025



Peoples Experience (July 25)





Assure	As part of All Wales Out-Patient Transformation. Weekend / evening working via insourcing to commence end August to reduce patient waiting lists - Improving Manual Handling and ANTT training compliance remains a focus – training dates shared with teams and Senior Nurses overseeing to evidence compliance improvement. RGH have commenced bespoke study days to increase compliance - IPC standards across clinical areas. (Focus remains on De-cluttering, stock review, outstanding estates jobs, cleaning regimes etc.)
Inform	Planned Care QSRE in August used the revised Terms of Reference and reporting structure, which now consists of each Directorate reporting their Quality Safety data and slide packs. Theatres Department in PCH took part in hosting the Medical Director for NHS Wales, extremely positive feedback Quality Improvement Projects - The pressure ulcer prevention champions in PCH ITU continue their excellent work by rolling out Purpose T and associated care plans. - Face to face staff training undertaken. - Display boards created displaying good and bad examples. - Documentation audit ongoing and feedback provided to staff.
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:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Choose an item.
	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 <i>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</i>	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i> <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 Unscheduled Care Group
Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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 <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Quality & Safety Committee	08/09/2025	



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

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 (QSRE) meeting on 13th August 2025.

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

2. Purpose of this Meeting

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

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

3. Highlight Report

Alert / Escalate

There had been a notable increase in avoidable pressure ulcer (PU) incidents within unscheduled care settings across all acute sites over a 12-week period. This has resulted in 14 grade 3 and above pressure damage incidents being reported to the NHS Executive and resulting in moderate harm to our patients.

This matter has been escalated to the Directors of Unscheduled Care for action and has subsequently been raised with the Executive Team for oversight. A SBAR has been formulated by the Care Group and immediate actions have been agreed.

1. Targeted Audit and Thematic Analysis

An immediate audit of recent PU incidents is being conducted to identify common themes and root causes. The Quality Improvement (QI) team will complete a follow-up audit across all collaborative wards in August, with findings to inform the improvement session scheduled for 1st September 2025.

2. Enhanced Training Compliance

Mandatory training on PU prevention is being reinforced for all clinical staff in unscheduled care. Following compliance analysis, the Assistant Director has engaged the Clinical Practice Lead and Tissue Viability Nurse to deliver bespoke training in areas with low uptake.

3. Strengthening Clinical Governance

Documentation standards and escalation pathways are being reviewed to ensure clear accountability and timely clinical interventions.

4. Performance Monitoring and Reporting

A dedicated PU dashboard has been developed to enhance visibility of reported incidents. This will be integrated into monthly trajectory reporting to support ongoing monitoring and assurance.

5. Assurance Panel Engagement

Timely presentation of cases at the PU Assurance Panel is being prioritised to support learning and oversight.

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 targets has increased from 91% to 100% in June and July 2025. Currently, there are 21 open complaints and 1 are over the 30-day compliance. This is an increase from 14 to 21 open complaints since the last report however the maintaining traction on 100% compliance. The USC leadership team have provided a commitment to support, improve trajectories and have developed a mechanism to escalate when clinicians and nurses are unable to achieve 30-day compliance. This has been closely monitored by the USC Senior Leadership Team. During August QSRE meeting analysis of concerns and incidents are being triangulated. Ensuring that there is targeted intervention when any themes or trends have been identified. AMaT actions for USC as reviewed weekly by the USC Directors. There are no outstanding AMaT actions for the PCH Acute Site as of the 13th August 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	Nurse Director Role A highly experienced and dedicated Nurse Director has been successfully appointed to lead Unscheduled Care, date of commencement to be confirmed. The appointee brings a strong track record of clinical leadership and is recognised for their professionalism, strategic insight, and unwavering commitment to delivering high-quality patient care. Their appointment marks a significant step forward in strengthening the governance and operational delivery of urgent and emergency services across the Health Board. Unannounced HIW ED visit An unannounced HIW inspection of the ED at the RGH was conducted from 4th to 6th August 2025, the team received initial positive feedback and are currently awaiting the formal response. No immediate actions were identified as necessary. Ward 3, RGH- update. Ward 3, at RGH had a follow up unannounced visit on the 6th August 2025. This was conducted by the IPC team, PALS, and

Corporate Nursing. It highlighted several improvements, and notable progress included enhanced tidiness, better equipment storage with barcoding, and a significant rise in the IPC environmental audit score from 17.5% to 75.5%. PPE was readily available, and the ward appeared calm and purposeful, with staff showing positive engagement. However, concerns were raised about cleanliness in facility-managed areas, lack of display information, and incomplete documentation such as risk assessments and fluid balance records. Patient feedback was largely positive, though isolated issues with HCSW helpfulness and accessibility of water jugs were escalated. The presence of a permanent ward sister was seen as a positive step, with recommendations to build a strong team around her leadership.

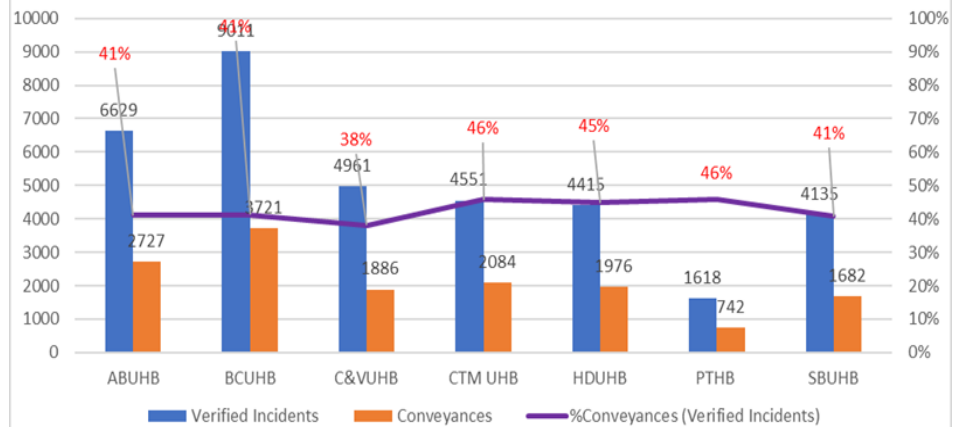
The **USC Performance and 30-Day Action Plan Update (August 2025)** for CTMUHB outlines significant progress and strategic planning in urgent and emergency care. Key actions include the development and implementation of rapid improvement plans, internal professional standards, and pilot programs such as UTC and UCC. Performance metrics show CTMUHB achieving the fastest ambulance handover times in Wales (average 24 minutes in July), with PCH and RGH leading nationally. Despite challenges like reduced inpatient capacity and a critical incident at POW, CTMUHB maintained low lost hours and improved conveyance rates.

The 30-day deliverables focus on operational enhancements such as defining roles, improving diagnostics access, and refining discharge processes. Transformational goals include discharge protocols and care home admission avoidance. Outcome targets aim for zero tolerance to extended ED waits and improved discharge timings. The 60- and 90-day plans build on these foundations, targeting further reductions in wait times, enhanced patient flow, and expanded community care capacity. The overarching goal is to achieve zero tolerance for 12-hour ED waits and 45-minute ambulance handovers by October 2025, supported by trajectory-based planning and system-wide coordination.

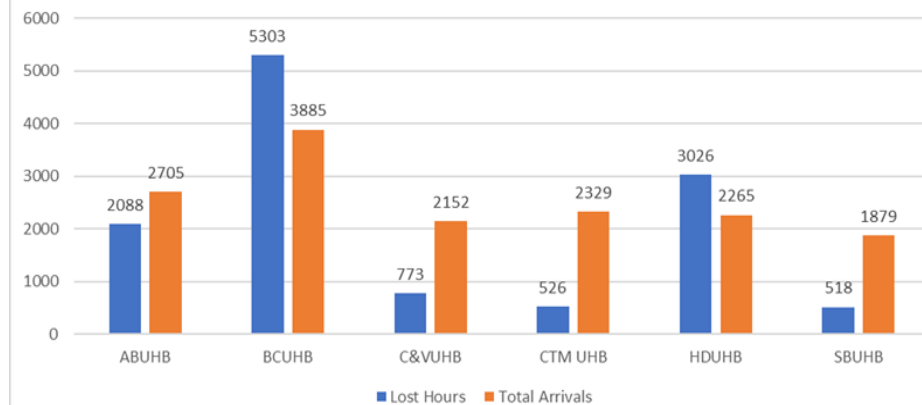
Please see below the performance graphs relating to Ambulance.



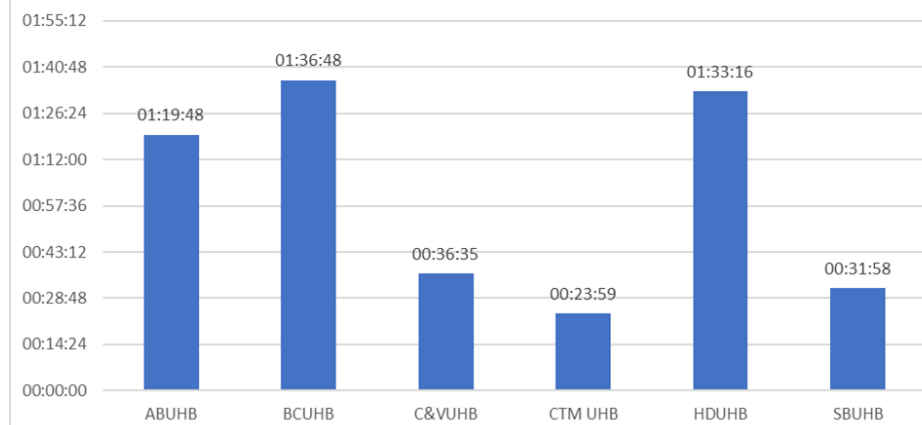
Verified Incidents and Conveyances

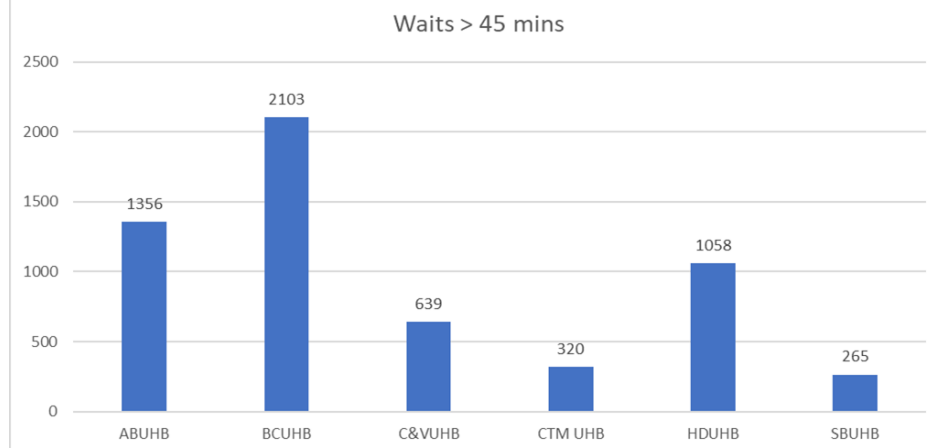


Lost Hours and Total Arrivals



Average Handover Rates

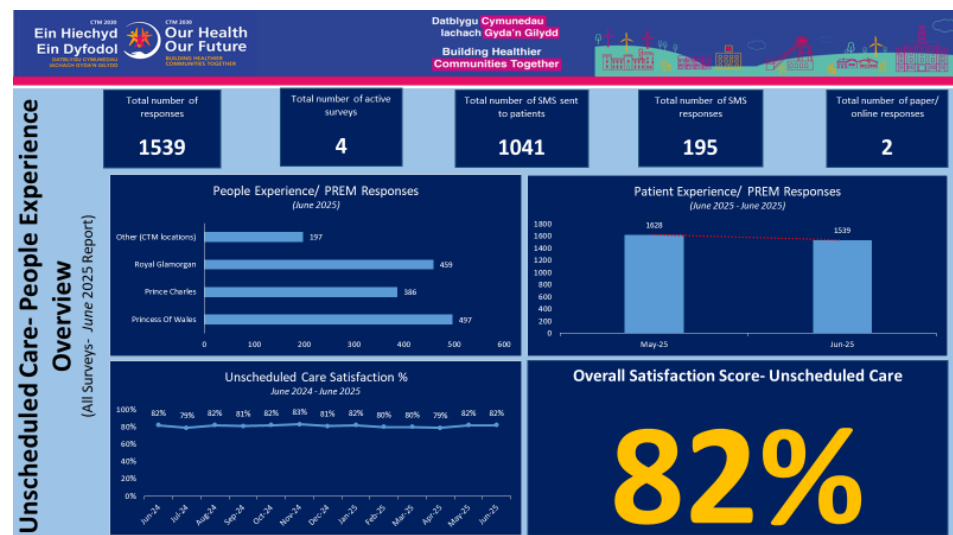




HIW action plan update

All HIW action plans reviewed and updated August 2025.

Inform



The Emergency Department (ED) national Patient Reported Experience Measures (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.



A Quality Improvement Project (QIP) is currently underway to enhance communication within the Emergency Department (ED) at POW. As part of this initiative, a PDSA (Plan-Do-Study-Act) cycle has been initiated to pilot the use of a Microsoft Teams channel. This platform aims to facilitate real-time, streamlined communication between the ED, Site Management Team, and wider operational leadership.

Project Aims:

- Improve communication within the ED to reduce delays in patient transfers to inpatient wards.
- Decrease the volume of telephone calls to the Nurse in Charge (NIC) and across the department.
- Support timely escalation of operational issues.
- Minimise delays in ambulance handovers.

The pilot, now six weeks in, has shown promising results. Plans are in place to extend the trial to the Acute Medical Unit (AMU) within the next two weeks for a four-week period, followed by a phased rollout to additional wards and departments.

Enhanced Supervision Standardisation & Marie Curie Companions Implementation

A Task and Finish Group has been established across CTMUHB to review and standardise enhanced supervision documentation and processes across all sites. This initiative aims to ensure consistency, clarity, and improved patient care through the following objectives:

- Review and update existing guidance, incorporating the newly developed risk assessment for enhanced supervision and its application across sites.
- Standardise definitions and expectations for varying levels of supervision.
- Establish consistent actions and review processes for 1:1 supervision, including patient risk assessment and mitigation of unintended consequences.
- Develop and implement a training package to support the rollout of new documentation across wards and units.

In parallel, CTMUHB is introducing Marie Curie Companion Volunteers across all inpatient wards and departments at PCH. Following the signing of the legal agreement, the volunteers will be formally introduced to teams during the August Head of Nursing Focus Group. The Companions will provide:

- Emotional and social support to patients nearing end of life.
- Assistance with advance care planning conversations.
- Bereavement support for families and carers.

These initiatives reflect CTMUHB's commitment to compassionate, consistent, and patient-centred care.



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 Registered Nurse (RN) and Healthcare Assistant (HCA) workforce action plans and outcomes of the Unit's daily multidisciplinary huddles.

Improvements noted specifically in:

- Leadership
- Multi Disciplinary Team (MDT) Communication
- Environment, IP&C
- 15 Steps
- Patient Safety
- Pharmacy
- One patient, One Day

Governance and Assurance

- Weekly Q&A action plan meeting with senior team.
- Fortnightly stroke performance touchpoint meeting with Executive team.
- Action log highlight report at monthly Stroke Operational Group.
- Stroke Operational Group highlight report feeds into monthly Stroke Performance Board.

Risk score reduced from 20 to 16.

Follow Up Assurance Visit took place on 21st July 2025. Formal report awaited but initial feedback noted clear improvement evident and positive patient feedback.

Focused work to improve 2 SSNAP KPIs –

- Time to CT scan (20 minutes)
- Time to Acute Stroke Unit admission (4 hours)
- 30/60/90 Day Improvement Cycle commenced on 11/08/25 with focus on patients presenting to RGH.

Key Activities

- Key stakeholder meeting – 07/08/25
- 30 improvement actions and goal in development.

- Action log daily updates
- Daily data and patient tracking review
- Weekly summary meeting and outcome report

30 Day Weekly Programme

Week One – process mapping and planning.

Week Two – Engagement, review and incremental target setting

Week Three – Launch

Week Four – Monitoring and improvement

60- & 90-Day Plan will include PCH and POW.

Stroke Service Redesign

Meeting arranged 18/08/25 with all key stakeholders to finalise proposed clinical pathway, workforce and bed modelling.

Regional Update

First meeting of South-Central Wales Stroke Operational Delivery Group held 13/08/25.

- Regional model discussed and agreed
- CTM to maintain Acute Stroke Unit
- Cardiff & Vale (C&V) to provide regional thrombectomy service

Consultation ends 29/08/25 and updated standards to be shared in September.

Key Risks / Matters for Escalation

Requirement for internal stroke dashboard to support improvement work.

30-day improvement manual data capture will inform all digital touchpoints to support dashboard build.



Stroke Performance

Stroke Quality Improvement Measures Current Month stats June 2025			Stroke Quality Improvement Measures Current Month stats July 2025		
% of patients who are diagnosed with a stroke who have direct admission to an acute stroke unit (<4 hours)			% of patients who are diagnosed with a stroke who have direct admission to an acute stroke unit (<4 hours)		
Admissions	No within 4 hrs	% compliance	Admissions	No within 4 hrs	% compliance
66	1	1.51%	53	1	1.88%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 45mins			Percentage of eligible stroke patients thrombolysed with a door to need time of <= 45mins		
Eligible patients thrombolysed	Thrombolysed <= 30 mins	% compliance	Eligible patients thrombolysed	Thrombolysed <= 30 mins	% compliance
5	1	20%	3	0	0%
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes			% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Patients diagnosed as stroke	Scanned <= 20 mins	% compliance	Patients diagnosed as stroke	Scanned <= 20 mins	% compliance
66	7	10.61%	53	1	1.88%
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour			% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour		
Patients diagnosed as stroke	Scanned <= 1 hr	% compliance	Patients diagnosed as stroke	Scanned <= 1 hr	% compliance
66	40	60.61%	53	19	35.84%
% of patients who are assessed by SNS within 4 hours			% of patients who are assessed by SNS within 4 hours		
Assessments	Assessed <= 4 hours	% compliance	Assessments	Assessed <= 4 hours	% compliance
66	19	28.79%	53	22	41.50%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours			% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Assessments	Assessed <= 14 hours	% compliance	Assessments	Assessed <= 14 hours	% compliance
66	31	46.97%	53	34	64.15%
% of patients who are assessed by OT within 24 hours			% of patients who are assessed by OT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance	Assessments	Assessed <= 24 hrs	% compliance
66	13	19.70%	53	20	37.73%
% of patients who are assessed by PT within 24 hours			% of patients who are assessed by PT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance	Assessments	Assessed <= 24 hrs	% compliance
66	13	19.70%	53	19	35.84%

KPIs for admission to Acute Stroke Unit (ASU) and time to CT being reviewed as part of improvement programme.

Lack of 7 day working impacting on all measures.

Ysbyty George Thomas (YGT) Update

In October 2024, YGT was reopened to support the critical incident in POW. Initially the 2 wards (Dinas and Fernhill) opened to 38 clinically optimised patients. Over the last 10 months, refurbishment has been carried out and the wards can now take a total of 58 patients.

The environment in YGT supports the rehabilitation and recovery of those patients awaiting to be discharged to either their own home or to a placement. There are dayrooms, space to walk around and plenty of outside space for patients and families.



	The teams are working with the third sector – Menshed in Maesteg, Daring to Dream to provide support for the patients in the hospital. Feedback from patients and their families has been overwhelmingly positive. Families appreciate there are areas for them to socialise away from the bed space and areas for patients to eat food. Some feedback received: “Space to walk around, it feels like home” “Once I visited once, I realised this was the right place for my mother to be cared for. I was worried about the travel time, but the parking is easy and it is a lovely place to come and visit mum.” The plan is for the hospital to remain open for clinically optimised patients and sit under the Primary and Community Care Group. POW Ward Moves The ward movement schedule outlines a series of relocations across CTMUHB facilities to support service optimisation and essential maintenance. Several moves have already been completed, including cardiology from Ward 4 to Ward 10 POW, gastroenterology services from Endoscopy RGH to POW, and critical care and surgical services consolidated within POW. Upcoming planned moves include COTE and STAR specialties transitioning between POW and RGH sites, with proposed dates ranging from late July to mid-September 2025. These changes are aligned with care group priorities—Unscheduled and Planned Care—and aim to enhance patient flow, service delivery, and infrastructure readiness. All dates are provisional and subject to adjustment based on service demand.
Appendices	

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: Inspiring People Improving Care
	Living 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 Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Leadership If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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	If no, please include rationale below:



	Outcome for Welsh Language (delete as appropriate): POSITIVE	
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

5.2.6

Quality, Safety & Experience Committee

Highlight Report from the Children & Families Care
Group Quality, Safety and Experience Meeting
held on 14th August 2025

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Suzanne Hardacre, Director of Midwifery & Nursing, Carl Verrecchia, Service Director Mohamed Elnasharty, Medical Director
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
Badgernet	Digital Maternity Information System

BR+	Birthrate Plus – nationally recognised midwifery workforce acuity tool
CTM	Cwm Taf Morgannwg
CYP	Children & Young People
HIW	Health Inspectorate Wales
PCH	Prince Charles Hospital
IQPD	Integrated Quality, Performance & Delivery
MatNeo SSP	Maternity and Neonatal Safety Support Programme
NHS	National Health Service
PACE	Playfulness, Acceptance, Curiosity and Empathy
PoW	Princess of Wales Hospital
QSE	Quality, Safety and Experience
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment
WG	Welsh Government
Wte	Whole Time Equivalent
NDIP	Neurodivergence Improvement Programme

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 14th August 2025.

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

2. Specific Matters for Consideration

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

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

3. Highlight Report

Alert / Escalate	- Health Inspectorate Wales (HIW) Unannounced visit to maternity unit at Princess of Wales Hospital Bridgend. No immediate assurances given. Initial feedback positive, draft report awaited. Estates colleagues supporting improved signage to maternity services from the front door. - Welsh Government national maternity and neonatal review Oversight Panel and Terms of Reference announced. Timescales for completion December 2025. Final report due January 2026. The review will consist of a multi-method assessment including: Desktop analysis of perinatal data and maternity reviews, women and family engagement, analysis of NHS staff survey results, organisational self-assessment, case note audit and site visits. - Special School Nursing (Risk ID 5753) remains the highest Care Group risk within Children & Families (Risk score 20). Sickness absence position improving in Bridgend. One registrant recruited to Heronsbridge, recruitment to Ysgol Ty Coch unsuccessful, back out to advert. Risk score reviewed but remains at 20 due to fragility of services.
Advise	- Risk ID 6199 reduced as PROMPT training compliance has significantly improved over the recent months due to additional sessions being supported. - Maternity Leadership and Culture Plan updated to reflect feedback from the Royal College of Midwives report. Director of Midwifery working with Assistant Director of Leadership & Culture to meet with teams and feedback themes and actions taken (including PACE review findings at Princess of Wales Hospital Bridgend). Director of Midwifery regularly undertakes 'listening events' across sites, feedback shared with individual staff and team members. - Waiting time performance for Neurodevelopment children (RISK ID 2808) currently remains at a risk score of 15. This is being reviewed to see how the NDIP funding received is likely to affect the trajectory. NDIP 25/26 – total budget for region and for ND team now confirmed by WG and is reduced from what was expected. This will limit our improvement opportunities and our aim to get below 78 weeks at March 2026. Raised at Welsh Government IQPD in July and monthly trajectory meetings with Performance and Escalation team.



	Menopause service review due to commence, the review will ensure provision within CTM is in accordance with national standards and guidance.
Assure	20 newly qualified midwives recruited, 17 starting end of September, 3 further due to commence in January (14.6 wte). Induction plans in place. Streamlining events attended by Heads of Midwifery at University of South Wales (USW) in readiness for March cohort of graduates. 7.96 wte streamlining nurses recruited across children and young people services (CYP). - Badgernet Maternity Information System implementation: Programme Board is underway and deployment of the system is on track for end of March 2026 in accordance with Welsh Government Quality Statement for Maternity and Neonatal Services. - Multi-professional baby abduction drills carried out across all maternity units in August. The exercise has highlighted the need for standardised security systems across all sites (weighted mattresses at RGH and PoW vs fully secure XTAG system in PCH). - Midwifery Birthrate + (BR+) Workforce review underway, draft report awaited (company contacted for update end of August). Information has been submitted to the BR+ team to ensure report will consider the workload of midwives, complexity of patients, impact of rising caesarean section rates and Maternity and Neonatal Safety Support Programme strategic changes to pathways of care such as maternity priority unit, transitional care, elective section cover. - External review of previous four nationally reportable incidents – midwifery review completed, awaiting outcome of obstetric review. Early learning highlighted from internal governance and assurance process and external recommendations completed (Improvement plan available for review on request). Internal investigations progressing. - Resolution to school hearing screening service progressing. School entry hearing screening service will move to audiology. Posts currently out to recruitment. - Healthcare support workers at PoW Maternity continue to be responsible for hostess trolley / mealtimes. Concerns raised

by the team as this task continues to detract from providing clinical care to women.

- Plans to fully return wards 17 and 18 at Royal Glamorgan Hospital underway, due to be completed October 2025.
- Gynaecology Cancer action plan underway to deliver significant improvement in cancer treatment for our population. July Performance dipped to around 31% (unvalidated but August trajectory heading over 40% and should continue to improve as we work on both the triage at single point of access and the treatment stages. Risks to this are for the patients who require tertiary level treatment
- Gynaecology RTT target of no patients over 104 weeks at end of June 2025 and end of July met. August is presenting a small number of breaches that were not able to be treated due to consultant sickness and a higher proportion of Cancer patients operated on in month.
- Some outstanding estates issues remain following the re-opening at PoW. Work underway with Estates team to rectify as soon as possible.
- Maternity and Neonatal quarterly update shared at Welsh Government IQPD in August, included update of progress against Maternity and Neonatal Quality Statement actions.
- Multi professional wellbeing event held 31st July at PoW for Maternity and Neonatal teams. The day included yoga, meditation, learning and listening sessions.
- Midwifery and Health Visitor skills sessions introduced across all areas to share learning and build relationships.

Risk Register

There is currently one risk scoring high with 16 or more. Discussed with executive colleagues

Risk ID	Description	Score
5753	Inadequate Special School Nurse provision	20



Inform	- Research, Development and Service Improvement update received at Care Group Quality and Safety Committee in August. Several clinical research portfolio, non-portfolio, commercial, non-commercial and service evaluation projects underway across the Care Group. - Health & Safety have recently supported the review of Entonox exposure levels across maternity services. This involved environmental and personal monitoring. The Care Group team is working through actions to reduce risks in the areas with higher readings. - Consent training within maternity has commenced across sites for obstetricians. - Senior nurse for gynaecology reviewing pathways for bereavement support for pregnancy loss <16 weeks to enhance and standardise care for women and families at all gestations. - Sickness absence among nursing workforce within special care baby units at PCH and PoW improving. - Labour ward beds at PCH reaching end of life. Capital bid for replacement labour ward beds at PCH approved
Appendices	Not applicable.

4. Assessment

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



Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals <i>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</i>	If more than one applies please list below: A Globally Responsible Wales
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	Whole-systems Perspective If more than one applies please list below: - Culture and Valuing People - Leadership - Learning, Improving and Research
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not a policy or guideline
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not a policy or guideline



<i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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.	

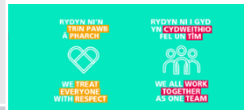
5. Recommendation

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



Agenda Item 5.3	23 September 2025	Quality and Safety Committee	Health Inequalities
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Report Details:		Impact Assessment:	
FOI Status:	Please select: Open	Indicate the Quality / Safety / Patient Experience Implications:	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Therefore, this impacts on patient outcome and experience
If closed please indicate reason:	Not applicable	Related Health and Care Standard	Equitable Leadership
Prepared By: <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Consultant in Public Health	Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	N/A
Presented By: <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Philip Daniels Executive Director of Public Health	Are there any Legal Implications /Impact.	N/A
Approving Executive Sponsor:	Philip Daniels Executive Director of Public Health	Are there any resource (capital/Revenue/Workforce Implications / Impact?	N/A
Report Purpose	Please Select: For Discussion	Link to Strategic Goals	Please Select: Sustaining Our Future Inspiring People Improving Care Creating Health



What Are Health Inequalities?

"Health inequalities are avoidable, unfair and systematic differences in health between different groups of people"



Why Health Inequalities Matter



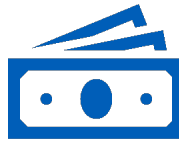
Moral



Clinical



Strategic



Financial

Why Health Inequalities Matter



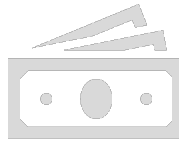
Moral



Clinical



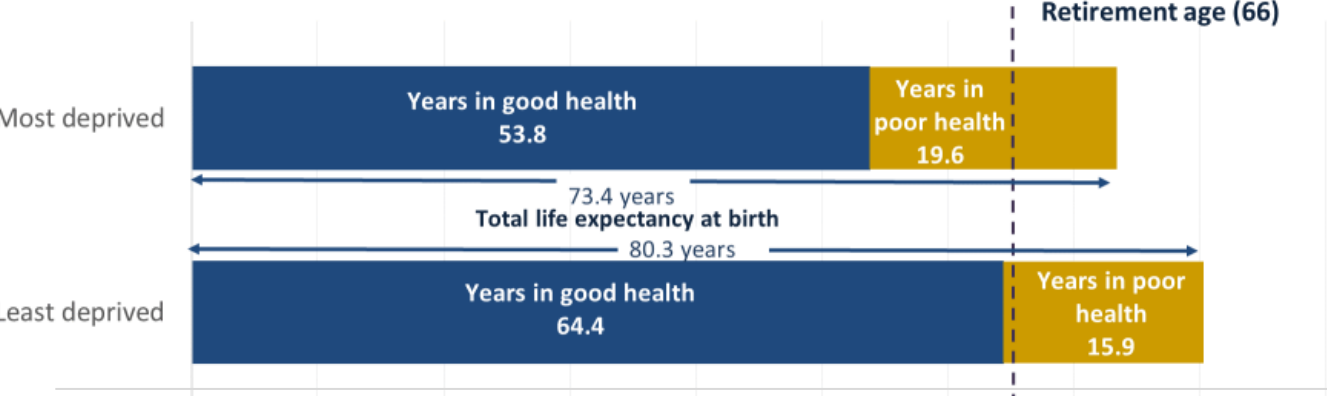
Strategic



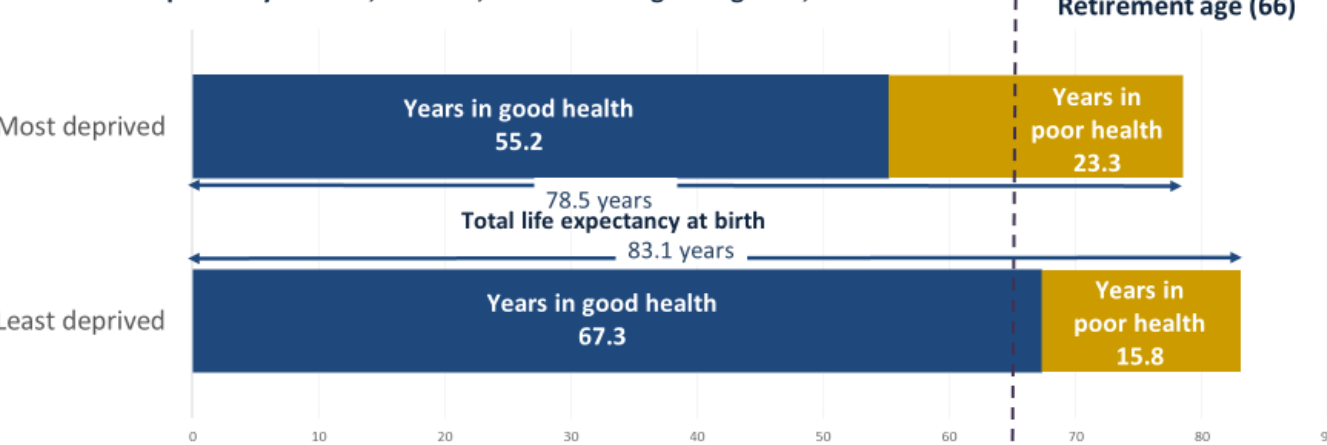
Financial

In CTM, those living in the least deprived areas live longer, and have around a decade more time in good health

Years of life expectancy at birth, males, Cwm Taf Morgannwg UHB, 2018-2020



Years of life expectancy at birth, females, Cwm Taf Morgannwg UHB, 2018-2020



Produced by CTM LPHT using PHOF (PHW) data

Life expectancy and healthy life expectancy in Cwm Taf Morgannwg UHB, 2018-2020

In CTM, men living in the least deprived areas live around 7 years longer, and have around 10 years more time in good health.

In CTM, women living in the least deprived areas live around 5 years longer, and have around 12 years more time in good health.



Compared to the least deprived areas of the UK, among people living in the most deprived areas:



Mental health

the depression rate is **2 x** higher

2 x as many people are in contact with mental health services

3 x as many people are in hospital - and **5 x** as many stay longer than 60 days
nearly **4 x** as many people are detained under the Mental Health Act



Bowel cancer

diagnosis of bowel cancer is **36% lower**

fewer people take part in screening (64% vs 75%)

fewer people are diagnosed early (42% vs 55%)
the mortality rate is **25% higher**



Covid-19

cases of Covid-19 were **1.5 x** higher

there was **lower vaccine uptake** (79% vs 93%)

hospital admission rates due to Covid-19 were **3 x** higher
the number of people dying with Covid-19 was **2.5 x** higher

Source: [The King's Fund](#)

Why Health Inequalities Matter



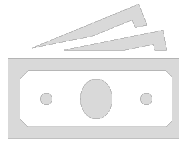
Moral



Clinical



Strategic

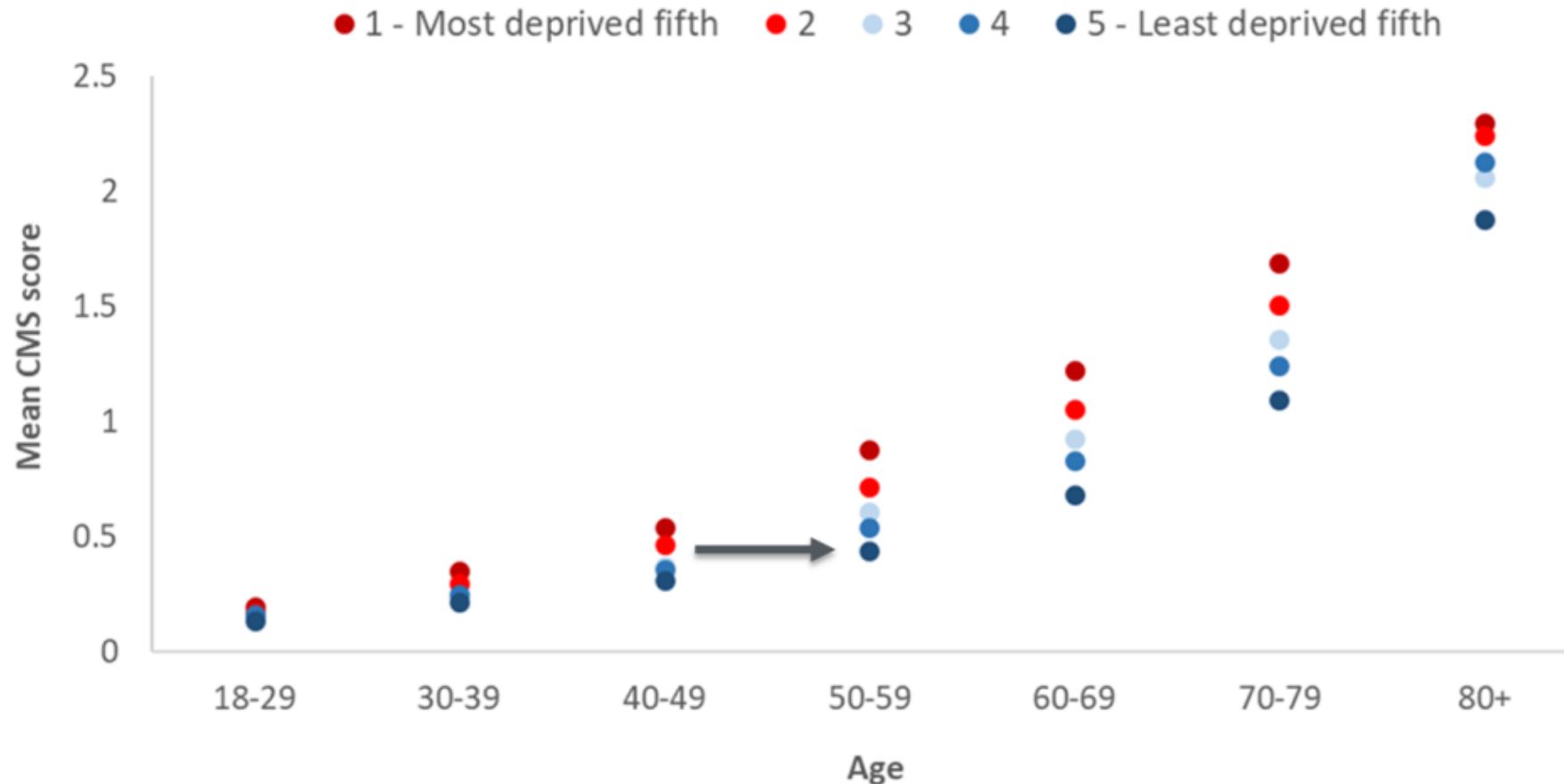


Financial

Multimorbidity in Cwm Taf Morgannwg UHB

More deprived have chronic conditions around 10 years earlier

Mean Cambridge Multimorbidity Score by age group and deprivation (WIMD fifths), CTM , 2024



- In CTM, inequalities are widening substantially from age 50 onwards.
- Patients in their 40s living in the two most deprived fifths have higher mean scores than patients in their 50s in the least deprived fifth.

Note: Note: Using primary care segmentation data up to September 24. Based on 43 out of 44 practices. CMS based on 37 chronic conditions and their weightings (Payne et al, 2020).

Why Health Inequalities Matter



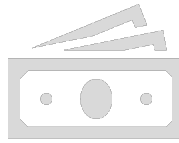
Moral



Clinical



Strategic



Financial

Leveraging legislation & policy



The Well-being of Future
Generations (Wales) Act 2015



The Health and Social Care (Quality and
Engagement) (Wales) Act 2020



A More Equal Wales: The Socio-
economic Duty 2021



NHS Wales Technical Planning Guidance
2025/28



Health Impact Assessment
(Wales) Regulations



CTM 2030: Our Health, Our Future

Why Health Inequalities Matter



Moral



Clinical

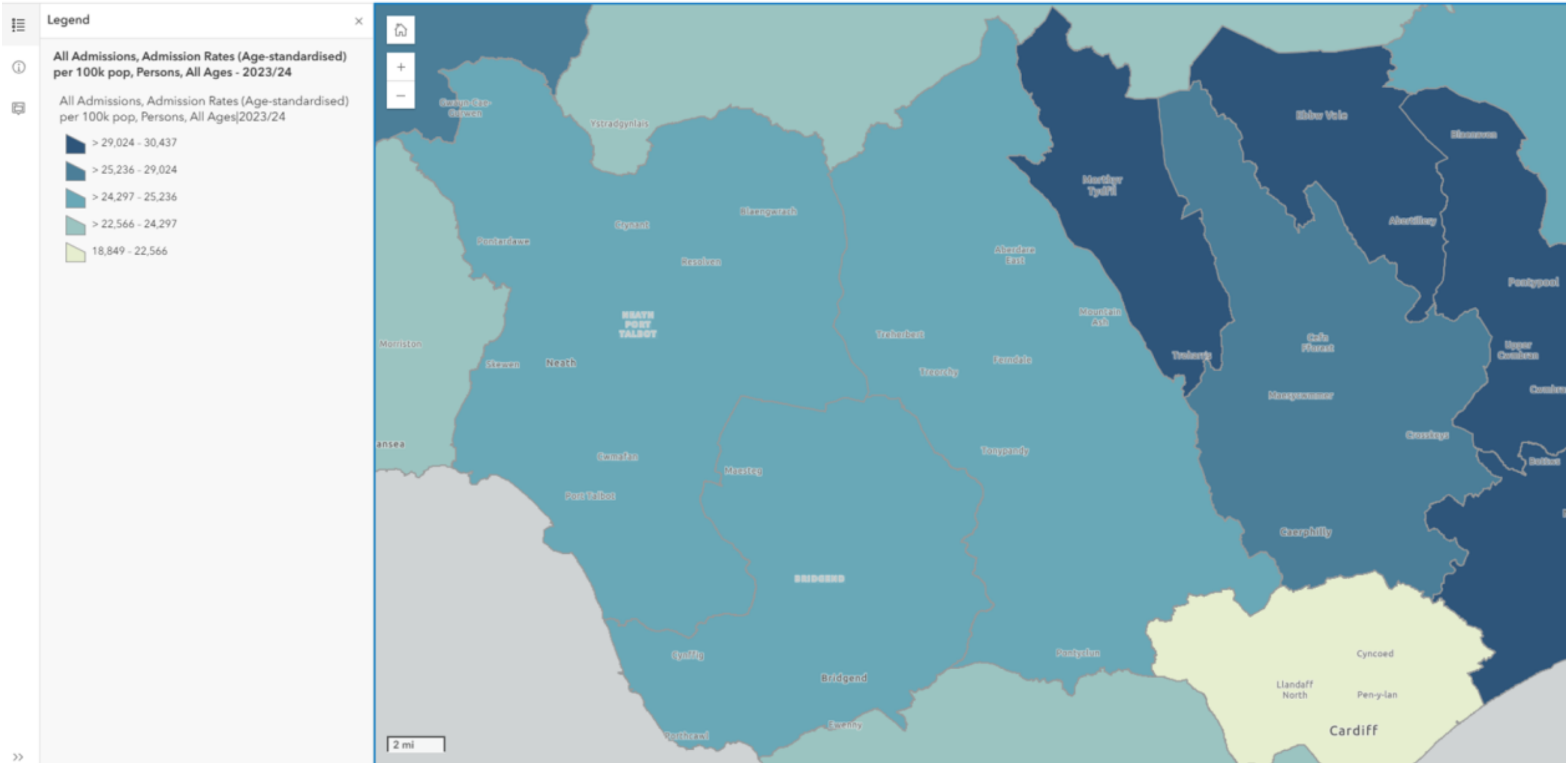


Strategic



Financial

All Admissions, Admission Rates (Age-standardised) per 100k pop, Persons, All Ages - 2023/24



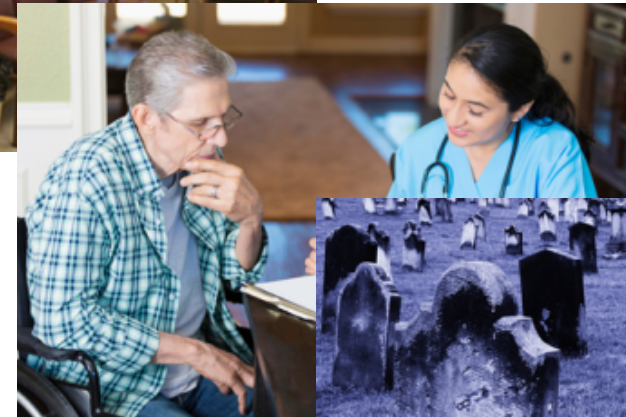
What Are Health Inequalities?

*"Health inequalities are avoidable, unfair and **systematic differences** in health between different groups of people"*



Healthcare inequalities

- Accesses
- Experiences
- Outcomes

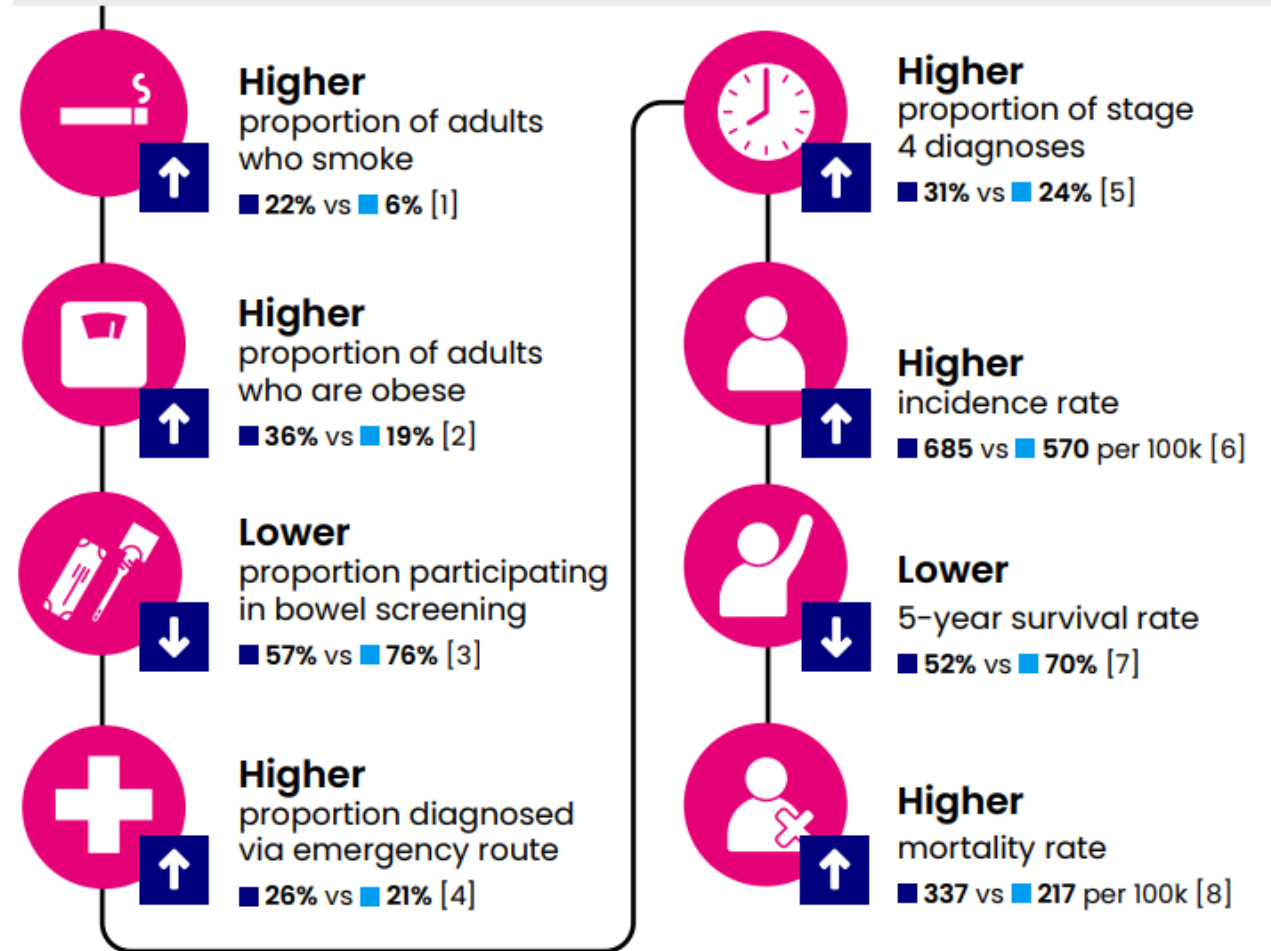


Cancer as an example for healthcare inequalities

Deprivation inequalities across the cancer pathway

■ Most deprived* ■ Least deprived*

Compared to least deprived areas, people living in the **most deprived** areas have a...



Do we routinely look at all our health board data with an inequalities lens?

What Are Health Inequalities?

*"Health inequalities are avoidable, unfair and systematic differences in health between **different groups of people**"*



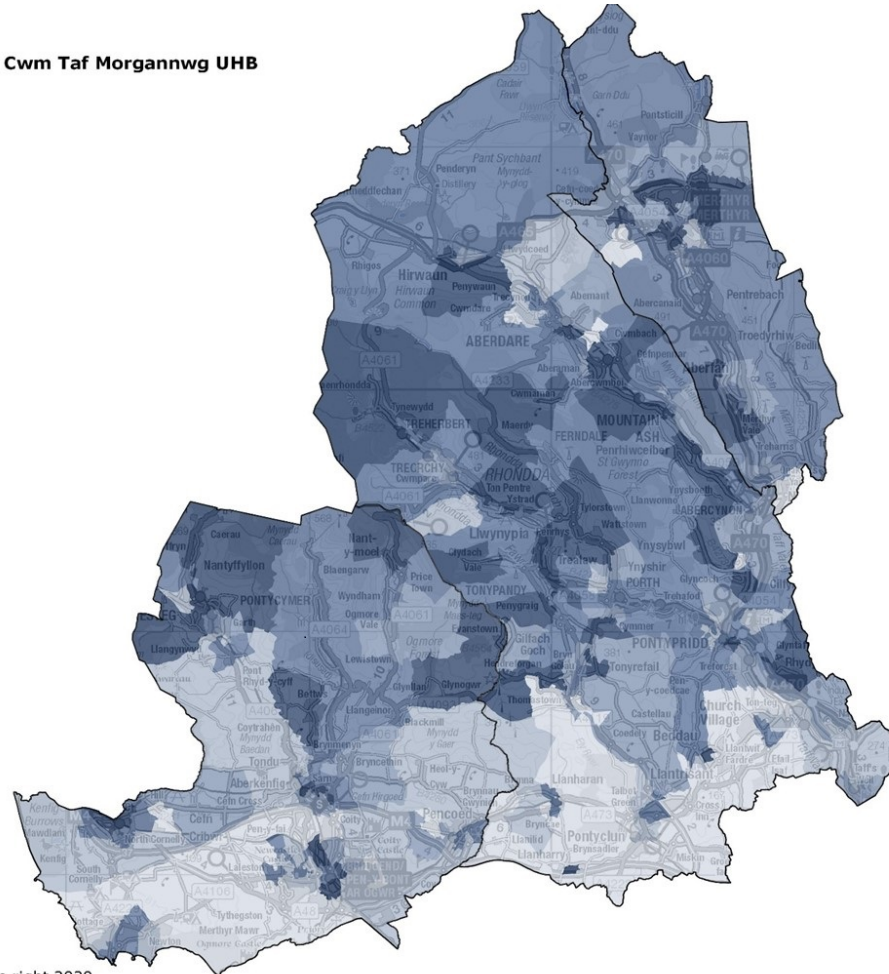
Deprivation in CTM

Large inequalities exist within the Health Board area

Welsh Index of Multiple Deprivation (WIMD) 2019, Cwm Taf Morgannwg UHB

LSOA, national fifths of deprivation

- Most deprived (73)
- Next most deprived (92)
- Middle (37)
- Next least deprived (34)
- Least deprived (42)
- Local authority boundary



Produced by Public Health Wales Observatory, using WIMD 2019

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Contains OS data © Crown copyright and database right 2020

56.5% of the population in CTM are living in the two most deprived fifths in Wales (WIMD, 2019).

The highest levels of deprivation lie mainly in the valleys to the north of the Health Board area;
Merthyr Tydfil has the highest percentage of LSOAs in the 'most deprived' and 'next most deprived' fifths, followed by RCT.

Area	% of LSOAs in two most deprived fifths
Bridgend	44.1%
Merthyr Tydfil	66.9%
Rhondda Cynon Taf	61.5%
CTM UHB	56.5%

Source: Welsh Index of Multiple Deprivation (WIMD), 2019

Inclusion health groups

“A term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma; experience stigma and discrimination; and are not consistently accounted for in electronic records (such as healthcare databases)”

Inclusion health groups



Homelessness and rough sleeping



Gypsy and Roma Travellers



Sex Workers



Vulnerable migrants



Prisons and those in contact with criminal justice system



People with drug and alcohol dependence

What are the other inclusion health groups within our region?



Four key paradigm shifts

Shift from	Move to
Health inequalities on the ‘too difficult’ pile; believing change is someone else’s responsibility	Focusing on the things we can do within our spheres of influence Identifying practical steps we can all take in our work
Tick box, late-stage consideration of inequalities issues	Ongoing, proactive consideration of inequalities throughout programmes of work, particularly when faced with choices or decisions
Only describing the problem	Creating solutions through innovation and quality improvement
General statements of ambition	Explicit strategies, action plans and deliverables; demonstrable impact

Please do not delete this slide...

Specific Matters for Consideration:

Consider the impact of inequalities across CTM
Consider how we can embed equity into routine practice, proactively identifying solutions, and ensuring health inequalities are addressed across all programmes of work.

Key Risks / Matters for Escalation:

None

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Recommendation

The Committee are asked to:

- Consider and discuss the information in the presentation and the implications for CTM

Next Steps

The Committee are asked to:

- Consider the suggestions on slide 23 and how these can be enacted across CTM



Agenda Item

6.1

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
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
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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
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1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.07.25 and 31.08.25 taken from systems on 03.09.25, unless otherwise specified.

Key areas to note in this reporting period are:

- Reduction in the number of formal complaints open over 30 working days
- One upheld PSOW report received
- Increase in number of outstanding National Reportable Incidents
- Decrease in number of incidents where duty of candour was triggered
- One regulation 28 report received
- Increase in medication incidents reported
- Increase in patient fall incidents reported

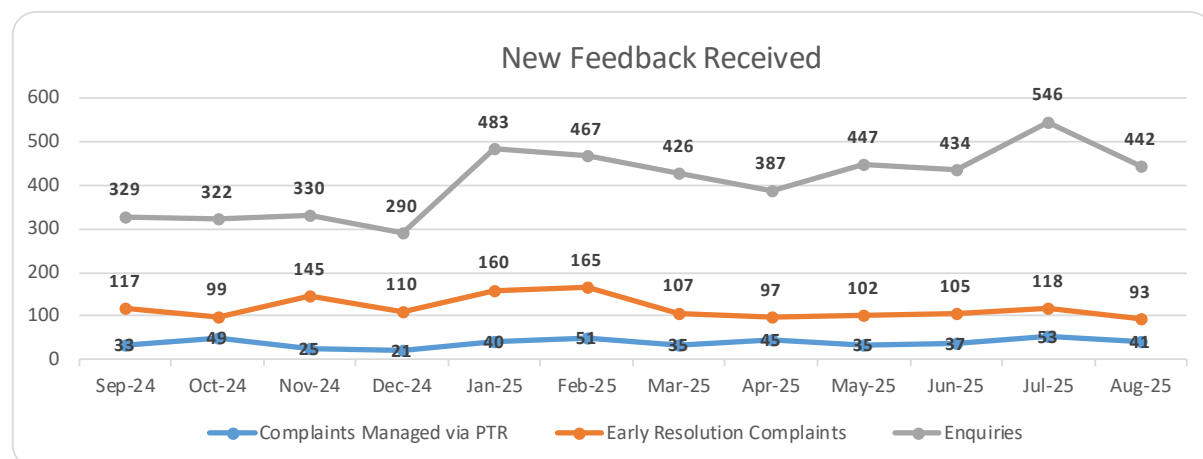
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

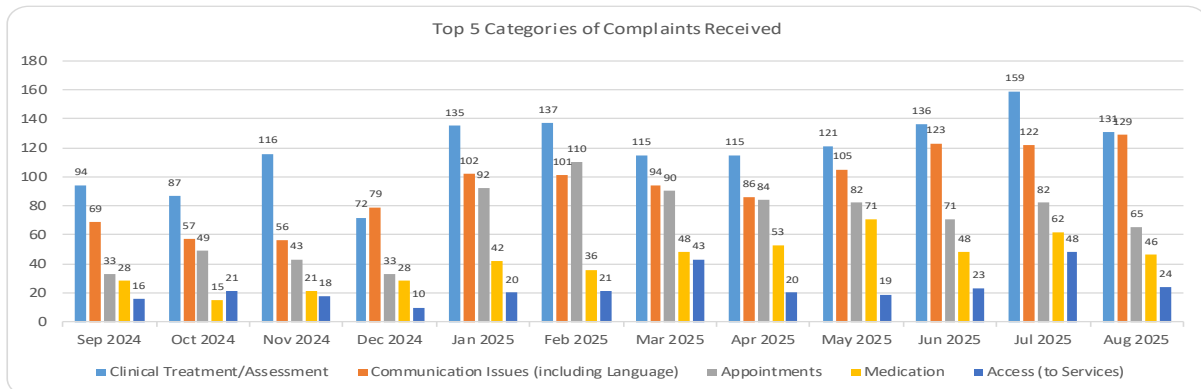
Complaints & Enquiries

New Complaints Received

Between the 01.07.25 and 31.08.25 the Health Board received a total of 305 complaints and 988 enquiries. Of 305 complaints received, 94 were categorised as formal and managed under the Putting Things Right Regulations (PTR). The number of complaints and enquiries increased during July 2025 however the number was consistent with previous months for August 2025.

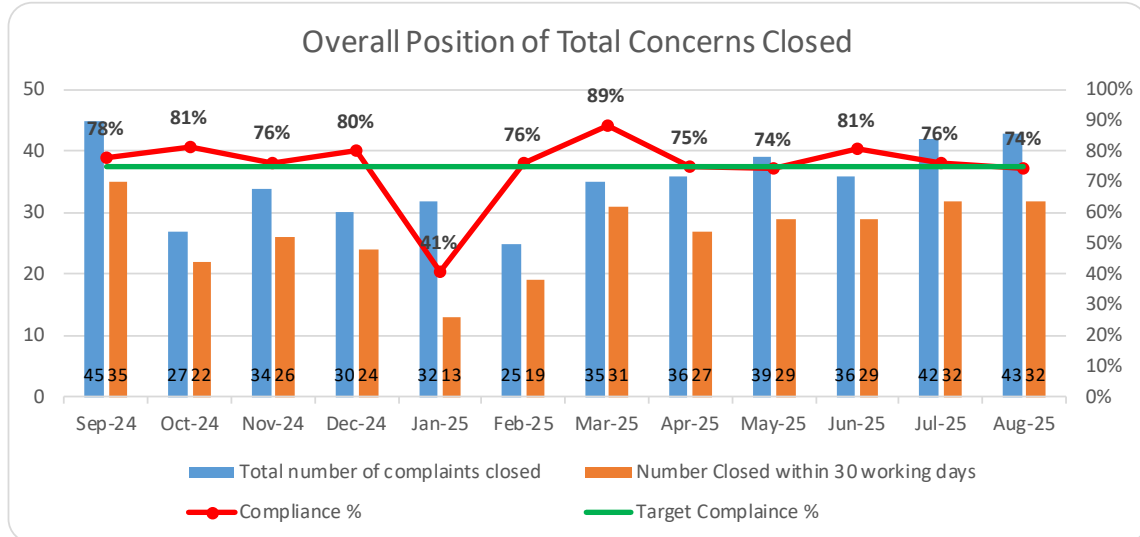


For all feedback (Complaints and Enquiries) received in July and August 2025, accounting for 57% of the feedback received, the top 3 types remain consistent with previous months. These relate to Clinical Treatment / Assessment (290), Communication Issues (including Language) (251) and Appointments (147).



Closed Complaints

Within the period of 01.07.25 to 31.08.25, the Health Board closed a total of 78 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 03.09.25, the Health Board had 64 open formal complaints. Of these, 13 complaints were open over 30 working days which represents an improvement from the position at the beginning of July. Focused work continues to be undertaken to improve the efficiency of the Health Board's concerns triage process to ensure a timely response.



Public Services Ombudsman for Wales

Open cases

As at the 03.09.25 the Health Board has 34 open Public Services Ombudsman for Wales (PSOW) Cases. Of these, 20 are awaiting a response from the PSOW.

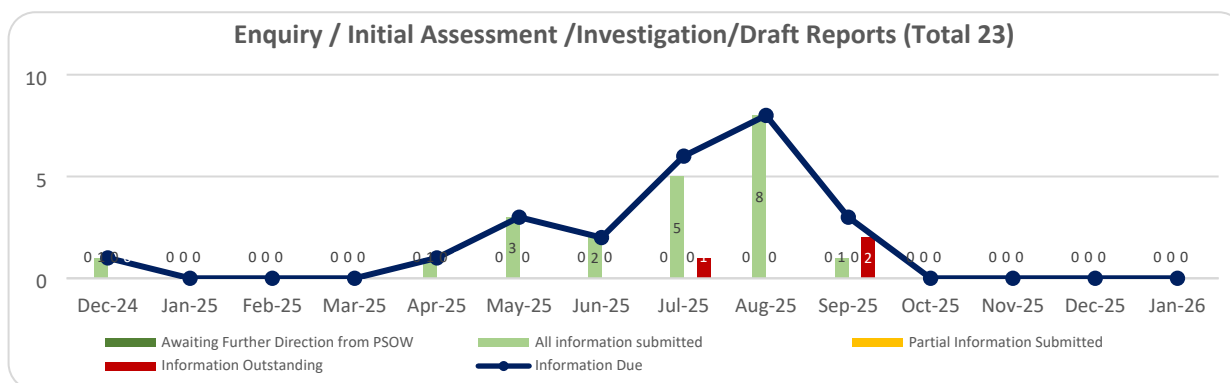


Current Status	Enquiry / Initial Assessment/ Investigation	Early Settlement	Draft Report Comments	Final Report Compliance	Information Only	Total
All evidence submitted and awaiting closure by PSOW	0	0	0	0	0	0
Awaiting further direction from PSOW	0	0	0	0	2	2
Information Received	0	0	0	0	0	0
Information Submitted	14	2	1	1	0	18
Information Outstanding	5	3	1	1	0	10
Information Partially Submitted	2	1	0	1	0	4
Total	21	6	2	3	2	34

New PSOW Cases Received

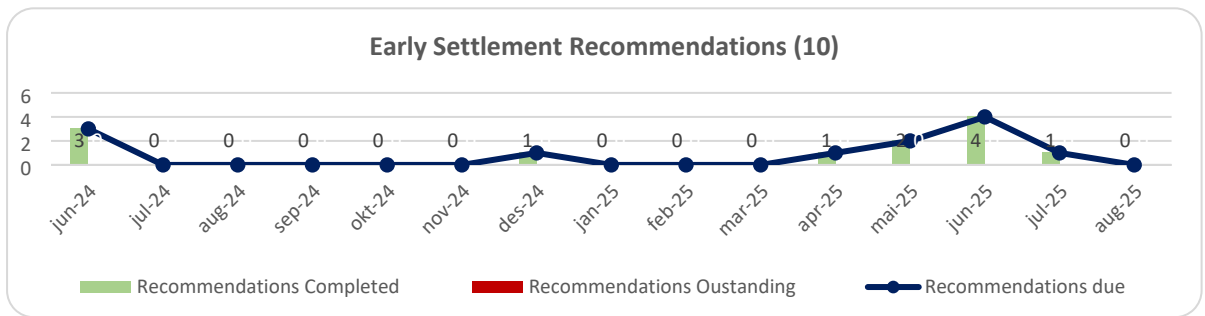
The Health Board received notification of 22 new referrals to the Public Services Ombudsman for Wales (PSOW) between the 01.07.25 and 31.08.25. Of the 22, 15 were received as enquiries, 6 as decision not to investigate and 1 as full investigation.

Of the 23 cases, the Health Board currently has at 03.09.25 in the enquiry / initial assessment/investigation stage, 3 cases which have outstanding actions. One action is currently overdue. This is reflected in the chart below:



Early Settlement Proposal

During the same period the Health Board agreed 6 early settlement proposals. It should be noted that more than one action can be attributed to a case. As at the 07.03.25, the Health Board has 9 open early settlement cases, with 25 associated case actions. Of the 25 actions, none are currently overdue the deadline agreed with the PSOW

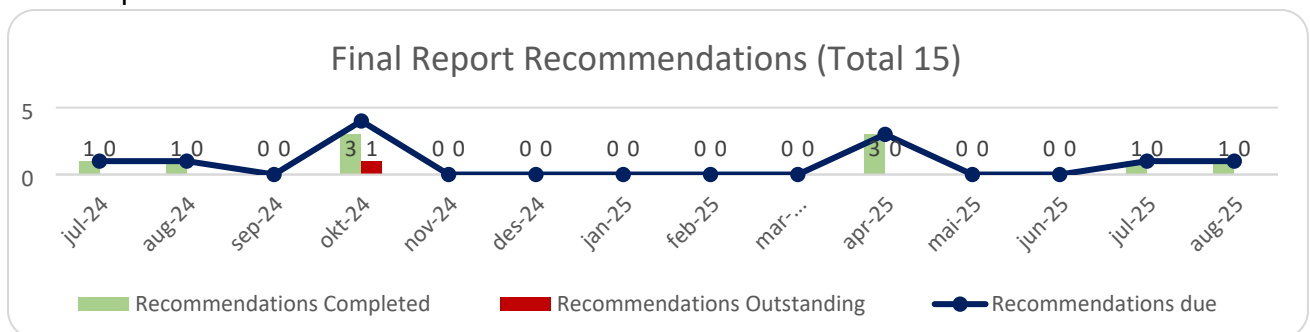


Final Reports

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

The PSOW issued an upheld case following its investigation as to whether the care and treatment provided in September 2023 to a patient experiencing depression and anxiety was clinically appropriate, specifically whether action taken to risk assess, explain side effects of the medication and the level of contact with professionals was adequate. The Ombudsman’s investigation recognised that there were aspects of the assessment that were in keeping with relevant guidance in terms of the treatment offered. However, the investigation highlights clinical shortcomings in the process relating to patient discussion regarding the medication plan and side effects, review of the patient risk assessment and collaborative working with the GP. The report concludes that even if the failings identified had not occurred, this does not mean that the decisions, management or outcome for the patient would have been different. The PSOW upheld the complaint on the basis that the possibility that the outcome may have been different represents an injustice to the family. In response to the report, the Care Group have shared the learning via their governance structures, are in the process of reviewing its local processes and will be undertaking a sample audit to determine any opportunities for improvement.

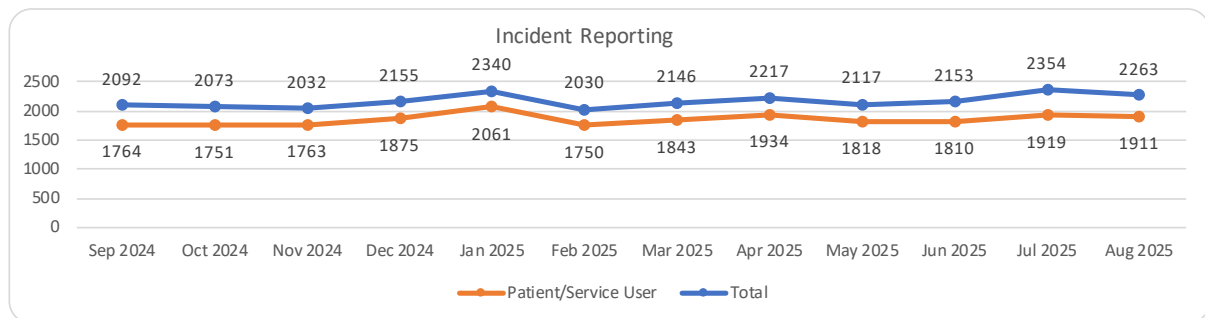
As at 02.05.25, the Health Board has 3 cases which are currently in the final report stage of the PSOW process. These cases have 14 associated recommendations. Of these recommendations, 4 are currently outstanding, with 1 currently overdue the timescale for completion.



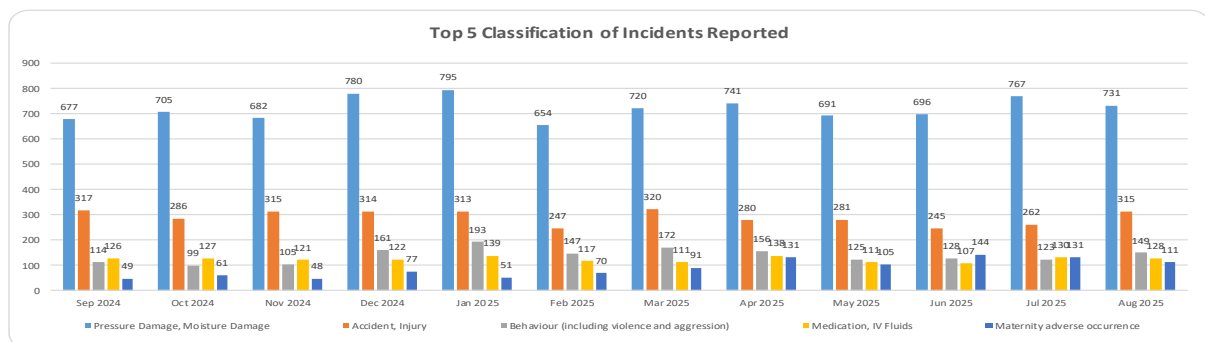
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,617 incidents were reported as occurring between 01.07.25 to 31.08.25, this represents an increase of 347 when compared with the previous 2 months (4,270). 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 4,617 incidents reported, 83% (3,830) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

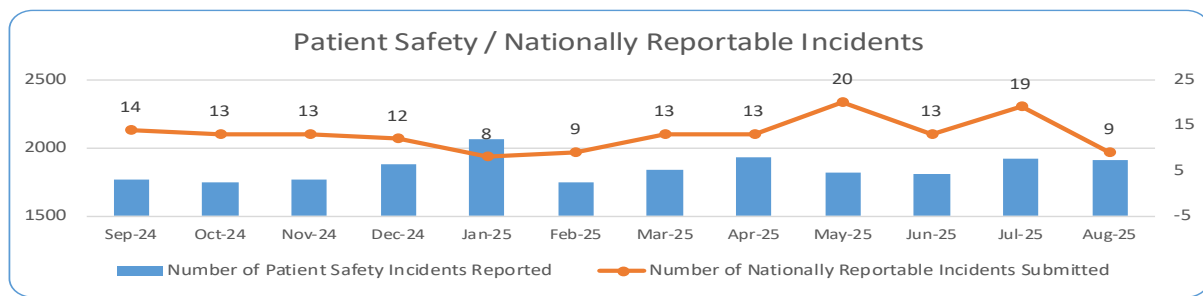


The top 5 classification of incidents reported as occurring in July and August 2025, linked to a patient affected incident are: Pressure Damage /Moisture Lesion (1,498), Accident, Injury (577) and Behaviour (including violence and aggression) (272), Medication, IV fluids (258) and Maternity adverse occurrence (242). This is consistent with the previous two-month period, apart from Medication, IV fluids have switched places with Maternity adverse occurrence. The trend for the top 5 classification of incidents is highlighted in the chart below:



Nationally Reportable Incidents

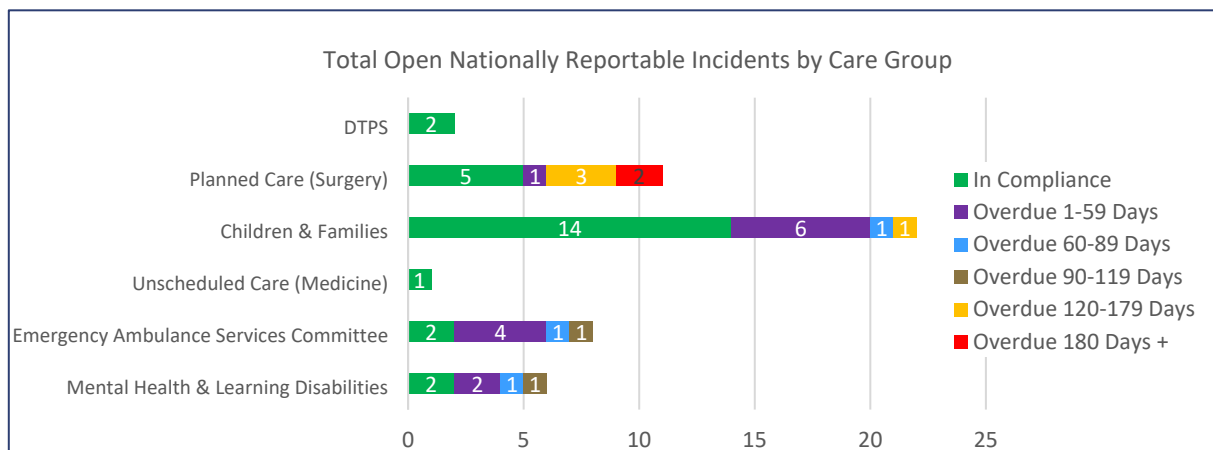
Between 01.07.25 and 31.08.25, 28 Nationally Reportable Incidents were submitted to the NHS Performance & Improvement Team. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



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

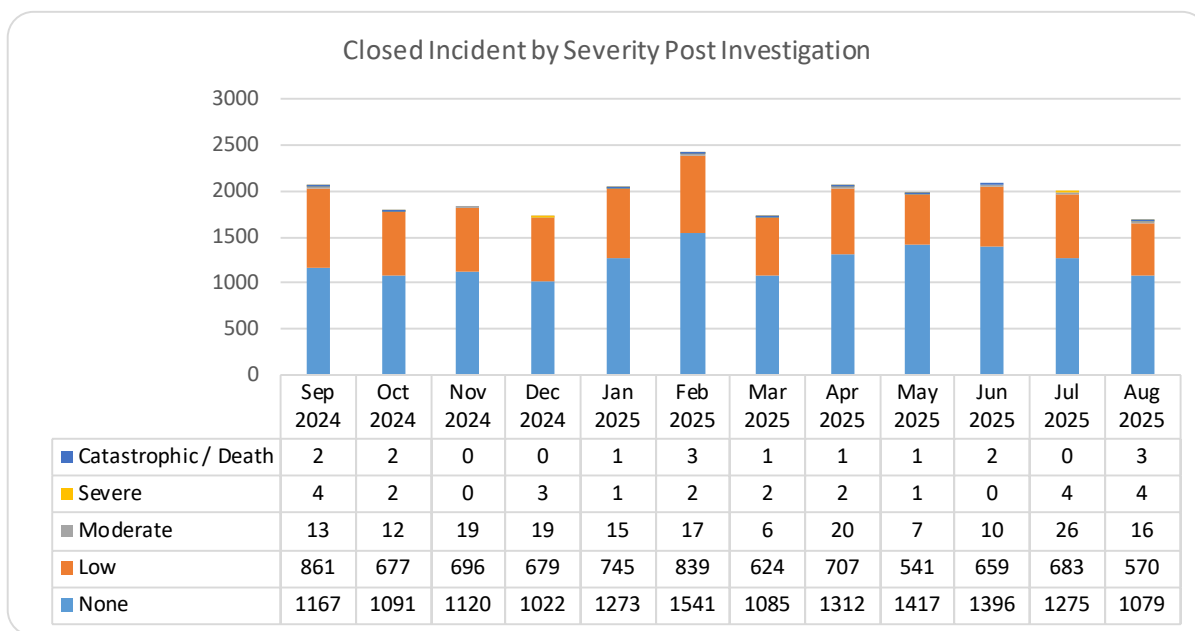
	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Total
Access, Admission	2	0	0	0	0	0	1	1	3	1	0	0	8
Accident, Injury	0	1	0	0	0	0	0	0	0	0	0	0	1
Assessment, Investigation, Diagnosis	2	1	0	0	0	0	1	0	2	0	2	0	8
Behaviour (including violence and aggression)	0	0	1	0	0	0	0	0	0	0	0	0	1
Equipment, Devices	0	0	0	0	0	0	0	1	0	0	0	0	1
Infection Prevention and Control	3	0	0	2	0	0	4	3	2	0	0	0	14
Maternity adverse occurrence	1	3	2	2	4	1	3	0	5	2	0	5	28
Monitoring, Observations	1	0	0	0	0	0	0	0	0	0	0	0	1
Nutrition, Hydration	0	0	0	0	0	1	0	0	0	0	0	0	1
Patient/service user death	0	0	2	0	1	1	0	1	1	1	1	1	9
Pressure Damage, Moisture Damage	3	8	6	7	2	4	4	3	7	6	15	3	68
Transfer, Discharge	1	0	0	0	1	1	0	4	0	2	0	0	9
Treatment, Procedure	1	0	2	1	0	1	0	0	0	1	1	0	7
Total	14	13	13	12	8	9	13	13	20	13	19	9	156

As at the 01.09.25, the Health Board currently has 50 open Nationally Reportable Incidents, of which 24 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 01.07.25 and 31.08.25 a total of 3,660 patient safety incidents were closed. The 12 month trend is reflected in the table below.

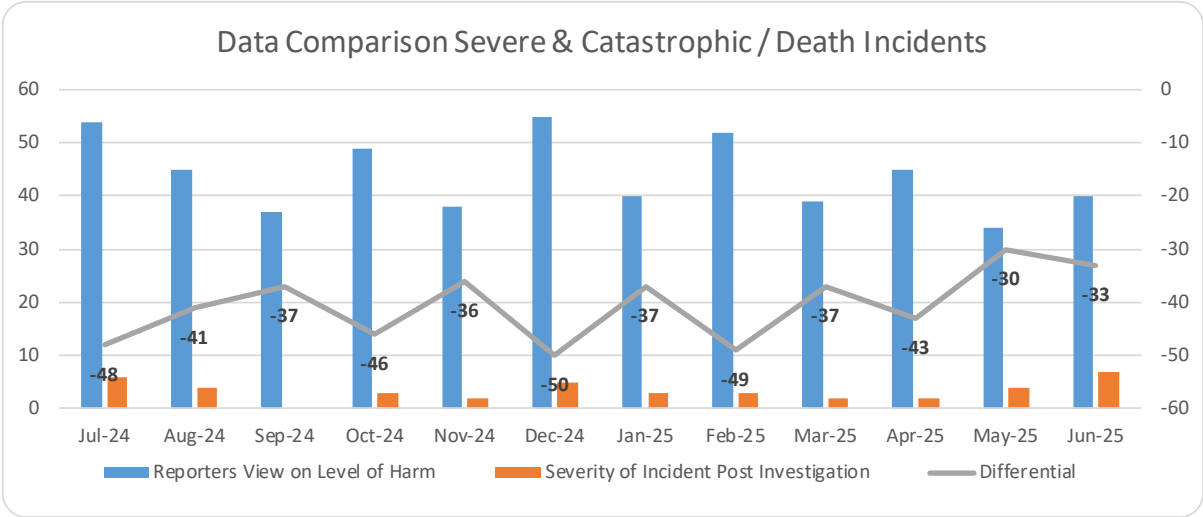


Of the 3,660 patient safety incidents closed, 11 were closed with severity post investigation of severe harm (8) or catastrophic/ death (3). A breakdown of incidents is provided in the table below:

	Unscheduled Care	Planned Care	DTPS	Total
Access, Admission	0	1	0	1
Accident, Injury	0	1	0	1
Infection Prevention and Control	2	0	0	2
Medication, IV Fluids	0	0	1	1

Treatment, Procedure	0	6	0	6
Total	2	8	1	11

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.

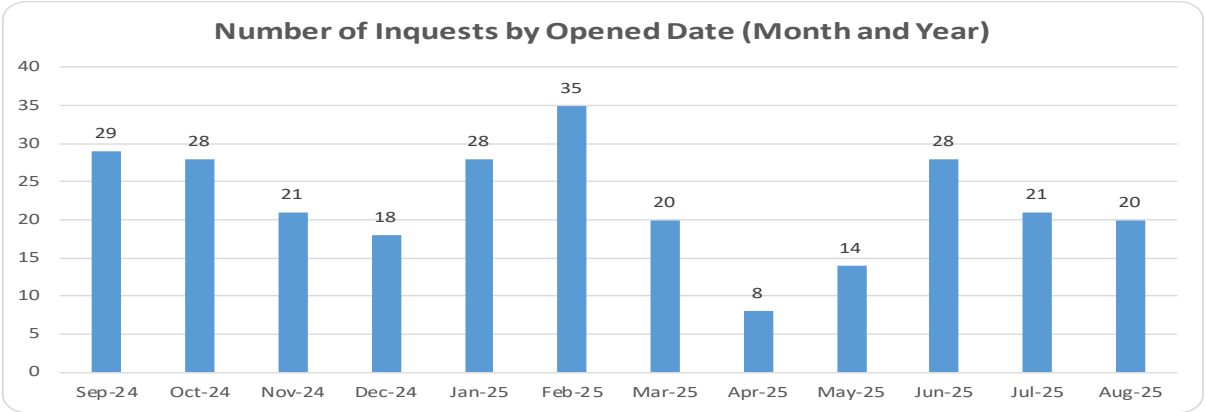
Number of Incidents	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Where Duty of Candour Triggered	21	15	15	13	9	8	13	15	21	17	8	10

Number of Incidents	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Where In-person notification completed	19	10	15	13	8	5	12	15	19	17	8	7
Where letter of notification sent	19	10	15	13	7	5	11	13	17	16	7	6

2.3 Inquests Case Activity

New Inquests Received

In the time period 01.07.25 to 31.08.25, the Health Board received notification of 41 inquests. This is a slight decrease when compared with the previous 2 month period (42). A trend graph of the inquests opened during period is provided below.

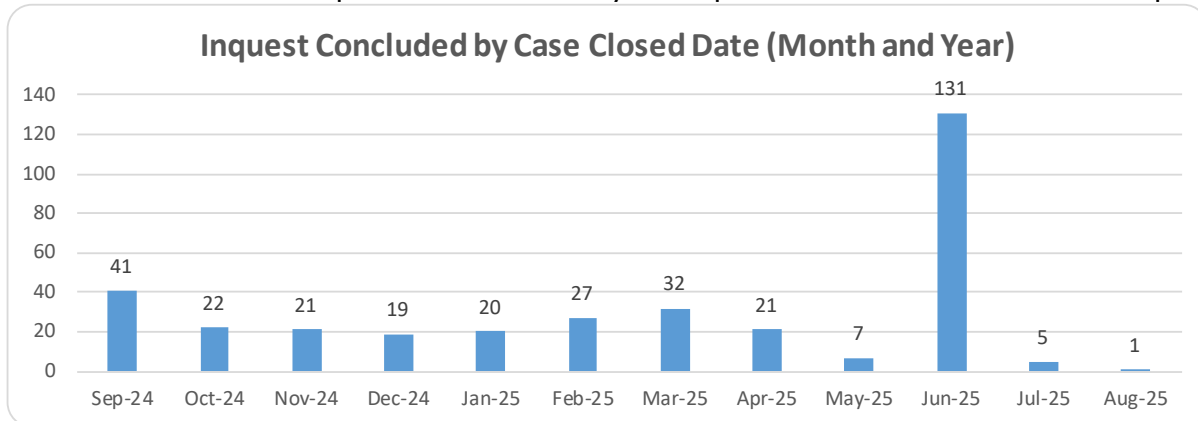


Of the 41, the highest number of inquests were received for the Unscheduled Care Group. A breakdown of inquests received by Care Group is provided below.

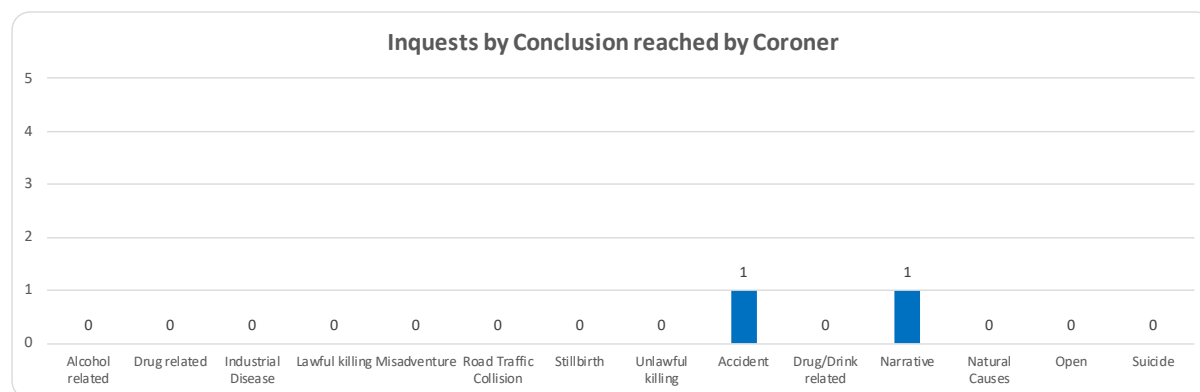
Care Group	Number Received
Children and Families	2
Primary Care and Community	1
Mental Health and Learning Disabilities	9
Planned Care	9
Unscheduled Care	18
DTPS	0
Not Specified	1
Total	41

Inquests Concluded

During the same 2 month period, 6 inquest cases were closed on the Health Board’s Datix system. A trend graph of inquests concluded during the period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 6 inquests cases closed on Datix, 4 were discontinued by the Coroner prior to hearing. Of the remaining cases, one was concluded with a narrative conclusion (1) and one with an outcome of accident (1). A further breakdown of the outcome of inquests closed between the 01.07.25 and 31.08.25 is provided in the chart below.



Regulation 28 Reports / HMC Letter Received

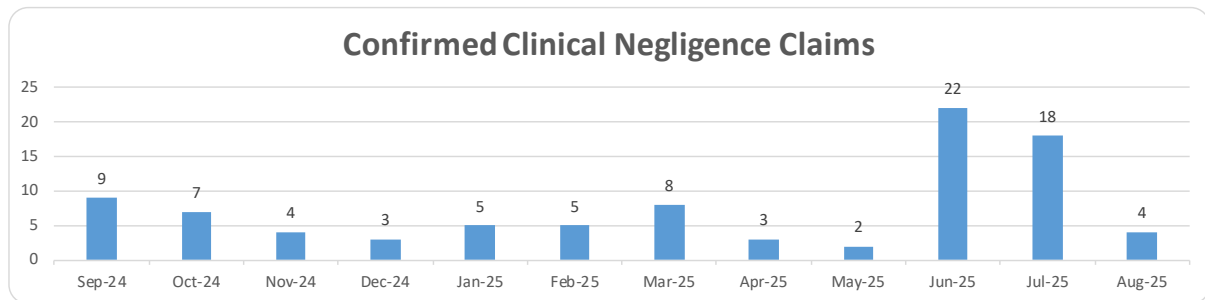
On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. Between the 01.07.25 and 31.08.25 the Coroner issued 1 regulation 28 report to the Health Board relating to alcohol, drug and medication following a death in the prison.

Whilst the Health Board was not responsible for the Healthcare at the time of the patient’s death, the Regulation 28 Report outlined that there was, and remains, an absence of specified prescribed timeframes in policies and procedures within which intervention, ongoing support, and/or case load allocation to/from Dyfodol must occur for prisoners likely to be at risk of substance misuse. The absence of prescribed timeframes poses the real risk of delayed support and intervention to drug users.

2.4 Clinical Negligence Claims

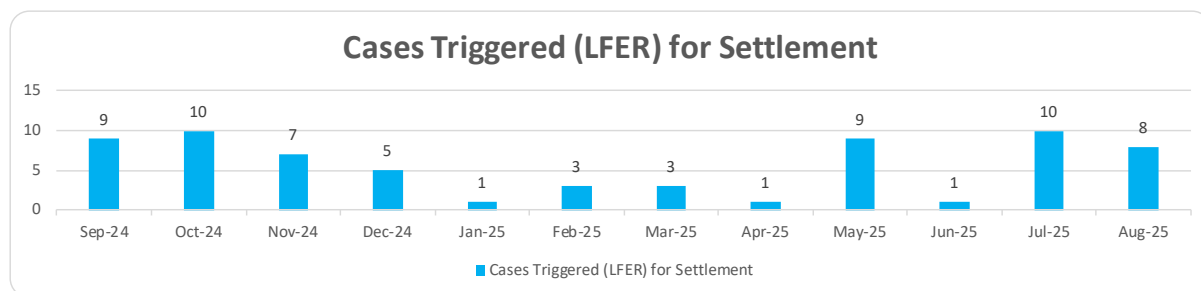
New Confirmed Clinical Negligence Claims

Between the 01.07.25 and 31.08.25 the Health Board received confirmation of a total of 22 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



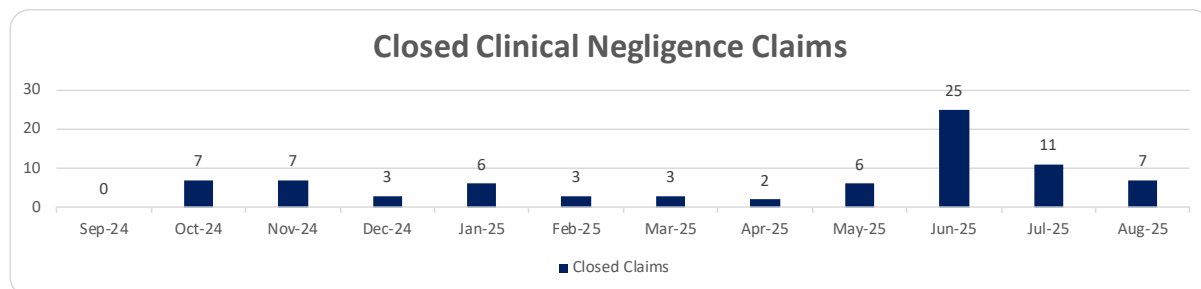
Clinical Negligence Claims triggered for settlement

Between the 01.07.25 and 31.08.25 the Health Board had 18 Clinical Negligence Claims that were 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

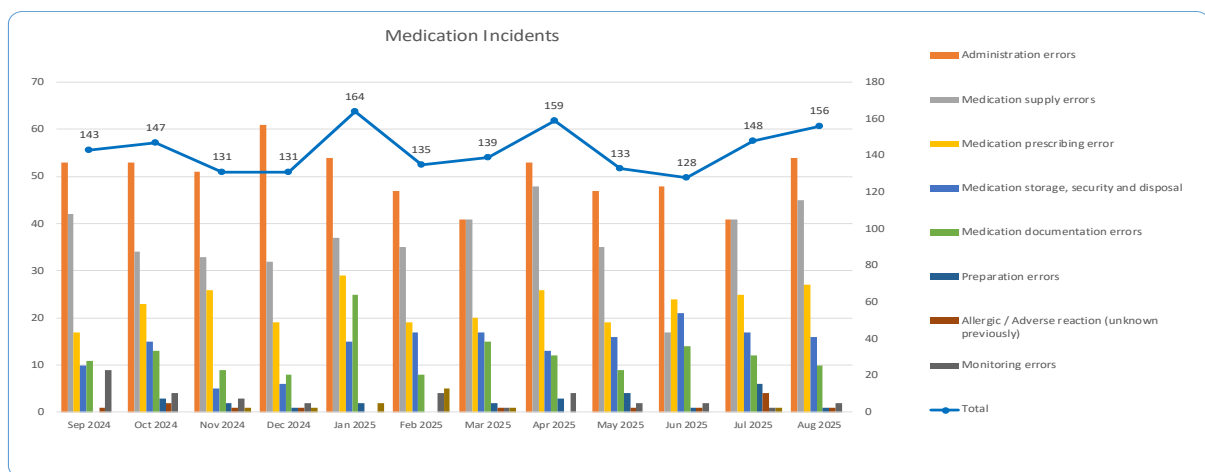
Between the 01.07.25 and 31.08.25 the Health Board closed 18 Clinical Negligence Claims. The trend for clinical negligence claims closed in the last 12 months is highlighted in the chart below:



2.5 Specific Quality & Safety Metrics

2.5.1 Medication Safety

A total of 304 medication incidents were reported as occurring between 01.07.25 and 31.08.25. This is an increase of 43 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 (86), and medication prescribing errors (52).

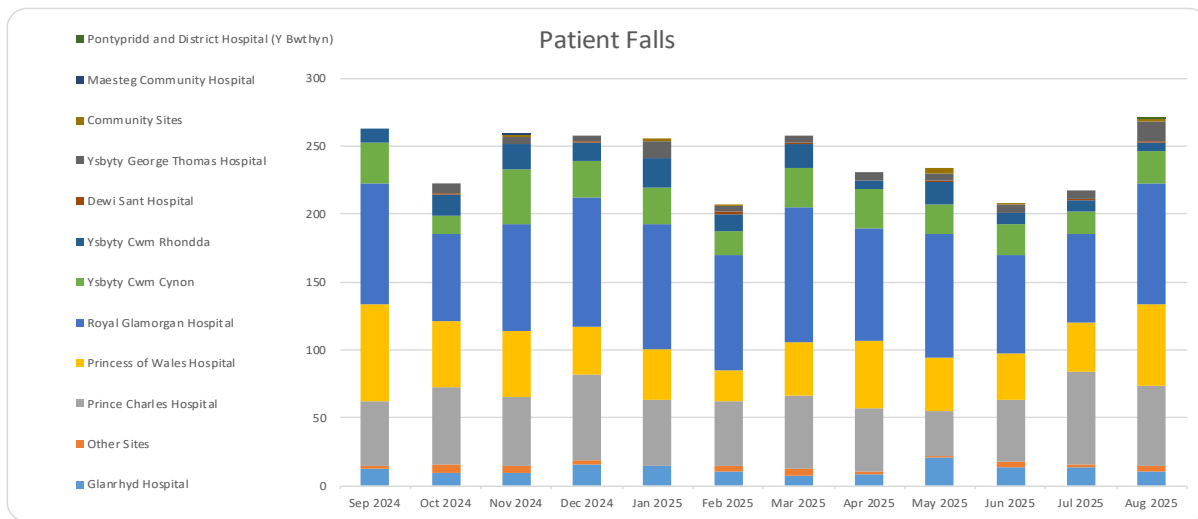


87% of the medication incidents were reported as resulting in no (128) or low (135) harm, with the remaining reported as resulting in moderate harm (35), severe harm (5) and catastrophic harm / death (1). It should be noted that this is the reporter’s view of the level of harm and is subject to change following investigation.

2.5.2 Patient Falls Incidents

A total number of 488 falls, where the person affected was a patient, were reported during July and August 2025. This represents an increase of 45 compared with the previous two months.

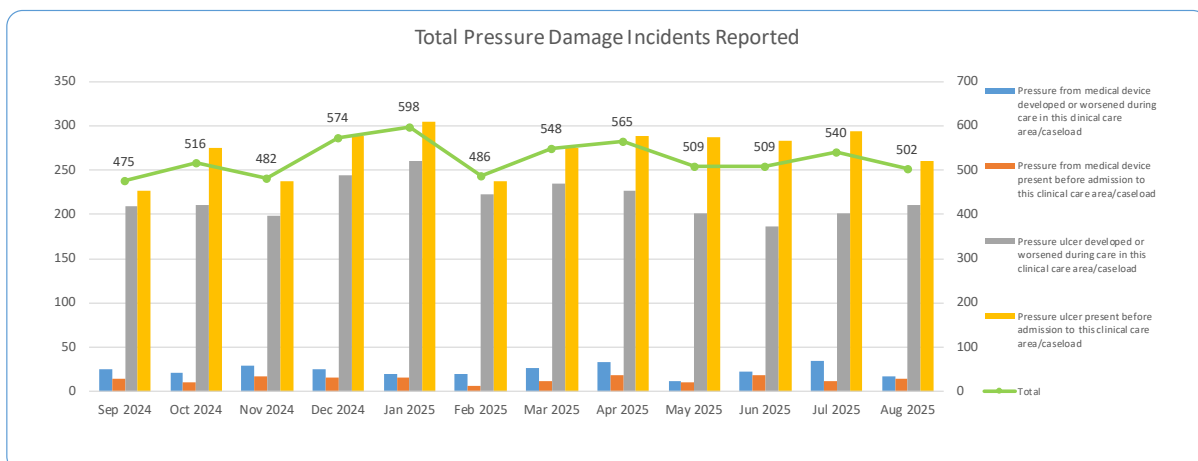
Of the falls incidents within the time period, 94% were reported as no (178) or low (280) harm. The remaining incidents were reported as resulting in moderate (25) and severe (5) harm. No incidents relating to patient falls were reported as resulting in severe harm or catastrophic harm / death. Once again, it should be noted that this is the reporter’s view of the level of harm and is subject to change following investigation.



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

2.5.3 Pressure Damage

Between the 01.07.25 and 31.08.25, a total of 1042 pressure damage incidents were reported, of which 463 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (579) were reported as being present before admission to this clinical care area/caseload.



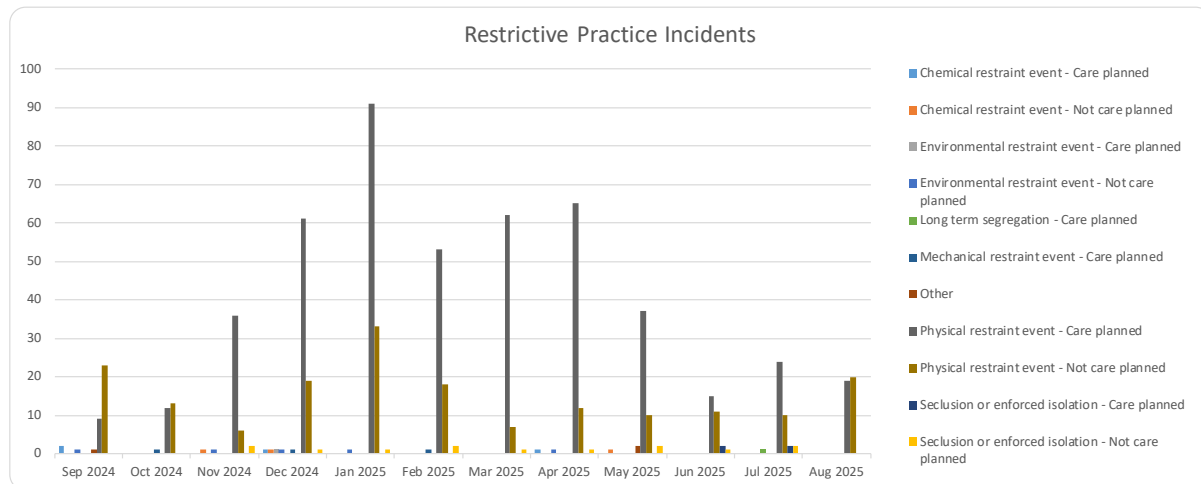
Of the 463, identified as developing or worsening during current caseload, 237 were identified as occurring within the community, which represents an increase of 19 compared with the previous two-month period (218).

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

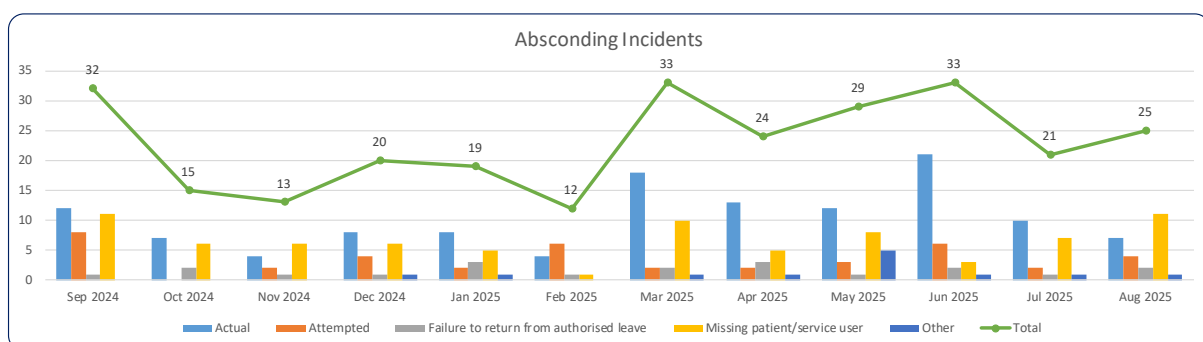
Between 01.07.25 and 31.08.25, a total of 78 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 3 incidents when compared to the previous two months.



Of the 78 incidents, 32 were reported as not care planned (not included in the care and treatment plan for the patient) and 46 were reported as care planned (included in the care and treatment plan for the patient), 0 were recorded as Other. The highest number of incidents were reported as occurring on the Coity Clinic (PICU), Princess of Wales Hospital (30).

Absconding incidents

During July and August 2025, a total of 46 incidents were reported under the category of absconding, which represents a decrease of 16 when compared with the previous two-month period. 18 were recorded as missing patient/service user, with the remaining recorded as actual absconding (17), attempted absconding (6), failure to return from authorised leave (3), and other (2). The highest number of incidents were reported as occurring in the Emergency Care Centre at the Prince Charles Hospital (12).



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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / 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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

- **NOTE** 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

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 1

Quality, Safety & Experience Committee

People's Experience Activity Report June - July 2025

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
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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

To understand the needs of our communities and if the services we are providing meet those needs the People's Experience team continue to explore new opportunities of engagement.

Date	Event	Attendance
23 rd June	Sea Cadets – HMS Cambria, Cardiff	Head of People's Experience & PALS team.
24 th June	BCBC Forces Fest Event – Primary Schools	Head of People's Experience & PALS team.
25 th June	Armed Forces Reserves Event - Senedd	Head of People's Experience & Clinical Bereavement Lead
26 th June	Health promotion Event – Armed Forces – Valley Veterans	People's Experience Team – PALS, Bereavement, Carers, Chaplaincy.
8 th July	Golden Thread Event – Regional Partnership Board	Head of People's Experience & Carers Lead.

NHS Wales People's Experience Framework and Toolkit

Work is ongoing in this area and Head of People's Experience has linked in with Care Group Leads to establish links, population of the self-assessment tool is underway in some areas with others still being explored.

Ongoing Projects

Filming to support Ysbyty George Thomas Hospital

As the Health Board is utilising and has expanded the number of patients beds on site it was felt a video to showcase the improvements made to benefit patients environment here. A number of patient stories were collected as well to provide further insight for patients and families being transferred here.

Falls/Pressure Area review

Draft leaflets for patients and families have been created with input from specialties involved in this area of work and patient representatives. These

are due to be finalised over the next two months with the purpose of two leaflets supporting community and acute settings.

Communication systems across CTMU HB

Head of People's Experience is part of a working group supporting the exploration of a new communication system related to appointment letters, how we communicate with the public etc. Introductions have been made to Llais to support community engagement through their outreach program and input has been provided with the proposed survey via CTMU HB for public engagement.

Toiletry/clothing for emergency situations across CTMU HB

Following conversations with third sector organisations and staff within the Health Board regarding patients who find themselves with no support to access toiletries and clothing during a hospital admission, exploration of support mechanisms was taken forward. Head of People's Experience and Head of Charities have worked together to source toiletries/clothing for each site to access in emergencies to ensure the dignity and respect of our patients is maintained. The items are due to be delivered to the HB in September for dissemination across community/acute sites.

Patient Satisfaction Feedback

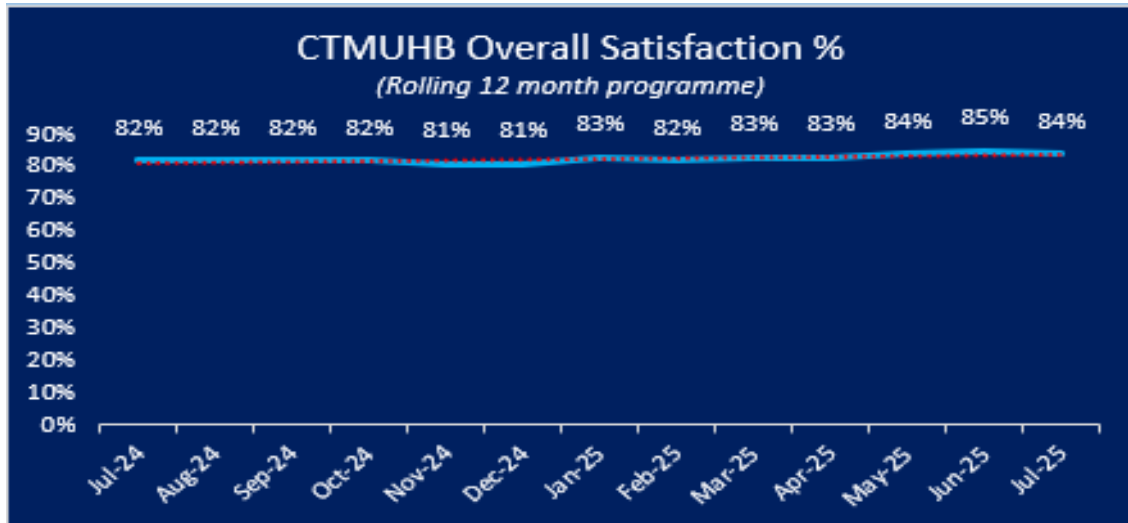
Use of the All Wales Survey has increased across the Care Groups and a number of departments are working with Value Based Healthcare team to explore how they can increase feedback from patients/families via this format.

There are two volunteers working in Princess of Wales supporting feedback via the 'Have your say' cards and a further volunteer has started in Prince Charles Hospital to support here.

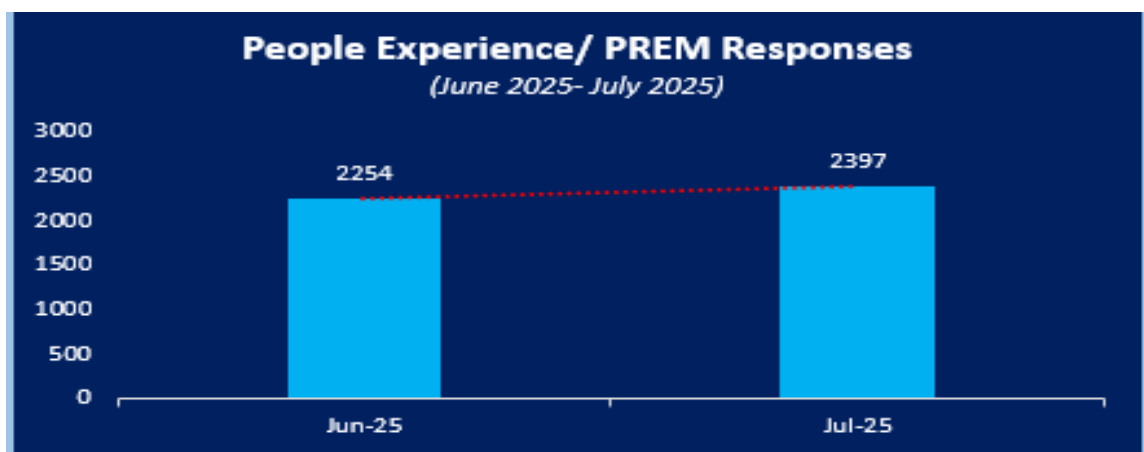
Reports are sent to Care Groups and senior staff to review and action accordingly to ensure feedback filters through into improvements and shared learning across the Health Board.



Overview of feedback satisfaction score for CTMU HB



Number of responses from the public



compassionate
delayed compassion "not listen"
"a shambles" reassuring concerned
"waste of time" pleased wonderful terrible
eventually enjoyed delay fantastic disgusting
complaint brilliant friendly impressed
ridiculous stressful amazing happy
empathy awful excellent
supportive comfortable lovely rude dismissive
ignored appalling pleasant exceptional
anxiety "at ease" anxious
kindness outstanding complain
"my concerns" unacceptable disappointed
apologetic "not acceptable"

Chaplaincy

The number of people the team support is continuing to increase due to proactively ensuring their presence on the wards across the HB.

Number of people supported with significant spiritual and pastoral care.	
Patients	467
Relative's/carers	294
Staff	293

Lead Chaplain has worked with the Value Base Healthcare team to explore how we gain more feedback on the service from the people they support to develop services further. This is now in place and the team are looking to raise awareness of this.

Bereavement

Clinical Bereavement Lead continues to explore ways we can support our patients, families, carers and staff to improve bereavement services across the Health Board:

- Attended training to be able to support plaster cast imprints for families with baby loss
- Supporting Palliative/end of life pathways with bereavement support
- Communal Cremation services supported across the Health Board for pregnancy loss

Volunteers

Engagement with the community to increase the number of volunteers that support the Health Board in various roles is ongoing. The support that is provided through this is an invaluable way of improving the experience of our patients and families:

Number of People who have expressed interest in volunteering	
Contacts	70
Interviewed	15
Inducted	24
Recruited	22

- Volunteers started across the sites in Prince Charles, Royal Glamorgan, Ysbyty Cwm Cynon/Cwm Rhondda and PALS team, Princess of Wales Hospital.
- Team have supported volunteer induction training for volunteers supporting Palliative Care in Prince Charles Hospital through Marie Curie.
- Exploration of avenues to gain feedback from volunteers and staff via a survey to understand the impact of the service provided and further opportunities.

Armed Forces/Veterans

The team supported a large event with Valley Veterans hub during Armed Forces week in June. This enabled the HB to look at raising awareness of the wider support available to armed forces/veterans' community not only from a health but community aspect as well.

Over 150 people attended the event and 30 stalls offering a wide range of services. The project team are now working together with Valley Veterans to look at the wider impact and learning that will come from this event to improve the health and wellbeing of this community.





PALS (Patient Advice Liaison Service)

Contact with patients, families and unpaid carers is being increased across the Health Board in a proactive way to look at how they can support those utilising the services.

Number of PALS contacts across CTM	
June	271
July	342

Top Three Themes
Communication Issues
Clinical treatment/Assessment
Patient care

- Member of the PALS team supported Valley Veterans event during Armed Forces week
- New member of team started end of July on a secondment basis which will bring further opportunities to support and explore engagement opportunities

Unpaid Carers

Corporate Unpaid Carers Lead has attended a number of events to highlight the links available within the Health Board to support any queries that carers may have within a health journey of those they support in their caring role.

- Provided input into the Pressure Area/Falls Task and finish group to ensure work being undertaken for patient information leaflets reflects the carers voice within this.
- Provided training to Band 6 District Nursing/Community Services In Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon.
- Attended carer's events in Bridgend Carers and Dementia Friendly, Pontypridd.

3. Key Risks / Matters for Escalation

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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	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 Quality, Safety & Experience Committee is asked to **NOTE** this report and the next steps.

6. Next Steps

- 6.1 **Patient Stories** – exploration of campaign with Communication team to highlight patient stories as a form of feedback and alignment with subjects in Quality & Safety/Public Board arena to ensure voice of the community is highlighted in these Forums.
- 6.2 **Armed Forces/Veterans** – work is underway to collate the information provided from the community, third sector stakeholders and a working group has been established to take this forward.



Agenda Item

6.2

Quality, Safety & Experience Committee

Clinical Negligence Claims

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting
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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	
UHB	University Health Board

1. Introduction

A clinical negligence claim is a legal action for compensation arising from the alleged harm or loss to a patient as the result of substandard medical care.

For a negligence claim to succeed, the claimant must prove the following three elements:

- 1. Duty of Care:** There is a duty of care owed by the Healthcare Organisation to the patient
- 2. Breach of Duty:** The duty has been breached and
- 3. Causation:** The breach in the duty has caused harm to the patient (and the harm was reasonably foreseeable). This is referred to as 'causation'.

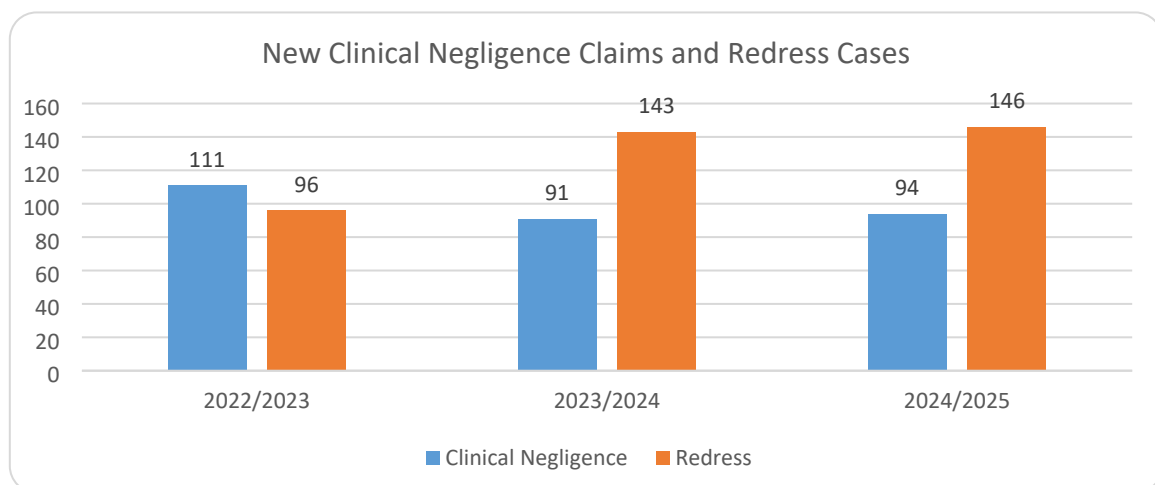
Where during an investigation of a complaint or incident a breach of duty of care is identified which has potentially resulted in harm to the patient, the case will be transferred to the Redress process for a further detailed investigation to establish if a qualifying liability exists.

Reports provided to the Audit, Risk and Assurance Committee have indicated a potential increase in the number of clinical negligence claims received by the Health Board. This paper will outline an analysis of clinical negligence claims, along with redress activity for the previous 3 years (01.04.2022 to 31.03.25).

2. Specific Matters for Consideration

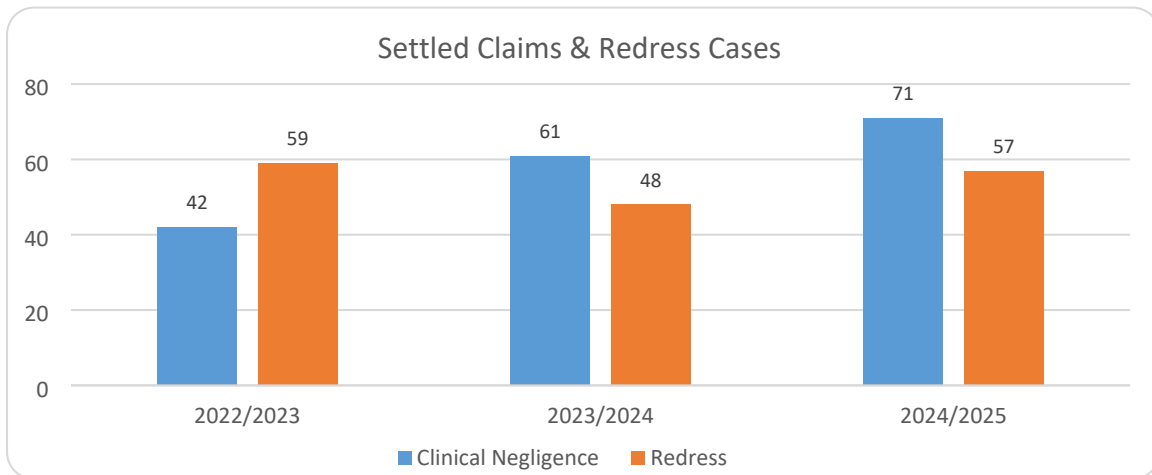
New Claims Received

The number of new confirmed clinical negligence claims received by the Health Board decreased in 2023/2024 when compared with 2022/2023 and remained consistent in 2024/2025. In comparison the number of new cases transferred to redress has increased. This correlates with the implementation of Duty of Candour on the 01.04.23. This trend is reflected in the chart below.



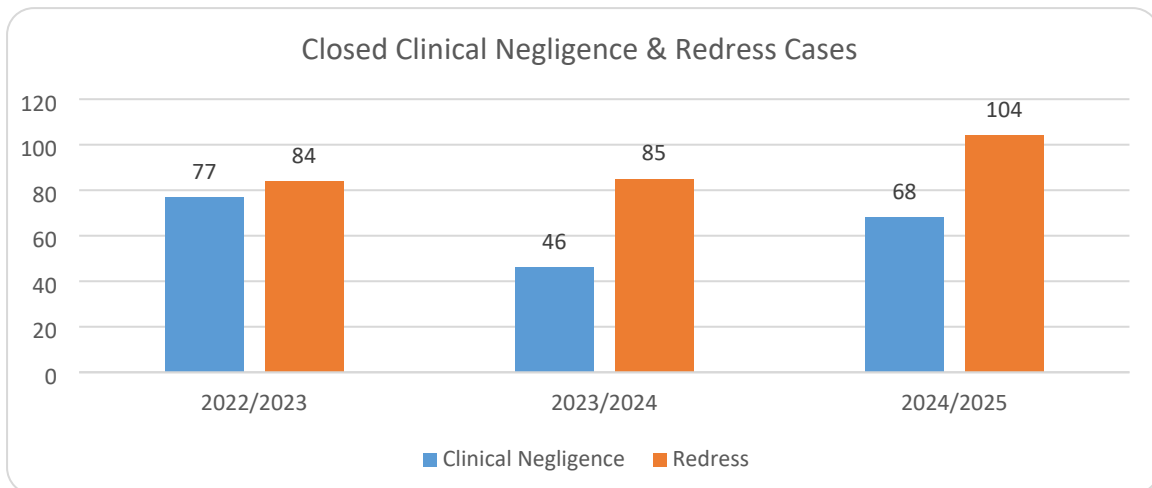
Settled Claims & Redress Cases

Whilst the number of new clinical negligence claims remained consistent, the number of cases where an admission of liability or offer of settlement was made continued to increase from 2022/2023. In the same time period, the number of redress cases where an admission of liability was made remained relatively consistent.



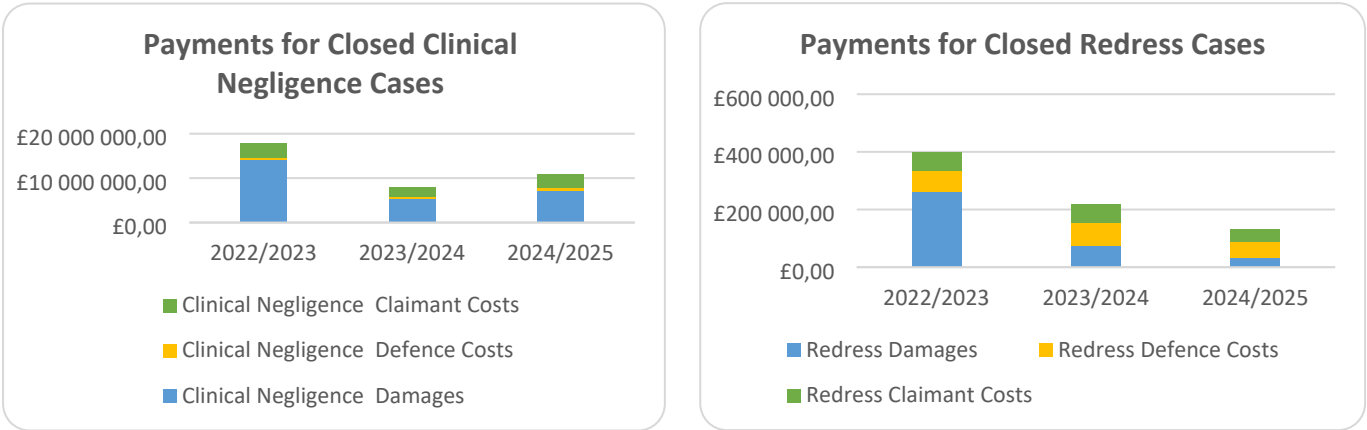
Closed Claims

As a result of a cleansing exercise and targeted work to conclude matters the number of clinical negligence and redress cases closed increased during 2024/2025. This is reflected in the chart below.



Throughout the management of a clinical negligence claim and redress case, costs can be incurred which are categorised as damages, defence costs and claimant costs. It should be noted that payments can be made at various points throughout the case, frequently occurring in separate financial years. Review of the payments made for cases closed during the previous 3 years has identified that whilst there was a continuation of the decrease of the total payments for redress cases, an

increase has been highlighted in relation to clinical negligence claims during 2024/2025.



3. Key Risk / Matters for Escalation

- The number of cases transferred to redress has continued to increase. This rise is likely to continue from 2026/2027 onwards if the proposal to increase the threshold of the value of redress cases to £50,000 as part of the revision of the Putting Things Right regulations is agreed. It is envisaged that as a result of this the number of clinical negligence claims received will decrease.
- Focused work is being undertaken to address the historic clinical negligence and redress cases currently awaiting conclusion. As this work progresses and cases are brought to a conclusion this will be reflected in an increase in the total payments made.

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	Not Applicable
	If more than one applies please list below:



150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Safe If more than one applies please list below: Effective Efficient Timely 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: ☒ Outcome: This report outlines Inquest Activity one of the key areas of quality across the Health Board.	No: ☐ 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: ☐ Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	No: ☒ 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	Yes (Include further detail below) The Report relates to the Coroner's process.	



Enw da / Reputational	Yes (Include further detail below)
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes. This includes regulation 28 reports.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

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



Agenda Item

7.1

Quality, Safety & Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	23 September 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary
Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	August / September	RISKS REVIEWED
Executive Leadership Group	15 September 2025	REVIEWED AND 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 September 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 **799** 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.

- 2.10 118 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.81 out of a maximum score of 5.
- 2.11 100% of the 118 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 118 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:
- *"The session covered how to raise, and review risks and it was useful to understand the frequency of reviews based on risk score as I had been told unless its scores over 20 it doesn't trigger, so that was reassuring."*
 - *"Not so scared about process now and know how to seek support"*.
 - *"Really informative - little knowledge of risk prior to this training"*.

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Patient, Care and Safety Directorate (Infection, Prevention and Control)

- Datix Risk ID 1793 – "Lack of isolation facilities available – negative pressure rooms". Risk score of 16. New risk escalated to the Organisational Risk Register in September 2025.
- Datix Risk ID 4218 – "Reduced on site Consultant Microbiologist/IPC Doctor cover for Bridgend. Risk score of 16. New risk escalated to the Organisational Risk Register in September 2025.

Facilities Directorate

- Datix Risk ID 6052 - Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrakarts). Risk score of 20. New risk escalated to the Organisational Risk Register in September 2025.

3.2 CHANGES TO RISKS

Risk Score Increased

Central Directorate – Commissioning / Diagnostics, Therapies, Pharmacy & Sciences (DTPS) Care Group

- Datix Risk ID 5821 – "Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB)". Risk score increased from a 16 to a 20 in September iteration of the Organisational Risk Register as currently a sustainable solution has not been identified.

Risk Score Decreased

Unscheduled Care – Care Group

- Datix Risk ID 4632 – “Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)”. As a result of the progress made against the ‘Improvement Action Plan” and work to stabilise the service, the risk has been reduced from a likelihood score of 20 to a 16 in the Organisational Risk Register for September 2025. Further detail is captured in Appendix 1.

Patient Care & Safety Directorate

- Datix Risk ID 6230 – “Proactive management and compliance with Medical Negligence or Personal Injury claims at Pre-Action Protocol stages”. The risk score has reduced from a 16 to a 12 this period as a significant amount has been completed with Personal Injury activity. Additional work continues with clinical negligence; however, it has been stabilised with a number of actions by the leadership and specialist team.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Primary, Care & Community

- Datix Risk ID 6053 – “Failure to secure an alternative Clinical System for GP practices on Vision”. Digital Health Care Wales have now concluded the sale of the systems to a new provider. The Health Board contract has been novated with the migration of practices to EMIS. As at 3rd September an update has confirmed that notification from the provider has been received that the transfer is complete. Risk has therefore been mitigated and can be closed.

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

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



3.5 EMERGING RISKS

Identified in the July 2025 iteration of the Organisational Risk Register:

- 3.5.1 **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. The deep dive to understand the risks around this activity is ongoing and yet to be escalated to the Organisational Risk Register.
- 3.5.2 **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. The Primary, Care and Community Care Group are further reviewing this risk and consider that at this stage it does not require escalation to the Organisational Risk Register.
- 3.5.3 **Unscheduled Care – Care Group** – ‘Lack of Resuscitaire in Princess of Wales Emergency Department’ (Datix Risk ID 6152). This risk will not be escalated to the Organisational Risk Register as the risk score has been significantly reduced as the Resuscitaire equipment for the Emergency Department has been received and is currently being put together by the Electro-Biomedical Engineering (EBME) department. The interim arrangements regarding the Resuscitaire from maternity is scheduled to cease at the end of September allowing for training on the new Resuscitaire equipment.

Identified in September 2025 iteration of the Organisational Risk Register

- 3.5.4 The Chief Operating Officer has been undertaking **deep dive reviews of risk with Care Groups** to review all risks within their areas. As a result of this exercise some changes are anticipated to the Organisational Risk Register in the coming months.

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 emergency and elective demand	Chief Operating Officer	Quality, Safety & Experience Committee and Operational	16 (C4XL4)

	 	b) Enough capacity to meet emergency demand		Delivery Committee	20 (C4xL5)
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:	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
Date 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
6052	Chief Operating Officer	Facilities Directorate	Facilities Director	Sustaining Our Future	Statutory Duty, Regulation, Mandatory Requirements	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrafraks)	If: The patient beverage trolley fleet is not maintained/replaced Then: Patients are unable to be fed breakfast and beverages. This is an essential part of the patient care. Resulting In: Patient hydration and nutrition non-compliance. Existing fleet of beverage trolleys in CTM UHB require a replacement programme (as per regen trolleys). The current fleet (sourced from the Seren assets) are 10 plus years old and maximum life is 10 years old if maintained. The Ultrafraks are used for patient breakfast and beverages and then on used on average 5 times a day for beverages so are heavy use. The current models at all district general and community sites are not able to be put on maintenance contracts due to age, hence compliant. Several sites are now running with one per two/three wards and the service level is one per ward. VCC have 1 beverage trolley that is non-repairable.	There is a repair programme in place at each site when equipment is broken. However the beverage trolleys are too old to put on maintenance contracts. Replacement is the only alternative. An agreed replacement process has been approved, the risk will remain high until such time we have sufficient spares from replaced carts to maintain the existing equipment.	There is not enough budget in revenue to purchase singularly and the beverage trolleys are manufactured to order (cost decreases with volume). An investment bid has been included in the Facilities MTP (submitted March 2025) An agreed replacement process has been approved, the risk will remain high until such time we have sufficient spares from replaced carts to maintain the existing equipment.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	8 (CxL2)	New risk escalated to the Organisational Risk Register in September 2025	15.01.2025	31.08.2025	30.09.2025
5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning DTFS Care Group	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	If: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigations, 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 GPs have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update September 2025. Risk reviewed 29 August 2025 - North Bristol trust have now confirmed that they are unable to offer a service due to their own capacity and recruitment issues. Would be able to look at long term commissioning solution (min 5 years) as this would allow commitment to expand team Webb Government will be working with Health Boards to consider different options, likely all options will put a cost pressure on NHS Wales but size of cost pressure is not currently known. An updated waiting list from Cardiff and Vale UHB has indicated that there are 50 CTM residents on the waiting list, 17 of which are dated, so plan is to start releasing funding from 26/27 LTA with expectation to release all by 27/28 which can be utilised to fund longer term solution. There is some ringfenced funding for 25/26 so the team are exploring possibility of insourcing/outourcing but this would need a procurement process if taken forward. As a result of the current position the risk score has been increased due to North Bristol Trust being currently unable to deliver a service in line with last year and no other sustainable solution yet identified as yet.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	4 (CxL1)	Increased from a score of 16 in September 2025	08.07.2024	29.08.2025	31.10.2025
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 Pypn, 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 one - and health schools programmes - working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: healthy environments, healthy settings, healthy people, leadership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	Update September 2025 The Healthy Weight Steering Group is currently developing a healthy weight road map for CTMUHB, outlining actions and strategic direction over the short, medium and long term. This will be in line with Healthy Weight: Healthy Wales, and take into consideration health board actions under the new national action plan. The Healthy Weight roadmap is under development and due to Board for approval in November 2025. There is a business case in place for sustainability and increased capacity for Pypn (level 1+), and a CYP level 3 weight management service. A level 3 weight management service will help improve outcomes for some of our most disadvantaged children. Update 16.08.25 funding has not yet been released for this business case as it is dependent on savings as part of the DMTF. A further panel for scrutiny was held for all DMTF business cases on 19th August before resubmission back to ELG for consideration.	Quality, Safety & Experience Committee Strategic Development Committee	20	CxL5	9 CxL3	↔	06.05.2025	02.09.2025	14.10.2025
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 WGL 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 mediflex sessions to manage post mortem demand.	Plan to improve timely death certification by CTMUHB specific QR code to alert wider staff and reduce delays and education videos from MES to improve accuracy. Continue to improve on communication with families around delays and estimated timescales. Update September 2025 The requirement for QR code solution has been escalated to the Director of Digital to help find a solution. Respite awaited. QR code with additional details would improve communication between departments and potentially speed up the process for families.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	CxL5	12 (CxL3)	↔	05.03.2025	18.08.2025	18.10.2025
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 Com TWT 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 signed 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 address Health Board wide ways of working and Standard Operating Procedures to manage patient pathways in a consistent ways across CTMUHB. Update September 2025 - The Digital and Data Directorate are currently undergoing a review of this risk and an update will be received in the next iteration of the Organisational Risk Register.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	CxL4	5 (CxL1)	↔	19.03.2025	05.09.2025	31.10.2025
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: • Specialist 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 list. • All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be reported and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being rolled in the UHB to assist with longer term planning. • Outpatient 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 L&G 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 September 2025 Unscheduled Care Impact of a temporary centralisation of stroke into one site. There has been continuous planning on clinical pathways and diversion of emergency intakes that again has impacted on the capacity and resilience across the full CTMUHB system. There has been some improvement against trajectories for emergency demand. Specifically, in total reduction of last ambulance hour. Planned Care Update: Progress made on >104 week. All specialities aim to maintain <104 weeks with the exception of Orthopaedics. Regional Outpatient Insourcing commenced at CTMUHB on 6th September 2025. Aiming to reduce Outpatient waiting times across all specialities The Orthopaedic Elective unit commenced at the Princess of Wales Hospital from 1st September 2025. 3 dedicated operating theatres for Arthroplasty with a protected Ward of 28 beds. Princess of Wales Theatres fully opened on the 1st September 2025. All Cataract surgery was consolidated to the Princess of Wales Eye Unit on 1st September 2025. Focusing on standardisation and delivery of HVLC. Regional Cataract Plan continues through Q2-Q4 to reduce Cataracts wait list further. The Vascular Network (VNU) process has been adopted by CTMUHB. Theatre across CTMUHB remain closed Endoscopy moved back to Princess of Wales Hospital in June 2025. With the Endoscopy recovery plan commencing August 2025 to December 2025. FIT Board refocused on delivery of key actions for each group, with focus of all specialities on PFU and SDS.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	12 C4 + L3	↔	13.7.2023	09.09.2025	31.10.2025
5276	Director of Digital	Central Support Function - Digital and Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Function (ED) Overcrowding 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 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. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stake take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	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. Update September 2025 Risk reviewed on the 27 August 2025 - Call Path deployment has now been pushed back to October 2025 and is now very close to Micro deployment - concerns around short time frames planned for User Acceptance Testing sign off and Cutover Qualification (CQ). Blood Sciences deployment is now delayed until 2026 due to significant issues in the aliquoting process in Biochemistry. It has been agreed to roll out on a per discipline basis instead of per Health Board. The predicted time lines are: Pre production environment - July 2025 (completed). Production Environment - Beginning of October 2025. Call Path and Andrology - End of October 2025. Microbiology - Beginning November 2025 Blood Transfusion and Blood Sciences - No dates yet agreed, likely in the new year.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL4	5 (CxL1)	↔	26.10.2022	27.08.2025	29.09.2025
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 branches 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 experiences, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filing assessment spaces compromised the ability to provide timely rapid assessment of urgent 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 test 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 Meesteg community hospital. Daily site wide safety meeting to ensure fire 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 A&EC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The emergency departments across CTM remain overcrowded. There are many internal actions being undertaken within Care Group to reduce attendances, improve flow and reduce overcrowding. • CTM UHB Development of Urgent & Emergency Care Rapid Improvement Plan (45 minute ambulance handover and 90-day ED performance) • T&E Rapid Improvement Plan through 6 Goals Programme - S&O - 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 - 3 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 (SPCA) meeting with Primary & Community Care Programme established. • Targeted recruitment of Acute Medicine Consultants following new investment to provide 7/7 Update September 2025 Risk reviewed on the 15 August 2025 to note that there is ongoing transformational work within the Health Board and Emergency Departments to help ease crowding and remove corridor care. Currently planning stages underway	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	12 (CxL3)	↔	24.09.2019	3.9.2025	3.10.2025
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 from 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 804+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if their 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 September 2025 The risk was reviewed by the Service Director for Primary Care and Community on the 10 August 2025 which noted that discussions took place 6 August 2025 with the Chief Operating Officer, Service Director for JCC and Planned Care where it was agreed that a plan would be worked up for the Vanguard theatres with a trajectory plan for reducing the list by end of March 2026 as well as a plan for regular additional theatre to support ongoing demand. Risk score will be reviewed but currently remains unchanged.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	9 CxL3	↔	20.04.2023	10.08.2025	01.10.2025

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Date 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
15753	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 the 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 Rhonda 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 September 2025 Risk remains unchanged, with further discussions between Local Authority and Health Board planned for early autumn 2025 to work through solutions.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL3	8 (CxL2)	↔	16.04.2024	03.09.2025	01.10.2025
154632	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 optimal 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. • Risk 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 thrombolysis service at Bristol and updated RCT guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update September 2025 The risk was reviewed on the 20 August 2025 and the risk score was reduced from a 20 to a 16 as a result of the 'Improvement Action Plan'. The Executive Team have acknowledged the improvements made. Immediate Improvement programme commenced in April to support stabilisation, all improvement triggers and specific actions RAG rated on action plan. Initial action plan rating April - 13 red actions Updated July action plan rating - 5 red actions Development of Stroke Service Transformation Programme (30/60/90 day) focus on 2 key stroke metrics - Admission to stroke unit within 4 hours Time to CT less than 20 minutes Stroke Service Redesign review in place with all key stakeholders Senior oversight of stroke improvement programme - fortnightly meetings with executive team to review action plan progress.	Quality, Safety & Experience Committee Operational Delivery Committee	19	CxL4	12 (CxL13)	+	11.05.2021	18.08.2025	18.10.2025
151793	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety - Infection Prevention and Control	Infection Prevention and Control HxH	Improving Care	Safety/Well-being Patients/Staff/Public	Lack of isolation facilities available- negative pressure rooms	If there are no negative pressure isolation facilities available. Then: there will be no appropriate isolation facilities to manage patients with infections transmitted via the airborne route. Resulting in: an increased risk of infection to other patients/ staff/visitors. There are 2 positive pressure ventilated lobby rooms available at Prince Charles Hospital. Non compliant with national guidance/ Welsh Government expectation.	High Consequence Infectious Diseases (HCID) 1 plan prioritizes Prince Charles Hospital for HCID cases for use of the positive pressure lockers. Capital funding approved to build 2 negative pressure rooms in the Health Board.	While there are some cubicles available for isolation, the lack of correct ventilation with negative pressure ventilation leaves a risk for airborne infections to be transmitted, especially. Capital funding has been agreed to support developments to build negative-pressure rooms on the acute sites. The location will be determined by the sites to link with the inpatient pathways, as well as the location within the hospital site, being determined by the need to support patient flow and suitable areas to meet the patients' fundamental needs of care delivery. During the lead time for these dedicated isolation rooms to be completed, the current practice of isolation in suitable single-patient cubicles in line with IPC isolation policy will be adhered to. Risk Monitored by the Ventilation Safety Group and Infection Prevention and Control Committee.	Quality, Safety & Experience Committee	16	4x4	4 (CxL1)	New risk escalated to the Organisational Risk Register in September 2025	16.12.2014	04.08.2025	04.11.2025
164218	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety - Infection Prevention and Control	Infection Prevention and Control HxH	Improving Care	Safety/Well-being Patients/Staff/Public	Reduced on site Consultant Microbiology (IPC Doctor cover for Bridgend)	If there is no dedicated on site Microbiology cover - Then: there will be no antimicrobial/ ITU ward rounds, no root cause analysis to learn from incidents. Resulting in: mismanagement of patients/ inappropriate treatment and no learning to influence practice. IPC Doctor support is required to help support/deliver the IPC and decontamination agenda Concerns raised regarding SLA and role of microbiologist under it support IPC.	Service Level Agreement (SLA) for microbiology support under review at present moment. IPC team continues to invite microbiologists on duty at Princess Of Wales (POW) Hospital in Bridgend on a regular basis. Cause Analysis. Working towards joint meetings between IPC microbiology for POW and microbiology for the other sites to work towards same processes and support across CTM.	SLA to be reviewed. IPC has sent GAP analysis and SBAR with identified gaps and concerns to inform new SLA. Risk Monitored by the Infection Prevention and Control Committee.	Quality, Safety & Experience Committee	16	4x4	4 (CxL1)	New risk escalated to the Organisational Risk Register in September 2025	16/07/2010	04.08.2025	04.11.2025
176228	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 incidents, an increase in potential enactment of the Coroners powers, including under Schedule 1 - "Power to require evidence to be given or produced".	Review initiated to understand CTMHJB's position in terms of the number of inquests underway and the response to requests. Review and re-map internal processes in the management of inquest cases within the organisation. Weekly coronial meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage inquests effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 - Weekly escalation meeting established with Senior Coroner's Officer to highlight cases requiring urgent action. Weekly meetings with Legal & Risk to track action and progress with high-risk/high-profile inquests. Works continues to be undertaken to improve the accuracy and robustness of information contained within the Datix Cymru system. Enhanced reports and trackers being developed to support the operational management of inquests. Mechanisms for providing reporting and providing assurance to be embedded. Documentation for supporting staff with the inquest process to be finalised.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	CxL2 = 8	↔	3.7.2025	09.09.2025	31.10.2025
186229	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) 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. Misad 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 CTMHJB'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. Validity of data using the Data System. Listening and Learning Framework	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 - LFER workshop held 04/09/25 with the health board internal Legal Services team and Heads of Quality & Safety to review the recently revised LFER process and to look at implementing a revised and smarter way of working. Revised process to be further updated and to include timescales for actions ensuring deadlines are adhered to. Final documentation to be shared at the Executive Director led Quality & Safety weekly meeting on Monday 29th September 2025 for Exec review and approval with an action for immediate implementation. Further work will be progressed to undertake a wider review of how learning is further embedded across CTM, and will take place with support of the QI team in reviewing the Listening & Learning Framework and the Learning Repository. Collaborative work continues between the Assistant Director of Nursing and the health board assigned WRP Principal Safety & Learning Advisor, with a meeting scheduled to discuss the format and set up of an internal CTMHJB Learning From Events Report Panel, with engagement from the WRP Principal Safety & Learning Advisor. Terms of Reference for the LFER panel will be developed including membership & frequency and presented to the Executive Director led Quality & Safety weekly meeting for approval.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	CxL2 = 8	↔	3.7.2025	09.09.2025	31.10.2025
196231	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 CTMHJB's position in terms of the number of cases underway and the response to requests. Current controls: Putting Things Right - Handling Concerns Procedures Engagement with Legal & Risk Services. Experienced Concerns Handlers in post.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025: The organisation is maintaining performance in the management of concern responses within 30 days. The acknowledgement within 2 working days has been improved, however, will need additional time and support to embed, thus providing confidence to lessen the risk. Work continues to attend to the responses in early resolution and tailor the outcome of the Organisational Change Process changes to reflect the resource needs in attending to focus on localised early resolution.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	CxL2 = 8	↔	3.7.2025	09.09.2025	31.10.2025
205304	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. Update September 2025 The output from the AHU is continuously monitored internally & externally The estates department maintain the AHU regularly. There are contingency plans in place to outsource products from elsewhere. Capital management group will be followed up for progress. Next review scheduled for November 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	16	CxL4	4 (CxL1)	↔	29.11.2022	3.09.2025	28.11.2025
213567	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 IPC, HBS 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 licence. - 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 invitations of the laboratory environment. Controls to reduce the use of reception/dissection as a thoroughfare including signage and demarcation belt. Workflow established to maximise efficiency of limited space. Block and slide filing removed from laboratory area where possible. System of work including check established in dissection to minimise risk of error. IPC and HBS 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. Controls to reduce the use of reception/dissection as a thoroughfare including estates to look at long term solutions. Update September 2025 Risk reviewed on the 20 August 2025 - Procuring workbenches to support initial conversion of office space to support initial Invest to Save paper of increase of one Pathologist and associated workloads. Awaiting estates work to convert the office. Statement of Need (SON) for feasibility study of preferred option for medium term option to be prepared.	Quality, Safety & Experience Committee Operational Delivery Committee	19	CxL4	C3xL2 6	↔	28.05.2019	20.08.2025	30.09.2025

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Cats. 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		
1	5045	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Impact on the safety – Physical and/or Psychological harm	Access to Neurology Inpatient and Outpatient Services for CTM Residents	If: there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of RTE; Then: existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue; Resulting In: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients.	An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint x3 consultant neurologists within CTM as part of the Neurology Liaison Plan. Update September: Ongoing capacity challenges are faced in Royal Glamorgan Hospital and Prince Charles Hospital with long waiting times, lack of epilepsy nurse service and a lack of inpatient provision. Agreement has been given to appoint 2x Consultant Neurology Liaison posts within CTM in line with the plan for developing a neurology liaison model across CTM; the care group have been working with the CTM recruitment & retention lead to pull together a recruitment pack that will maximise the chances of successfully recruiting to the posts. The care group have also been working with commissioning colleagues to progress development of the neurology LTA with CBV and SBuHB, so that it accurately reflects current service provision and that as a commissioner of neurology services, CTM are receiving the appropriate level of service. Update from CBV received. Summary: • Confirmed that the reporting of the WL would stay with CBV until >52wk backlog is cleared. • Nobody waiting over 104 weeks. • The locum started in Dec 24 and will remain in post until Dec 25 • Performance against 52 weeks continues to improve with a total of 576 patients above that target at end of August. Further assurance requested via Commissioning colleagues of delivery of the remaining 575 patients >52 weeks. The locum consultant in RGH is expected to remain in post until at least the end of December 2025 and there has been some funding allocated for WL's to support both CBV and CTM. The care group have requested further assurance via CTM commissioning colleagues on the delivery of the remaining >52 weeks patient cohort.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C&L4	8 (C&L2)	↔	09.3.2022	20.06.2025	31.10.2025	
25	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 Ysbyr Cwm Cymer (YCC) for MerthyrCymer. Then: there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant complement. Resulting In: a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status.	Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant. Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards	Update September 2025 The Care Group has had a successful recruitment to all the vacant SPC CNS vacancies restoring 7 day working for the service as a whole across the Health Board footprint. Risk score currently remains unchanged.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 (C&L2)	↔	11.10.2023	03.09.2025	03.10.2025	
26	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 September 2025 Risk Reviewed 27 August 2025 and remains unchanged at present. Control measures remain fragile The Adult directorate are proposing changes to the RGH inpatient model that potentially could have a positive impact but these are yet to be approved. Meeting arranged for 26/09/2025 to further review medical workforce options.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	12 (C&L3)	↔	06.01.2022	27.08.2025	31.10.2025
27	4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care	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 21.8.2025 - Progress against the timeframes outlined in the Project Initiation Document for the Policy Review programme are being met. A revised approval process is being progressed to achieve consistency between Clinical and Non Clinical Written Control Documents. The "Policy on Policies" has been revised significantly and is out for early consultation with a limited audience prior to seeking more detailed consultation. A new SharePoint page and master library is in development. Capacity is challenged as this is being led by two members of the CG & QA function who have a number of competing priorities, however, currently no indication the end of year deadline would not be met. Next risk review October 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 (C&L2)	↔	26.10.2021	21.8.2025	31.10.2025	
30	5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety	Impact on the safety – Physical and/or Psychological harm	Due to business sensitivities this risk will be considered / reviewed in Closed Session of the Committee.		Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C&L4	C&L4 12	↔	31.01.2024	25.06.2025	31.08.2025		
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. CTM/MB 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 CBV and AB to get the work done. There was a strong commitment from Pen-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 DigitalHealthCare Wales provider status and open sharing of data between Health Boards. The current proposal has not been agreed between ABuHB and DHCW. CTM/MB are asking and raising the concern, however, cannot directly resolve. Update September 2025 - remains as August 2025. It is raised at the relevant forums (All Wales Medical Director Meetings) regularly. No changes to risk score.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 (C&L2)	↔	26.04.2024	04.09.2025	31.10.2025
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 September 2025 - risk reviewed 27 August. Discussion within the Care Group about reducing the risk score however at the MHLD Operational Management Board it was agreed to delay any reduction until the release of the South Wales Police revised S135/6 policy. This is scheduled for release in Oct 2025 and the Care Group will consider the risk score at this point.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	16	C&L4	12 (C3&L4)	↔	08.12.2023	27.08.2025	31.10.2025
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 PIPN 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 JHTP 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 JHTP process.	Update September 2025 - Risk reviewed 19 August. No change to the risk score and mitigations remain current as outcome of the Integrated Medium Term Plan discussions is awaited.	Quality, Safety & Experience Committee Strategic Development Committee	16	C&L4	8 (C&L2)	↔	13.10.2023	19.08.2025	10.11.2025	
34																			

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Date 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
41	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 CTHUHB's position in terms of the number of inquiries underway and the response to requests. Current controls: ICP underway to consider structures of the function. Benchmarking and learning from other organisations.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. Update September 2025 -The recovery programme continues to make progress in standardising and stabilising processes and work plans. The Organisational Change Process remains delayed as a result of the prioritisation of work and gaps in senior leadership owing to non-work-related absence.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C3xL5	C3xL2 = 6	↔	1.7.2025	09.09.2025	31.10.2025
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).	Update September 2025 External review commissioned on Nationally Reported Incidents. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) - the action plan and risk will be further reviewed once external report received. Response received from obstetrician reviewer with further information requested.	Quality, Safety & Experience Committee.	15	C5xL3	10 (C5xL2)	↔	14.05.2025	10.09.2025	31.10.2025
39	3337	Chief Operating Officer Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Central Support Function: Digital & Data Director of Primary Care and Mental Health Services	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health Future	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 CTHUHB staff who currently use WCCIS via local authority over to CTHUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update July 2025 -The Care Group are currently in the third week of the procurement process which has allowed suppliers to bid. This is scheduled to finish on 5th July when the Care Group should be in a position to know how many suppliers are in the procurement activity. Update September 2025 - no further update at this point. Risk reviewed and no change to score.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	29.08.2025	31.10.2025
42	4691	Chief Operating Officer Linked to RTE Risk 4803, 4799, 3273 and 3019.	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes. Service/business interruption	New Mental Health Unit If: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation - Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 - 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update September 2025 Risk reviewed 27 August 2025 - no change at present Meeting arranged with Adult Directorate to fully update mitigation to include; Potential ward moves Cessation of PCU SLA with SRUHB Impact of National programmes of work Changes to the RCH inpatient model Single S116 suite	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C5xL5)	6 (C5xL2)	↔	15.06.2021	27.08.2025	31.10.2025
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 NIP. The health board's 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. 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. Update September 2025 - Reviewed at Strategic Group Meeting in July and agreed score to remain the same. Next review scheduled for the 14 October.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	02.09.2025	14.10.2025
44																	

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)
6230	Executive Director of Nursing / Deputy CEO	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. Update September 2025 - A significant amount has been completed with PI. Additional work continues with clinical negligence, however, it has been stabilised with a number of actions by the leadership and specialist team. The risk score has been reviewed and the likelihood reduced from a 4 to a 3.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	12	C4xL2 = 8

De-escalation Rationale
Update September 2025 - A significant amount has been completed with PI. Additional work continues with clinical negligence, however, it has been stabilised with a number of actions by the leadership and specialist team. The risk score has been reviewed and the likelihood reduced from a 4 to a 3. The risk will continue to be monitored by the Patient, Care and Safety Directorate risk review process.

	A	B	C	D	E	F	G	H	I	J	K
	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
1											
	6053	Chief Operating Officer	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.	DHCW have now concluded the sale of the systems to a new provider . The Health Board contract has been novated with the migration of practices to EMIS. As at 3rd September an update has confirmed that notification from the provider has been received that the transfer is complete. Risk has therefore been mitigated and can be closed.	Quality, Safety & Experience Committee. Operational Delivery Committee.	sep-25	DHCW have now concluded the sale of the systems to a new provider . The Health Board contract has been novated with the migration of practices to EMIS. As at 3rd September an update has confirmed that notification from the provider has been received that the transfer is complete. Risk has therefore been mitigated and can be closed.
2											



Agenda Item

7.2

Quality, Safety & Experience Committee

**HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN
TRACKER REPORT**

Dyddiad y Cyfarfod / Date of Meeting	23 rd September 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

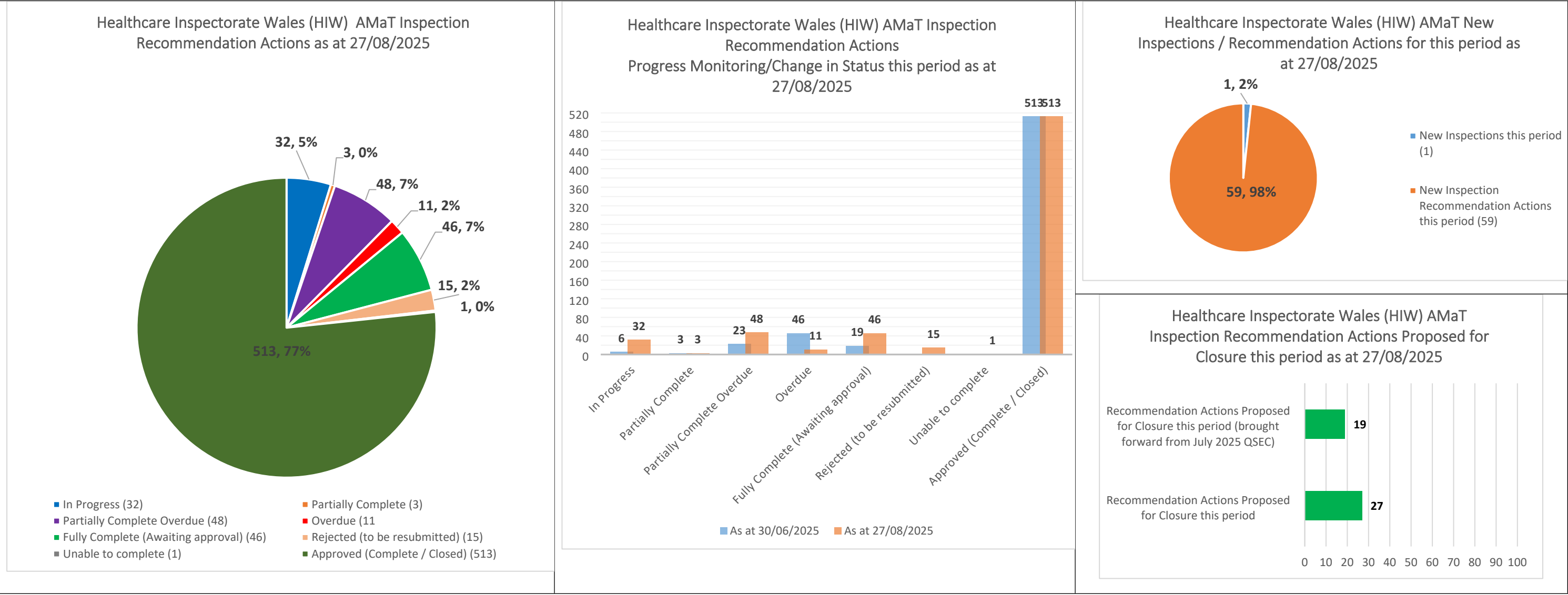
Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

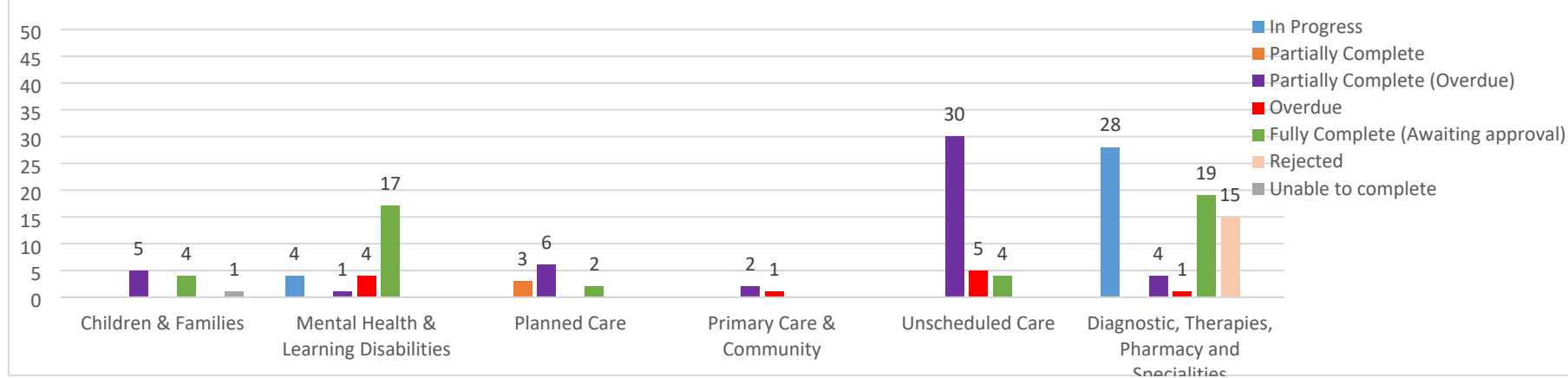
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales

AMaT	Audit Management and Tracking
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Compliance Dashboard



Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions by Care Group as at 27/08/2025
(excluding Approved / Closed Actions)



NB: 15 "rejected" actions are due to user error and the care group are in the process of obtaining further evidence to support.

1. Situation /Background

- 1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker (Appendix 1) of the accepted Improvement Plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 1st July to 27th August 2025.
- 1.2 Committee Members will recall that the HIW Tracker report produced for the Committee in July was deferred due to time constraints at the last meeting. Therefore, this report captures the latest position as at 27 August 2025. The July 2025 cover report is included in the meeting folder in Admincontrol, should Members wish to compare the position and the tracker updates available upon request. This report has captured an improvement in the updates recorded, however further input from Care Groups is required to continue to update and close actions that are overdue.

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. As reported in the July paper, a review of the 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. The team continue to raise new queries and requests in order to improve upon the effectiveness of compliance requirements within the inspection module.
- 2.4 The response rate in terms of providing updates to inspection actions during the last reporting period was 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. Further engagement continues with Executive Nurse Directors in order to gain momentum in the regular updating of actions by Care Groups.

2.5 A breakdown of the status position with regards to all actions up to the 27th August 2025 is detailed below Please note that this also includes actions that were reported on in the July report but were not presented or discussed at the July meeting of the Committee.

- A total of **669 actions** are reported with a further breakdown of the stages towards compliance reported in *table 1* located in the dashboard at the beginning of this report.
- **513** Actions were Fully complete, approved and closed with a further **46** actions fully complete and awaiting approval.

2.6 **New Inspections / Actions**

- There were **2** new Improvement Plans and **22** actions added last period and included in July's report.
- **1** new Improvement plan and **59** actions added for 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. As described previously, where updates have not been received more than twice this has been flagged on the tracker. As part of a targeted approach, a separate, individualised report was produced and provided to the Deputy Executive Director of Nursing in order to facilitate planned focus work with individual Care Groups to improve the position.

3.2 The Head of Quality Assurance and Compliance and Assistant Director of Governance and Risk continue to offer targeted sessions at the appropriate forums within Care Groups, with the aim of improving both the regularity of updates and also the quality of updates provided.

3.3 Ongoing AMaT system developments and requests are continuing in order to deliver a system and process that is required for improved quality assurance and compliance. The 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.

- 3.4 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 – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-acten.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies, please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies, please list below: Efficient, Equitable, Safe, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies, please list below:

Impact Assessment



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

5. Recommendation

- 5.1 The Quality, Safety & Experience Committee are asked to **NOTE** the contents of this report and the activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.

6. Next Steps

- 6.1 The Head of Quality Assurance and Compliance will continue to work with Care Group Leads in order to provide assurance of the Health Board's engagement and compliance with HIW recommendations and Improvement Plans.

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	22	22	Planned Care Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	2	2	Primary Care & Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	17	18	Mental Health & Learning Disabilities Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/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 Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	2	2	Unscheduled Care Sarah Follows, Unscheduled Care Group - Service Director
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	7	7	Primary Care & Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	50	50	Unscheduled Care Sarah Follows, Unscheduled Care Group - Service Director
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 Llewellyn, 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
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	09/01/2024	2	27	Children & Families Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	14	36	Children & Families Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13.11.2024	27	46	Mental Health & Learning Disabilities Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	27.01.2025	13	14	Mental Health & Learning Disabilities Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2025/261	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	20.05.2025	4	8	Diagnostic, Therapies, Pharmacy and Specialities Carl Verrecchia, Service Director
Healthcare Inspectorate Wales (HIW)/2025/264	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20.05.2025	24	59	Diagnostic, Therapies, Pharmacy and Specialities Carl Verrecchia, Service Director

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.
Rejected (To be resubmitted)	This Inspection action was submitted as Fully complete (Awaiting Approval) however more narrative is required to satisfy closure of the action and to provide assurance it has been completed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.
Unable to Complete	This action is unable to be completed.

HIW Inspections Recommendation Actions Tracker as at 27/08/2025 (for Quality, Safety and Experience Committee 23/09/2025)										
Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWS, 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 UHF'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	August 2025 Update (21/8/25) - Regional digital eye care board meeting 19/8/25. Awaiting confirmation from digital team re configuration completeness and next step of UAT. Clinical risk log needs to be completed via digital service. Funding needs to be approved post Jan 27. Local implementation meeting to be established. April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD8/1	The implementation of Open Eyes will provide optometrists with access to patient information that will promote, simplify and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024	31.12.2025	Partially complete	August 2025 Update (21/8/25) - Regional digital eye care board meeting 19/8/25. Awaiting confirmation from digital team re configuration completeness and next step of UAT. Clinical risk log needs to be completed via digital service. Funding needs to be approved post Jan 27. Local implementation meeting to be established. April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Healthcare Inspectorate Wales (HIW)/2017/141/MD10/1	Documents and resource related to FUNB patients are shared between the business Informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PIFU Patients with appointments cancelled	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update (21/8/25) - Health Board strategy being developed to manage patients backlog. PIFU and SOS pathways being agreed and implemented in accordance with CIN recommendations. These pathways will be applied retrospectively to FUNB list. April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Healthcare Inspectorate Wales (HIW)/2017/141/MD11/1	Patients on the FUNB and New list are all given a HRF and target date. When booking, clinics the booking office will filter by target date and HRF ensuring that patients are booked into the most appropriate sub-specialty clinic by priority status. However, we continue to hold significant risk with the FUNB cohort and further resource in terms of validation and capacity is required.	Planned Care	01.04.2024	01.06.2025	Fully complete (Awaiting approval)	August 2025 Update (21/8/25) - All patients are allocated a risk factor and given a target date. April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Healthcare Inspectorate Wales (HIW)/2017/141/MD12/1	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A Significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	August 2025 Update (21/8/25) - Health Board strategy being developed to address and manage backlog. PIFU and SOS being implemented via CIN recommendations. These pathways will be applied retrospectively to FUNB list. April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	Healthcare Inspectorate Wales (HIW)/2017/141/MD13/1	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update (21/8/25) - Health Board strategy being developed to address backlog of FUNB patients. Meetings in diary to complete all outstanding NW's. PIFU and SOS pathways to be implemented in accordance with CIN recommendations. These will be applied retrospectively to FUNB list. April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	Healthcare Inspectorate Wales (HIW)/2017/141/MD14/1	a) CTM has a well established optometry department which has a number of experienced, highly skilled and qualified optometrists working across glaucoma, medical retina, DRSS, unscheduled care, paediatric clinics and specialist contact lenses. Recent expansion of the service to include community optometrists on a sessional basis which has increased our capacity across these services whilst additionally improving training to community optometrists to in turn reduce referrals and improve referral quality. Hospital based optometry due to start implementing an optometry laser led pathway to improve SLT and laser capacity in the coming months.	Planned Care	01.04.2024	01.06.2025	Fully complete (Awaiting approval)	August 2025 Update (21/8/25) - Appointed into head of optometry and orthoptic post with start date of 5th August 25. April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HIW)/2017/141/MD15/1	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CARRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete	August 2025 Update (27/8/2025) - Recruitment unsuccessful. New optometry lead appointed who is reviewing this and in discussions with HEIW. Re placements this year qualifies for 0.5 WTE band 4. Working through with HEIW finance. February, April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/141/MD17/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update (27/08/2025) - as of today, we are still waiting WG decision re further advice / shared learning. February, April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	August 2025 Update (21/8/25) - Head of optometry appointed into and commenced 5th Aug 25. February, April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HIW)/2017/141/MD21/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPQS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	August 2025 Update (21/8/25) - Head of optometry appointed and in post from 5th Aug 25. Glaucoma Sa post on TRAC. February, April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2020/139	08/09/2020	Quality Check Summary Ysbyty Cwm Rhonda [Ysbyty Cwm Rhonda - 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 (8th 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.

Healthcare Inspectorate Wales (HIW)/2021/137	30/06/2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MD3/1	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete (Overdue)	August 2025 Update - physical health monitoring meeting is being held in September, following this evidence will be presented at QSR in October meeting with a view to being sign off. June 2025 Update - after discussion at QSE it was felt more evidence was required to meet the recommendation estimated date July 25.
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Healthcare Inspectorate Wales (HIW)/2022/131/MD1/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Unable to Complete	August 2025 Update - This action is unable to be completed - this matter has been escalated to the exec colleagues and was raised on the recent HIW inspection Aug 2025. 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.
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	Risk assessments are undertaken and recorded in patient records. Medical discussion and decisions are accurately recorded in patient records.	Healthcare Inspectorate Wales (HIW)/2022/131/MD4/1	The specific areas of risk assessment, medical discussions and decisions will be added to the record keeping audit and all service medical staff to participate in this annual audit to drive multi professional improvement in this area.	Children & Families	01.08.2022	01.08.2022	Fully complete (Awaiting approval)	August 2025 Update - Patient information forms now in place for all patients who visit through ANC - notes audit has been scheduled. December 2024, February, April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Additional welfare support is available for KIT staff.	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 10 days where staff can lead on KIT requirements before returning back to their role following their period of maternity leave.
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: The backlog of incidents are cleared and consideration of further funding should continue.	Healthcare Inspectorate Wales (HIW)/2022/131/MD7/1	Incident backlog due to be closed by 31.5.22. Service agreed target: All incidents managed and closed within 3 months – using Datix action tracker for ongoing work.	Children & Families	01.06.2022	01.10.2023	Fully complete (Awaiting approval)	August 2025 Update - this matter was explored with the recent HIW inspection Aug 2025. Oldest NRI currently February 2025. December 2024, February, April, June 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MD18/1	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Overdue	August 2025 Update - The matrix is still in place and working effectively as the risk mitigation for the retrieval and sharing of patient information throughout MH in CTMUHB. MH Single Clinical Record - evaluation is now ¾ complete. Reference site visits to meet with other Hb's who are using the digital systems has taken place with good information obtained. Financial scoring to take place by the end of August with total scoring known by middle Sept (indicative). Procurement anticipated to be complete by end of September 2025 (indicative) Supplier will be known in Autumn 2025. 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.
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/1	The oversight of this recommendation will be via the Policies Group. The newly established Policy Review group will have an operational scope to: •Review & RAG 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	Fully complete (Awaiting approval)	August 2025 Update - Evidence attached to show the established Policy Group, embedded into the agenda on the evidence is ToR, the group meets bi-monthly. This action is now fully complete and was signed off at QSE in Nov 2023. 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 MHL/D 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 QSR Board. Awaiting confirmation of Mental Health Measure Policy, Refeeding Policy being discussed at CTM Nutrition Group, awaiting feedback)
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/2	Mental health policies will follow the agreed organisational process for ratification. All MH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 in date and approved 13 Expired 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" (recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	August 2025 Update - To note, updates have been added from February to July 25, current position is as follows: In date – 55 Under review -5 Awaiting ratification – 4 (for OMB Sept) 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)
Healthcare Inspectorate Wales (HIW)/2023/134	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales (HIW)/2023/134/MD2/1	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance- ED • Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. • An As 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. • All 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 PLS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation", training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	August 2025 Update - Following targeted intervention the BLS for AMU has increased to 72% and ED compliance has increased to 74%. ED Compliance for ILS has increased to 65%. July 2025 Update - Clinical decisions Unit (CDU) is now called Acute Medical Unit (AMU) - Basic Life Support (BLS) 48% Intermediate Life Support (ILS) 61% Emergency Department- Basic Life Support (BLS) 26% Intermediate Life Support (ALS) 53.1% Advanced Life Support (ALS) 60%. Further Training is booked for August 2025 and the new Senior Nurse for Practice Development in the Emergency Department commences role in August 2025. Training dates for ILS and ALS are booked as per availability from the Resuscitation Training Department.
Healthcare Inspectorate Wales (HIW)/2023/140	16/05/2023	HMP Parc	HMP Parc: Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken. To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August 2025 - No update against this recommendation action has been received on these occasions. October 2024 Update - Discussion with Head of Healthcare within HMP Parc, chaser email sent to GP contractors to request update on process with implementation of recommendation.
Healthcare Inspectorate Wales (HIW)/2023/140	16/05/2023	HMP Parc	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MD7/1	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care & 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	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	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	Fully complete (Awaiting approval)	August 2025 Update - Regional collaborative work ongoing with CBV UHB. First South Central Stroke Operational Delivery Group meeting held 13/08/25 with attendance by Exec Stroke Leads for both health boards. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	Healthcare Inspectorate Wales (HIW)/2023/155/MD2/1	This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	August 2025 Update - No further update. This action will continue to be led by PHW. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and PHW should work closely with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Healthcare Inspectorate Wales (HIW)/2023/155/MD3/1	CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	August 2025 Update - no further update. CTM UHB will continue to engage with PHW, Health Boards across Wales and any relevant organisations. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.

Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD5/1	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily Safe2Start meeting which provides assurance around site based escalation, staffing, patient safety and clinical priorities. The meeting allows the identification of clinical priorities, including stroke patients, and time frames for movement to appropriate inpatient beds. All patient flow constraints are discussed and risk is shared across the acute inpatient wards and community sites in order to balance risk within the Emergency Department. This remains an action-focused meeting, with clear ownership and delivery prior to the afternoon meeting. As part of this work, under the 6 Goals national programme, the Safe2Start template has been revised to include SAFER, Red2Green and both internal and external delay metrics. There was a delay in launching the new template due to access required into SAFECARE to display nurse staffing levels, this is being worked through by informatics colleagues with the new template expected to be completed and implemented by November 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Optimise, a programme of work under the national Goals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Unscheduled Care	01.11.2023	01.11.2023	Partially complete (Overdue)	August 2025 Update - The overarching Action Plan has supported this work whereby the below is embedded and the Senior Stroke Team undertake a formal patient review daily identifying who does not require ongoing care within the Stroke Unit and that includes discharge and transfer out internally across the HB and neighbouring HB's (formally discussed on the national call at 11.00 daily. The detail is communicated robustly to the Flow Team daily and updated accordingly to ensure Stroke capacity available. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales (HIW)/2023/155/MD6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - CTM wide review of stroke pathway ongoing including all workforce requirements. The need for dedicated pharmacy support will be included in this service review. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD7/1	Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	August 2025 Update - CTM inpatient stroke service currently based at Royal Glamorgan Hospital only following critical incident and urgent service change. No reported issues with phlebotomy provision. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD8/1	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cymru. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS Exec colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our speciality demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	Partially complete (Overdue)	August 2025 Update - The Stroke Unit for CTM has been relocated to the RGH since January 2025 and this work is ongoing due to the change of service. The review to date has identified that the demand for CTM is supported more efficiently from the RGH. There is ongoing regional stroke work where this is currently being worked through. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	Healthcare Inspectorate Wales (HIW)/2023/155/MD9/1	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health board continues to build on its use of data to enhance the provision of business intelligence to offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - the introduction of SDEC, STAMP, Surgical and Trauma Assessment Units that has supported the concerns identified. These are now established at RGH but review of surgical, medical and trauma pathways will be reviewed post critical incident to confirm whether these units are fully formalised. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD10/1	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within work streams 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams reviewing 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 Goals Board.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - SAFER, Red2Green and right patient, right time now embedded in daily practice and implemented across wards. Lead Nurse for Optimise in post to support patient flows across the Health Board. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Healthcare Inspectorate Wales (HIW)/2023/155/MD11/1	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD12/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	August 2025 Update - E-triage not currently in place in CTM. OCP now complete. Awaiting update from Service Manager, Emergency & Acute Medicine to confirm FAST training programme for clerical staff. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Healthcare Inspectorate Wales (HIW)/2023/155/MD13/1	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Stroke Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and query arriving at our emergency departments. In addition, we are currently reviewing our nurse specialist provision in order to create capacity to better support the early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	August 2025 Update - collaborative work with WAST continues, specifically following temporary consolidation of inpatient stroke services at Royal Glamorgan Hospital. WAST colleagues included in Stroke Programme Board / Stroke Operational Group. CNS workforce included within the Stroke Service Redesign programme. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD14/1	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below "table removed for AMAT purposes"), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCI where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	August 2025 Update - This action remains ongoing. Stroke inpatient services currently centralised at Royal Glamorgan Hospital. Stroke Service Redesign programme reviewing the full stroke pathway, including community / rehabilitation provision with bed modelling and workforce review to ensure that flow through the pathway is not blocked. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. Triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	August 2025 Update - Awaiting update from Clinical Director, Emergency Medicine re internal ED mitigations. Triage times and numbers of patients awaiting triage are noted on 3x daily HB conference calls. E-triage not currently implemented in any Health Board Emergency Departments. 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	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	August 2025 Update - Review of stroke clinical workforce is included in the Stroke Service Redesign programme. Stroke services currently centralised at Royal Glamorgan Hospital with clinical teams combined to support one Acute Stroke Unit. New stroke consultant recently appointed and will start January 2026. CNS workforce also centralised at Royal Glamorgan Hospital to support emergency presentations and ward patients. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. The 3 CTM Emergency Departments continue to provide emergency stroke care. Stroke teaching is included in induction programmes for ED resident doctors.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	August 2025 - Stroke Services currently centralised at the Royal Glamorgan Hospital. CNS Stroke Workforce currently centralised too. CNS workforce being reviewed as part of the Stroke Service Redesign programme. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	August 2025 Update - remains ongoing with digital team as per August 24 update. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HIW)/2023/155/MD19/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	August 2025 Update - awaiting update from Clinical Director, Emergency Medicine. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	August 2025 Update - awaiting update from Clinical Director, Emergency Medicine. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NIC 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 branches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	August 2025 Update - Time to CT Scan KPI is now 20 minutes. Performance against this KPI is reported via Stroke Operational Group to Stroke Performance Board. Current improvement programme in progress to identify any delays to scan and process map patient journey to CT scan with involvement of all key stakeholders. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.

Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD25/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	August 2025 Update - Thrombolysis guideline has been updated nationally to 30 minutes (following CT scan within 20 minutes). Performance against this target is monitored monthly and reported via Stroke Operational Group to Stroke Programme Board. Current improvement work reviewing this key metric with all key stakeholders engaged. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this is continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - Work continues to improve 4 hour performance. Stroke inpatient services are currently centralised at Royal Glamorgan Hospital and improvement work ongoing to support improvement in 4 hour performance with process mapping and key stakeholder involvement. Dedicated ambulance transfer vehicle commissioned for clinical transfers from PCH / POW to RGH to support transfer for emergency patients to Royal Glamorgan Hospital. 4 hour performance measured and reported at Stroke Operational Board and Stroke Programme Board. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, upurged into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - Inpatient stroke services currently centralised at Royal Glamorgan Hospital. Agreement that confirmed strokes only will be admitted to the Acute Stroke Unit to prevent medical outliers occupying stroke capacity. Daily aim to ensure ringfenced stroke bed to support flow and stroke pathway. Stroke demand on all three sites discussed at Safe to Start meetings twice daily and at HB conference calls. Ring fenced beds and ASU capacity continues to form part of the out of hours and weekend planning cycle of the HB. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD31/1	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieve this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	August 2025 Update - Following the temporary relocation of stroke services the therapy workforce has been reviewed and an investment proposal has been submitted as part of the IMTP process, the outcome of which is awaiting. This is linked to recommendation 38 regarding the need for funded 7 day service. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - due to critical incident and urgent service move, Stroke Services now currently centralised at Royal Glamorgan Hospital. There is currently no psychology support for stroke patients across the Health Board. The lack of psychology support is noted on the corporate risk register (risk ID 4632). 0.6 wte Neuropsychology post currently advertised. This will support stroke services. The need for psychology support will be included in the workforce review as part of the Stroke Service Redesign programme. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAIP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - CTM UHB continues to offer a 5 day clinical model. The Health Board aim is to provide a 7 day clinical model to support patient outcome and experience. Workforce requirements to support this are being identified as part of the Stroke Service Redesign programme and will require investment as the current workforce is unable to support 7 day working. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - Inpatient acute stroke services currently centralised at Royal Glamorgan Hospital. Dedicated therapy bay established within the Acute Stroke Unit for use by all therapists. Community hospital provision - 8 funded stroke specific rehabilitation beds at Ysbyty Cwm Rhonda (ability within current workforce to flex up to 14 patients if required). Stroke Service Redesign programme reviewing workforce model and optimum patient pathway. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions. ognised as a risk and is regularly reviewed.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the D2RA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - awaiting update from Primary & Community Care Group DM. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase uptake for Pathway 1 are included on board round guidance as well as guidance on selection of patients. 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 AMMT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - awaiting update from Primary & Community DM. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD41/1	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GLIC 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 PuCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	August 2025 Update - awaiting update from Primary & Community DM. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD42/1	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce. December 2024, February, April, June 2025 Update - An update against this recommendation action has not been provided on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD44/1	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	August 2025 Update - Patient discharge manually updated on whiteboards by ward staff. Currently no progress with 'push report' functionality. 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	13/11/2023	Appendix C - Improvement Plan: Angellton 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	30.07.2024	Fully complete (Awaiting approval)	July 2025 Update - signed off at QSE July 25 meeting, evidence uploaded. April 2025 Update-Awaiting dashboards to be disseminated , once this is completed we can take to QSR6 for sign off and provide evidence
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	Overdue	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.
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/6	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	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.
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/7	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area- this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	Overdue	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.
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DaS (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	July 2025 Update - ED Fire Training Compliance Registered Nurses - 75.6% Health Care Support Workers -69.0% CDU (now AMU) Fire Training Compliance Registered - Registered Nurses - 92% Health Care Support Workers - 96% April 2025 Update - An update against this recommendation action has not been provided on this occasion.

Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/M030/1	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	July 2025 Update - Violence and aggression training compliance CDU (now named AMU) Registered Nurses - 9.0% Health care Support Workers - 0.0% Awaiting training dates from Violence and Aggression Training Teams Violence and aggression training compliance ED Registered Nurses - 75% Health Care Support workers - 76% MCA training compliance AMU Registered Nurses - 57% Health Care Support Workers - 92.5% MCA training compliance ED - Registered Nurses -57% Health Care Support workers - 92.5% Safeguarding training compliance AMU (Adult) Registered Nurses 52.7% Health Care Support Workers 100% (Children) Registered Nurses 96% Health Care Support Workers 93% Safeguarding training compliance ED (Adult) Registered Nurses 77% Health Care Support Workers 77% (Children) Registered Nurses 91% Health Care Support Workers 85% April 2025 Update - An update against this recommendation action has not been provided on this occasion.
Healthcare Inspectorate Wales (HIW)/2024/165	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/7	g)Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024	01.02.2024	Partially complete (Overdue)	February, April, June, August 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	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/10	j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	February, April, June, August 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	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	June, August 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.
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits of attracting staff to CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	June, August 2025 Update - An update against this recommendation action has not been provided on these occasions. March 2025 Update - Mat-Neo services in PoW has now re-opened - Will revisit this work , contact made with recruitment to meet in April 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	June, August 2025 Update - An update against this recommendation action has not been provided on these occasions. 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.
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Datix reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	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	Fully complete (Awaiting approval)	July 2025 Update - Governance review completed and presented in directorate and care group QSPE and Mat Neo programme board. Implemented April 2025. 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	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	5. The health board must develop a policy in line with best practice guidelines that ensures the safety, privacy, dignity and rights of patients can be maintained throughout the mixed gender wards as well as keeping patients of the same gender safe in dormitories.	Healthcare Inspectorate Wales (HIW)/2024/235/MD5/2	The Health Board has developed a Single Sex accommodation policy. The draft version is currently going through the Health Board's ratification process.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	Overdue	August 2025 Update - revised date for completion is now 31st October 2025. 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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	7. The health board must develop a policy to provide guidance to staff regarding patients' use of electronic equipment, mobile phone devices and access to the internet.	Healthcare Inspectorate Wales (HIW)/2024/235/MD7/1	There is an all Wales Social Media Policy and a Health Board policy that supports use of mobile phones within hospital settings. Both policies are out of date. A request has been made to update the Health Boards policy.	Mental Health & Learning Disabilities	30.06.2025	30.06.2025	Overdue	August 2025 - Revised completion date 31st October 2025. 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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	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 2025 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 off at QSE. April 2025 Update - In progress.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	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	Fully complete (Awaiting approval)	August 2025 Update - completed and signed off at QSE in August - evidence attached. June 2025 Update - Remains estimated date for completed 31/08/25. April 2025 Update - In progress.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	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/MD15/5	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 25. April 2025 Update - In progress.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	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)/2025/241/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 25. April 2025 Update -In progress.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	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 PCUs (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 PCUs (NAPICU) standards outline best practice standards and minimum requirements. The Directorate will review the seclusion arrangements against the NAPICU standards and benchmark against the current provision the directorate have, outline areas of improvement and share within the Care Group QSRE meeting in May 25. April 2025 Update - In progress.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	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	27.01.2025	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/MD2/2	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	Fully complete (Awaiting approval)	July 2025 Update - agreed and signed off in July 2025 QSE meeting. June 2025 Update - completed, evidence attached, needs to go to QSE in July for sign off .
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	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 25.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	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	27.01.2025	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 25 QSE, another pieces of evidence is available but wont upload.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	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 25 QSE.

Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	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	27.01.2025	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	27.01.2025	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	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	9. The health board must ensure that a mental health pharmacist is allocated to the ward to support staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD9/1	Pharmacy provision to form part of the wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. The mitigation includes; Ysbyty Cwm Cynon pharmacy teams screen medication charts and supply medication to the wards and the Principle Pharmacist for Mental Health supports the ward on an adhoc basis 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.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	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	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	11. The health board must ensure that a dietician is allocated to the ward to support staff and meet the needs of the patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD11/1	Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. Mitigation includes; all patients have a risk assessment which determines the level of risk. There is a scoring mechanism in place from 0-7+ based on nutritional risk. If the score is 7+ then the patient requires referral to Dietetic service. In this scenario the Advanced Nurse Practitioner (ANP) or Doctor also prescribe supplements, advise on diet plan and nursing staff would complete weekly weights.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	June 2025 Update - Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. Estimated 31/12/25.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	12. The health board must ensure that policies are reviewed to ensure they are current.	Healthcare Inspectorate Wales (HIW)/2025/241/MD12/1	The policies identified within the inspection that were; - Mental Health policies - Management of violence and behaviours that challenge, no review date (this has been completed) - Corporate / Health Board policies - Health and safety policy, review date August 2024 - Consent to examination or treatment, review May 2024 - Policy for safe support and supervision of patients, review date October 2018 - PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents, however, at appropriate intervals there will be engagement with the Assistant Medical Director Quality & Clinical Effectiveness, who leads on Clinical Written Control Documents to ensure consistency and flow. Project Objectives: - To establish a baseline compliance position for Non-Clinical Written Control Documents - To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc. - To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. - 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
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	13. The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HIW)/2025/241/MD13/1	It has been agreed that a priority for the Older Adult Mental Health Directorate is to complete a pan CTM inpatient redesign review which will scope a widespread multi-disciplinary establishment review.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	In progress	June 2025 Update - Estimated completion 31/12/25.
Healthcare Inspectorate Wales (HIW)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The 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	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The 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	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/1	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	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/2	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	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/3	CTM DRL group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRLs. The DRL group will feed into CTM image optimisation team and radiation safety committee.	Diagnostic, Therapies, Pharmacy and Specialities	05.06.2025	05.06.2025	Partially complete (Overdue)	August 2025 Update (20/08/2025) - Meeting scheduled for 22/7/2025 cancelled. Date of next meeting to be held in September (Date TBC). 22/07/2025: The next meeting is scheduled to take place following the DRL audit conducted by RPS Cardiff. 05/06/2025: The inaugural meeting took place, and the terms of reference were agreed upon.
Healthcare Inspectorate Wales (HIW)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	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 CTMLHUB 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	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	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/MD3/3	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	Fully complete (Awaiting approval)	June 2025 Update (2/6/25) - 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. 30/5/25 - EPs and DRLs were ratified outside of committee by RPS chair June 2025 Update (5/6/25) - Audit from QA Superintendent radiographer stating No recorded exceeded DRL for May 2025.
Healthcare Inspectorate Wales (HIW)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	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	27.06.2025	Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	1. The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Healthcare Inspectorate Wales (HIW)/2025/264/MD1/1	Footer amended to display March 2025.	Diagnostic, Therapies, Pharmacy and Specialities	17.07.2025	17.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 17.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	1. The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Healthcare Inspectorate Wales (HIW)/2025/264/MD1/2	Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	1. The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Healthcare Inspectorate Wales (HIW)/2025/264/MD1/3	All amended EPs will be shared and acknowledgement of changes required and recorded.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	2. The employer must ensure that training and competency is evidenced prior to duty holder entitlement.	Healthcare Inspectorate Wales (HIW)/2025/264/MD2/1	Review existing practitioner and operator duty holders training and competency evidence. Ensure that practitioner and operator training and competency prior to entitlement is assessed for specific tasks e.g. Cardiologists practitioner training to justify imaging in theatre. Duty holder competency will be assessed by ongoing referral form audit i.e. accurate completion of request form; signature, adequate clinical information, date.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	3. The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	Healthcare Inspectorate Wales (HIW)/2025/264/MD3/1	EP2 - Schedule 2, 1 (b) Procedure for the identification of the individuals entitled to act as referrer or Practitioner or Operator within a specified scope of practice Page 5 amended to include medical director responsibility for entitling radiology clinical director.	Diagnostic, Therapies, Pharmacy and Specialities	17.07.2025	17.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 17.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	3. The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	Healthcare Inspectorate Wales (HIW)/2025/264/MD3/2	Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	3. The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	Healthcare Inspectorate Wales (HIW)/2025/264/MD3/3	All amended EPs will be shared and acknowledgement of changes required and recorded.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/1	PACs team to generate a list of individual external referrers with GMC numbers. Scoping work to commence internally and nationally re: practicable ways to issue entitlement to external referrers.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Overdue	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/2	CTMHUB employer's procedures will be available via the intranet to employers/referrers outside CTMLHUB.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/3	Entitlement will be issued to external referrers in other health boards via email to indicate their duty holder roles and responsibilities, information on how to access referral guidelines, and how to make/amend/ cancel a referral.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/4	CTMLHUB is leading a benchmarking exercise to understand the approaches in place across Wales.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/5	Discussion and escalation at national groups, with a view to developing an agreed All Wales approach.	Diagnostic, Therapies, Pharmacy and Specialities	03.09.2025	03.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/5	Entitlement of external referrers will be an agenda item at the following groups: The All-Wales Imaging Quality Forum	Diagnostic, Therapies, Pharmacy and Specialities	03.09.2025	03.09.2025	In progress	Added to tracker August 2025.

Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/6	Entitlement of external referrers will be an agenda item at the following group: Radiography Professional Heads Group	Diagnostic, Therapies, Pharmacy and Specialities	13.08.2025	13.08.2025	Partially complete (Overdue)	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	5. The employer must ensure that the entitlement letter of non-medical referrers is signed by the appropriate entitler in accordance with the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD5/1	Non-Medical referrer entitlement letter template updated to include Radiology Clinical Director as responsible for entitlement of non-medical referrers.	Diagnostic, Therapies, Pharmacy and Specialities	21.07.2025	21.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 21.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	6. The employer must ensure that the non-medical referrers who were clinically evaluating are appropriately entitled and that the entitlement is supported by relevant training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD6/1	Review of NMR documentation in relation to operators that carry out clinical evaluation.	Diagnostic, Therapies, Pharmacy and Specialities	31.05.2025	31.05.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete May 2025 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	6. The employer must ensure that the non-medical referrers who were clinically evaluating are appropriately entitled and that the entitlement is supported by relevant training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD6/2	Scope of practice for clinical evaluation and entitlement by Radiology CD will be sent to existing NMRs on receipt of evidence of training and competency Policy for NMRs will be updated to include entitlement for clinical evaluation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/1	Email all CT staff to remind them of their responsibilities as a practitioner, justifying the exposure; the role of the operator authorising under authorisation guidelines.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 31.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/2	Retrospective audit of CT forms justified by a Radiographer to ensure exposures have been justified appropriately.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/3	To be discussed at CT modality user group meeting, pan-CTM to clarify justification or authorisation process for Radiographers.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/4	If authorisation as an operator is agreed, guidelines will be issued by an individually named practitioner.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	8. The employer must ensure that individuals outside radiology performing practitioner and operator tasks are appropriately entitled. The entitlement should be underpinned with the appropriate training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD8/1	Review duty holder entitlement outside of Radiology. Identify any gaps and entitle, where appropriate, following confirmation of training and competency.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	9. The employer must ensure that the employer's procedure is updated to reflect further detail and clarification around the processes for duty holders outside radiology and the review of training and competency prior to entitlement.	Healthcare Inspectorate Wales (HIW)/2025/264/MD9/1	EP2 – Schedule 2, 1 (b) Procedure for the identification of the individuals entitled to act as referrer or Practitioner or Operator within a specified scope of practice amended to clarify that the Professional Head of Radiography will entitle Radiographers as referrers, practitioners and operators. The Radiology Clinical Director will entitle the Professional Head of Radiography to entitle Radiographers. The Radiology Clinical Director will entitle medical and non-medical referrers.	Diagnostic, Therapies, Pharmacy and Specialities	21.07.2025	21.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 21.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	10. The employer must ensure that the procedure accurately reflects who is acting as the operator in relation to pregnancy enquiries and that they are appropriately entitled.	Healthcare Inspectorate Wales (HIW)/2025/264/MD10/1	Amended EP3 – Schedule 2, 1 (c) Procedure for making enquiries of individuals of childbearing potential to establish whether the individual is pregnant or breastfeeding: Page 7 clarifies Radiographers are appropriately entitled as operators and perform the pregnancy check in theatre.	Diagnostic, Therapies, Pharmacy and Specialities	17.07.2025	17.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 17.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	11. The employer must ensure that the employer's procedure is updated to contain the correct reference.	Healthcare Inspectorate Wales (HIW)/2025/264/MD11/1	EP13 Schedule 2, 1 (m) Procedure for non-medical exposures updated to include 2020 version.	Diagnostic, Therapies, Pharmacy and Specialities	17.07.2025	17.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 17.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	12. The employer must ensure that: • All AMaT forms are completed fully to support robust audit • The clinical audit schedule includes the list of all scheduled audits, timeframes and frequency of audit and the individuals responsible for performing the audit and ensuring findings are actioned.	Healthcare Inspectorate Wales (HIW)/2025/264/MD12/1	Meet with clinical audit team, and radiology audit leads to ensure that all audits are registered on AMaT, and all documentation is complete. Ensure clinical audit schedule is updated to include timeframes, frequency of audit and responsible person for carrying out audit.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for RIMEJR audits should be set at 100%, with robust analysis and appropriate readout within a specified timeframe • Scope of RIMEJR audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/1	Review of observational and referral form compliance audit.	Diagnostic, Therapies, Pharmacy and Specialities	31.05.2025	31.05.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete May 2025 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for RIMEJR audits should be set at 100%, with robust analysis and appropriate readout within a specified timeframe • Scope of RIMEJR audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/2	Target for compliance set to 100%.	Diagnostic, Therapies, Pharmacy and Specialities	14.07.2025	14.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 14.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for RIMEJR audits should be set at 100%, with robust analysis and appropriate readout within a specified timeframe • Scope of RIMEJR audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/3	Observation and referral form audit will be added to AMaT system to ensure action plans in place, robust analysis and re-audit in an appropriate time frame.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for RIMEJR audits should be set at 100%, with robust analysis and appropriate readout within a specified timeframe • Scope of RIMEJR audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/4	Clinical evaluation audit outside Radiology to be added to RIMEJR schedule i.e., evidence of clinical evaluation documented within patient notes.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for RIMEJR audits should be set at 100%, with robust analysis and appropriate readout within a specified timeframe • Scope of RIMEJR audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/5	Audit frequency changed from annual to every 2 months. Readout of areas that fall below 100% will take place as required.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	14. The employer must ensure that the procedure is amended to correctly reflect the actions that needed to be taken when justifying and authorising medical exposures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD14/1	EP19 Procedure for justification and authorisation of medical exposure Page 5 amended to clarify that the operator documents the name of the practitioner on the referral form. EP will be refiled via chair action outside Radiation Safety Committee. All amended EPs will be shared and acknowledgement of changes required and recorded. Amended EPs will be added to CTMUHB SharePoint.	Diagnostic, Therapies, Pharmacy and Specialities	21.07.2025	21.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 21.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	15. The employer must review the gaps in the QC records and the inconsistencies in baselines between the policy and manufacturer recommendations.	Healthcare Inspectorate Wales (HIW)/2025/264/MD15/1	QC gaps reviewed and addressed. Documentation updated to ensure all QC tests required are included.	Diagnostic, Therapies, Pharmacy and Specialities	17.07.2025	17.07.2025	Fully complete (Awaiting approval)	Added to tracker August 2025; this action is marked as Complete 17.7.25 as per the Report and will be presented to the Quality, Safety & Experience Committee on Tuesday 23rd September 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	15. The employer must review the gaps in the QC records and the inconsistencies in baselines between the policy and manufacturer recommendations.	Healthcare Inspectorate Wales (HIW)/2025/264/MD15/2	Meeting with MPEs to review baselines and manufacturer recommendations. Will review policy and amend.	Diagnostic, Therapies, Pharmacy and Specialities	29.07.2025	29.07.2025	Partially complete (Overdue)	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	16. The employer must ensure that the process to ensure that training records and the review of entitlement are checked at suitable intervals and evidenced appropriately.	Healthcare Inspectorate Wales (HIW)/2025/264/MD16/1	All training records and entitlement will be reviewed at personal development reviews. All staff that perform PDR's will be reminded.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Partially complete (Overdue)	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	17. The employer must ensure clinical evaluations performed by individuals outside radiology are audited on a regular basis.	Healthcare Inspectorate Wales (HIW)/2025/264/MD17/1	Audit of orthopaedic follow up referrals to be implemented. RIMEJR audit schedule updated to include frequency.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	18. The employer must ensure that staff are reminded of the intellectual task of justification and exposure and how this differs to authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD18/1	CPD session to be delivered on changes to employers procedures to include the difference between justification and authorisation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&C25 – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/1	Putting things right leaflets will be available in Welsh.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&C25 – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/2	Patient experience champions have been appointed on each site to support gathering of feedback.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&C25 – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/3	Feedback Friday to be implemented i.e., staff will actively ask patients to give feedback. Once feedback has been gathered 'you said, we did' board will be displayed.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20. The department must continue to highlight the business case to the employer and ensure that a decision is made in a timely manner.	Healthcare Inspectorate Wales (HIW)/2025/264/MD20/1	A case has been submitted for additional radiography staff that supports the future workforce model and demand as part of the R&TF investment priorities for 2025-26 across the sites. This will continue to remain the priority for Radiology. To date, no source of funding has been identified. Additional staff have been rostered out of hours at RGH temporarily while services from POW are temporarily relocated.	Diagnostic, Therapies, Pharmacy and Specialities	30.04.2026	30.04.2026	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	21. The health board is to inform HIW of the actions taken to increase this percentage compliance.	Healthcare Inspectorate Wales (HIW)/2025/264/MD21/1	Action plan developed to support timely appraisals. Dates are pre-planned. There is a process for escalation should the expected date not be met.	Diagnostic, Therapies, Pharmacy and Specialities	31.12.2025	31.12.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	21. The health board is to inform HIW of the actions taken to increase this percentage compliance.	Healthcare Inspectorate Wales (HIW)/2025/264/MD21/2	Plan to have documented 1.1 interim meeting every three months to support staff with ongoing objectives and wellbeing.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	21. The health board is to inform HIW of the actions taken to increase this percentage compliance.	Healthcare Inspectorate Wales (HIW)/2025/264/MD21/3	Quarterly modality/staff user groups re-established to support peer discussion around performance and development.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/1	There are processes in place to address the negative responses and concerns, including staffing. There are already reports of staff confirming that morale in the department is much improved during staff survey face to face discussions. Regular band 7 meetings and information sharing with the 8a site superintendent is contributing to staff feeling more positive. CTMUHB has appointed a Professional Head of Radiography in 2025 who has oversight of each radiology department and is leading this work. A review of staffing and activity and demand is also underway on all sites to ensure equity and safe working practices.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	In progress	Added to tracker August 2025.

HIW Inspections Recommendation Actions Tracker as at 27/08/2025 (for Quality, Safety and Experience Committee 23/09/2025)												
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/2	Staff training in CT have been assigned a mentor and the health board are supporting CT staff to attend external CT training courses to further enhance skills.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/3	Radiology has a newly appointed Quality manager in the team who is actively working with the national QSI improvement partner There is investment from the health board to promote and support this work.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/4	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Re-establishment of modality user groups – promote team communication.	Diagnostic, Therapies, Pharmacy and Specialities	30.06.2025	30.06.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/5	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Leadership team development (AFFINA questionnaire and development days)	Diagnostic, Therapies, Pharmacy and Specialities	30.07.2025	30.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/6	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Staff Newsletter	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/7	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Pilot of patient safety huddles: share staffing levels, equipment issues, site concerns – opportunity for staff to voice concerns and feel involved and valued.	Diagnostic, Therapies, Pharmacy and Specialities	30.06.2025	30.06.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/8	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Patient experience champions on all sites established.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/9	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Wellbeing champions to be established.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/10	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Radiology staff survey roadshow days at all sites. To discuss staff survey themes and listen to areas of concern and ideas for improvement.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/11	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Preceptorship programme to be developed for Band 7 team leaders.	Diagnostic, Therapies, Pharmacy and Specialities	31.12.2025	31.12.2025	In progress	Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/12	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Head of Radiography to meet monthly with the Site &a Superintendents. Communication to be cascaded down to the teams and staff to escalate concerns and suggestions up.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/13	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Senior managers have developed a weekly roster across all sites to improve visibility.	Diagnostic, Therapies, Pharmacy and Specialities	31.05.2025	31.05.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	23. The health board must ensure that all staff receive duty of candour training.	Healthcare Inspectorate Wales (HIW)/2025/264/MD23/1	Source appropriate duty of candour training for staff i.e., e-learning	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	In progress	Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	24. The health board is to inform HIW of the actions they will take to ensure all patients have equal and fair access to the right health care at the right time, without fear of discrimination.	Healthcare Inspectorate Wales (HIW)/2025/264/MD24/1	All patients will be treated fairly and in turn in CTMUHB – staff are trained to recognise patients' individual needs and to be always responsive. Staff meetings and PDRs will provide opportunities to remind staff to be alert and sensitive to each service users' needs when they are visiting this service.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	24. The health board is to inform HIW of the actions they will take to ensure all patients have equal and fair access to the right health care at the right time, without fear of discrimination.	Healthcare Inspectorate Wales (HIW)/2025/264/MD24/2	The Health board is actively looking at innovative ways to ensure all patients can access the right healthcare at the right time regardless of any protected characteristic. We will ensure all staff complete mandatory training modules by assigning a module of the month.	Diagnostic, Therapies, Pharmacy and Specialities	30.06.2025	30.06.2025	Rejected (To be resubmitted)	August 2025 Update - This action was updated as Fully complete (Awaiting Approval) however more narrative is required as to assurance of closure. Added to tracker August 2025.		



Agenda Item

7.3

Quality, Safety & Experience Committee

Coroner's Inquest – Case Activity & Lessons Learned

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting
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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	
UHB	University Health Board
WAST	Welsh Ambulance Services NHS Trust

MRCP	Magnetic Resonance Cholangiopancreatography
ERCP	Endoscopic Retrograde Cholangiopancreatography
GMC	General Medical Council
BNF	British National Formulary

1. Introduction

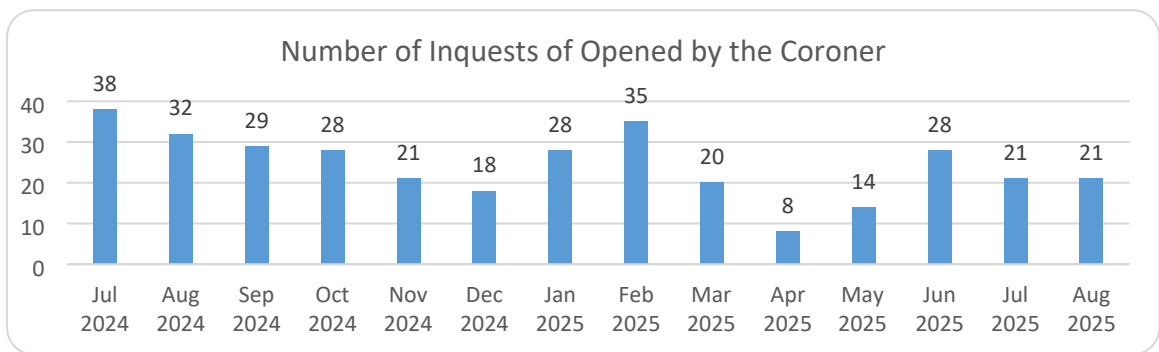
An inquest is a formal investigation by the Coroner to determine how a person died. They are held in certain circumstances, for example if the death was sudden or unexpected.

The purpose of this report is to provide an overview of inquest activity within the Health Board between the **01.07.24 to 31.08.25**.

2. Specific Matters for Consideration

New Inquests Received

In the time period 01.07.24 to 31.08.25, the Health Board received notification of 341 inquests being opened by the Coroner. This remains consistent with the previous 12 month period. A trend graph of inquests opened is provided below.



Of the 341 Inquests opened, the highest number were received within the Unscheduled Care Group. A breakdown of inquests received by Care Group is provided below.

Care Group	Number
Children and Families	16
Community	7
Diagnostics, Therapies, Pharmacy & Specialist Care	3
Mental Health and Learning Disabilities	95
Planned Care	63
Primary Care	6
Unscheduled Care	151

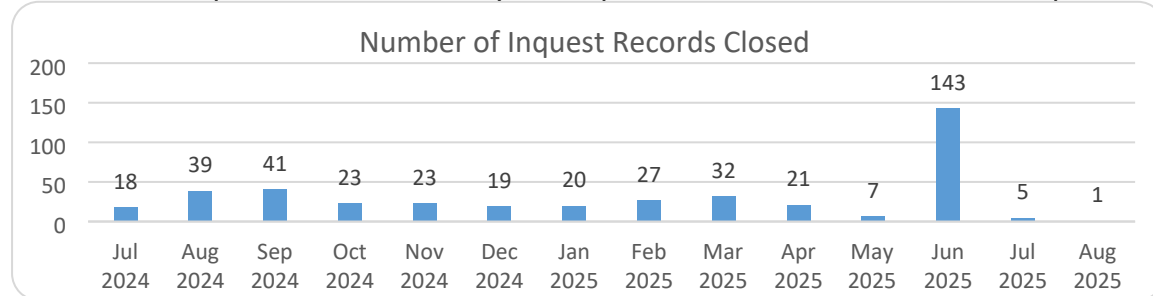


Total

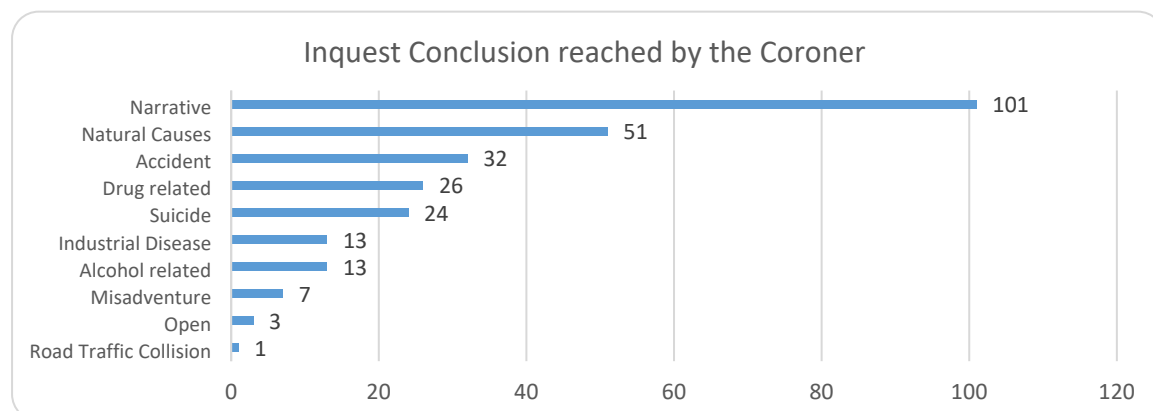
341

Inquests Concluded

During the same 12 month period, 419 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 as reflected in the trend graph of inquests provided below. It should be noted that inquests will not always be opened and closed in the same period.

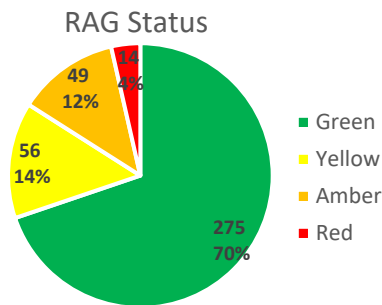


Of the 394 inquest records closed on Datix Cymru, the hearing date or conclusion has not been made available by the Coroner to the Health Board for 123 cases. Of the remaining cases, 56% were concluded with a narrative conclusion (101) or an outcome of natural causes (51). A further breakdown of the conclusion reached by the Coroner for inquests closed between the 01.07.24 and 31.08.25 is provided in the chart below.



RAG Status

For all inquests opened within the Health Board a RAG assessment is conducted to determine the level of complexity, concern and risk associated with the case. This assessment considers a number of factors (e.g. family concerns, a related incident, media interest, potential for regulation 28 report) and is subject to continuous review until the inquest process is concluded. The majority of inquests will be identified as Green (low complexity, no significant concerns or risk). 70% (275) of the 394 cases closed between 01.07.24 and 31.08.25 were concluded with a RAG status of green. A breakdown is provided in the chart below.



Alongside the RAG assessment, consideration will be given as to whether instruction of Legal & Risk Services is required. All Red cases will be automatically referred to Legal & Risk Services, with amber and yellow cases considered on a case by case basis. Of the 394 closed, Legal & Risk were instructed on 64 cases.

Regulation 28 Reports

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 01.07.24 and 31.08.25 the Coroner issued 4 regulation 28 reports to the Health Board. On a further 4 cases whilst the Coroner did not issue a regulation 28 report, a letter identifying opportunity for improvement was issued to the Health Board during the same time period.

A summary of the regulation reports and letters received is provided in the table below:

Inquest Hearing date	Care Group	Conclusion reached by Coroner	Regulation 28 / Letter	Type of Regulation 28 Report	Main Issue	Date issued	Date Response Due	Date Submitted
19/09/24	Unscheduled Care	Narrative	Letter received	Hospital Death (Clinical Procedures and medical management) related deaths	Monitoring of blood levels when prescribed Trimethoprim	19/09/24	13/11/24	15/10/24
12/05/25	Planned Care	Narrative	Letter received	Other related deaths	Delays in Ambulance Handover	18/06/25	01/10/25	
17/09/24	Children and Families	Narrative	Regulation 28 Report	Hospital Death (Clinical Procedures and medical management) related deaths	Delays in investigations and diagnosis of endometrial cancer	20/09/24	12/11/24	08/11/24
14/11/24	Planned Care Primary Care & Community	Narrative	Letter received	Community Health Care and emergency services related deaths	Delay in ambulance transfer following inpatient fall.	14/11/24	08/01/25	19/03/25
15/01/25	Unscheduled Care	Narrative	Regulation 28 Report	Hospital Death (Clinical Procedures and medical management) related deaths	Delays in Ambulance Handover	20/01/25	14/03/25	01/04/25

26/03/25	Unscheduled Care	Natural Causes	Letter received	Wales Prevention of Future Deaths Reports (2019 onwards)	Delay in assessment and escalation of care	28/03/25	25/04/25	25/04/25
31/03/25	Mental Health and Learning Disabilities	Narrative	Regulation 28 Report	Alcohol, Drug and Medication related deaths	Timescales for referrals for substance misuse within the Prison	31/07/25	25/09/25	
24/02/25	Unscheduled Care	Narrative	Regulation 28 Report	Hospital Death (Clinical Procedures and medical management) related deaths	Failed discharge and referral	06/03/25	31/07/25	21/07/25

Learning Themes and Improvement Actions

To address the opportunities for learning within the regulation 28 reports the following improvement actions have been identified:

1. Referral and Diagnostic Pathways
 - Strengthen triage protocols and clinician awareness to ensure urgent cases are correctly flagged
 - Audit referral classifications and improve escalation for re-referrals with worsening symptoms
 - Enhance safety-netting and follow-up processes
2. Patient Communication
 - Adopt multi-modal communication strategies for urgent cases
 - Record and use patient communication preferences
 - Escalate when patients do not respond to appointment offers
3. Emergency Department Care
 - Collaborate with WAST to improve ambulance handovers and discharge pathways
 - Improve patient monitoring in non-clinical areas and create dedicated escalation spaces
4. Ambulance Transfer Delays from Community Hospitals
 - Strengthen escalation protocols and staff training on communicating acuity
 - Explore interim transfer solutions and assess feasibility of a dedicated service
 - Use transfer data for future planning and continue collaboration with WAST
 - Enhance documentation and follow-up of escalation attempts
5. Imaging and Reporting
 - Standardise MRCP reporting to include key anatomical details relevant to ERCP planning

6. Documentation

- Deliver targeted training based on GMC guidance
- Make documentation resources easily accessible
- Reinforce nursing documentation standards
- Conduct monthly audits with feedback to staff and supervisors

7. Policy and Guidance Updates

- Finalise the failed discharge policy
- Improve access to clinical guidance (e.g., BNF antibiotic link)

3. Key Risk / Matters for Escalation

Whilst the number of new inquests being opened has remained consistent with the previous 12 months, it should be noted that the complexity of cases has increased along with a shortened timescale for the submission of information to the Coroner. In addition, there is a greater expectation on the Health Board to produce internal investigation reports as well as the sourcing and provision of independent expert evidence. This places an increased pressure both on the Clinical Services and the Corporate Legal Services Team.

As a result of this, there is an increased risk of:

- Schedule 5s due the ability of the Clinical Service to engage in a timely manner
- Delays in obtaining advice from Legal & Risk due to the number of cases requiring referral
- Requirement to provide lessons learnt statements and identify a witness to present this information at an Inquest hearing
- Regulation 28 reports where evidence of learning is not available for submission to the Coroner prior to the inquest hearing

Work continues to be undertaken to improve the capture of learning and monitoring of improvement actions from inquests to enhance the reporting of key themes arising from inquests.

4. Assessment

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



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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome: This report outlines Inquest Activity one of the key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>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</i>	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



<i>Impact Assessment Screening?</i>		appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	The Report relates to the Coroner's process.	
Enw da / Reputational	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes. This includes regulation 28 reports.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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



Agenda Item

7.4

Quality, Safety & Experience Committee

Internal Audit Review - Duty of Candour

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting
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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 University Health Board

1. Situation /Background

The internal audit of the implementation of the Duty of Candour was completed in March 2025 in line with the 2024/2025 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (CTM).

The purpose of the review was to consider the process and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.

During the review the following risks were considered:

- 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.

2. Specific Matters for Consideration

The review provided the Health Board with **“reasonable assurance”** in relation to the implementation of Duty of Candour. “Reasonable Assurance is identified as some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved”.

A breakdown of assurance against the objectives of the review are highlighted in the table below:

Objectives	Assurance
1 Process and procedures	Reasonable
2 Training and support	Reasonable
3 Operation and compliance	Limited
4 Monitoring and reporting	Reasonable

It should be noted that the objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

On conclusion of the findings, the following key matters were identified as arising from the review:



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

3. Key Risks / Matters for Escalation

From the key matters arising nine recommendations were made. Of these, two recommendation was highlighted as a high priority for addressing. The recommendations relate to:

- High priority
 - Development of detailed operating procedures to support the accurate completion of Datix Cymru records
 - Review of current forms utilised within Datix Cymru to be undertaken
- Medium priority
 - Analysis of data on the variations in harm levels at various stages of the incident process to identify any themes and trends
 - Ensuring a consistent approach to amendments to the assessment of level of harm
 - Further development of the duty of candour standard operating procedure with emphasis on adherence to timescales
 - Implementation of a duty of candour review/audit of closed records
 - Checking of reports to confirm the accuracy of data used for monitoring implementation of Duty of Candour
- Low priority
 - Extending the availability and monitoring of duty of candour awareness training
 - Incorporating guidance for complex cases into the standard operating procedure

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:
	Not Applicable



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

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



	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

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

6. Next Steps

Implement the agreed management actions within the Internal Audit Review Report and provide progress updates at future Committee meetings.

Duty of Candour Final Internal Audit Report

March 2025

Cwm Taf Morgannwg University Health Board



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
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Cwm Taf Morgannwg
University Health Board



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Review reference:	CTMUHB-2324-10
Report status:	Final
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Debrief meeting:	January 2025
Draft report issued:	January 2025
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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

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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 summary¹

Objectives	Assurance
1 Process and procedures	Reasonable
2 Training and support	Reasonable
3 Operation and compliance	Limited
4 Monitoring and reporting	Reasonable

¹The 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 and 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 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	Head of Concerns & Business Intelligence
		31.10.25	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	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.	Medium	
2.1b	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.		
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	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.	High	
3.1b	Once produced, the procedures should be made accessible to staff via the Duty of Candour intranet pages.		
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 reminded 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 reminded 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.



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Agenda Item
7.5

Quality, Safety & Experience Committee

Highlight Report from the Health, Safety & Fire Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
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	Carolyn Donoghue, Independent Member & Vice Chair of the Health, Safety & Fire Sub Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Committee Chair and Executive Director lead.	04/09/2025	Endorsed

Acronyms / Glossary of Terms	
Nil	

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 4 September 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**

Concerns:

Manual Handling Training

The Sub Committee expressed concern in relation to the low level of compliance and 'Do Not Attends' for manual handling training, particularly in the Medical and Dental staff groups. The Committee stressed the need to ensure that there is targeted work within Care Groups, led by Senior Medical Leadership, to improve compliance and reinforce the expectations and importance of statutory and mandatory training.

Positive Escalation:

Hospital Site Managers – Environmental Walkarounds

The Sub Committee commended the Hospital Site Managers for the noticeable improvements being made in maintaining clear corridors and evacuation routes across sites. The Committee recognised that this will be a continuing risk that will require monitoring, however, took assurance as to the positive progress/steps underway. The Committee will await with interest the evaluation of the "Put Away" role which is being trialled at Prince Charles Hospital to determine proof of concept.

Advise	The Sub Committee received a Shared Listening and Learning Story with regards the fire incident at Taith Newydd in November 2024. The presentation outlined the incident response, investigations and actions taken as well as the opportunities to learn from the incident. Whilst recognising the cross organisational boundaries and complexities, the Committee took assurance that the Executive Director for People will be escalating the challenges highlighted within the report regarding adherence to Cwm Taf Morgannwg University Health Board policies and procedures. The Assistant Director Health, Safety & Fire Report was discussed in detail noting the updates in relation to ongoing Health and Safety activities, audits, engagement with the Health & Safety Executive and training compliance. Attention was drawn to concerns in relation to funding equipment maintenance and the Sub Committee noted the ongoing efforts to consider and explore the available funding options. The following key matters were highlighted to the Sub Committee from the Fire Safety Report: • One active fire enforcement notice from South Wales Fire and Rescue Service with regards to the Prince Charles Hospital Ground and First Floors. • Recent audit activity undertaken by the South Wales Fire and Rescue Service in Dewi Sant Health Park which resulted in an Information Notice being received which requires several corrective actions, particularly regarding wedged open fire doors and corridor management. • Environmental improvements as noted in the highlight section of the report. Overarching Highlight Report – Care Groups – The Sub Committee were alerted to concerns raised by the Facilities Directorate in relation to the increasing requirement for Security Colleagues to provide a security presence in clinical areas which is outside their role remit and is having a negative impact on the Security Teams ability to maintain the appropriate security patrols and other tasks related functions. The Committee were apprised of the plans to develop a collaborative approach to mitigate the risks in this area. Highlight Report – Primary Care & Community – The Sub Committee were alerted to the activity in relation to the aforementioned audit from South Wales Fire & Rescue Service at Dewi Sant Hospital, and were assured that an action plan had been developed and despite the corrective works the site is considered safe.
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	Other areas highlighted by the Care Group to the Sub Committee were ongoing challenges in terms of securing Fire Incident Co-ordinators at Community Sites and initial feedback from a Health and Safety and Infection Prevention and Control audit of Community Vaccination Centres, where it is anticipated that the findings will express concerns that the venues do not comply with current standards for high-volume clinical activity. The Sub Committee were alerted to the security challenges presented in the Highlight Report from the Mental Health & Learning Disabilities Care Group, in relation to access arrangements at two of the Care Groups sites. Assurance was provided that work is underway to strengthen controls and improve overall security. Discussion was also held on several recent fire activations on site and the Committee were assured that Directorate teams now receive ward-level activation reports, enabling Service Managers to target local interventions and reduce repeat occurrences where trends emerge.
Assure	The Sub Committee endorsed the Terms of Reference for Committee approval, subject to them being updated to include attendance, as required, from Hospital Site Managers. The Sub Committee were delighted to note the improvement in district nursing manual handling compliance in Bridgend which was highlighted in the Highlight Report from the Primary Care & Community Care Group as it had reached 91% compliance. The Committee stressed the importance of sharing this as a positive example for other areas. Health, Safety & Fire Performance Report – a detailed summary was provided to the Sub Committee in terms of: • Incident Reporting and Trends • The importance of robust risk management in terms of the regular review of risks to ensure they are up to date or closed where appropriate. • Progress on training compliance, with small improvements shown in most areas, except for the Manual Handling Compliance for Medical and Dental as outlined in the 'alert' section of this report. • Personal Injury Claims Data Sets was noted in terms of the improvement needed to support appropriate classification to provide robust data for analysis. The Sub Committee welcomed an update on the Health Surveillance Programme which outlined the progress being made to address gaps in monitoring workplace risks such as noise exposure, with a phased approach being undertaken based on risk prioritisation. The Sub Committee acknowledged that the

	programme of work involves collaboration with internal teams such as audiology and respiratory and recognised the motivation and momentum among staff to implement the surveillance measures. The updates to the risks assigned to the Sub Committee on the Organisational Risk Register were noted. The Sub Committee agreed that the Estates Risks currently just assigned to the Operational Delivery Committee would also be received at the Sub Committee in future for visibility. The Sub Committee were also apprised of the limitations within the current risk system and the future planning of a replacement risk system which will be required by November 2027. Private "In Committee" meeting The Sub Committee considered a business sensitive risk in closed session.
Inform	The following items were Approved via the consent agenda: • Unconfirmed Minutes of the meeting held on the 5 June 2025 • Unconfirmed 'In Committee' minutes of the meeting held on the 5 June 2025. • Unconfirmed minutes of the meeting held on the 3 April 2025, noting that these minutes were being brought back to the Sub Committee to approve the amendment to reflect that the Organisational Health and Safety Policy was endorsed for approval by the Quality, Safety & Experience Committee for a further 3-year period. The following item was Noted via the consent agenda: • Health, Safety & Fire Sub Committee Cycle of Business.
Appendices	Not applicable

3. Assessment

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

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

4. Recommendation

- 4.1 The Quality, Safety & Experience Committee is asked to **NOTE** the highlights outlined in section 2 of this report. The Committee are also being asked to **approve** the Organisational Health and Safety Policy for a further 3-year period and approve the Health, Safety & Fire Sub Committee Terms of Reference.



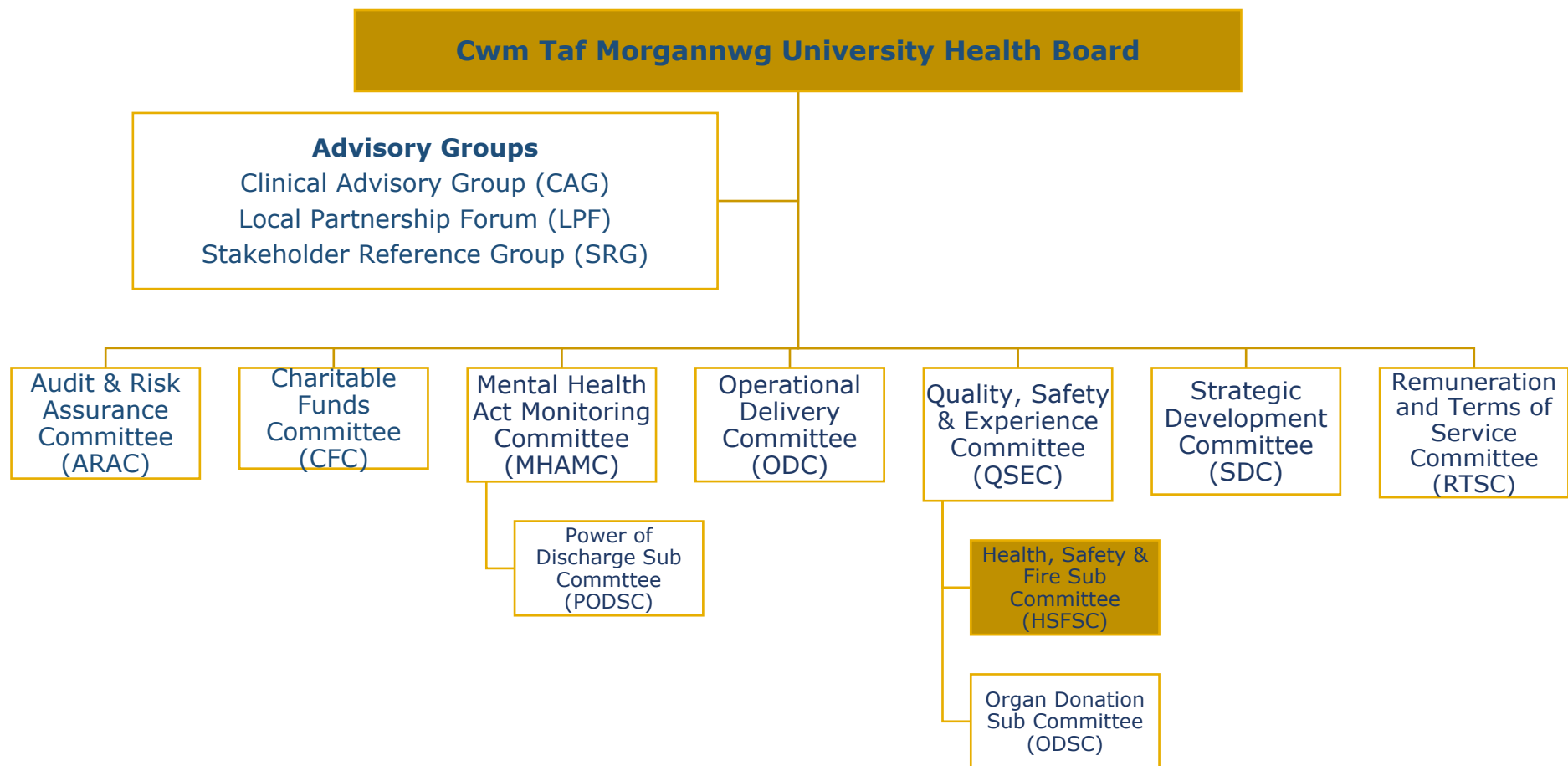
GIG
CYMRU
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WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

HEALTH, SAFETY & FIRE SUB COMMITTEE

Terms of Reference & Operating Arrangements
(Schedule 3.5b of the Standing Orders)

Last Approved: Health Board Meeting 26th September 2024
CTM_Corporate_Governance@wales.nhs.uk



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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Board Meeting	26 th September 2024	Approved	No later than the end of September 2025.

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

- 1.1 The Quality, Safety & Experience Committee, established as a Committee of the Board, has established a Health, Safety & Fire Sub Committee, the 'sub committee'.
- 1.2 CTMUHB has a statutory obligation by virtue of the Health and Safety at Work etc. Act 1974 (Section two sub-section seven) to establish and maintain a Health and Safety Committee: *"it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed"*.
- 1.3 The main objectives of the sub committee is to:
 - Promote a healthy and safe working environment for staff employed in CTMUHB through positive co-operation between Managers and Safety Representatives on health and safety issues.
 - Provide a framework for agreeing and endorsing Health, Safety, Fire Policies and Strategies.
 - Agree strategies that will ensure effective health safety and fire management within CTMUHB and monitor progress against the Strategy
 - Act as a forum for monitoring the prevention of workplace accidents, avoidance of industrial injuries and disease and for instructing on preventative and remedial measures.

2. Purpose

- 2.1 The purpose of 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 CTMUHB's health and safety and fire safety policies, approve and monitor delivery against the Health Safety and Fire 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 and the accountable officer on where and how, its health safety and fire management may be strengthened and developed further.

3. Scope and Duties

- 3.1 The Health, Safety & Fire Sub Committee will be concerned with the health, safety, fire and welfare of all staff employed throughout CTMUHB and those who may be affected by risks arising out of or in connection with work activities.
- 3.2 With regard to its role in providing advice to the Board and Quality, Safety & Experience Committee, the sub committee will comment specifically upon the adequacy of assurance arrangements and processes for the provision of an effective health safety and fire function.
- 3.3 With regard to its role in providing advice to the Board, it will encompass:
- Staff health and safety;
 - Premises health and safety;
 - Violence and aggression (including security strategy);
 - Fire safety;
 - Risk assessment;
 - Manual handling;
 - Health, welfare, hazard substances, safety environment;
 - Patient health and safety – patient falls (If RIDDOR Reportable), patient manual handling;
 - Staff healthy lifestyle / health promotion activities;
 - Estates Compliance Activity;
 - Personal Protective Equipment;
 - Staff health and well-being;
 - Facilities Compliance Activity.
- 3.4 The subcommittee will support the Board with regard to its responsibilities for health safety and fire by:
- Receiving assurance that the health and safety action plan is on track for delivery;
 - reviewing the comprehensiveness of assurances in meeting the Board and the accountable officer's assurance needs across the whole of the health board's activities, both clinical and non-clinical;
 - Considering and endorsing policies as determined by the board.
- 3.5 To achieve this, the committee's programme of work will be designed to provide assurance that:
- objectives set out in the health safety and fire action plan are on target for delivery in line with agreed timescales;
 - standards are set and monitored in accordance with the relevant standards for Health Services in Wales;
 - robust proactive and reactive health and safety plans are in place across the health board;

- policy development and implementation is actively pursued and reviewed;
- where appropriate and proportionate health safety and fire incidents and ill health events are investigated and action taken to mitigate the risk of future harm;
- reports and audits from enforcing agencies and internal sources are considered and acted upon;
- employee health and wellbeing activities are in place in line with CTMUHB's commitment to be a public health practicing organisation and aligned to the corporate health standards;
- employee Health and safety competence and participation is promoted;
- decisions are based upon valid, accurate, complete and timely data and information.

3.6 Risk - Scrutinise risks on the Organisational Risk Register that fall within the remit and control of the Committee.

4. Membership

4.1 The Membership of the Sub Committee is as follows:

Chair	Independent Member
Vice Chair	Independent Member of the Board
Attendees	• Executive Director for People (Executive Lead) • Deputy Chief Operating Officer – Acute Services (Care Group nominated lead in their absence) • Assistant Director – Health, Safety & Fire • Director of Corporate Governance / Board Secretary (or nominated deputy) • Chair of the Staff Side Health & Safety Committee • Assistant Director of Planning - (Capital and Estates)/ Strategic and Operational Planning or Head of Operational Estates • Divisional Director Of Facilities • Hospital Managers

4.2 By invitation the Sub Committee Chair may invite any other officers from CTMUHB or those outside the organisation where appropriate. The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

4.3 Member Appointments - The membership of the sub Committee shall be determined by the Quality, Safety & Experience Committee, based on the recommendation of the Sub Committee Chair. The membership of the Sub Committee will be reviewed annually.

5. Quorum

- 5.1 A quorum shall be at least two Independent Members (one of which must be the Committee Chair or Vice Chair).

6. Meeting Secretariat

- 6.1 The secretariat will be as determined by the Director of Corporate Governance/Board Secretary.

7. Frequency of Meetings

- 7.1 Meetings shall meet no less than 4 times a year, and otherwise as the Chair of the Sub Committee deems necessary.

8. Withdrawal of Individuals in Attendance

- 8.1 The Sub Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9. Circulation of Papers

- 9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10. Delegated Powers, Authority & Access

- 10.1 The sub committee is authorised by the Quality, Safety & Experience Committee to investigate or have investigated any activity within its terms of reference. In doing so, the sub committee shall have the right to inspect any information, records or documents of the health Board relevant to the committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
 - other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.
- 10.2 The sub committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

- 10.3 The sub committee may, subject to the approval of the Board/Quality, Safety & Experience Committee, establish task and finish groups to carry out on its behalf specific aspects of sub committee business.
- 10.4 The Chair of the Sub Committee shall have reasonable access to Executive Directors and other relevant senior staff.
- 10.5 The Executive Lead for health, safety and fire shall have unrestricted access to the chair of the Health, Safety and Fire Sub Committee.

11. Accountability & Responsibility

- 11.1 The Sub-Committee is directly accountable to the Quality, Safety & Experience Committee, for its performance in exercising the functions set out in these terms of reference.
- 11.2 Due to the sensitivity of potential staff/ patient information received, the Sub-Committee will at all times be aware of the importance of confidentiality, and ensure that they comply with the CTMUHB's policies within this area of work.
- 11.3 The Sub-Committee shall embed CTMUHB's values, vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.
- 11.4 The requirements for the conduct of business as set out in the CTMUHB's Standing Orders are equally applicable to the operation of the Sub Committee.

12. Reporting

- 12.1 The Sub-Committee, through its Chair and Members, shall work closely with the Quality, Safety & Experience Committee and other appropriate forums to provide assurance in relation to:
- Joint planning and co-ordination of Board and Committee business; and
 - Sharing of information
- 12.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.
- 12.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive written update reports following each meeting which details the business undertaken on its behalf.
- 12.4 The Sub-Committee Chair, supported by the Sub-Committee meeting secretariat, shall:

- Report formally, regularly and on a timely basis to the Quality, Safety & Experience Committee on the Sub-Committee's activities. This includes the submission of a routine Committee Highlight report, as well as the presentation of an Annual Report within six weeks of the end of the financial year.
- Bring to the Quality, Safety & Experience Committees attention any significant matter under consideration by the Sub-Committee.

13. Applicability of Standing Orders to Committee Business

- 13.1 The requirements for the conduct of business as set out in CTMUHB's Standing Orders are equally applicable to the operation of the Sub Committee, except in the following areas:
- Quorum

14. Chairs Action on Urgent Matters

- 14.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub Committee need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with at least two other members of the Sub Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Sub Committee for consideration and ratification.
- 14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

15. Review

- 15.1 These Terms of Reference shall be approved by the Quality, Safety & Experience Committee and subject to review at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.



Agenda Item

7.6

Quality, Safety & Experience Committee

Public Services Ombudsman for Wales
Turning the Page Annual Report & Annual Letter

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting
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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		
PSOW	Public Services Ombudsman for Wales	
CTM	Cwm Taf Morgannwg University Health Board	
WAST	Welsh Ambulance Services Trust	

1. Situation /Background

The Public Services Ombudsman for Wales (PSOW) published their 2024/2025 Annual Report in July 2025. The report outlines all activity managed by the PSOW in relation to Public Services in Wales. A full copy of the report can be found at [Annual Reports and Accounts - Public Services Ombudsman for Wales](#)

The report provides detail against four strategic aims set out by the PSOW during 2024/2025:

- Strategic Aim 1:** Delivering justice with a positive impact for people and public services
- Strategic Aim 2:** Increasing accessibility and inclusion
- Strategic Aim 3:** Increasing impact of proactive improvement work
- Strategic Aim 4:** Ensuring that we are a healthy, efficient and accountable organisation

To coincide with the publication of the annual report, the PSOW issued their annual letter to the Health Board (copy attached in appendix).

2. Specific Matters for Consideration

New Complaints received by the PSOW

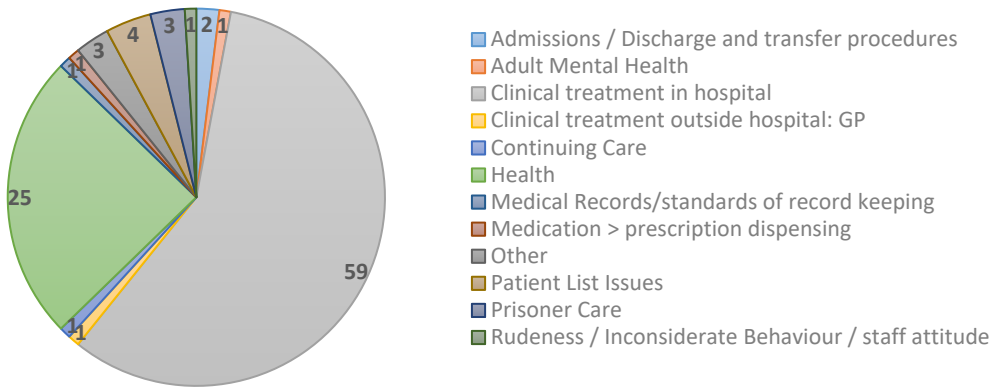
The PSOW annual report highlights that since 2019/2020 the number of new complaints in relation to public services being referred to their office has increased by 44%. Of the new complaints referred to the PSOW, Health remains the most common subject overall.

During 2024/2025 the PSOW received 973 complaints in relation to Health Boards and WAST. Of these, 10% (0.23 per 1,000 residents) related to care and treatment provided by Cwm Taf Morgannwg University Health Board (CTM). A comparison on All Wales basis is provided in the table below:

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	178	595412	0.30
Betsi Cadwaladr University Health Board	236	691991	0.34
Cardiff and Vale University Health Board	149	518269	0.29
Cwm Taf Morgannwg University Health Board	102	446514	0.23
Hywel Dda University Health Board	130	388139	0.33
Powys Teaching Health Board	20	134439	0.15
Swansea Bay University Health Board	134	389640	0.34
Welsh Ambulance Services University NHS Trust	24	-	-
Total	973	3164404	0.28

The report outlines that across NHS Wales the common subject of complaints relates to clinical treatment in hospital. Across NHS Wales 16% of complaints received by the PSOW related to complaint handling during 2024/2025, of which none related to CTM. A breakdown of subjects referred to the PSOW for CTM is provided in the table below:

New Complaints Received by the PSOW for CTM



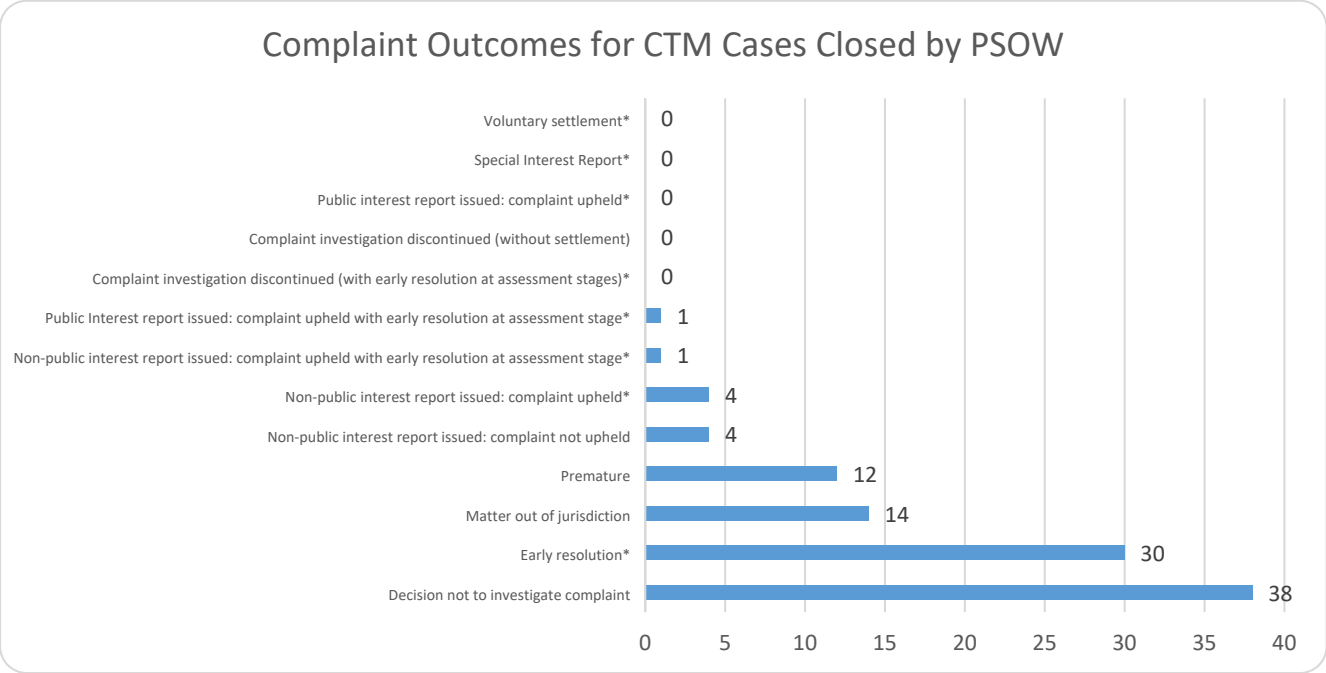
Cases Closed and Interventions by the PSOW

During 2024/2025 the PSOW closed 982 complaints in relation to NHS Wales. Of these 104 were in relation to care and services provided by CTM.

Intervention refers to a complaint outcome when the PSOW decided that something has gone wrong with public services and things must be put right. This could be by making recommendations or agreeing early resolution or settlement of a complaint. The PSOW intervened this year in 27% of the complaints about Health Boards & WAST in Wales that were closed. For CTM, the PSOW intervened in 35% (36) of the cases closed. A comparison on All Wales basis is provided in the table below:

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	50	176	28%
Betsi Cadwaladr University Health Board	64	227	28%
Cardiff and Vale University Health Board	27	154	18%
Cwm Taf Morgannwg University Health Board	36	104	35%
Hywel Dda University Health Board	43	131	33%
Powys Teaching Health Board	6	25	24%
Swansea Bay University Health Board	33	136	24%
Welsh Ambulance Services University NHS Trust	4	29	14%
Total	263	982	27%

Of the complaints closed, the PSOW made a decision to not investigate the complaint in 37% (38) of cases. A breakdown of the outcome of CTM complaint cases closed during 2024/2025 is provided below:



*denotes an intervention by the PSOW

Recommendations & Compliance

Where the PSOW identifies failings or opportunities for learning, recommendations for improvement actions will be made. In 2024/2025 the PSOW made 101 recommendations to CTM. These were either in the form of an early resolution settlement or following the issuing of a final investigation report.

Within 2024/2025 there were 120 recommendations that were due for completion. To ensure their investigations drive improvement, the PSOW monitor compliance with recommendations. The annual report and letter highlight the challenges experienced within the CTM during the year which is reflected in compliance with timescales being achieved in 39% of cases. Previous reports to Committee have outlined the improvement actions undertaken to address this issue. The all Wales comparison is highlighted in the table below.



Health Board	Number of recommendations made on complaints closed in 2024-25	Number of recommendations falling due in 2024-25	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	136	151	60%
Betsi Cadwaladr University Health Board	194	190	55%
Cardiff and Vale University Health Board	72	101	61%
Cwm Taf Morgannwg University Health Board	101	120	39%
Hywel Dda University Health Board	137	135	82%
Powys Teaching Health Board	16	10	20%
Swansea Bay University Health Board	86	87	53%
Welsh Ambulance Services University NHS Trust	18	6	17%

Actions from Annual letter

The PSOW annual letter requests that the Health Board:

- Present the Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Consider the data in the annual letter, alongside the Health Board data, to understand more about Health Board performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.
- Provide the PSOW office with a copy of the Health Board's Annual Report for 2024-25 on the Duty of Candour and Quality.
- Inform the PSOW of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

3. Key Risks / Matters for Escalation

The annual report references a public interest report following the Health Board lack of response to a draft report and recommendations proposed by PSOW. The annual letter further highlights the general difficulties and challenges the Health Board experienced during 2024/2025. Improvement actions have been implemented and significant progress has been made in relation to compliance with PSOW related activity. This is outlined in the Patient Safety and Quality Dashboard on a bi-monthly basis.

An update on progress against the actions outlined in the annual letter will be provided at the next Quality, Safety and Experience Committee meeting.

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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies please list below: Efficient Equitable 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome: Learning from complaints and PSOW cases is essential to inform improvements in quality, safety and experience.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i> <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Report is a national report that applies to everyone



Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	Yes (Include further detail below)
	The PSOW report is within the Public Domain and contains details regarding complaints management within 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

The Committee is asked to **NOTE** of the report.

6. Next Steps

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

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

Ask for: Communications



01656 641150



Caseinfo@ombudsman.wales

Date: 14 August 2025

PERSONAL & CONFIDENTIAL

Jonathan Morgan
Cwm Taf Morgannwg University Health Board

By email only

CTM_BoardMember@wales.nhs.uk
paul.mears@wales.nhs.uk
CTM_PSOW@wales.nhs.uk

Dear Jonathan Morgan

Annual Letter 2024-25

Role of PSOW

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

Purpose of letter

Through this letter, we want to give you an update on our work, share key trends in complaints about local government in Wales and highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Complaints about public services

This letter, as always, coincides with the publication of our Annual Report. Again, we saw an increase in the number of people contacting us about public services. Since 2019-20, the volume of new complaints about public services reaching our office has increased by 44%.

We also closed a record number of complaints about public services – 5% more than last year. This year, we intervened (found that something has gone wrong, and recommended how to put things right) in 18% of complaints that we closed. Positively, this year we resolved many more complaints early on. 87% of our interventions this year involved Early Resolution, compared to 70% in 2023-24.

Page 1 of 10

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

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

We understand that people who come to us want their complaints resolved as quickly as possible and we are committed to dealing with them in a timely manner.

Overall, we assessed incoming complaints, or intervened with an Early Resolution, within an average of 4 weeks; well within our target of 6 weeks. We have also reduced the time it takes us to complete an average investigation, from 64 weeks in 2023-24, to 53 weeks this year.

During 2024-25, we received 949 complaints about health boards. This is an increase of only 1% since last year, and shows that the rate of increase in health board complaints is still slowing down. Still, we are now receiving 26% more complaints about health boards than in 2019-20.

Predictably, most complaints about health boards concern health services. By far, the most common area of these complaints is clinical treatment in hospital. In addition, about 16% of complaints about health boards related to complaint handling. This was a welcome drop from 18% the year before.

We intervened in 27% of health board complaints that we closed – compared to 31% last year.

In 2024-25, we received 102 complaints about Cwm Taf Morgannwg University Health Board and closed 104 – some complaints were carried over from the previous year. Cwm Taf Morgannwg University Health Board's intervention rate was 35%. You can find detailed information on complaints about your organisation that we handled this year can be found in the appendices.

During the first half of 2024-25, we faced general difficulties with your Health Board. These difficulties led to unacceptable delays in the Health Board responding to requests for information which caused us delays in starting investigations and achieving compliance with recommendations made within the agreed timescales.

We published 1 public report in the public interest relating to your Health Board in September 2024. As you will be aware, this case concerned informed consent and post-operative care and we made several recommendations to the Health Board. The Health Board failed to confirm if it accepted the recommendations and, for that reason, the report was issued as a public interest report. I am pleased that compliance with our recommendations is now complete.

We made 101 recommendations to your organisation during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2024-25, 120 recommendations were due. 39% of the recommendations due was complied with in the timescale agreed. Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Supporting improvement of public services

We continued our work on supporting improvement in public services.

During 2024-25, we concluded our second wider own initiative investigation which looked into unpaid carers' needs assessments in Wales. We considered whether 4 local councils – Caerphilly, Ceredigion, Flintshire and Neath Port Talbot - undertook carers' assessments in line with their statutory obligations.

We published the report on this investigation in October 2024. We found that only 2.8% of people in those council areas who identified as carers had received a needs assessment. In addition, only 1.5% had received a proper support plan following their assessment. Many carers were also not aware of their rights with regard to assessments and support services that might be available to them.

We identified some areas of good practice by the councils we investigated. However, we also made several recommendations including to:

- improve recording practices
- improve how information is shared with carers
- offer staff refresher training on carers' rights
- collaborate better with the healthcare sector.

We invited the other local councils in Wales to make similar improvements.

As we did in the case of our first own initiative investigation, we have been actively monitoring how organisations' have been complying with our recommendations.

We are planning to review compliance with the recommendations and any other impacts of the report in October 2025.

Currently 54 organisations across Wales operate our model complaints policy. This includes all local councils, all health boards and now most housing associations - representing about 85% of the complaints which we receive.

Our offer of free complaints handling training has remained popular and we provided a further 52 training sessions to public bodies across Wales during the year. This brings the total to 550 training sessions and 10,000 people, since 2020.

We have continued our work to publish complaints statistics, gathered from public bodies, with data published twice a year. We expect to publish the data on complaints handled by local councils in Wales during 2024-25 in the Autumn. This data allows us to see information with greater context – for example, during 2024-25, 6.13% of complaints made to NHS bodies went on to be referred to us.

Finally, this year we also published 1 thematic report, which included as case studies complaints about health boards:

- 'Equality Matters' (January 2025): a thematic report on inclusion and accessibility across public services.

This report includes general recommendations for public service providers, drawing on lessons learned from our casework.

Action we would like your organisation to take

Further to this letter can I ask that your organisation takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.
- Provide my office with a copy of the Health Board's Annual Report for 2024-25 on the Duty of Candour and Quality.
- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

I would like to thank you, and your officers, for your continued openness and engagement with my office.

Yours sincerely

Michelle Morris

Michelle Morris

Public Services Ombudsman

Cc. Paul Mears, Chief Executive, Cwm Taf Morgannwg University Health Board
Claire Adams, PSOW Liaison Officer, Cwm Taf Morgannwg University Health Board

Information Sheet

Appendix A shows the number of complaints received by PSOW for all health boards in 2024-25. These complaints are contextualised by the population of each authority.

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

Appendix C shows intervention rates for all health boards in 2024-25. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints which PSOW closed for the Health Board in 2024-25. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	178	595412	0.30
Betsi Cadwaladr University Health Board	236	691991	0.34
Cardiff and Vale University Health Board	149	518269	0.29
Cwm Taf Morgannwg University Health Board	102	446514	0.23
Hywel Dda University Health Board	130	388139	0.33
Powys Teaching Health Board	20	134439	0.15
Swansea Bay University Health Board	134	389640	0.34
Welsh Ambulance Services University NHS Trust	24	-	-
Total	973	3164404	0.28

Appendix B – Complaints received (by organisation)

Cwm Taf Morgannwg University Health Board	Complaints Received	% Share
Admissions/discharge and transfer procedures	2	2%
Adult Mental Health	1	1%
Ambulance Services	0	
Appointment procedures (including outpatients)	0	
Care Homes	0	
Child and Adolescent Mental Health	0	
Clinical treatment in hospital	59	58%
Clinical treatment outside hospital; Dentist	0	
Clinical treatment outside hospital; GP	1	1%
Clinical treatment outside hospital; Other	0	
Clinical treatment outside hospital; Physiotherapist	0	
Complaints Handling	0	
Confidentiality	0	
Continuing care	1	1%
De-Registration	0	
Disclosure of personal information / data loss	0	
Funding	0	
Gender Identity Funding	0	
Health	25	25%
Housing	0	
Medical records/standards of record-keeping	1	1%
Medication > Prescription dispensing	1	1%
Non-medical services	0	
Nosocomial (Framework)	0	
Other	3	3%
Out of Hours GP care	0	
Patient list issues	4	4%
Poor/No communication or failure to provide information	0	
Prisoner Care	3	3%
Referral to treatment time	0	
Rudeness/inconsiderate behaviour/staff attitude	1	1%
Various Other	0	
Total	102	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	50	176	28%
Betsi Cadwaladr University Health Board	64	227	28%
Cardiff and Vale University Health Board	27	154	18%
Cwm Taf Morgannwg University Health Board	36	104	35%
Hywel Dda University Health Board	43	131	33%
Powys Teaching Health Board	6	25	24%
Swansea Bay University Health Board	33	136	24%
Welsh Ambulance Services University NHS Trust	4	29	14%
Total	263	982	27%

Appendix D – Complaint outcomes (by organisation) (* denotes intervention)

Cwm Taf Morgannwg University Health Board	Complaint Outcomes	% Share
Complaint investigation discontinued (with early resolution at assessment stages)*	0	
Complaint investigation discontinued (without settlement)	0	
Decision not to investigate complaint	38	37%
Early resolution*	30	29%
Matter out of jurisdiction	14	13%
Non-public interest report issued: complaint not upheld	4	4%
Non-public interest report issued: complaint upheld*	4	4%
Non-public interest report issued: complaint upheld with early resolution at assessment stage*	1	1%
Premature	12	12%
Public interest report issued: complaint upheld*	0	
Public Interest report issued: complaint upheld with early resolution at assessment stage*	1	1%
Special Interest Report*	0	
Voluntary settlement*	0	
Total	104	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2024-25	Number of recommendations falling due in 2024-25	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	136	151	60%
Betsi Cadwaladr University Health Board	194	190	55%
Cardiff and Vale University Health Board	72	101	61%
Cwm Taf Morgannwg University Health Board	101	120	39%
Hywel Dda University Health Board	137	135	82%
Powys Teaching Health Board	16	10	20%
Swansea Bay University Health Board	86	87	53%
Welsh Ambulance Services University NHS Trust	18	6	17%

Gofynnwch am: Cyfathrebu



01656 641150



Caseinfo@ombwdsmon.cymru

Dyddiad: 14 Awst 2025

PERSONOL A CHYFRINACHOL

Jonathan Morgan
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Drwy e-bost yn unig

CTM_BoardMember@wales.nhs.uk
paul.mears@wales.nhs.uk
CTM_PSOW@wales.nhs.uk

Annwyl Jonathan Morgan

Llythyr Blynnyddol 2024-25

Rôl OGCC

Fel y gwyddoch, ein rôl ni fel Ombwdsmon Gwasanaethau Cyhoeddus Cymru yw ystyried cwynion am wasanaethau cyhoeddus, ymchwilio i achosion honedig o dorri'r Cod Ymddygiad ar gyfer Cynghorwyr, gosod safonau ar gyfer ymdrin â chwynion gan gyrrff cyhoeddus a sbarduno gwelliant mewn ymdrin â chwynion a dysgu o gwynion. Rydym hefyd yn cynnal ymchwiliadau i wasanaethau cyhoeddus ar ein liwt ein hunain.

Diben y llythyr

Trwy'r llythyr hwn, rydym am roi diweddariad i chi ar ein gwaith, rhannu tueddiadau allweddol mewn cwynion am lywodraeth leol yng Nghymru a thynnu sylw at unrhyw faterion penodol i'ch sefydliad, ynghyd â chymau yr hoffwn i'ch sefydliad eu cymryd.

Cwynion am wasanaethau cyhoeddus

Mae'r llythyr hwn, fel bob amser, yn cyd-fynd â chyhoeddi ein Hadroddiad Blynnyddol. Unwaith eto, gwelsom gynnydd yn nifer y bobl sy'n cysylltu â ni am wasanaethau cyhoeddus. Ers 2019-20, mae nifer y cwynion newydd am wasanaethau cyhoeddus sy'n cyrraedd ein swyddfa wedi cynyddu 44%.

Tudalen 1 o 11

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Rydym yn hapus i dderbyn ac
ymateb i ohebiaeth yn y Gymraeg.

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

Caewyd y nifer uchaf erioed o gwynion am wasanaethau cyhoeddus – 5% yn fwy na'r llynedd. Eleni, gwnaethom ymyrryd (canfod bod rhywbeth wedi mynd o'i le, ac argymhell sut i gywiro pethau) mewn 18% o'r cwynion a gaewyd. Ar nodyn cadarnhaol, eleni fe wnaethom ddatrys llawer mwy o gwynion yn gynnar. Roedd 87% o'n hymyriadau eleni yn ymwneud â Datrysiad Cynnar, o'i gymharu â 70% yn 2023-24.

Rydym yn deall bod pobl sy'n dod atom eisiau i'w cwynion gael eu datrys cyn gynted â phosibl ac rydym wedi ymrwymo i ddelio â nhw'n brydlon.

Yn gyffredinol, gwnaethom asesu cwynion a ddaeth i law, neu ymyrryd gyda Datrysiad Cynnar, o fewn 4 wythnos ar gyfartaledd; sydd ymhell o fewn ein targed o 6 wythnos. Rydym hefyd wedi lleihau'r amser y mae'n ei gymryd i gwblhau ymchwiliad ar gyfartaledd, o 64 wythnos yn 2023-24, i 53 wythnos eleni.

Yn ystod 2024-25, cawsom 949 o gwynion am fyrddau iechyd. Mae hyn yn gynydd o 1% yn unig ers y llynedd, ac mae'n dangos bod cyfradd y cynnydd mewn cwynion am fyrddau iechyd yn dal i arafu. Fodd bynnag, rydym bellach yn derbyn 26% yn fwy o gwynion am fyrddau iechyd nag yn 2019-20.

Yn ôl y disgwyl, mae'r rhan fwyaf o gwynion am fyrddau iechyd yn ymwneud â gwasanaethau iechyd. Y maes mwyaf cyffredin o'r cwynion hyn, o bell ffordd, yw triniaeth glinigol yn yr ysbyty. Yn ogystal â hyn, roedd tua 16% o'r cwynion am fyrddau iechyd yn ymwneud â delio â chwynion. Roedd hyn yn ostyngiad sydd i'w groesawu o 18% y flwyddyn flaenorol.

Gwnaethom ymyrryd mewn 27% o gwynion am fyrddau iechyd a gaewyd gennym – o'i gymharu â 31% y llynedd.

Derbyniwyd 102 o gwynion am Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg a chaewyd 104 – cafodd rhai cwynion eu cario drosodd o'r flwyddyn flaenorol. Cyfradd ymyrraeth Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg oedd 35%. Gallwch ddod o hyd i wybodaeth fanwl am gwynion am eich sefydliad y rhoddwyd sylw iddynt eleni yn yr atodiadau.

Yn ystod hanner cyntaf 2024-25, fe wnaethom wynebu anawsterau cyffredinol gyda'ch Bwrdd Iechyd. Arweiniodd yr anawsterau hyn at oedi annerbyniol wrth i'r Bwrdd Iechyd ymateb i geisiadau am wybodaeth a achosodd oedi cyn cychwyn ymchwiliadau a chydymffurfio â'r argymhellion a wnaed o fewn yr amserlenni y cytunwyd arnynt.

Cyhoeddwyd 1 adroddiad cyhoeddus er budd y cyhoedd yn ymwneud â'ch Bwrdd Iechyd ym mis Medi 2024. Fel y gwyddoch, roedd yr achos hwn yn ymwneud â chydysniad gwybodus a gofal ôl-lawdriniaeth ac fe wnaethom sawl argymhelliad i'r Bwrdd Iechyd. Methodd y Bwrdd Iechyd â chadarnhau a oedd yn derbyn yr argymhellion ac, am y rheswm hwnnw, cyhoeddwyd yr adroddiad fel adroddiad budd y cyhoedd. Rwy'n falch bod y camau i gydymffurfio â'n hargymhellion bellach wedi'u cwblhau.

Yn 2024-25, gwnaethom 101 o argymhellion i'ch sefydliad. Er mwyn sicrhau bod ein hymchwiliadau a'n hadroddiadau yn hybu gwelliant, gwnawn waith dilynol ar gydymffurfiaeth â'r argymhellion y cytunwyd arnynt gyda'ch sefydliad. Yn 2024-25, roedd angen cydymffurfio â 120 argymhelliad. Cyflawnwyd 39% o argymhellion oedd angen eu cwblhau o fewn yr amserlen y cytunwyd arni. Caiff argymhellion ac amserlenni ar gyfer cydymffurfio ag argymhellion bob amser eu cytuno gyda'r corff cyhoeddus dan sylw cyn eu cwblhau, ac felly rydym yn disgwyl sefydliadau i gydymffurfio o fewn yr amserlenni y cytunwyd arnynt.

Cefnogi'r gwaith o wella gwasanaethau cyhoeddus

Gwnaethom barhau â'n gwaith ar gefnogi gwelliannau mewn gwasanaethau cyhoeddus.

Yn ystod 2024-25, gwnaethom gwblhau ein hail ymchwiliad ehangach ar ein liwt ein hunain a oedd yn edrych ar asesiadau o anghenion gofalwyr yng Nghymru. Edrychwyd ar 4 cyngor lleol – Caerffili, Ceredigion, Sir y Fflint a Chastell-nedd Port Talbot – i weld p'un ai oedden nhw'n cynnal asesiadau gofalwyr yn unol â'u rhwymedigaethau statudol.

Cyhoeddwyd yr adroddiad ar yr ymchwiliad hwn ym mis Hydref 2024. Canfuom mai dim ond 2.8% o bobl yn ardaloedd y cynghorau hynny a nododd eu bod yn ofalwyr oedd wedi derbyn asesiad o anghenion. Yn ogystal â hyn, dim ond 1.5% oedd wedi derbyn cynllun cymorth priodol yn dilyn eu hasesiad. Nid oedd llawer o ofalwyr chwaith yn ymwybodol o'u hawliau mewn perthynas ag asesiadau a gwasanaethau cymorth a allai fod ar gael iddynt.

Nodwyd rhai meysydd o arfer da gan y cynghorau yr ymchwiliwyd iddynt. Fodd bynnag, gwnaethom hefyd sawl argymhelliad gan gynnwys:

- gwella arferion cofnodi
- gwella sut mae gwybodaeth yn cael ei rhannu â gofalwyr
- cynnig hyfforddiant diweddarau i staff ar hawliau gofalwyr
- cydweithio'n well â'r sector gofal iechyd.

Gwahoddwyd y cynghorau lleol eraill yng Nghymru i wneud gwelliannau tebyg.

Fel y gwnaethom yn achos ein hymchwiliad cyntaf ar ein liwt ein hunain, rydym wedi bod yn monitro sut mae sefydliadau wedi bod yn cydymffurfio â'n hargymhellion. Rydym yn bwriadu adolygu cydymffurfiaeth â'r argymhellion ac unrhyw effeithiau eraill yr adroddiad ym mis Hydref 2025.

Ar hyn o bryd mae 54 o sefydliadau ledled Cymru yn gweithredu ein polisi cwynion enghreifftiol. Mae hyn yn cynnwys yr holl gynghorau lleol, pob bwrdd iechyd a bellach y rhan fwyaf o gymdeithasau tai - sy'n cynrychioli tua 85% o'r cwynion a dderbyniwn.

Mae ein cynnig o hyfforddiant am ddim ar ymdrin â chwynion wedi parhau i fod yn boblogaidd a darparwyd 52 o sesiynau hyfforddi pellach i gyrff cyhoeddus ledled Cymru yn ystod y flwyddyn. Mae hyn yn dod â'r cyfanswm i 550 o sesiynau hyfforddi a 10,000 o bobl, ers 2020.

Rydym wedi parhau â'n gwaith i gyhoeddi ystadegau cwynion, a gasglwyd gan gyrff cyhoeddus, gyda data'n cael ei gyhoeddi ddwywaith y flwyddyn. Rydym yn disgwyl cyhoeddi'r data am gwynion sy'n cael sylw gan gynghorau lleol yng Nghymru yn ystod 2024-25 yn yr Hydref. Mae'r data hwn yn caniatáu inni weld gwybodaeth gyda mwy o gyd-destun – er enghraifft, yn ystod 2024-25 aeth 6.13% o'r cwynion a wnaed i gyrff y GIG ymlaen i gael eu cyfeirio atom.

Yn olaf, cyhoeddom hefyd 1 adroddiad thematig eleni, a oedd yn cynnwys astudiaethau achos o gwynion am fyrdau iechyd:

- 'Mae Cydraddoldeb o Bwys' (Ionawr 2025): adroddiad thematig ar gynhwysiant a hygyrchedd ar draws gwasanaethau cyhoeddus.

Mae'r adroddiad hwn yn cynnwys argymhellion cyffredinol ar gyfer darparwyr gwasanaethau cyhoeddus, gan roi ystyriaeth i'r gwersi a ddysgwyd o'n gwaith achos.

Camau yr hoffem i'ch sefydliad eu cymryd

Ymhellach i'r llythyr hwn, a gaf ofyn i'ch sefydliad gymryd y camau canlynol:

- Cyflwyno fy Llythyr Blynnyddol i'r Bwrdd yn ystod y cyfle nesaf sydd ar gael a rhoi gwybod i mi pryd y bydd y cyfarfodydd hyn yn cael eu cynnal.
- Ystyried y data yn y llythyr hwn, ochr yn ochr â'ch data eich hun, i ddeall mwy am eich perfformiad ar gwynion, gan gynnwys unrhyw batrymau neu dueddiadau a chydymffurfiaeth eich sefydliad ag argymhellion a wnaed gan fy swyddfa.
- Rhoi copi o Adroddiad Blynnyddol y Bwrdd Iechyd ar gyfer 2024-25 i'm swyddfa ar y Ddyletswydd Gonestrwydd ac Ansawdd.
- Rhoi gwybod i mi am ganlyniad ystyriaethau a chymau gweithredu arfaethedig y cyngor yng nghyswllt y materion uchod erbyn cyn gynted â phosibl.

Hoffwn ddiolch i chi, a'ch swyddogion, am barhau i fod yn agored, ac am ymgysylltu, gyda fy swyddfa.

Yn gywir

Michelle Morris

Michelle Morris

Ombwdsmon Gwasanaethau Cyhoeddus

Cc. Paul Mears, Prif Weithredwr, Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg
Claire Adams, Swyddog Cyswllt OGCC, Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg

Taflen Wybodaeth

Mae **Atodiad A** yn dangos nifer y cwynion a gafodd OGCC ar gyfer pob bwrdd iechyd yn 2024-25. Caiff y cwynion hyn eu rhoi mewn cyd-destun gan boblogaeth pob awdurdod.

Mae **Atodiad B** yn dangos categori pob cwyn a gafwyd, a pha gyfran o'r cwynion a gafwyd sy'n cynrychioli ar gyfer y Bwrdd Iechyd.

Mae **Atodiad C** yn dangos cyfraddau ymyrru ar gyfer pob bwrdd iechyd yn 2024-25. Mae ymyrraeth yn cael ei gategoreiddio naill ai gan gŵyn a gadarnhawyd (naill ai cadarnhawyd er budd y cyhoedd neu cadarnhawyd nid er budd y cyhoedd), penderfyniad cynnar, neu setliad gwirfoddol.

Mae **Atodiad D** yn dangos canlyniadau'r cwynion a gaeodd OGCC mewn cysylltiad â'r Bwrdd Iechyd yn 2024-25. Mae'r tabl hwn yn dangos y niferoedd, a'r gyfran y mae pob canlyniad yn ei chynrychioli ar gyfer y Bwrdd Iechyd.

Mae **Atodiad E** yn dangos perfformiad o ran cydymffurfriad ar gyfer pob bwrdd iechyd.

Atodiad A – Cwynion a gafwyd (trosolwg)

Bwrdd Iechyd	Cwynion a gafwyd	Poblogaeth	Cafwyd fesul 1,000 o drigolion
Bwrdd Iechyd Prifysgol Aneurin Bevan	178	595412	0.30
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	236	691991	0.34
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	149	518269	0.29
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	102	446514	0.23
Bwrdd Iechyd Prifysgol Hywel Dda	130	388139	0.33
Bwrdd Iechyd Addysgu Powys	20	134439	0.15
Bwrdd Iechyd Prifysgol Bae Abertawe	134	389640	0.34
Cyfanswm	949	3164404	0.28

Atodiad B – Cwynion a gafwyd (yn ôl sefydliad)

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	Cwynion a Gafwyd	% rhannu
Gweithdrefnau derbyn/rhyddhau a throsglwyddo	2	2%
Iechyd Meddwl Oedolion	1	1%
Gwasanaethau Ambiwylans	0	
Gweithdrefnau apwyntiad (gan gynnwys cleifion allanol)	0	
Cartrefi Gofal	0	
Iechyd Meddwl Plant a Phobl Ifanc	0	
Triniaeth glinigol mewn ysbyty	59	58%
Triniaeth glinigol y tu allan i ysbyty; Deintydd	0	
Triniaeth glinigol y tu allan i ysbyty; Meddyg Teulu	1	1%
Triniaeth glinigol y tu allan i ysbyty; Eraill	0	
Triniaeth glinigol y tu allan i ysbyty; Ffisiotherapydd	0	
Ymdrin â chwynion	0	
Cyfrinachedd	0	
Gofal Parhaus	1	1%
Dadgofrestriad	0	
Datgelu gwybodaeth bersonol / colli data	0	
Ariannu	0	
Cyllid Hunaniaeth Rhywedd	0	
Iechyd	25	25%
Tai	0	
Cofnodion Meddygol/Safonau cadw cofnodion	1	1%
Meddyginiaeth > Dosbarthu presgripsiynau	1	1%
Gwasanaethau anfeddygol	0	
Dim tystiolaeth o galedi neu anghyfiawnder	0	
Eraill	3	3%
Gofal Meddyg Teulu y Tu Allan i Orlau	0	
Materion rhestr glaf	4	4%
Cyfathrebu gwael/ Dim cyfathrebu neu fethiant i ddarparu gwybodaeth	0	
Gofal Carcharorion	3	3%
Amser rhwng atgyfeirio a thriniaeth	0	
Anfoesgarwch/ ymddygiad anystyriol/ agwedd staff	1	1%
Eraill Amrywiol	0	
Cyfanswm	102	

Atodiad C – Achosion lle ymyrrodd OGCC (trosolwg)

Bwrdd Iechyd	Nifer yr ymyriadau	Nifer y cwynion a gaewyd	% yr ymyriadau
Bwrdd Iechyd Prifysgol Aneurin Bevan	50	176	28%
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	64	227	28%
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	27	154	18%
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	36	104	35%
Bwrdd Iechyd Prifysgol Hywel Dda	43	131	33%
Bwrdd Iechyd Addysgu Powys	6	25	24%
Bwrdd Iechyd Prifysgol Bae Abertawe	33	136	24%
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	4	29	14%
Cyfanswm	263	982	27%

Atodiad D – Achosion lle ymyrrodd OGCC (yn ôl sefydliad) (* yn dynodi ymyrraeth)

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	Canlyniada u Cwynion	% rhannu
Rhoddwyd gorau i'r ymchwiliad i'r gŵyn (gyda datrysiad cynnar yn ystod y camau asesu)*	0	
Rhoddwyd y gorau i ymchwilio'r gŵyn (heb setliad)	0	
Penderfynu peidio ymchwilio cwyn	38	37%
Datrys yn gynnar*	30	29%
Mater tu hwnt i awdurdodaeth	14	13%
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn heb ei chadarnhau	4	4%
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn wedi'i chadarnhau*	4	4%
Adroddiad nad yw er budd y cyhoedd wedi'i gyhoeddi: cwyn wedi'i chadarnhau a'i datrys yn gynnar yn y cam asesu*	1	1%
Cynamserol	12	12%
Adroddiad Budd y Cyhoedd wedi'i gyhoeddi: y gŵyn wedi ei chadarnhau*	0	
Adroddiad Budd y Cyhoedd wedi'i gyhoeddi: cwyn wedi'i chadarnhau gyda datrysiad cynnar yn ystod y cam asesu*	1	1%
Adroddiad Budd Arbennig	0	
Setliadau gwirfoddol*	0	
Cyfanswm	104	

Atodiad E – Cymhariaeth o berfformiad cydymffurfio

Bwrdd Iechyd	Nifer yr amgymhellion a wnaed ar gwynion y caewyd yn 2024-25	Nifer yr amgymhellion sy'n ddyledus yn 2024-25	% yr argymhellion, y cydymffurfiwyd â dyddiad targed cytûn
Bwrdd Iechyd Prifysgol Aneurin Bevan	136	151	60%
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	194	190	55%
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	72	101	61%
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	101	120	39%
Bwrdd Iechyd Prifysgol Hywel Dda	137	135	82%
Bwrdd Iechyd Addysgu Powys	16	10	20%
Bwrdd Iechyd Prifysgol Bae Abertawe	86	87	53%
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	18	6	17%

Agenda Item	8.1.1
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Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 22 July 2025 9:00am-12:00pm
Venue	The Hub, Royal Glamorgan Hospital, Llantrisant (Microsoft Teams link also created for attendees unable to attend in person)

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Hayley Proctor	Independent Member
	Patsy Roseblade	Independent Member
	Kath Palmer	Vice Chair/Independent Member
In Attendance	Greg Dix	Executive Director of Nursing/Deputy CEO
	Sallie Davies	Deputy Medical Director
	Suzanne Hardacre	Director of Midwifery
	Sarah Follows	Unscheduled Care Group Service Director
	Owen Weeks	Unscheduled Care Group Medical Director
	Hannah Wilton	Director of Pharmacy & Medicines Management
	Philip Daniels	Executive Director of Public Health
	Sarah James	Deputy Chief Operating Officer
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Lloyd Griffiths	Head of Nursing, Mental Health & Learning Disabilities
	Lauren Edwards	Executive Director of Allied Health Professionals & Healthcare Sciences (Virtually)
	Rhian Beynon	Research & Development Manager
	Gaynor Jones	Staff Side Representative (Virtually - In part)
	Lucie Owen	Primary Care & Community Care Group Nurse Director (Virtually)
	Richard Hughes	Deputy Director of Nursing (Virtually)
	Sharon O'Brien	Planned Care, Care Group Nurse Director (Virtually)

	Hannah Jones	Audit Wales (Virtually - Observing)
	Chris Beadle	Assistant Director of Health, Safety & Fire (Virtually)
	Daniel Price	Regional Director, Llais (Virtually)

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions C. Donoghue welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its hybrid form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	Apologies for Absence Apologies were received from: - Ana Llewellyn, Nurse Director Mental Health and Learning Disabilities - Dom Hurford, Executive Medical Director - Gethin Hughes, Chief Operating Officer - Mohamed Elnasharty, Consultant Obstetrics Gynaecology and Sexual Health; - Cally Hamblyn, Assistant Director of Governance & Risk
1.3	Declarations of Interest There were no interests declared
2.	CONSENT AGENDA BUSINESS
2.1	C. Donoghue reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 8) that the Committee Members wished to bring forward to the main agenda for discussion. Following a request made by H Proctor, C Donoghue agreed to defer the Internal Audit Review on the Duty of Candour to the next meeting and agreed for this to be placed on the main agenda for discussion, given that the Health Board did not seem to be performing well in this area at present.
Action:	Internal Audit Review on the Duty of Candour to be deferred to the September meeting and placed on the main agenda for discussion.
3.	COMMITTEE GOVERNANCE ARRANGEMENTS
3.1	Action Log The action log was received and noted. C Donoghue requested that an update was provided against action 5.2d (Consideration to be given to the most

	appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes) for the next meeting as action status remained in progress.
Action:	Update to be provided against action 5.2d (Consideration to be given to the most appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes) for the next meeting.
3.2	Matters Arising Not Captured on the Action Log
	There were no matters arising.
4.	STAFF AND SERVICE USER EXPERIENCE
4.1	Shared Listening & Learning Story - Unpaid Carers
	D. Watkins & C. Read shared the presentation which provided a reflection on C Read's experiences of being an unpaid carer whilst navigating healthcare services. The presentation also highlighted the work undertaken by the Health Board as a result of listening to Carers feedback. C Donoghue extended her thanks to D Watkins and C Read for sharing the presentation which contained a number of areas which the Health Board would need to reflect on in regard to making things easier for carers and patients. K Palmer welcomed the presentation and story which she found to be powerful and recognised the presentation highlighted the positive steps being taken within secondary care and hospital settings to improve processes for Carers and queried whether this was being replicated in community and primary care settings. D Watkins advised that he had provided training to Band 6 and 7 nursing staff within the community to enable staff to identify carers at home and raise awareness with them that they can notify their GP that they are a carer. Members noted that an issue had been raised with Welsh Government that the Carers Register was no longer available which had made things difficult in regard to identification of carers within the Community. P Roseblade made reference to caring for adults, with carers for adults not always being included in medical conversations, particularly elderly adults being cared for, who don't necessarily want the clinician to know the full extent of the difficulties they are having. P Roseblade sought clarity as to how the carers ensure that they can get this information across given that they were the people that were seeing those difficulties, given that the adult they were caring for did not want to share the information. D Watkins advised that part of his role included involving carers in the hospital discharge process and advised that hopefully, in addition to the Carer's passport, this would allow time for staff and carers to build up a relationship which should make them more comfortable in sharing information. Members noted that a lot of carers do not see themselves as carers and just see themselves undertaking family duties. L Edwards introduced herself and her role and explained that the staff involved in the care outlined in the story fell under her remit and added that the information shared was helpful. L Edwards welcomed the work being undertaken in supporting carers and ensuring their voices were being heard and expressed the need to ensure the Carer voice was being linked into services within the Health Board, which she would be happy to discuss further with D Watkins.

	G Dix extended his thanks to D Watkins and C Read for sharing the presentation and advised he was also present at the Regional Partnerships Board meeting when this item was presented. G Dix added that it was important that both patient and carers voices were heard at this Quality, Safety & Experience Committee and advised that one of the challenges for the Health Board was in relation to team resource, with D Watkins being the only member within the team at present supporting 14,000 staff. G Dix advised that consideration needed to be given as to how all these pieces of work could be integrated within all services, wards and departments, which was challenging at present given the limited resource. C Donoghue advised that she felt this was an area that needed to be revisited given that the Committee had been made aware that there were issues that needed to be addressed. C Donoghue extended her thanks to D Watkins and C Read for sharing the powerful story.
Resolution:	The Committee NOTED the presentation.
Action:	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed.
5.	SETTING THE SCENE – SERVICE DELIVERY
5.1	Report from the Clinical Executives
	Clinical Executive colleagues presented the report and highlighted the key matters for Members attention. P Roseblade made reference to page 5 and the reference made to the Unscheduled Care Nurse Director vacancy and advised that no update had been included against this vacancy. G Dix advised that interviews were being held for this post on the 1 August 2025. P Roseblade referred to the paragraph on page 5 which stated that several closure bundles were prepared for executive review but did not state what these closure bundles related to. G Dix advised that when there had been an investigation undertaken into falls, pressure ulcers and medication errors, reports were received and considered at scrutiny meetings, actions were identified and then the whole incident was closed as a closure bundle and subsequently reported to this Committee and Welsh Government. C Donoghue added that whilst the report states that there had been an increase in pressure ulcer incidents, no information had been included as to the causes behind this increase and the lessons that had been learnt as a result. C Donoghue advised that it would be helpful if more detail could be provided on this in future reports. P Roseblade referred to page 7 and the update provided in relation to the Discharge and Return Policy, which she found to be unclear and added there appeared to be a whole sentence missing at the start of the paragraph. S Davies advised that a Regulation 28 was served following an inquest where a patient had been discharged from the Emergency Department without having a surgical review from the surgeon who undertook their previous surgery. Members noted that the incident occurred several years ago and policies and procedures had been strengthened and now state that surgical reviews must be undertaken at



	Emergency Departments if patients re-present by the Surgical Team who undertook the original surgical procedure. P Roseblade referred to page 12 which stated that there was a non-agreement between Primary and Secondary Care in relation to preconception care and diabetes in pregnancy and queried what the consequence of this non agreement would be. P Daniels advised that there were inconsistencies in place in regard to where people were being tested and advised that he would circulate additional information on this matter to Members outside the meeting. H Proctor welcomed the update provided in the report in relation to the work being undertaken to establish a unified policy on staff uniforms during periods of adverse weather. H Proctor also referred to the update within the report in relation to gender services, which was an issue being experienced within every department and discipline given the complexity of the cases presenting and queried how this was being addressed. S Davies advised that the Health Board had made a request to be able to perform these surgeries but had encountered issues in getting agreement given that the service was commissioned by NHS England. H Proctor made reference to Public Health and the variances across the Health Board in regard to Service Level Agreements and queried whether there was a plan to review all Service Level Agreements that were currently in place. P Daniels confirmed that reviewing service level agreements was an area of focus within the Diabetes Programme Board. C Donoghue extended her thanks to the Clinical Executive Directors for the presentation of the report.
Resolution:	The Committee NOTED the report.
Actions:	Future reports to include more detail on the causes behind the increase in pressure ulcer incidents and the lessons that had been learnt Information to be shared with Members outside the meeting in relation to the consequences of the non-agreement between Primary and Secondary Care in relation to preconception care and diabetes in pregnancy
5.2	Care Group Highlight Reports
	C. Donoghue invited the Care Group Leads to present their respective reports, requesting them to focus on the areas highlighted in the alert/escalate section.
5.2.1	Children & Families Care Group
	S. Hardacre presented the report and highlighted the matters included in the alert/escalation section. P Roseblade made reference to the recent reports via the media in relation to Swansea Bay UHB and queried how this would affect Cwm Taf Morgannwg UHB, particularly as Welsh Government had now announced they were undertaking a full review of Maternity Services in Wales. P Roseblade added that she assumed that all the learning from the events that occurred prior to Bridgend joining the Health Board had been rolled out into the Princess of Wales Hospital. S Hardacre

advised that Welsh Government were seeking assurances that services across Wales were safe at this moment in time and had articulated that there will be clear Terms of Reference developed for this review and a Chair appointed to oversee this review. Members noted that a lot of the work being undertaken by Welsh Government would be in the form of desk top reviews of performance metrics, with a review also being undertaken in regard to culture, leadership and development.

S Hardacre advised that in response to the query raised by P Roseblade regarding the former Cwm Taf and reviewing Bridgend, a piece of work was undertaken 18 months ago to benchmark against the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) recommendations to ensure a gap analysis was in place. Members noted that the Team felt assured that the service was where it needed to be and noted that the Team were now going to undertake a further workforce review to ensure the workforce in place was fit for the future, given some of the changes being seen within Maternity Services, for example, the increase being seen in C-Sections and the associated rise in risk of infections. S Hardacre added that the service had good governance processes in place which had been commended nationally, particularly in relation to the Perinatal engagement framework.

G Jones made reference to the issues being experienced with staffing levels on the Special Care Baby Unit at Princess of Wales Hospital and sought clarity as to the current position in relation to recruitment of staff. S Hardacre confirmed that active recruitment was being undertaken and added that there may be opportunities for staff members to be moved into the unit via the lateral moves scheme. Members noted that the significant amount of activity being seen on both units, Prince Charles Hospital (PCH) and Princess of Wales Hospital (POW), was having a short-term impact, in addition to short- and long-term sickness absence which was being managed by the Team. In response to a further query raised by G Jones, S Hardacre confirmed that consideration was given to recruiting via streamlining and this was deemed to be not appropriate for the type of roles that needed to be covered.

In response to a query raised by K Palmer as to the timescales for putting a solution in place for Special School Nursing given that the issues appeared to be escalating, S Hardacre commended the work being undertaken by the Senior Nurse and Heads of Nursing within Special Schools to try and keep everyone safe and advised that there were issues in regard to the way in which the special school nurses were funded by the schools which meant that staff were being governed by schools and being deployed in a way in which schools see fit. Members noted that there were challenges around recruitment given that opportunities for development were limited within special schools. S Hardacre advised that ongoing discussions were being held with Llais following concerns they raised regarding the service. Executive Team discussions were also being held in relation to sustainability of the current model and policy discussions were also being held Welsh Government on the concerns being expressed regarding this service. C Donoghue advised that she would welcome an update on this matter in the Care Group Highlight report at the September meeting.



	C Donoghue advised that in relation to Maternity Services, it was evident that whilst a significant amount of work had been undertaken in this service over the last few years in relation to culture and training, there appeared to be more work to do in this area in regard to improving culture and encouraging staff to speak out, which was concerning. S Hardacre advised that she had discussed the pressure point areas with G Dix and added that she felt that whilst improvements were being seen in quality and safety on the Princess of Wales Hospital site, further work needed to be undertaken on understanding the issues being experienced within Maternity Services at Prince Charles Hospital.
Resolution:	The Committee NOTED the highlights outlined in section 3 of this report.
Action:	Update to be included in September iteration of the report on the work being undertaken to address Special School Nursing issues
5.2.2	Unscheduled Care - Care Group
	O. Weeks presented the report and highlighted the matters contained within the alert/escalate section. K Palmer welcomed the significant improvement highlighted within the report in relation to Ambulance Handover performance. S Follows advised that one of the key elements for the Committee to note was that patient care was not being compromised as a result of achieving this performance, with the Team being commended by the Marek Team for not providing corridor care within the Emergency Departments. P Roseblade also commended the Team on the Ambulance Handover performance achievement. P Roseblade made reference to the internal unannounced ward assurance visits and queried how frequently these were being undertaken. R Hughes advised that the visits, which were separate from the planned accreditation visits, would be triggered through a number of mechanisms, with some visits being requested by the site operational teams and some visits being requested by the Care Group Leadership Teams. An assurance visit could also be requested following a review of various key quality indicators at the weekly Executive Led Patient Safety meetings. G Dix added that there would be a number of audits that would occur monthly as standard, for example, Infection Prevention & Control, Environmental and Cleaning, with any triggers or red flags being identified through governance processes resulting in an initial unannounced visit being enacted. S Follows advised that the Senior Leadership Team within Unscheduled Care had also recently introduced unannounced visits to areas within the Unscheduled Care service. S O'Brien added that Nurse Directors had a mechanism in place for asking the Team to undertake a more formal ward assurance visit to review any areas of concern. C Donoghue advised that she found it assuring and encouraging to hear how these visits were being triggered.
Resolution:	The Committee NOTED the report.
5.2.3.	Planned Care - Care Group
	S. O'Brien presented the report and highlighted the matters contained within the alert/escalate section.



	P Roseblade made reference to the moves being undertaken within Trauma & Orthopaedic Services and sought clarity as to whether consolidating trauma surgery onto the one site would create any issues and queried the statement made within the report that consultation had commenced, despite the outcome already being decided. S O'Brien confirmed that the consultation process referred to within the report was with staff via the Organisational Change Process and added that this consultation had already commenced with Trauma staff who had to transfer to the Royal Glamorgan Hospital site following the commencement of roof repairs at the Princess of Wales Hospital and the elective orthopaedic staff normally based at Royal Glamorgan Hospital. Members noted the consultation with nursing staff went well with all staff achieving the outcome they requested. C Donoghue referred to the update provided within the inform section of the report in relation to developments in Gastroenterology and General Surgery, and added that it would be good for the Committee to be provided with the impact of this and queried where the expected outcomes would be seen, for example, reduction in waiting lists, patients having to spend less time in hospital. C Donoghue advised that she would welcome an update from G Hughes on this.
Resolution:	The Committee NOTED the report.
Action:	Update to be provided by G Hughes on what the impacts and expected outcomes were likely to be in relation to the developments within Gastroenterology and General Surgery, for example, reduction in waiting lists, patients having to spend less time in hospital.
5.2.4	Mental Health & Learning Disabilities Care Group
	L. Griffiths presented the report and highlighted the key matters for members attention. K Palmer welcomed the update provided in relation to the completion of the implementation of E-Whiteboards within Mental Health Services which would hopefully help to improve services and would help with contingency planning and bed pressures. C Donoghue made reference to the external commissioning of PMVA Module D training which she felt was a positive step forward. C Donoghue referred to the update contained within the report on ligature risks identified at Royal Glamorgan and queried whether this ligature risk was new or previously missed, given that previous assurance had been provided that anti-ligature work was complete. L Griffiths provided clarity that this was an emerging risk that had been identified in an external environment by a new senior nurse with experience from NHS England and added that all other wards had routine annual anti-ligature checks completed. Members noted that the current issue was isolated to one area.



	K Palmer made reference to an action that remained open on the action log in relation to assurances being provided in relation to Learning Disability Services and advised that she would welcome an update on this at a future meeting.
Resolution:	The committee NOTED the report.
Action:	Update to be presented to a future meeting on assurances being provided in relation to Learning Disability Services.
5.2.5	Diagnostics, Therapies, Pharmacy & Specialities
	H. Wilton presented the report and highlighted the matters contained within the alert/escalate section. H Proctor made reference to the update provided within the report in relation to LIMS (Laboratory Information System) and sought clarity as to whether a plan was in place to address the delays being experienced. In response, H Wilton advised that the Director of Digital and the Chief Executive had written to Digital Healthcare Wales advising of the criticality of this project and the need for this to be escalated in terms of priority. C Donoghue advised that LIMS was an area that had been discussed frequently at the former Digital & Data Committee and at Strategic Development Committee and added that she was concerned that whilst the risks were well known, the delays being experienced would result in the risks coming to fruition as opposed to them being mitigated. L Edwards advised that the concerns that had been raised by this Health Board were concerns shared by other Health Board's and was an issue that was high on the agenda for Cwm Taf Morgannwg. Members noted that the matter was also being discussed at the Operational Delivery Committee. C Donoghue noted the issues highlighted within the report in relation to the Orthotics contract and the delays experienced in the tender process which had resulted in the new provider not being able to provide a clinician until 4 August 2025, which she found to be disappointing given this would have a negative impact on patients.
Resolution:	The committee NOTED the report.
5.2.6	Primary Care & Communities Care Group
	L. Owen presented the report and highlighted the matters contained within the alert/escalate section. Members noted that the issue highlighted in the report in relation to reduced Medical Cover at Ysbyty Cwm Cynon had now been resolved as a result of mitigations that had been put into place. K Palmer expressed her disappointment at the position regarding the Paediatric General Anaesthetic Lists given that the Dental Team were still waiting to hear from Planned Care colleagues regarding list availability, and added that she did not feel assured on this matter at present and sought clarity as to how this matter was going to be resolved given the significant number of children that were waiting for treatment and would likely need to be reassessed. C Donoghue advised that given that the Committee received a detailed update on this matter at the last meeting, and that this was largely dependent on Theatre List



availability in order for the Care Group to address the position, she suggested that the Chief Operating Officer is asked to provide an update to the Committee on this matter. S James advised that she would be happy to obtain an update from G Hughes on this and added that this was partly dependent on the return of services to Princess of Wales Hospital, which was on track for completion in September 2025. K Palmer also advised that Members would find it helpful if they could be advised of the future plan as to how this position could be addressed over the next two to three years. L Owen confirmed that the children waiting on the list would likely needed reassessment which could lead to more complex surgery being required.

K Palmer made reference to the care home fee issues identified within the report and sought clarity as to whether there were risks that this would likely be an issue for other care homes within Cwm Taf Morgannwg which she felt the Health Board needed greater understanding of. L Owen advised that the update included in the report specifically related to Continuing Health Care fees as opposed to the general nursing aspect, and added that the Health Board had also been contacted by a second Care Home in relation to the Continuing Healthcare fee the Health Board were paying. Members noted that the Care Group Service Directors would now be meeting with finance colleagues to discuss CHC fees further given that it appeared the Health Board appeared to be an outlier in this area compared to the rest of Wales.

K Palmer made reference to the Wound Clinic Service and the Wound Clinic Bus which she had been informed about during one of her visits within the Health Board, which she felt was a fantastic service given that it took the service into community areas, and particularly supported vulnerable people. K Palmer sought clarity as to whether the Care Group were looking to take more services into the community. L Owen advised that in addition to the Wound Clinic Bus, the Wound Clinic delivered services across six different sites in addition to patient homes. Members noted that the Care Group were currently reviewing the amalgamation of the Wound Clinic, Lymphoedema and Tissue Viability services to create a One Stop Shop clinic for patients, which was a long-term plan for the Care Group.

K Palmer advised that she was pleased to see the increase to 46% in relation to the Diabetes 8 Care Processes and advised that whilst the increase was fantastic, she assumed the service was aiming for further improvement in this area. L Owen advised that the Care Group were working closely with GP Practices to achieve further improvement in this area.

G Dix made reference to the Community Nursing specification, which included a target of 80% of the service to be delivered over the weekend. Members noted that this had caused some concern from a workforce perspective amongst existing staff and noted that there were now around eight or nine vacancies within the Community Nursing service, which was a position the service had not previously experienced. G Dix advised that as yet an impact had not been seen, a decrease in admissions had not been seen, or a decrease in length of stay because of this particular service specification, hence a discussion taking place with Welsh Government in regards to impact. G Dix advised that he remained concerned that the Health Board would lose significant experienced District

	Nursing staff given that they do not want to work weekends. L Owen advised that the deliverables that were put into place by Welsh Government do not have measurable outcomes which has been fed back to Welsh Government. P Roseblade welcomed the report which she found to be succinct and advised that there were two matters discussed today which would now require reporting against and would therefore receive focus, Paediatric General Anaesthetic lists and Diabetes. P Roseblade advised that she understood the pressures the services were under, and added that whilst nothing has changed for the children waiting for treatment on the General Anaesthetic lists, now that performance against this would be reported, the Health Board now thinks that the position will change for them. P Roseblade made reference to the incidents that occurred at Parc Prison and queried the nature of these incidents. L Owen advised that the themes and trends being monitored related to Medication Administration Errors which occur for a number of reasons, including supply errors. Members noted that the Team are reviewing the position and provided assurance that the numbers of incidents were low at present. H Wilton advised that an improvement in one area, specifically the increase in the diabetes 8 care processes to 46%, could lead to a perceived deterioration in another area, such as the prescribing cost budget. H Wilton clarified that this is not actually a negative outcome, but rather a result of positive progress in diabetes care, and advised colleagues not to be surprised if improvements in one metric affect related metrics elsewhere
Resolution:	The committee NOTED the report.
Action:	Chief Operating Officer to provide an update on the plans in place to address the Paediatric General Anaesthetic Waiting list position given that this was largely dependent on Theatre List availability
5.3	Stroke Services Progress Report
	S Follows presented the report and highlighted the key matters for Members included. Members noted the report also captured an update against the actions captured at the May 2025 meeting. C Donoghue extended her thanks to S Follows for presenting the comprehensive update and sought clarity as to what mechanism would be used to decide what the long-term solution was going to be for Stroke Services. S Follows advised that the communication cascaded to staff is that the temporary move was for a period of 12 months, with the Care Group focussing on stabilisation of the service and foundation building at the current site. Members noted that a stroke service redesign piece of work was also being undertaken to determine the optimal clinical pathway, workforce requirements, and structure for hyper-acute, acute, and rehabilitation phases and noted that it was hoped that as a result of this piece of work improvements would be seen in quality indicators and outcomes for stroke patients. S Follows added that in relation to the longer-term plan, despite some improvements in medical workforce, there was not yet a robust consultant workforce in place to safely run the service across two sites, including on-call

	rotas and clinics. Members noted that the long-term plan would form part of the integrated clinical services plan and would align with regional work, but for now, the arrangement remains short-term due to workforce constraints. G Jones sought confirmation as to how the service could guarantee that patients would be placed in a bed within a four-hour window, particularly those patients who self-present at Princess of Wales and Prince Charles Hospitals and then require ambulance transfer to Royal Glamorgan Hospital. S Follows advised that for patients presenting directly to RGH (by self-presentation or ambulance), the 4-hour target can be achieved due to improved patient flow and bed availability, however, she advised that achieving this for patients at the Princess of Wales and Princes Charles hospitals required further work, particularly as this was dependent on ambulance transfer. Members noted the need for significant engagement and communication with members of the public to ensure patients attend the right hospital for Stroke care. L Edwards highlighted that the regional model for stroke services was key for future planning and explained that Cwm Taf Morgannwg did want to make a service change and then have to change the model again if the regional model differed. L Edwards advised that the Health Board was pushing to regain pace in relation to the regional work and added that a regional meeting was scheduled for mid-August and emphasised the need to accelerate discussions to determine future service options based on regional decisions. K Palmer welcomed the report and the detailed update that had been provided and added that she hoped that focus on this matter would continue in the short term. P Roseblade made reference to Early Supported Discharge for stroke patients and sought clarity as to whether this was dependent on the availability of reablement or community nursing teams to provide ongoing care at home and also queried whether there was a measure of readmission for those discharged early. L Edwards advised that the Early Supported Discharge teams have specific criteria for patient eligibility and added that there had been no capacity issues from the data she had seen, with eligible patients having their needs met. L Owen confirmed that that the Early Supported Discharge Teams could pick up patients ready for discharge within 24-28 hours, with no delays being reported. H Proctor raised concerns that only 46.6% of the recommended Allied Health Professional (AHP) staffing is available to deliver a 5-day rehab service for stroke patients, yet there was still a push for a 7-day service and questioned how the team could provide the required 3 hours of therapy per day for the number of patients with less than half the recommended workforce. H Proctor noted that the action plan in the report focused on medical, nursing, and pharmacy, but lacked an AHP or therapist action plan. H Proctor also emphasized the need to include rehab goals and outcomes in future reports. S Follows advised that she would be happy to capture this in future Stroke Services Progress reports.
Resolution:	The report was NOTED .
Action:	Future reports to include focus on AHP and Therapies workforce availability to

	deliver a 7-day service, along with rehab goals and outcomes.
6.	DELIVERING OUR PLAN
6.1	Patient Safety, Quality & Experience Dashboard
	K. Jenkins-Forrester presented the report and highlighted the key matters for Members attention. P Roseblade made reference to the patient safety incidents and nationally reportable incidents and advised that at paragraph 2.2 within the report it stated that a total 4272 incidents were reported during the reporting period, the figure contained within the bar graph later in the report differed from the 4272 figure. K Jenkins-Forrester agreed to review this and added that she would provide a response by email outside the meeting. K Palmer referred to the data included within the report in relation to the increase in Absconding Incidents and queried whether this was an issue that Committee Members needed to be concerned about. K Jenkins-Forrester advised that peaks and troughs tended to be seen in regard to patient absconsions and would typically be dependent on the cohort of patients on the wards at a point in time, which made it difficult to identify themes and trends. L Griffiths advised that from a Mental Health & Learning Disability Care Group perspective whilst there were no issues that required escalating at this point, he would be happy to undertake a further review of the position and include an update in the highlight report for the September 2025 meeting. L Edwards stated that a zero number of absconsions was not necessarily desirable because positive risk-taking and supporting people to access the community (which may result in late returns from leave) were important. L Edwards assured that the care group investigates absconsions, follows escalation processes, and added that there were no common themes or concerns emerging from these incidents. K Palmer raised a query on the vacancy within the Patient Advice Liaison Service (PALS) and queried whether this was something that the Committee should be concerned about. R Hughes advised that there was no need for concern at this stage and added that temporary support was being provided to the Patient Care & Safety Team in relation to early resolutions. Members noted that the Team were currently prioritising where resource was required and noted that there were still five other PALS officers in place providing cover. R Hughes advised he would continue to keep the situation under close scrutiny.
Resolution:	The committee NOTED the content of the report
Actions:	Response to be provided outside the meeting regarding inconsistencies reported in figure contained in paragraph 2.2 regarding number of incidents reported compared to bar chart graph contained later in the report Review to be undertaken of any themes and trends that needed to be highlighted to the Committee in relation to patient absconsions. Update to be included in Care Group Highlight report for the September 2025 meeting.
6.1.1	Committee Referral - Details of the medical negligence claims from the losses and special payments report - Verbal Update



	K. Jenkins-Forrester presented a verbal update and advised that while the number of clinical negligence claims received had not increased year on year, the number of claims settled, and the associated damages and costs had increased over the past 12–18 months. K Jenkins Forrester added that she is working with finance colleagues to break down and triangulate this information and plans to bring a more detailed report to the next committee meeting. P Roseblade advised that she was content with the proposed approach and added that as Chair of the Audit, Risk & Assurance Committee, she would be happy to wait for the detailed report to be presented to the September 2025 Quality, Safety & Experience Committee before this referral was closed down at Audit, Risk & Assurance Committee.
Resolution:	The Committee NOTED the report
Action:	Detailed written update to be presented to the September 2025 meeting of the Quality, Safety & Experience Committee
6.2	Overview of the Development & Delivery of the Research & Development Strategy
	R. Beynon presented the report and highlighted the key matters for Members attention. C Donoghue recognised that a significant amount of work had been undertaken in developing this Strategy and had received a significant amount of discussion and input and noted that the monitoring of the Strategy would be undertaken at the Research & Development Delivery Group. G Dix advised that a Strategy on a page had been developed, and Members agreed it would be helpful if this could be shared with them outside the meeting.
Resolution:	The Committee ENDORSED for Board approval the CTMUHB R&D Strategy 2025-30.
Action:	Strategy on a page to be shared with Committee members following the meeting.
6.3	Annual Duty of Quality Report
	R. Hughes presented the report and advised that the final version of the report would be presented to the September Board for approval. C Donoghue commented that whilst the Annual Duty of Quality report was longer than last year, she had found it more accessible and readable due to its format, with quick sections rather than large blocks of text. C Donoghue also expressed willingness to write a foreword for the report and advised that she had been asked to share the report with her Quality & Safety Committee Chair counterparts in other Health Board's.
Resolution:	The Annual Duty of Quality Report was ENDORSED for Board APPROVAL
6.4	People Experience Forum Update
	R. Hughes presented the report and highlighted key matters for members attention. In response to a query raised by H Proctor as to the purpose, remit and membership of the Forum, R Hughes explained that the People Experience



	Forum meets quarterly and includes representatives from Llais, Care Groups, the Corporate Team, Value-Based Healthcare, and quality improvement professionals and added that consideration was also being given to adding a community member to the group. Members noted that an Operational Group was also in place which meets monthly to discuss and work on actions identified from the Forum, with the forum aiming to enhance and support care groups in the field of patient experience. P Roseblade questioned whether underfunding, as mentioned in the report at discussion point B, was a fact or just a perception and emphasized that while everyone wants more money in the health service, it's also important to use existing funds efficiently and effectively. P Roseblade expressed concern that the report presented underfunding as fact and asked whether advocacy for increased funding was directed at the Health Board or Welsh Government, stating the discussion did not seem quite right. R Hughes acknowledged feedback from P Roseblade and clarified that the intention was not to state underfunding as fact. R Hughes explained that the group was highlighting concerns about the lack of psychological therapies in intensive care and emphasized the need for storytelling from families and patients to inform responses. R Hughes agreed to review the statement to better reflect the intended message, focusing on concerns rather than asserting underfunding as fact. In response to a query raised by K Palmer as to how this report connected to the People's Experience Activity data contained within the Quality Dashboard, given that the two should tie up, R Hughes advised that the dashboard-level people experience data is provided at every meeting, and the Forum report is meant to enhance that by offering deeper discussions and assurance. R Hughes added that the Forum report should complement and further enhance the assurance from the dashboard, giving insight into conversations with service leaders and agreed to consider feedback and the suggested more alignment between the reports to make them more relatable. Following discussion, it was suggested that for future meetings, there should be one agenda item on People's Experience, particularly when the update from the People's Experience Forum was due to be received. In relation to the query raised by K Palmer regarding the ongoing concerns about estates and quality, which is an open action on the action log, C Donoghue advised that an updated response will need to be sought in relation to this action, as referred to earlier in the meeting.
Resolution:	The Quality, Safety & Experience Committee NOTED the highlights outlined in this report and; APPROVED the two questions within the recommendation section of the report.
Action:	R Hughes to review the statement made within the report in relation to underfunding to better reflect the intended message, focusing on concerns rather than asserting underfunding as fact.

	For future meetings, there should be one agenda item on People's Experience, particularly when the update from the People's Experience Forum was due to be received.
7.	GOVERNANCE, RISK AND ASSURANCE
7.1	Organisational Risk Register – Risks Assigned to Quality & Safety Committee
	G. Watts presented the report and highlighted the key matters for members attention. P Roseblade commented on the risk relating to Learning from Events Reports which had again been added as a new risk despite discussions being held previously at the Audit, Risk & Assurance Committee where it was argued that the risk should be removed, which was subsequently agreed by Committee Members. P Roseblade added that there was an issue regarding credibility here in terms of risks being added and removed and whilst she understood the position was dynamic, there needed to be some underlying stability in relation to the risk register. K Palmer advised that she found it helpful to have the risk position summarised within the cover report which provided members with an overview of new and emerging risks. In response to a query raised by K Palmer regarding the risk relating to the stability of the legal services function and what the impact of this risk was, G Dix advised that there had been some significant staffing changes within the Legal Services Team and added there needed to be a greater level of understanding in relation to the processes and structures on a case by case basis. Members noted that some management resource had been moved around to address the workforce challenges being experienced.
Resolution:	The Committee REVIEWED the risks escalated to the Organisational Risk Register at Appendix 1 and CONSIDERED whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.
7.2	Health Inspectorate Wales (HIW) Audit Tracker Report
	C Donoghue requested that this item was deferred to the next meeting for further discussion and was provided with assurance from S Follows that the number of recommendations outstanding for Unscheduled Care would be addressed in time for the next meeting.
Resolution:	The Committee NOTED the contents of this report
Action:	Healthcare Inspectorate Wales Audit Tracker Report to be presented back to the September meeting on the main agenda for further discussion.
8.	CONSENT AGENDA
8.1	ITEMS FOR APPROVAL
8.1.1	Unconfirmed Minutes of the Meeting held on 20 May 2025
	The Committee APPROVED the minutes.
8.1.2	Unconfirmed Minutes of the In Committee Meeting held on 20 May 2025

	The Committee APPROVED the minutes
8.1.3	Quality, Safety & Experience Committee Terms of Reference The Terms of reference were ENDORSED for Board approval
8.1.4	Health, Safety & Fire Sub Committee Highlight Report 5 June 2025 (including the Health, Safety & Fire Sub Committee Annual Report) The highlight report was APPROVED .
8.2	ITEMS FOR NOTING
8.2.1	Non-Routine Committee Business (Forward Plan) The Forward Work Plan was NOTED .
8.2.2	Annual Cycle of Business The Annual Cycle of Business was NOTED .
8.2.3	CTMUHB National Clinical Audit Programme Quarter 1 Update 2025-2026 The report was NOTED .
8.2.4	Human Tissue Act (2004) Compliance and Progress Report The progress report was NOTED .
8.2.5	Organ Donation Sub Committee Highlight Report The report was NOTED .
8.2.6	Internal Audit Review Duty of Candour This item was deferred to the September 2025 meeting for discussion via the main agenda.
8.2.7	Internal Audit Review Service User Experience The internal audit report was NOTED .
8.2.8	Annual Unpaid Carer's Report The report was NOTED by the Committee.
9.	CLOSE OUT BUSINESS
9.1	Committee Highlight Report to Board C Donoghue sought confirmation as to whether there were any matters Committee Members wished to escalate on this occasion. K Palmer suggested that concerns raised in relation to Paediatric General Anaesthetic Waiting Lists was highlighted as an area for escalation within the Committee Highlight report to Board.
Action:	Concerns raised in relation to Paediatric General Anaesthetic Waiting Lists to be highlighted as an area for escalation within the Committee Highlight report to Board.
9.2	Meeting Feedback

	C Donoghue invited members to provide feedback in the meeting or outside if that was preferable. P Roseblade and K Palmer advised they both felt the meeting was well chaired. P Roseblade commented that she would find it helpful if more papers could be circulated together given there were a number of to follow items on this occasion, which impacted on her ability to review the full pack of papers.
9.3	Any Other Business
	There was no other business.
10.	PRIVATE / CLOSED SESSION BUSINESS
	The following reports were 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
11.	Date and Time of Next meeting: Tuesday 23rd September 2025 at 9:00am

Agenda Item	8.1.1
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Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 22 July 2025 9:00am-12:00pm
Venue	The Hub, Royal Glamorgan Hospital, Llantrisant (Microsoft Teams link also created for attendees unable to attend in person)

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Hayley Proctor	Independent Member
	Patsy Roseblade	Independent Member
	Kath Palmer	Vice Chair/Independent Member
In Attendance	Greg Dix	Executive Director of Nursing/Deputy CEO
	Sallie Davies	Deputy Medical Director
	Suzanne Hardacre	Director of Midwifery
	Sarah Follows	Unscheduled Care Group Service Director
	Owen Weeks	Unscheduled Care Group Medical Director
	Hannah Wilton	Director of Pharmacy & Medicines Management
	Philip Daniels	Executive Director of Public Health
	Sarah James	Deputy Chief Operating Officer
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Lloyd Griffiths	Head of Nursing, Mental Health & Learning Disabilities
	Lauren Edwards	Executive Director of Allied Health Professionals & Healthcare Sciences (Virtually)
	Rhian Beynon	Research & Development Manager
	Gaynor Jones	Staff Side Representative (Virtually - In part)
	Lucie Owen	Primary Care & Community Care Group Nurse Director (Virtually)
	Richard Hughes	Deputy Director of Nursing (Virtually)
	Sharon O'Brien	Planned Care, Care Group Nurse Director (Virtually)

	Hannah Jones	Audit Wales (Virtually - Observing)
	Chris Beadle	Assistant Director of Health, Safety & Fire (Virtually)
	Daniel Price	Regional Director, Llais (Virtually)

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions C. Donoghue welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its hybrid form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	Apologies for Absence Apologies were received from: - Ana Llewellyn, Nurse Director Mental Health and Learning Disabilities - Dom Hurford, Executive Medical Director - Gethin Hughes, Chief Operating Officer - Mohamed Elnasharty, Consultant Obstetrics Gynaecology and Sexual Health; - Cally Hamblyn, Assistant Director of Governance & Risk
1.3	Declarations of Interest There were no interests declared
2.	CONSENT AGENDA BUSINESS
2.1	C. Donoghue reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 8) that the Committee Members wished to bring forward to the main agenda for discussion. Following a request made by H Proctor, C Donoghue agreed to defer the Internal Audit Review on the Duty of Candour to the next meeting and agreed for this to be placed on the main agenda for discussion, given that the Health Board did not seem to be performing well in this area at present.
Action:	Internal Audit Review on the Duty of Candour to be deferred to the September meeting and placed on the main agenda for discussion.
3.	COMMITTEE GOVERNANCE ARRANGEMENTS
3.1	Action Log The action log was received and noted. C Donoghue requested that an update was provided against action 5.2d (Consideration to be given to the most

	appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes) for the next meeting as action status remained in progress.
Action:	Update to be provided against action 5.2d (Consideration to be given to the most appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes) for the next meeting.
3.2	Matters Arising Not Captured on the Action Log
	There were no matters arising.
4.	STAFF AND SERVICE USER EXPERIENCE
4.1	Shared Listening & Learning Story - Unpaid Carers
	D. Watkins & C. Read shared the presentation which provided a reflection on C Read's experiences of being an unpaid carer whilst navigating healthcare services. The presentation also highlighted the work undertaken by the Health Board as a result of listening to Carers feedback. C Donoghue extended her thanks to D Watkins and C Read for sharing the presentation which contained a number of areas which the Health Board would need to reflect on in regard to making things easier for carers and patients. K Palmer welcomed the presentation and story which she found to be powerful and recognised the presentation highlighted the positive steps being taken within secondary care and hospital settings to improve processes for Carers and queried whether this was being replicated in community and primary care settings. D Watkins advised that he had provided training to Band 6 and 7 nursing staff within the community to enable staff to identify carers at home and raise awareness with them that they can notify their GP that they are a carer. Members noted that an issue had been raised with Welsh Government that the Carers Register was no longer available which had made things difficult in regard to identification of carers within the Community. P Roseblade made reference to caring for adults, with carers for adults not always being included in medical conversations, particularly elderly adults being cared for, who don't necessarily want the clinician to know the full extent of the difficulties they are having. P Roseblade sought clarity as to how the carers ensure that they can get this information across given that they were the people that were seeing those difficulties, given that the adult they were caring for did not want to share the information. D Watkins advised that part of his role included involving carers in the hospital discharge process and advised that hopefully, in addition to the Carer's passport, this would allow time for staff and carers to build up a relationship which should make them more comfortable in sharing information. Members noted that a lot of carers do not see themselves as carers and just see themselves undertaking family duties. L Edwards introduced herself and her role and explained that the staff involved in the care outlined in the story fell under her remit and added that the information shared was helpful. L Edwards welcomed the work being undertaken in supporting carers and ensuring their voices were being heard and expressed the need to ensure the Carer voice was being linked into services within the Health Board, which she would be happy to discuss further with D Watkins.

	G Dix extended his thanks to D Watkins and C Read for sharing the presentation and advised he was also present at the Regional Partnerships Board meeting when this item was presented. G Dix added that it was important that both patient and carers voices were heard at this Quality, Safety & Experience Committee and advised that one of the challenges for the Health Board was in relation to team resource, with D Watkins being the only member within the team at present supporting 14,000 staff. G Dix advised that consideration needed to be given as to how all these pieces of work could be integrated within all services, wards and departments, which was challenging at present given the limited resource. C Donoghue advised that she felt this was an area that needed to be revisited given that the Committee had been made aware that there were issues that needed to be addressed. C Donoghue extended her thanks to D Watkins and C Read for sharing the powerful story.
Resolution:	The Committee NOTED the presentation.
Action:	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed.
5.	SETTING THE SCENE – SERVICE DELIVERY
5.1	Report from the Clinical Executives
	Clinical Executive colleagues presented the report and highlighted the key matters for Members attention. P Roseblade made reference to page 5 and the reference made to the Unscheduled Care Nurse Director vacancy and advised that no update had been included against this vacancy. G Dix advised that interviews were being held for this post on the 1 August 2025. P Roseblade referred to the paragraph on page 5 which stated that several closure bundles were prepared for executive review but did not state what these closure bundles related to. G Dix advised that when there had been an investigation undertaken into falls, pressure ulcers and medication errors, reports were received and considered at scrutiny meetings, actions were identified and then the whole incident was closed as a closure bundle and subsequently reported to this Committee and Welsh Government. C Donoghue added that whilst the report states that there had been an increase in pressure ulcer incidents, no information had been included as to the causes behind this increase and the lessons that had been learnt as a result. C Donoghue advised that it would be helpful if more detail could be provided on this in future reports. P Roseblade referred to page 7 and the update provided in relation to the Discharge and Return Policy, which she found to be unclear and added there appeared to be a whole sentence missing at the start of the paragraph. S Davies advised that a Regulation 28 was served following an inquest where a patient had been discharged from the Emergency Department without having a surgical review from the surgeon who undertook their previous surgery. Members noted that the incident occurred several years ago and policies and procedures had been strengthened and now state that surgical reviews must be undertaken at

	Emergency Departments if patients re-present by the Surgical Team who undertook the original surgical procedure. P Roseblade referred to page 12 which stated that there was a non-agreement between Primary and Secondary Care in relation to preconception care and diabetes in pregnancy and queried what the consequence of this non agreement would be. P Daniels advised that there were inconsistencies in place in regard to where people were being tested and advised that he would circulate additional information on this matter to Members outside the meeting. H Proctor welcomed the update provided in the report in relation to the work being undertaken to establish a unified policy on staff uniforms during periods of adverse weather. H Proctor also referred to the update within the report in relation to gender services, which was an issue being experienced within every department and discipline given the complexity of the cases presenting and queried how this was being addressed. S Davies advised that the Health Board had made a request to be able to perform these surgeries but had encountered issues in getting agreement given that the service was commissioned by NHS England. H Proctor made reference to Public Health and the variances across the Health Board in regard to Service Level Agreements and queried whether there was a plan to review all Service Level Agreements that were currently in place. P Daniels confirmed that reviewing service level agreements was an area of focus within the Diabetes Programme Board. C Donoghue extended her thanks to the Clinical Executive Directors for the presentation of the report.
Resolution:	The Committee NOTED the report.
Actions:	Future reports to include more detail on the causes behind the increase in pressure ulcer incidents and the lessons that had been learnt Information to be shared with Members outside the meeting in relation to the consequences of the non-agreement between Primary and Secondary Care in relation to preconception care and diabetes in pregnancy
5.2	Care Group Highlight Reports
	C. Donoghue invited the Care Group Leads to present their respective reports, requesting them to focus on the areas highlighted in the alert/escalate section.
5.2.1	Children & Families Care Group
	S. Hardacre presented the report and highlighted the matters included in the alert/escalation section. P Roseblade made reference to the recent reports via the media in relation to Swansea Bay UHB and queried how this would affect Cwm Taf Morgannwg UHB, particularly as Welsh Government had now announced they were undertaking a full review of Maternity Services in Wales. P Roseblade added that she assumed that all the learning from the events that occurred prior to Bridgend joining the Health Board had been rolled out into the Princess of Wales Hospital. S Hardacre

advised that Welsh Government were seeking assurances that services across Wales were safe at this moment in time and had articulated that there will be clear Terms of Reference developed for this review and a Chair appointed to oversee this review. Members noted that a lot of the work being undertaken by Welsh Government would be in the form of desk top reviews of performance metrics, with a review also being undertaken in regard to culture, leadership and development.

S Hardacre advised that in response to the query raised by P Roseblade regarding the former Cwm Taf and reviewing Bridgend, a piece of work was undertaken 18 months ago to benchmark against the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) recommendations to ensure a gap analysis was in place. Members noted that the Team felt assured that the service was where it needed to be and noted that the Team were now going to undertake a further workforce review to ensure the workforce in place was fit for the future, given some of the changes being seen within Maternity Services, for example, the increase being seen in C-Sections and the associated rise in risk of infections. S Hardacre added that the service had good governance processes in place which had been commended nationally, particularly in relation to the Perinatal engagement framework.

G Jones made reference to the issues being experienced with staffing levels on the Special Care Baby Unit at Princess of Wales Hospital and sought clarity as to the current position in relation to recruitment of staff. S Hardacre confirmed that active recruitment was being undertaken and added that there may be opportunities for staff members to be moved into the unit via the lateral moves scheme. Members noted that the significant amount of activity being seen on both units, Prince Charles Hospital (PCH) and Princess of Wales Hospital (POW), was having a short-term impact, in addition to short- and long-term sickness absence which was being managed by the Team. In response to a further query raised by G Jones, S Hardacre confirmed that consideration was given to recruiting via streamlining and this was deemed to be not appropriate for the type of roles that needed to be covered.

In response to a query raised by K Palmer as to the timescales for putting a solution in place for Special School Nursing given that the issues appeared to be escalating, S Hardacre commended the work being undertaken by the Senior Nurse and Heads of Nursing within Special Schools to try and keep everyone safe and advised that there were issues in regard to the way in which the special school nurses were funded by the schools which meant that staff were being governed by schools and being deployed in a way in which schools see fit. Members noted that there were challenges around recruitment given that opportunities for development were limited within special schools. S Hardacre advised that ongoing discussions were being held with Llais following concerns they raised regarding the service. Executive Team discussions were also being held in relation to sustainability of the current model and policy discussions were also being held Welsh Government on the concerns being expressed regarding this service. C Donoghue advised that she would welcome an update on this matter in the Care Group Highlight report at the September meeting.

	C Donoghue advised that in relation to Maternity Services, it was evident that whilst a significant amount of work had been undertaken in this service over the last few years in relation to culture and training, there appeared to be more work to do in this area in regard to improving culture and encouraging staff to speak out, which was concerning. S Hardacre advised that she had discussed the pressure point areas with G Dix and added that she felt that whilst improvements were being seen in quality and safety on the Princess of Wales Hospital site, further work needed to be undertaken on understanding the issues being experienced within Maternity Services at Prince Charles Hospital.
Resolution:	The Committee NOTED the highlights outlined in section 3 of this report.
Action:	Update to be included in September iteration of the report on the work being undertaken to address Special School Nursing issues
5.2.2	Unscheduled Care - Care Group
	O. Weeks presented the report and highlighted the matters contained within the alert/escalate section. K Palmer welcomed the significant improvement highlighted within the report in relation to Ambulance Handover performance. S Follows advised that one of the key elements for the Committee to note was that patient care was not being compromised as a result of achieving this performance, with the Team being commended by the Marek Team for not providing corridor care within the Emergency Departments. P Roseblade also commended the Team on the Ambulance Handover performance achievement. P Roseblade made reference to the internal unannounced ward assurance visits and queried how frequently these were being undertaken. R Hughes advised that the visits, which were separate from the planned accreditation visits, would be triggered through a number of mechanisms, with some visits being requested by the site operational teams and some visits being requested by the Care Group Leadership Teams. An assurance visit could also be requested following a review of various key quality indicators at the weekly Executive Led Patient Safety meetings. G Dix added that there would be a number of audits that would occur monthly as standard, for example, Infection Prevention & Control, Environmental and Cleaning, with any triggers or red flags being identified through governance processes resulting in an initial unannounced visit being enacted. S Follows advised that the Senior Leadership Team within Unscheduled Care had also recently introduced unannounced visits to areas within the Unscheduled Care service. S O'Brien added that Nurse Directors had a mechanism in place for asking the Team to undertake a more formal ward assurance visit to review any areas of concern. C Donoghue advised that she found it assuring and encouraging to hear how these visits were being triggered.
Resolution:	The Committee NOTED the report.
5.2.3.	Planned Care - Care Group
	S. O'Brien presented the report and highlighted the matters contained within the alert/escalate section.



	P Roseblade made reference to the moves being undertaken within Trauma & Orthopaedic Services and sought clarity as to whether consolidating trauma surgery onto the one site would create any issues and queried the statement made within the report that consultation had commenced, despite the outcome already being decided. S O'Brien confirmed that the consultation process referred to within the report was with staff via the Organisational Change Process and added that this consultation had already commenced with Trauma staff who had to transfer to the Royal Glamorgan Hospital site following the commencement of roof repairs at the Princess of Wales Hospital and the elective orthopaedic staff normally based at Royal Glamorgan Hospital. Members noted the consultation with nursing staff went well with all staff achieving the outcome they requested. C Donoghue referred to the update provided within the inform section of the report in relation to developments in Gastroenterology and General Surgery, and added that it would be good for the Committee to be provided with the impact of this and queried where the expected outcomes would be seen, for example, reduction in waiting lists, patients having to spend less time in hospital. C Donoghue advised that she would welcome an update from G Hughes on this.
Resolution:	The Committee NOTED the report.
Action:	Update to be provided by G Hughes on what the impacts and expected outcomes were likely to be in relation to the developments within Gastroenterology and General Surgery, for example, reduction in waiting lists, patients having to spend less time in hospital.
5.2.4	Mental Health & Learning Disabilities Care Group
	L. Griffiths presented the report and highlighted the key matters for members attention. K Palmer welcomed the update provided in relation to the completion of the implementation of E-Whiteboards within Mental Health Services which would hopefully help to improve services and would help with contingency planning and bed pressures. C Donoghue made reference to the external commissioning of PMVA Module D training which she felt was a positive step forward. C Donoghue referred to the update contained within the report on ligature risks identified at Royal Glamorgan and queried whether this ligature risk was new or previously missed, given that previous assurance had been provided that anti-ligature work was complete. L Griffiths provided clarity that this was an emerging risk that had been identified in an external environment by a new senior nurse with experience from NHS England and added that all other wards had routine annual anti-ligature checks completed. Members noted that the current issue was isolated to one area.



	K Palmer made reference to an action that remained open on the action log in relation to assurances being provided in relation to Learning Disability Services and advised that she would welcome an update on this at a future meeting.
Resolution:	The committee NOTED the report.
Action:	Update to be presented to a future meeting on assurances being provided in relation to Learning Disability Services.
5.2.5	Diagnostics, Therapies, Pharmacy & Specialities
	H. Wilton presented the report and highlighted the matters contained within the alert/escalate section. H Proctor made reference to the update provided within the report in relation to LIMS (Laboratory Information System) and sought clarity as to whether a plan was in place to address the delays being experienced. In response, H Wilton advised that the Director of Digital and the Chief Executive had written to Digital Healthcare Wales advising of the criticality of this project and the need for this to be escalated in terms of priority. C Donoghue advised that LIMS was an area that had been discussed frequently at the former Digital & Data Committee and at Strategic Development Committee and added that she was concerned that whilst the risks were well known, the delays being experienced would result in the risks coming to fruition as opposed to them being mitigated. L Edwards advised that the concerns that had been raised by this Health Board were concerns shared by other Health Board's and was an issue that was high on the agenda for Cwm Taf Morgannwg. Members noted that the matter was also being discussed at the Operational Delivery Committee. C Donoghue noted the issues highlighted within the report in relation to the Orthotics contract and the delays experienced in the tender process which had resulted in the new provider not being able to provide a clinician until 4 August 2025, which she found to be disappointing given this would have a negative impact on patients.
Resolution:	The committee NOTED the report.
5.2.6	Primary Care & Communities Care Group
	L. Owen presented the report and highlighted the matters contained within the alert/escalate section. Members noted that the issue highlighted in the report in relation to reduced Medical Cover at Ysbyty Cwm Cynon had now been resolved as a result of mitigations that had been put into place. K Palmer expressed her disappointment at the position regarding the Paediatric General Anaesthetic Lists given that the Dental Team were still waiting to hear from Planned Care colleagues regarding list availability, and added that she did not feel assured on this matter at present and sought clarity as to how this matter was going to be resolved given the significant number of children that were waiting for treatment and would likely need to be reassessed. C Donoghue advised that given that the Committee received a detailed update on this matter at the last meeting, and that this was largely dependent on Theatre List



availability in order for the Care Group to address the position, she suggested that the Chief Operating Officer is asked to provide an update to the Committee on this matter. S James advised that she would be happy to obtain an update from G Hughes on this and added that this was partly dependent on the return of services to Princess of Wales Hospital, which was on track for completion in September 2025. K Palmer also advised that Members would find it helpful if they could be advised of the future plan as to how this position could be addressed over the next two to three years. L Owen confirmed that the children waiting on the list would likely needed reassessment which could lead to more complex surgery being required.

K Palmer made reference to the care home fee issues identified within the report and sought clarity as to whether there were risks that this would likely be an issue for other care homes within Cwm Taf Morgannwg which she felt the Health Board needed greater understanding of. L Owen advised that the update included in the report specifically related to Continuing Health Care fees as opposed to the general nursing aspect, and added that the Health Board had also been contacted by a second Care Home in relation to the Continuing Healthcare fee the Health Board were paying. Members noted that the Care Group Service Directors would now be meeting with finance colleagues to discuss CHC fees further given that it appeared the Health Board appeared to be an outlier in this area compared to the rest of Wales.

K Palmer made reference to the Wound Clinic Service and the Wound Clinic Bus which she had been informed about during one of her visits within the Health Board, which she felt was a fantastic service given that it took the service into community areas, and particularly supported vulnerable people. K Palmer sought clarity as to whether the Care Group were looking to take more services into the community. L Owen advised that in addition to the Wound Clinic Bus, the Wound Clinic delivered services across six different sites in addition to patient homes. Members noted that the Care Group were currently reviewing the amalgamation of the Wound Clinic, Lymphoedema and Tissue Viability services to create a One Stop Shop clinic for patients, which was a long-term plan for the Care Group.

K Palmer advised that she was pleased to see the increase to 46% in relation to the Diabetes 8 Care Processes and advised that whilst the increase was fantastic, she assumed the service was aiming for further improvement in this area. L Owen advised that the Care Group were working closely with GP Practices to achieve further improvement in this area.

G Dix made reference to the Community Nursing specification, which included a target of 80% of the service to be delivered over the weekend. Members noted that this had caused some concern from a workforce perspective amongst existing staff and noted that there were now around eight or nine vacancies within the Community Nursing service, which was a position the service had not previously experienced. G Dix advised that as yet an impact had not been seen, a decrease in admissions had not been seen, or a decrease in length of stay because of this particular service specification, hence a discussion taking place with Welsh Government in regards to impact. G Dix advised that he remained concerned that the Health Board would lose significant experienced District

	Nursing staff given that they do not want to work weekends. L Owen advised that the deliverables that were put into place by Welsh Government do not have measurable outcomes which has been fed back to Welsh Government. P Roseblade welcomed the report which she found to be succinct and advised that there were two matters discussed today which would now require reporting against and would therefore receive focus, Paediatric General Anaesthetic lists and Diabetes. P Roseblade advised that she understood the pressures the services were under, and added that whilst nothing has changed for the children waiting for treatment on the General Anaesthetic lists, now that performance against this would be reported, the Health Board now thinks that the position will change for them. P Roseblade made reference to the incidents that occurred at Parc Prison and queried the nature of these incidents. L Owen advised that the themes and trends being monitored related to Medication Administration Errors which occur for a number of reasons, including supply errors. Members noted that the Team are reviewing the position and provided assurance that the numbers of incidents were low at present. H Wilton advised that an improvement in one area, specifically the increase in the diabetes 8 care processes to 46%, could lead to a perceived deterioration in another area, such as the prescribing cost budget. H Wilton clarified that this is not actually a negative outcome, but rather a result of positive progress in diabetes care, and advised colleagues not to be surprised if improvements in one metric affect related metrics elsewhere
Resolution:	The committee NOTED the report.
Action:	Chief Operating Officer to provide an update on the plans in place to address the Paediatric General Anaesthetic Waiting list position given that this was largely dependent on Theatre List availability
5.3	Stroke Services Progress Report
	S Follows presented the report and highlighted the key matters for Members included. Members noted the report also captured an update against the actions captured at the May 2025 meeting. C Donoghue extended her thanks to S Follows for presenting the comprehensive update and sought clarity as to what mechanism would be used to decide what the long-term solution was going to be for Stroke Services. S Follows advised that the communication cascaded to staff is that the temporary move was for a period of 12 months, with the Care Group focussing on stabilisation of the service and foundation building at the current site. Members noted that a stroke service redesign piece of work was also being undertaken to determine the optimal clinical pathway, workforce requirements, and structure for hyper-acute, acute, and rehabilitation phases and noted that it was hoped that as a result of this piece of work improvements would be seen in quality indicators and outcomes for stroke patients. S Follows added that in relation to the longer-term plan, despite some improvements in medical workforce, there was not yet a robust consultant workforce in place to safely run the service across two sites, including on-call

	rotas and clinics. Members noted that the long-term plan would form part of the integrated clinical services plan and would align with regional work, but for now, the arrangement remains short-term due to workforce constraints. G Jones sought confirmation as to how the service could guarantee that patients would be placed in a bed within a four-hour window, particularly those patients who self-present at Princess of Wales and Prince Charles Hospitals and then require ambulance transfer to Royal Glamorgan Hospital. S Follows advised that for patients presenting directly to RGH (by self-presentation or ambulance), the 4-hour target can be achieved due to improved patient flow and bed availability, however, she advised that achieving this for patients at the Princess of Wales and Princes Charles hospitals required further work, particularly as this was dependent on ambulance transfer. Members noted the need for significant engagement and communication with members of the public to ensure patients attend the right hospital for Stroke care. L Edwards highlighted that the regional model for stroke services was key for future planning and explained that Cwm Taf Morgannwg did want to make a service change and then have to change the model again if the regional model differed. L Edwards advised that the Health Board was pushing to regain pace in relation to the regional work and added that a regional meeting was scheduled for mid-August and emphasised the need to accelerate discussions to determine future service options based on regional decisions. K Palmer welcomed the report and the detailed update that had been provided and added that she hoped that focus on this matter would continue in the short term. P Roseblade made reference to Early Supported Discharge for stroke patients and sought clarity as to whether this was dependent on the availability of reablement or community nursing teams to provide ongoing care at home and also queried whether there was a measure of readmission for those discharged early. L Edwards advised that the Early Supported Discharge teams have specific criteria for patient eligibility and added that there had been no capacity issues from the data she had seen, with eligible patients having their needs met. L Owen confirmed that that the Early Supported Discharge Teams could pick up patients ready for discharge within 24-28 hours, with no delays being reported. H Proctor raised concerns that only 46.6% of the recommended Allied Health Professional (AHP) staffing is available to deliver a 5-day rehab service for stroke patients, yet there was still a push for a 7-day service and questioned how the team could provide the required 3 hours of therapy per day for the number of patients with less than half the recommended workforce. H Proctor noted that the action plan in the report focused on medical, nursing, and pharmacy, but lacked an AHP or therapist action plan. H Proctor also emphasized the need to include rehab goals and outcomes in future reports. S Follows advised that she would be happy to capture this in future Stroke Services Progress reports.
Resolution:	The report was NOTED .
Action:	Future reports to include focus on AHP and Therapies workforce availability to

	deliver a 7-day service, along with rehab goals and outcomes.
6.	DELIVERING OUR PLAN
6.1	Patient Safety, Quality & Experience Dashboard
	K. Jenkins-Forrester presented the report and highlighted the key matters for Members attention. P Roseblade made reference to the patient safety incidents and nationally reportable incidents and advised that at paragraph 2.2 within the report it stated that a total 4272 incidents were reported during the reporting period, the figure contained within the bar graph later in the report differed from the 4272 figure. K Jenkins-Forrester agreed to review this and added that she would provide a response by email outside the meeting. K Palmer referred to the data included within the report in relation to the increase in Absconding Incidents and queried whether this was an issue that Committee Members needed to be concerned about. K Jenkins-Forrester advised that peaks and troughs tended to be seen in regard to patient absconsions and would typically be dependent on the cohort of patients on the wards at a point in time, which made it difficult to identify themes and trends. L Griffiths advised that from a Mental Health & Learning Disability Care Group perspective whilst there were no issues that required escalating at this point, he would be happy to undertake a further review of the position and include an update in the highlight report for the September 2025 meeting. L Edwards stated that a zero number of absconsions was not necessarily desirable because positive risk-taking and supporting people to access the community (which may result in late returns from leave) were important. L Edwards assured that the care group investigates absconsions, follows escalation processes, and added that there were no common themes or concerns emerging from these incidents. K Palmer raised a query on the vacancy within the Patient Advice Liaison Service (PALS) and queried whether this was something that the Committee should be concerned about. R Hughes advised that there was no need for concern at this stage and added that temporary support was being provided to the Patient Care & Safety Team in relation to early resolutions. Members noted that the Team were currently prioritising where resource was required and noted that there were still five other PALS officers in place providing cover. R Hughes advised he would continue to keep the situation under close scrutiny.
Resolution:	The committee NOTED the content of the report
Actions:	Response to be provided outside the meeting regarding inconsistencies reported in figure contained in paragraph 2.2 regarding number of incidents reported compared to bar chart graph contained later in the report Review to be undertaken of any themes and trends that needed to be highlighted to the Committee in relation to patient absconsions. Update to be included in Care Group Highlight report for the September 2025 meeting.
6.1.1	Committee Referral - Details of the medical negligence claims from the losses and special payments report - Verbal Update



	K. Jenkins-Forrester presented a verbal update and advised that while the number of clinical negligence claims received had not increased year on year, the number of claims settled, and the associated damages and costs had increased over the past 12–18 months. K Jenkins Forrester added that she is working with finance colleagues to break down and triangulate this information and plans to bring a more detailed report to the next committee meeting. P Roseblade advised that she was content with the proposed approach and added that as Chair of the Audit, Risk & Assurance Committee, she would be happy to wait for the detailed report to be presented to the September 2025 Quality, Safety & Experience Committee before this referral was closed down at Audit, Risk & Assurance Committee.
Resolution:	The Committee NOTED the report
Action:	Detailed written update to be presented to the September 2025 meeting of the Quality, Safety & Experience Committee
6.2	Overview of the Development & Delivery of the Research & Development Strategy
	R. Beynon presented the report and highlighted the key matters for Members attention. C Donoghue recognised that a significant amount of work had been undertaken in developing this Strategy and had received a significant amount of discussion and input and noted that the monitoring of the Strategy would be undertaken at the Research & Development Delivery Group. G Dix advised that a Strategy on a page had been developed, and Members agreed it would be helpful if this could be shared with them outside the meeting.
Resolution:	The Committee ENDORSED for Board approval the CTMUHB R&D Strategy 2025-30.
Action:	Strategy on a page to be shared with Committee members following the meeting.
6.3	Annual Duty of Quality Report
	R. Hughes presented the report and advised that the final version of the report would be presented to the September Board for approval. C Donoghue commented that whilst the Annual Duty of Quality report was longer than last year, she had found it more accessible and readable due to its format, with quick sections rather than large blocks of text. C Donoghue also expressed willingness to write a foreword for the report and advised that she had been asked to share the report with her Quality & Safety Committee Chair counterparts in other Health Board's.
Resolution:	The Annual Duty of Quality Report was ENDORSED for Board APPROVAL
6.4	People Experience Forum Update
	R. Hughes presented the report and highlighted key matters for members attention. In response to a query raised by H Proctor as to the purpose, remit and membership of the Forum, R Hughes explained that the People Experience

	Forum meets quarterly and includes representatives from Llais, Care Groups, the Corporate Team, Value-Based Healthcare, and quality improvement professionals and added that consideration was also being given to adding a community member to the group. Members noted that an Operational Group was also in place which meets monthly to discuss and work on actions identified from the Forum, with the forum aiming to enhance and support care groups in the field of patient experience. P Roseblade questioned whether underfunding, as mentioned in the report at discussion point B, was a fact or just a perception and emphasized that while everyone wants more money in the health service, it's also important to use existing funds efficiently and effectively. P Roseblade expressed concern that the report presented underfunding as fact and asked whether advocacy for increased funding was directed at the Health Board or Welsh Government, stating the discussion did not seem quite right. R Hughes acknowledged feedback from P Roseblade and clarified that the intention was not to state underfunding as fact. R Hughes explained that the group was highlighting concerns about the lack of psychological therapies in intensive care and emphasized the need for storytelling from families and patients to inform responses. R Hughes agreed to review the statement to better reflect the intended message, focusing on concerns rather than asserting underfunding as fact. In response to a query raised by K Palmer as to how this report connected to the People's Experience Activity data contained within the Quality Dashboard, given that the two should tie up, R Hughes advised that the dashboard-level people experience data is provided at every meeting, and the Forum report is meant to enhance that by offering deeper discussions and assurance. R Hughes added that the Forum report should complement and further enhance the assurance from the dashboard, giving insight into conversations with service leaders and agreed to consider feedback and the suggested more alignment between the reports to make them more relatable. Following discussion, it was suggested that for future meetings, there should be one agenda item on People's Experience, particularly when the update from the People's Experience Forum was due to be received. In relation to the query raised by K Palmer regarding the ongoing concerns about estates and quality, which is an open action on the action log, C Donoghue advised that an updated response will need to be sought in relation to this action, as referred to earlier in the meeting.
Resolution:	The Quality, Safety & Experience Committee NOTED the highlights outlined in this report and; APPROVED the two questions within the recommendation section of the report.
Action:	R Hughes to review the statement made within the report in relation to underfunding to better reflect the intended message, focusing on concerns rather than asserting underfunding as fact.

	For future meetings, there should be one agenda item on People's Experience, particularly when the update from the People's Experience Forum was due to be received.
7.	GOVERNANCE, RISK AND ASSURANCE
7.1	Organisational Risk Register – Risks Assigned to Quality & Safety Committee
	G. Watts presented the report and highlighted the key matters for members attention. P Roseblade commented on the risk relating to Learning from Events Reports which had again been added as a new risk despite discussions being held previously at the Audit, Risk & Assurance Committee where it was argued that the risk should be removed, which was subsequently agreed by Committee Members. P Roseblade added that there was an issue regarding credibility here in terms of risks being added and removed and whilst she understood the position was dynamic, there needed to be some underlying stability in relation to the risk register. K Palmer advised that she found it helpful to have the risk position summarised within the cover report which provided members with an overview of new and emerging risks. In response to a query raised by K Palmer regarding the risk relating to the stability of the legal services function and what the impact of this risk was, G Dix advised that there had been some significant staffing changes within the Legal Services Team and added there needed to be a greater level of understanding in relation to the processes and structures on a case by case basis. Members noted that some management resource had been moved around to address the workforce challenges being experienced.
Resolution:	The Committee REVIEWED the risks escalated to the Organisational Risk Register at Appendix 1 and CONSIDERED whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.
7.2	Health Inspectorate Wales (HIW) Audit Tracker Report
	C Donoghue requested that this item was deferred to the next meeting for further discussion and was provided with assurance from S Follows that the number of recommendations outstanding for Unscheduled Care would be addressed in time for the next meeting.
Resolution:	The Committee NOTED the contents of this report
Action:	Healthcare Inspectorate Wales Audit Tracker Report to be presented back to the September meeting on the main agenda for further discussion.
8.	CONSENT AGENDA
8.1	ITEMS FOR APPROVAL
8.1.1	Unconfirmed Minutes of the Meeting held on 20 May 2025
	The Committee APPROVED the minutes.
8.1.2	Unconfirmed Minutes of the In Committee Meeting held on 20 May 2025

	The Committee APPROVED the minutes
8.1.3	Quality, Safety & Experience Committee Terms of Reference The Terms of reference were ENDORSED for Board approval
8.1.4	Health, Safety & Fire Sub Committee Highlight Report 5 June 2025 (including the Health, Safety & Fire Sub Committee Annual Report) The highlight report was APPROVED .
8.2	ITEMS FOR NOTING
8.2.1	Non-Routine Committee Business (Forward Plan) The Forward Work Plan was NOTED .
8.2.2	Annual Cycle of Business The Annual Cycle of Business was NOTED .
8.2.3	CTMUHB National Clinical Audit Programme Quarter 1 Update 2025-2026 The report was NOTED .
8.2.4	Human Tissue Act (2004) Compliance and Progress Report The progress report was NOTED .
8.2.5	Organ Donation Sub Committee Highlight Report The report was NOTED .
8.2.6	Internal Audit Review Duty of Candour This item was deferred to the September 2025 meeting for discussion via the main agenda.
8.2.7	Internal Audit Review Service User Experience The internal audit report was NOTED .
8.2.8	Annual Unpaid Carer's Report The report was NOTED by the Committee.
9.	CLOSE OUT BUSINESS
9.1	Committee Highlight Report to Board C Donoghue sought confirmation as to whether there were any matters Committee Members wished to escalate on this occasion. K Palmer suggested that concerns raised in relation to Paediatric General Anaesthetic Waiting Lists was highlighted as an area for escalation within the Committee Highlight report to Board. Action: Concerns raised in relation to Paediatric General Anaesthetic Waiting Lists to be highlighted as an area for escalation within the Committee Highlight report to Board.
9.2	Meeting Feedback

	C Donoghue invited members to provide feedback in the meeting or outside if that was preferable. P Roseblade and K Palmer advised they both felt the meeting was well chaired. P Roseblade commented that she would find it helpful if more papers could be circulated together given there were a number of to follow items on this occasion, which impacted on her ability to review the full pack of papers.
9.3	Any Other Business
	There was no other business.
10.	PRIVATE / CLOSED SESSION BUSINESS
	The following reports were 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
11.	Date and Time of Next meeting: Tuesday 23 rd September 2025 at 9:00am



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

Date and Time of Meeting	Tuesday 22 July 2025 9:00am-12:00pm
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Patsy Roseblade	Independent Member
	Hayley Proctor	Independent Member
	Kath Palmer	Vice Chair/Independent Member
In Attendance	Gareth Watts	Director of Corporate Governance/Board Secretary
	Greg Dix	Executive Director of Nursing/Deputy CEO
	Suzanne Hardacre	Director of Midwifery
	Mohamed Elnasharty	Care Group Medical Director (Virtually)
	Sallie Davies	Deputy Medical Director
	Lloyd Griffiths	Head of Nursing, Mental Health & Learning Disabilities
	Philip Daniels	Executive Director of Public Health (Virtually)
	Richard Hughes	Deputy Director of Nursing (Virtually)
	Bryany Tweedale	Consultant Midwife
	Jodie Hodges	Perinatal Safety Support Manager
	Lauren Edwards	Executive Director of Allied Health Professionals and Healthcare Sciences (Virtually)

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.
1.2	Apologies for Absence
	Apologies were received from:



	- Ana Llewellyn, Nurse Director Mental Health and Learning Disabilities - Dom Hurford, Executive Medical Director - Gethin Hughes, Chief Operating Officer
1.3	Declarations of Interest
	There were none.
2.	MAIN AGENDA
2.1	Cwm Taf Morgannwg Stillbirth and Neonatal Death Thematic Review 2023 Births & MBRRACE-UK Perinatal Mortality Report: 2023 Births S Hardacre, B. Tweedale & J. Hodges presented the report and highlighted the key matters for Members attention. In response to a query raised by K Palmer as to whether a review had been undertaken in regard to mothers who were both overweight and were smokers, S Hardacre confirmed that a Consultant Midwife was undertaking a review of these types of cases and added that the Team were in the process of recruiting a Perinatal Midwife who would assist in undertaking these types of reviews. K Palmer extended her thanks to S Hardacre for the update and advised she was reassured that this was being reviewed by the Team. In response to a query raised by P Roseblade as to the difference between Anti Partum and Intra Partum, B Tweedale explained that Anti Partum related to a loss that occurred pre labour, with Intra Partum relating to a loss that occurred during labour. In response to a query raised by P Roseblade as to how information was being fed back to mothers who had suffered baby loss during their pregnancy in regards to their smoking habits, for example, B Tweedale advised that whilst this was a challenge, all mothers who had experienced a loss of their baby would be offered advice on managing future pregnancies, with steps being taken to ensure blame was not being placed on the mothers. P Daniels advised Members that given that a number of pregnancies were unplanned, the Public Health Team would be placing focus on this moving forwards. In closing the item, S Hardacre commended the Team for their Multi-Disciplinary Team work and B Tweedale shared a patient story. C Donoghue extended her thanks to the Team for sharing the story and for the care and compassion that staff had provided to the family during their difficult time.
Resolution:	The Committee NOTED the report and formally ACKNOWLEDGED the content and findings of the thematic review and the MBRRACE-UK Perinatal Mortality Report: 2023 births.
2.2	Mental Health & Learning Disabilities - Learning through Lived Experience L. Griffiths presented the report which summarised the learning undertaken from a patient story shared at a previous meeting. C Donoghue welcomed the report and the sharing of the learning contained within it.



Resolution:	The Committee NOTED the report.
2.3	Organisational Risk Register - Closed Risks
	G. Watts presented the Risk Register and highlighted the key matters for Members attention.
Resolution:	The Committee NOTED the report and the risks that had been escalated to the Organisational Risk Register.
3.	ANY OTHER BUSINESS
3.1	There was no other business to report.
4.	DATE AND TIME OF NEXT IN-COMMITTEE SESSION – TBC
	The date and time of the next In Committee session is to be confirmed.



Agenda Item

8.1.3

Quality, Safety & Experience Committee

PUTTING THINGS RIGHT ANNUAL REPORT

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval
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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	
PTR	Putting Things Right
PSOW	Public Services Ombudsman for Wales

1. Situation / Background

The Putting Things Right Annual Report 2024/2025 provides an overview of the Health Board’s performance and activity in relation to how the organisation has managed Concerns including complaints, incidents, claims, redress and inquests between 1st April 2024 and 31st March 2025.

In addition, the report will provide a summary of the Health Board’s implementation of the Duty of Candour requirements.

2. Specific Matters for Consideration

The key areas to note in relation to the implementation of Putting Things Right for 2024/2025 include:

- Reduction in the number of formal complaints received
- Continued improvement in compliance with the 30 working day target
- Slight increase in the number of Public Service Ombudsman for Wales referrals received
- Decrease in Nationally Reportable Incidents
- Increase in number of cases referred to Redress from the incident process
- Themes arising from complaints and patient safety incidents remain consistent with previous years

3. Key Risks / Matters for Escalation

The key risks / matters for escalation associated with the Putting Things Right Annual report relate to:

- Maintaining compliance with the 30 working day target
- Effective and timely management of Ombudsman Cases
- Reducing the number of open nationally reportable incidents
- Timely conclusion of redress cases

4. Assessment

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



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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Effective Efficient Equitable Person Centred Timely 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i>	Yes: ☒	No: ☐
Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i>	Yes: ☐	No: ☒
Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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	Yes (Include further detail below)	
Enw da / Reputational	Yes (Include further detail below)	



	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

The Quality, Safety & Experience Committee are asked to approve the content of the report.

6. Next Steps

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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

PUTTING THINGS RIGHT

Annual Report 2024/2025

Head of Concerns & Business Intelligence

PUTTING THINGS RIGHT & DUTY OF CANDOUR

ANNUAL REPORT 2024/2025

- 1.0 Introduction
- 2.0 Feedback
 - 2.1 Complaints
 - 2.2 Public Service Ombudsman for Wales
- 3.0 Patient Safety Incidents and
 - 3.1 Duty of Candour
 - 3.2 National Reportable Incidents
 - 3.3 Never Events
- 4.0 Legal Services
 - 4.1 Redress
 - 4.2 Claims
- 5.0 Inquests
- 6.0 Learning from Events Reports
- 7.0 Conclusion

1.0 Introduction

Putting Things Right is the process by which NHS Wales handles concerns, complaints, incidents, and claims in a consistent, fair, and transparent manner. It is governed by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, which set out the legal framework for managing feedback and ensuring appropriate redress when things go wrong.



The PTR process enables patients, families, carers, and staff to raise concerns about the care or services they receive or deliver. It ensures that:

- Concerns are acknowledged and investigated promptly
- Individuals affected are kept informed and supported
- Lessons are learned and shared to improve safety and quality
- Where appropriate, redress is offered in a timely and proportionate way

The Putting Things Right Annual Report 2024/2025 provides an overview of the Health Board's performance and activity in relation to how the organisation has managed Concerns including complaints, incidents, claims, redress and inquests between 1st April 2024 and 31st March 2025.

In addition, the report will provide a summary of the Health Board's implementation of the Duty of Candour requirements.

From April 2023 it is a legal requirement that all NHS Organisations implement the Duty of Candour whether a person receives care from the NHS, or from a regulated provider of health care services. Promoting a culture of openness, learning and improvement the statutory guidance commits care providers to be open and honest with service users and their families.

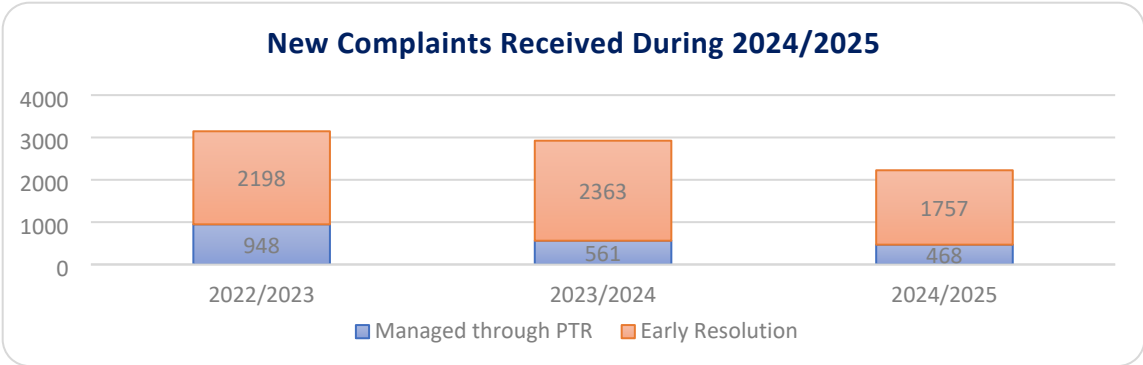
The Duty of Candour Statutory Guidance 2023 prescribe the actions that must be taken and supports the existing processes for 'Putting Things Right' (the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) with updates made to the PTR Regulations to include the Candour Guidance.

2.0 Feedback

2.1 Complaints

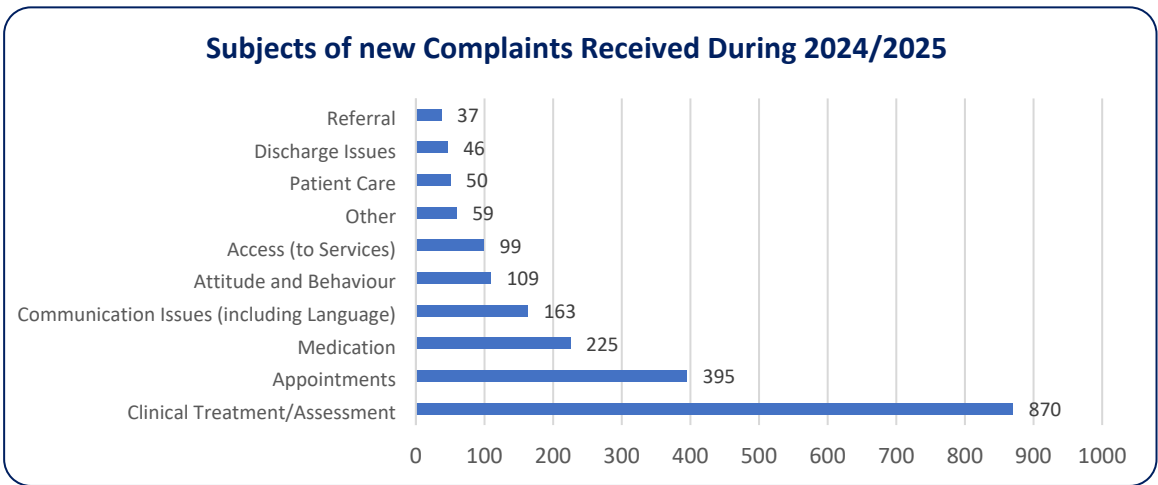
New Complaints

During 2024/2025 a total of 2,225 complaints were received by the Health Board, representing a decrease when compared with the previous year. Of the new complaints received, 468 were managed formally via the Putting Things Right process, a continuation of the decrease reported in 2023/2024. The remaining 1,757 were managed as early resolution complaints. The trend for the last 3 years is reflected in the table below.



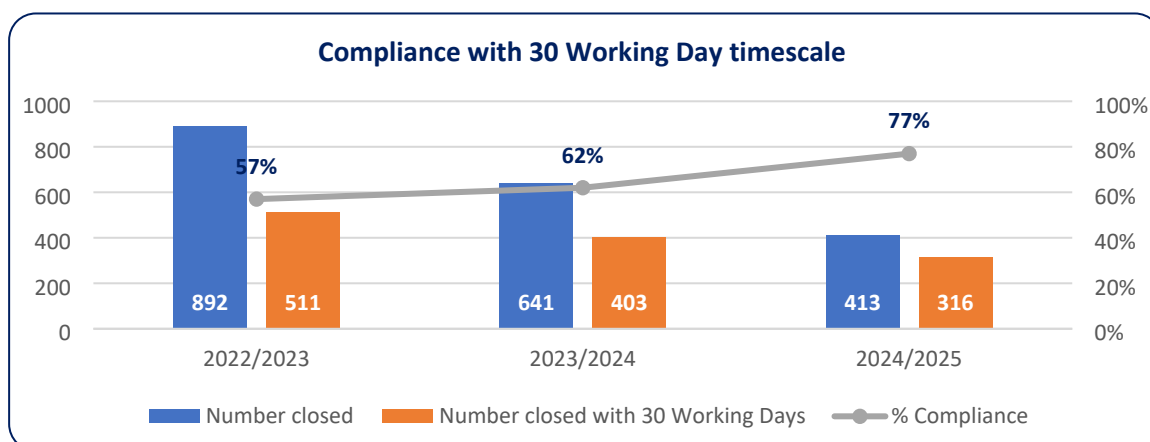
An important component of effective complaints management is ensuring timely acknowledgement to the person raising concerns. During 2024/2025, 69% of concerns received were acknowledged by the expected due date. Improvement action to increase compliance in this area have been identified.

Complaints will often refer to a number of issues of concern regarding the services or care and treatment being provided by the Health Board. Identification of these issues assists in identifying themes and trends, to inform areas for focused improvement work. The top 10 complaints for 2024/2025 are provided in the chart below:



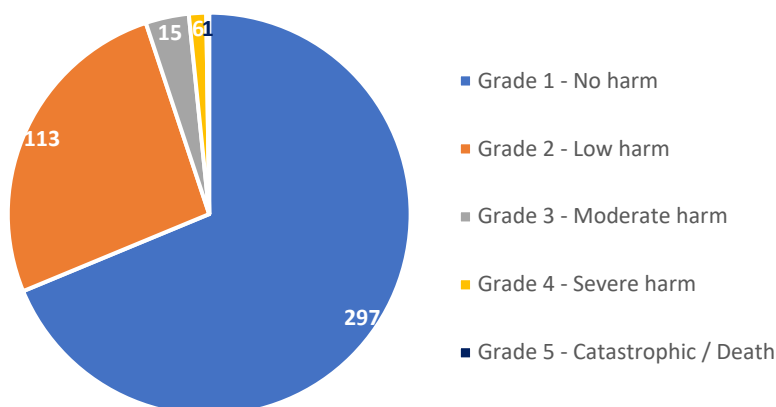
Complaints Closed during 2024/2025

A total of 432 complaints managed via Putting Things Right ("PTR") were closed during 2024/2025. Of the 432, 19 were closed and escalated to the redress process. Of the remaining 413, 77% were responded to within 30 working days target for responding to formal complaints.



On closure all complaints are graded from 1 (no harm) to 5 (catastrophic / death) in accordance with the All-Wales Grading Framework. 95% of complaints are closed with an outcome of grade 1 (297) and grade 2 (113).

Grade of Complaints Closed During 2024/2025

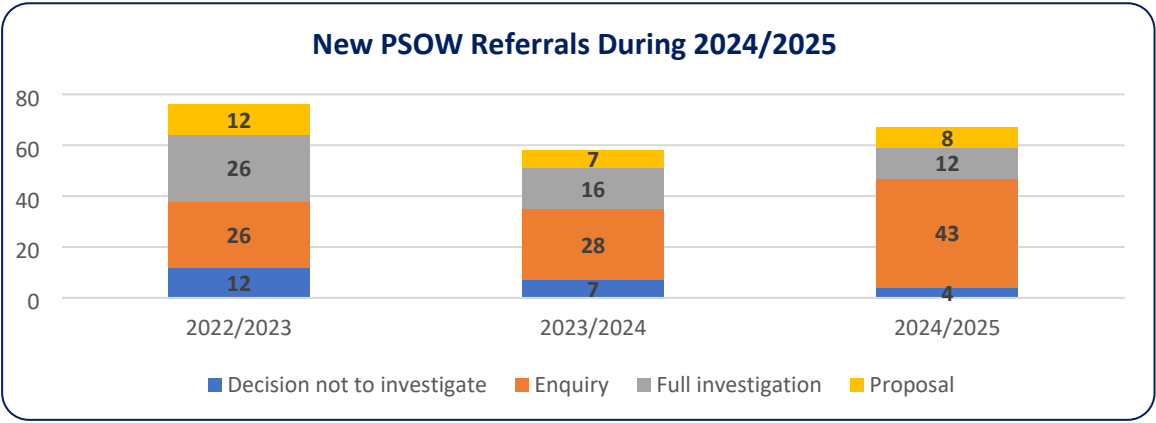


2.2 Public Service Ombudsman for Wales (PSOW)

The Public Services Ombudsman for Wales (PSOW) is an independent body established under the Public Services Ombudsman (Wales) Act 2005, with expanded powers under the 2019 Act. Where a complainant is dissatisfied with the complaints process or the response they receive from the Health Board, they can refer their case to the PSOW.

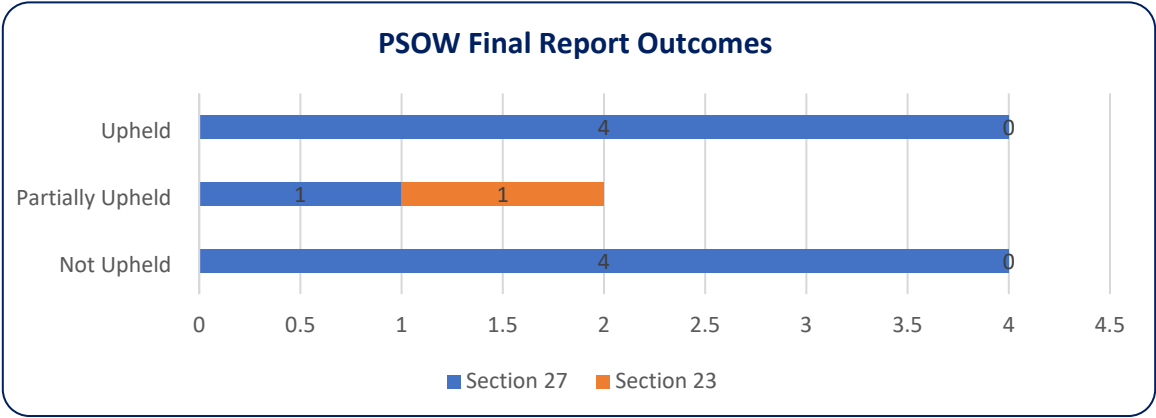
New referrals received

Between the 01.04.24 and 31.03.25, the Health Board received notification of 67 new referrals to the PSOW. This represents an increase when compared to the previous 12 month period. A trend and breakdown of PSOW referrals for the previous 3 years is provided in the chart below.



Final Reports

During 2024/2025 the PSOW issued 10 final reports to the Health Board. Of these, 4 were fully upheld and 2 partially upheld, whereby the Health Board accepted the recommendations and implemented actions to address the learning identified. A summary of the outcome of PSOW investigation final reports is provided in the table below.

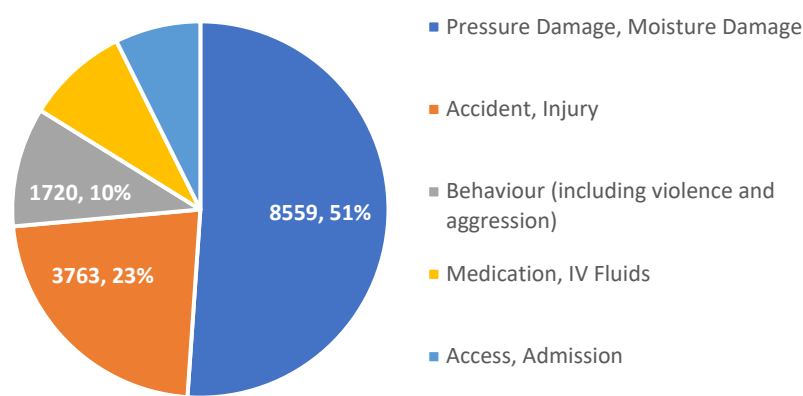


3.0 Patient Safety Incidents

There were 26,083 incidents reported between 01.04.24 and 31.03.25, of which 22,588 (87%) were reported as the patient being the person affected (patient safety incidents).

Accounting for 74% (16,750) the top five Patient Safety incidents reported for the year relate to: Pressure Damage/Moisture Damage; Accident, Injury (including patient falls); Behaviour (including violence and aggression; Medication, IV Fluids and Access, Admission. A breakdown of these is provided in the chart below.

Top 5 Classification of Incidents Reported



3.1 Duty of Candour

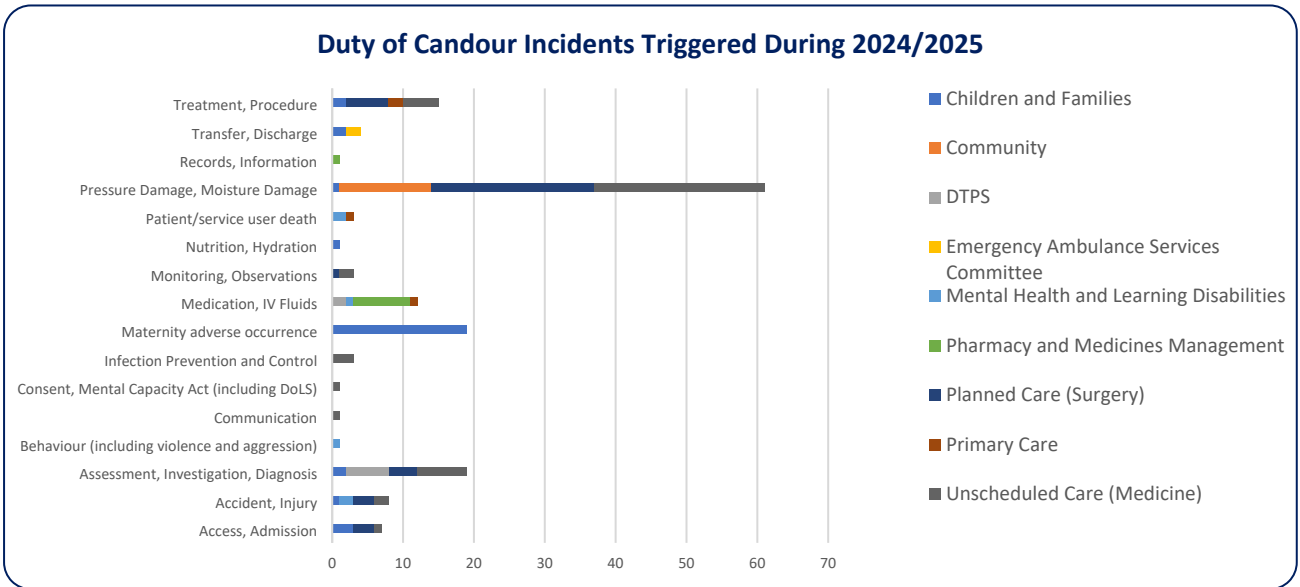
During 2024/2025, 3,541 patient safety incidents were graded by the reporter of the incident as moderate or above. Following Manager’s Interim Harm Assessment, 3,322 patient safety incidents were downgraded to low harm, no harm or the incident occurred prior to the introduction of the Duty. This represents a 94% downgrade rate across the Health Board. 735 incidents are awaiting a Manager’s Interim Harm Assessment to determine grade of harm. The table below provides a breakdown of the patient safety incidents reported as moderate and above, the manager’s harm assessment.

Manager's Interim Harm Assessment	Reporters View of Harm				
		Catastrophic / Death	Severe	Moderate	Total
	Catastrophic / Death	5	0	0	5
	Severe	1	5	3	9
	Moderate	4	11	103	118
	Low	97	94	1526	1717
	None	147	112	1346	1605
	Incident occurred Pre 01.04.23	0	0	2	2
Total		254	222	2980	3456

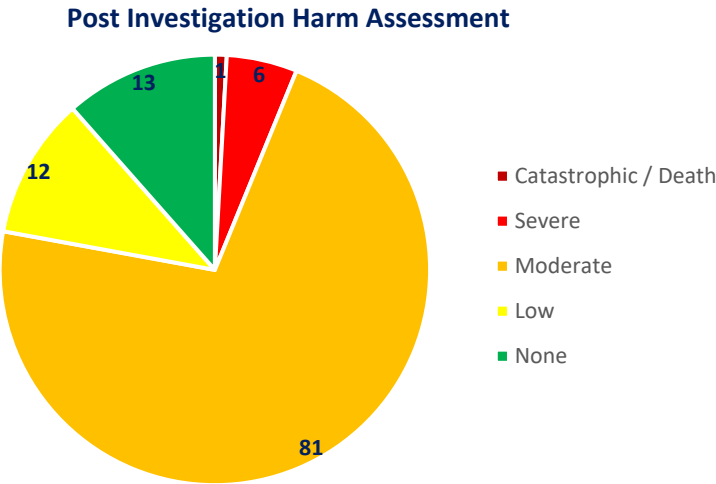
During the reporting period, data extraction from the Datix Cymru System has identified that 58 patient safety incidents were graded by the reporter as no or low harm which, following ‘Manager’s Interim Harm Assessment’, were re-graded as moderate harm or above.

Duty of Candour Triggered

Between the 01.04.24 and 31.03.25, of the 22,588 patient safety incidents reported, of which Duty of Candour was triggered for 159 (0.7%) incidents. A breakdown of Duty of Candour Incidents by classification and care group is provided in the chart below.



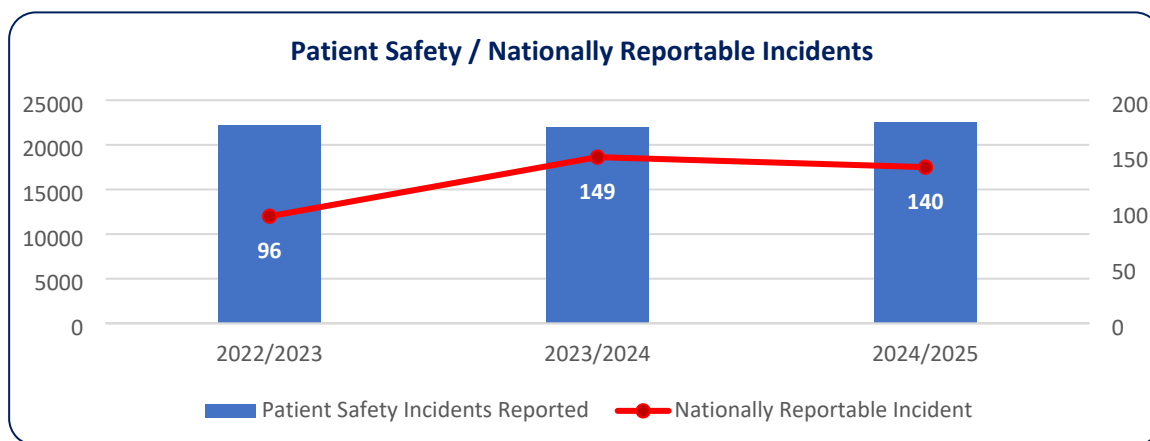
Of the 159 patient safety incidents which triggered the Duty, 113 incidents have been closed. Of those incidents closed, the post investigation harm assessment of 25 (22%) patient safety incidents were deemed as not causing moderate harm or above as a result of healthcare. A breakdown is provided in the table in below.



3.2 Nationally Reportable Incidents

Within the time period, 140 nationally reportable incident notifications were submitted to the NHS Performance & Improvement Team (NHS Executive). This represents a decrease when compared to the previous 12 months.

The incident reporting trend for the previous 3 years is reflected in the chart below.



3.3 Never Events

Never Events are patient safety incidents that are wholly preventable, where there is guidance and safety measures that provide strong systemic protective barriers available at a national level.

Never events have the potential to cause serious harm or death, although serious harm or death does not have to occur for it to be classed as a never event.

The Health Board reported 1 never event between 01.04.24 and 31.03.25, which related to wrong site surgery.

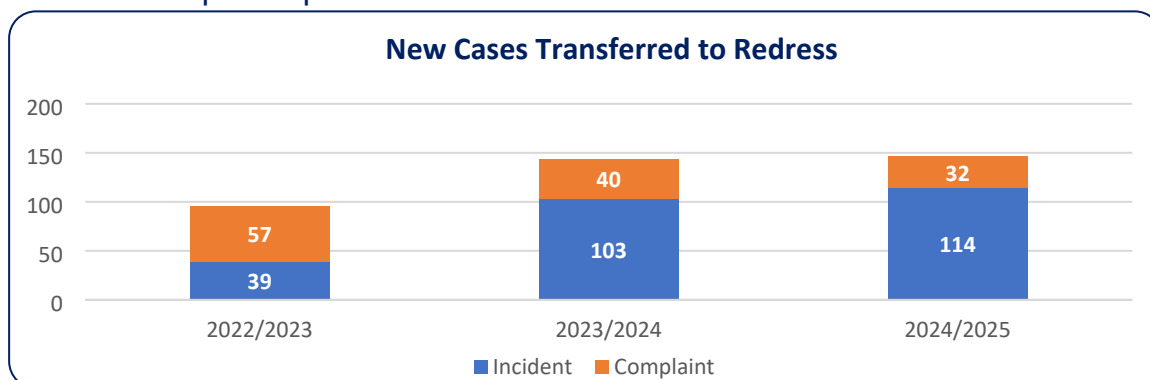
4.0

4.1 Redress

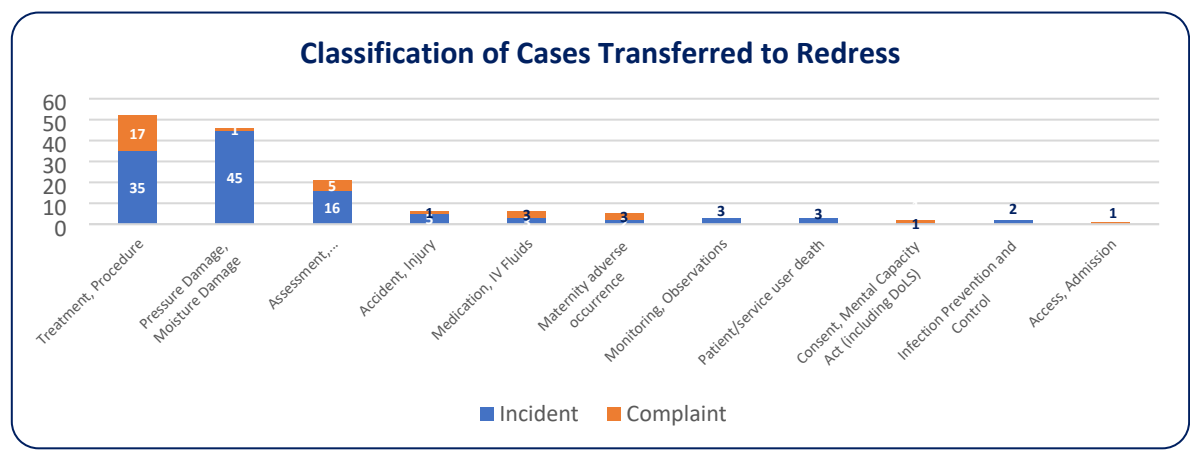
New Cases Transferred to Redress

If during the investigation of a complaint or incident a breach of duty of care is identified which has potentially resulted in harm to the patient, there may be a qualifying liability. At this stage, the complaint will transfer into the Redress process for a further detailed investigation.

Between 01.04.24 and 31.03.25, 146 cases were referred to Redress for review of breach of duty and for consideration as to whether the case is suitable for Redress. 114 were referred from the incident process and 32 from the complaint process.

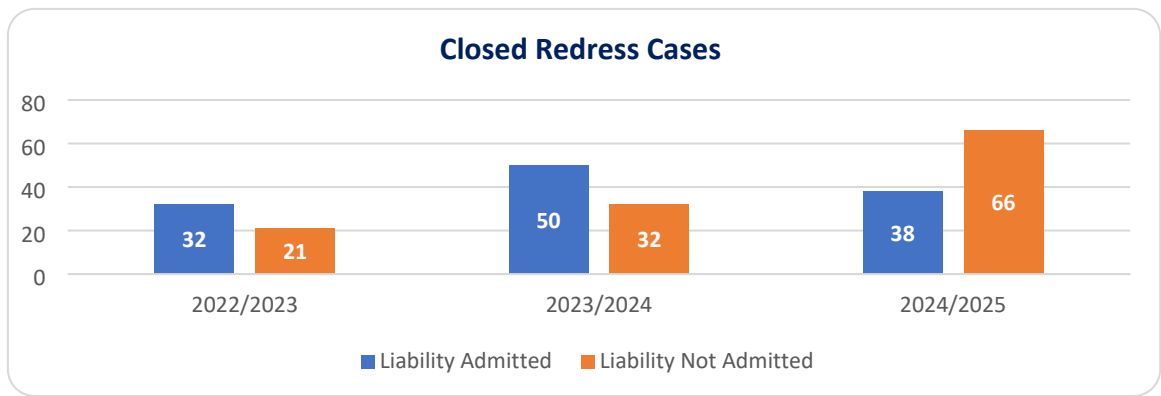


A breakdown of the classification of cases transferred to Redress is provided in the chart below:



Redress Cases Closed

It should be noted that Redress cases will not always be referred and closed within the same financial year. Therefore, the cases closed during 2024/2025 may have been received in previous years. 104 redress cases were closed between the 01.04.24 and 31.03.25, of these 38 were concluded with confirmation of a qualifying liability. The trend for the last 3 years is provided in the table below.



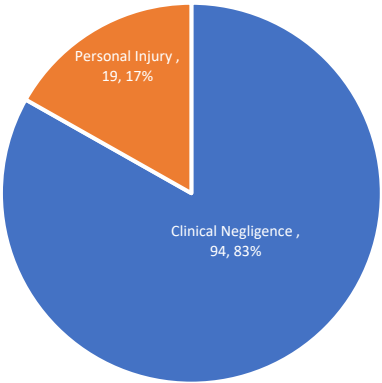
4.2 Claims

Where a case is of a higher value than £25,000, it will be transferred out of the Redress process and managed as a claim.

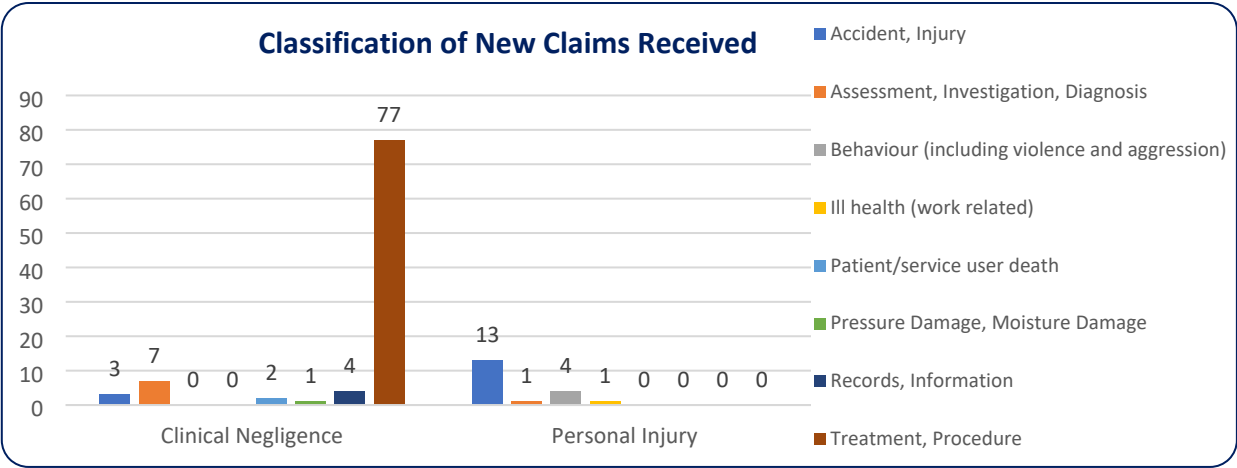
New Claims Received

Between the 01.04.24 and 31.03.25 the Health Board received notification of 113 new claims. These take the form of a clinical negligence and personal injury claims.

Total Number of New Claims Received

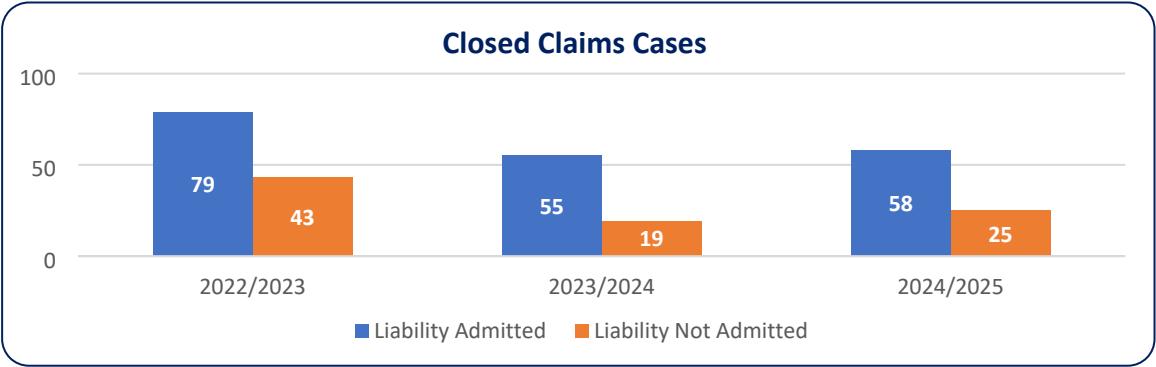


A breakdown of the classification of new claims received during 2024/2025 is provided in the chart below.

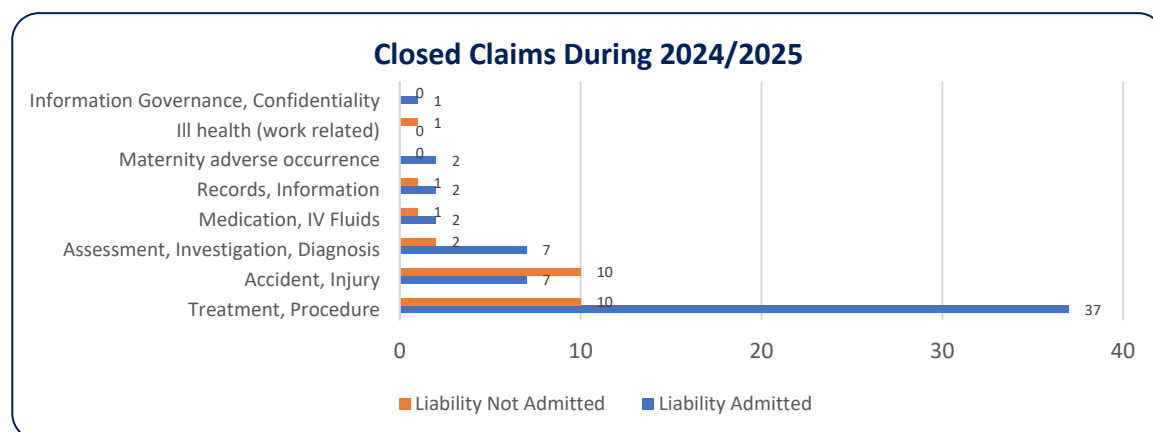


Claims Closed

During 2024/2025 a total 83 claims were closed. Of these, 58 were concluded with an admission of liability or risk-based settlement.



A breakdown of the classification and position regarding liability of claims closed during 2024/2025 is provided in the chart below.

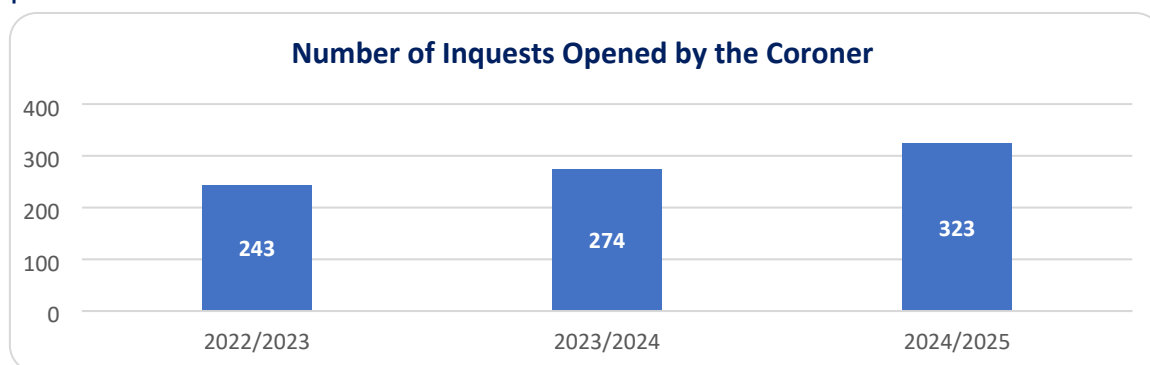


5.0 Inquests

An inquest is a formal investigation by the Coroner to determine how a person died. They are held in certain circumstances, for example if the death was sudden or unexpected. The Health Board must provide information in line with the directions of Coroner.

New Inquests Received

Between the 01.04.24 and 31.03.25 the Health Board received notification of 323 new inquests. This represents an increase when compared with the previous 2 years. A trend graph of inquests opened over the 3 year period is provided below.

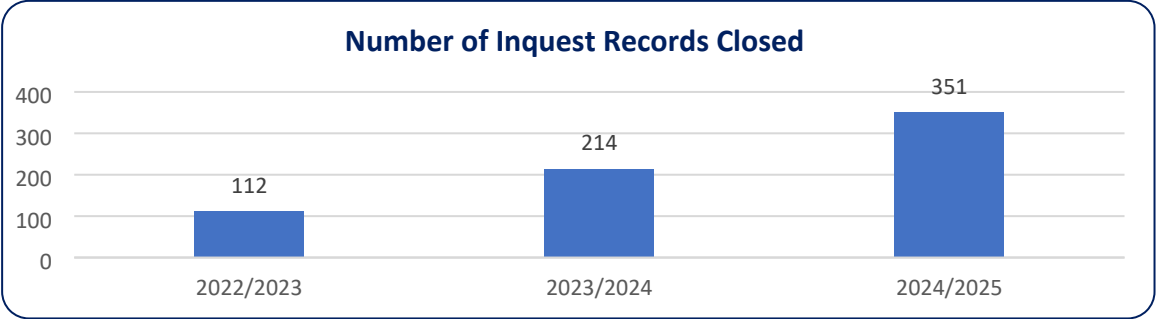


Of the 323 inquests opened, the highest number were received in the Unscheduled Care Group. A breakdown of inquest received by Care Group is provided below.

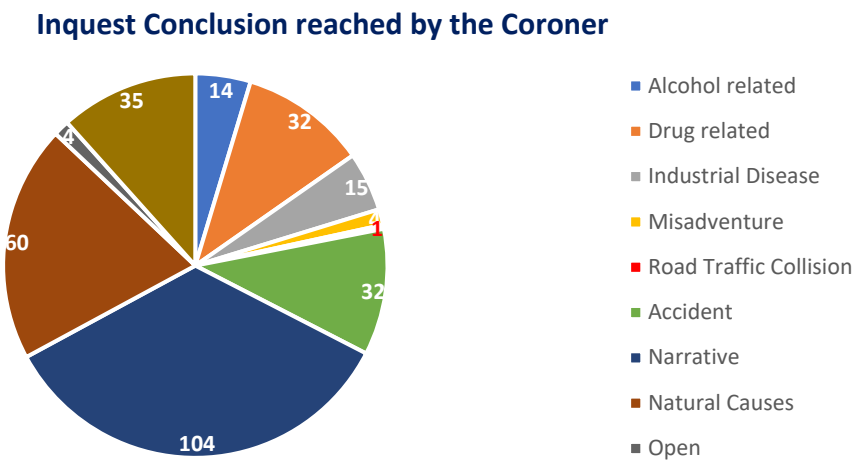
Care Group	Number
Children and Families	10
Diagnostics, Therapies, Pharmacy & Specialist Care	2
Mental Health and Learning Disabilities	89
Planned Care	56
Primary Care & Community Care	23
Unscheduled Care	143
Total	341

Closed Inquests

During the same period 351 inquest cases were closed on the Health Board’s Datix Cymru system. This represents a significant increase in activity when compared with the previous two years. It should be noted that inquests will not always be referred and closed within the same financial year.



Of the 351 inquest records closed on the Datix Cymru system, the hearing date or conclusion has not been made available by the Coroner to the Health Board for 50 cases. Of the remaining cases, 54% were concluded with a narrative (104) or natural causes (60) conclusion. A further breakdown of the conclusion reached by the Coroner for inquests closed during 2024/2025 is provided in the chart below.



Regulation 28 Reports

On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. During 2024/2025 the Coroner issued five regulation 28 reports to the Health Board. The key issues identified in the regulation 28 reports are summarised in the table below.

Inquest Hearing date	Date issued	Care Group	Conclusion reached by Coroner	Type of Regulation 28 Report	Main Issue
17/09/24	20/09/24	Children and Families	Narrative	Hospital Death (Clinical Procedures and medical management) related deaths	Delays in investigations and diagnosis of endometrial cancer

Inquest Hearing date	Date issued	Care Group	Conclusion reached by Coroner	Type of Regulation 28 Report	Main Issue
15/01/25	20/01/25	Unscheduled Care	Narrative	Hospital Death (Clinical Procedures and medical management) related deaths	Delays in Ambulance Handover
19/06/24	28/06/24	Mental Health & Learning Disabilities	Suicide	Alcohol, Drug and Medication related deaths	Access to all relevant documentation
17/05/24	29/05/24	Planned Care	Narrative	Hospital Death (Clinical Procedures and medical management) related deaths	Timeliness of Escalation and maintenance of fluid balance charts
24/02/25	06/03/25	Unscheduled Care	Narrative	Hospital Death (Clinical Procedures and medical management) related deaths	Failed discharge and referral

6.0 Learning from Event Reports

The Health Board is required to submit a signed Learning from Events Report (LFER), within 4 months of the decision to settle a case, to the Welsh Risk Pool.

All cases considered for reimbursement by the Welsh Risk Pool (WRP) are scrutinised for evidence of the lessons learned and improvement actions taken by the Health Board. Reimbursement, both interim and final reimbursement, will be deferred until the WRP Committee is satisfied with learning and the actions taken in a case.

A summary of activity for Learning from Events Reports due during 2024/2025 is summarised below:

	Claims	Redress	Total
Number of LFERs Triggered	83	58	141
Number of LFERs Due	92	53	145
Number of LFERs submitted	90	48	138
Number of LFERs Approved	64	37	101
Number of LFERs Deferred	71	45	116

7. Conclusion

The key areas to note in relation to the implementation of Putting Things Right for 2024/2025 include:

- Reduction in the number of formal complaints received
- Continued improvement in compliance with the 30 working day target
- Slight increase in the number of Public Service Ombudsman for Wales referrals received
- Decrease in Nationally Reportable Incidents

- Increase in number of cases referred to Redress from the incident process
- Themes arising from complaints and patient safety incidents remain consistent with previous years





Agenda Item

8.1.4

Quality, Safety & Experience Committee

Highlight Report from the Organ Donation Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Corinna McNeil & Shaun Miller-Jones, Specialist Nurses Organ Donation David Deekollu, AMD (Q&S)
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
ODR	Organ Donation Register
NORS	National Organ Retrieval Service.
DCD	Donation After Circulatory Death
DBD	Donation After Brain Death
NRP	Normothermic Regional Perfusion

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 meeting on 28 August 2025
- 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	• The Health Board achieved 100% referral rates for both DCD and DBD pathways, with 7 preceding donors resulting in 14 transplants (including 2 life-saving heart transplants). • Significant increase in ODR engagement: opt-ins nearly doubled and opt-outs also increased, reflecting greater public engagement. • Consent rates remain a challenge: 19% compared to the national average of 53% - detailed analysis has been undertaken with regard to family refusals and ongoing efforts to improve are in place. • Outreach projects and annual community engagement events have contributed to increased ODR registrations. • Marketing and Media Manager has been appointed to further boost engagement, with additional campaigns and collaborations planned. • Ongoing development of staff education packages and training is being undertaken to support organ donation conversations. • The Sub Committee heard a Presentation on Abdominal Normothermic Regional Perfusion (NRP) by the Clinical Lead of the Cardiff National Retrieval Team. The presentation provided details on the work being undertaken by the Team, the benefits of NRP and its impact on organ viability and transplant outcomes.
Assure	• CTMUHB 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. • The Health Board is recognised as exceptional in referral rates for potential organ donors by NHSBT. • 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 into the communities we serve.



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. - Annual report timing and alignment with committee meetings to be improved for better discussion and transparency. - Action plan proposed to map committee activities against terms of reference for clearer tracking and reporting. - The Sub Committee has agreed with the Chair of the Quality, Safety and Experience Committee that the Sub Committee's Annual Report for 2024-25 can be submitted to the January 2026 Quality, Safety and Experience Committee. - The Terms of Reference for the Organ Donation Sub Committee were received and endorsed at the meeting held on 28 August 2025 as part of their annual review and attached for Quality, Safety & Experience Committee approval. Any changes made have been highlighted in red.
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:
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 <i>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</i>	A More Equal Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Whole-systems Perspective
	If more than one applies please list below:



Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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	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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 and **APPROVE** the Organ Donation Sub Committee Terms of Reference which have been amended as a result of their annual review.



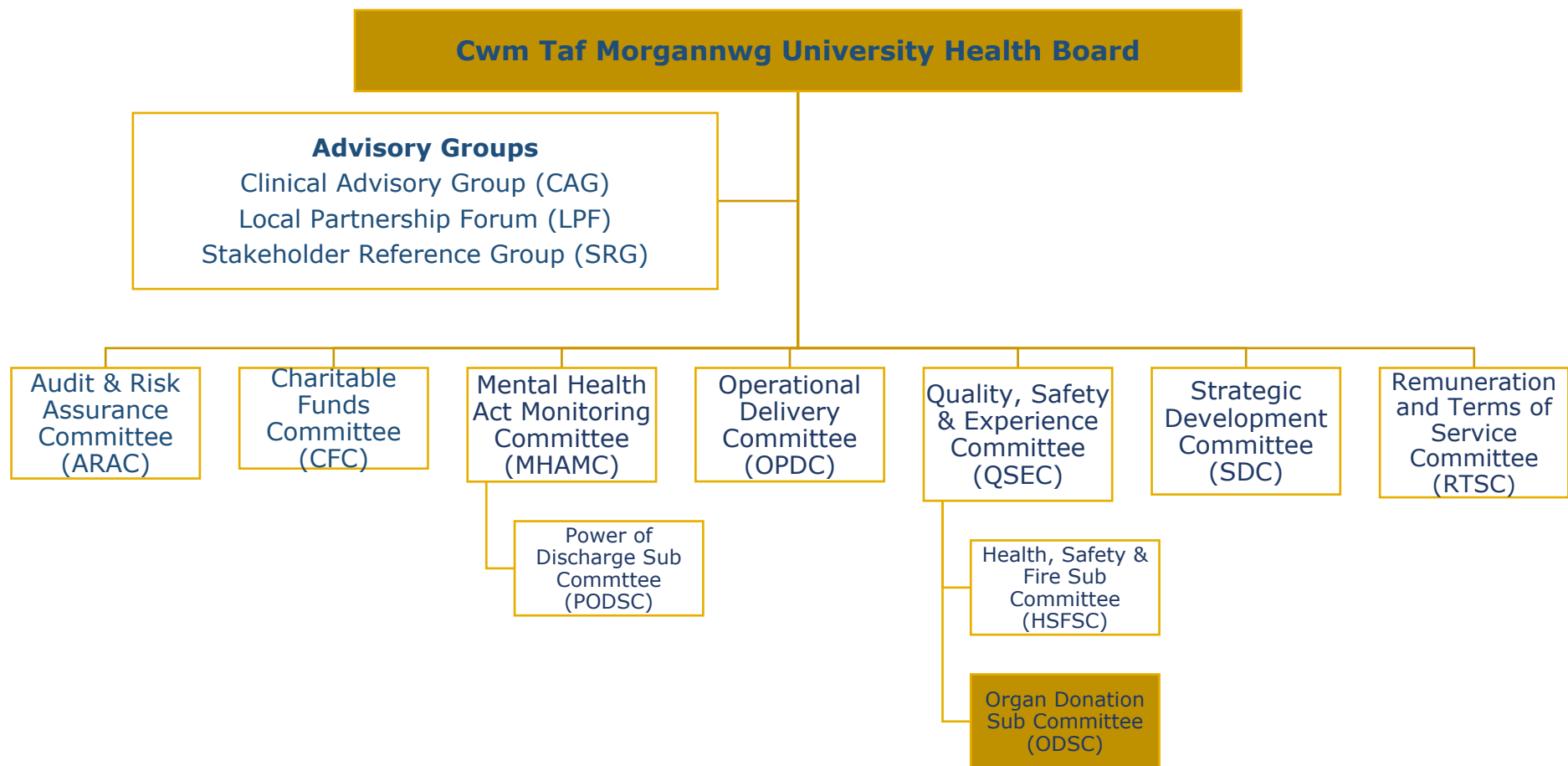
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

ORGAN DONATION SUB COMMITTEE

Terms of Reference & Operating Arrangements
(Schedule 3.5c of the Standing Orders)

Last Approved: Health Board Meeting 26th September 2024
CTM_Corporate_Governance@wales.nhs.uk



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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Board Meeting	26 th September 2024	Approved	No later than the end of September 2025.

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

- 1.1 The Quality, Safety & Experience Committee, established as a Committee of the Board, has established an Organ Donation Sub Committee.

2. Purpose

- 2.1 The purpose of the Organ Donation Sub Committee, the 'sub committee' is to:
- Influence policy and practice in order to ensure that organ donation is considered in all appropriate situations, and to identify and resolve any obstacles to this.
 - 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.

3. Scope and Duties

- 3.1 To ensure the purpose is achieved, the Sub Committee is responsible for the following:
- To lead on donation policy and practice across the CTMUHB, to raise awareness, and to ensure that donation is accepted and viewed as usual, not unusual. To maximise organ donation.
 - To ensure local policies and all operational aspects of donation are reviewed, developed and implemented in line with current and future national guidelines and policies.
 - To monitor donation activity from all areas of the hospitals within CTMUHB - primarily from Critical Care areas, including Emergency Medicine. Rates of donor identification, referral, and approach to the family and consent to donation will be collected through the UK Transplant Potential Donor Audit (PDA), to ensure submission of the data to NHS Blood and Transplant (NHSBT) on an agreed basis and to receive and analyse comparative data from other hospitals.
 - To report to the Medical Director not less than quarterly, and to the Board not less than six monthly, on comparative donation activity and any remedial action required.
 - To participate in all relevant national audit processes; to review audit data on donation activity; to monitor standards, test adherence to local policy and instigate any required actions.
 - To actively promote communication about donation activity to all appropriate areas of the hospital and to ensure that the information is received and understood.

- To ensure a discussion about donation features in all end of life care wherever appropriate and to ensure this is reflected in the local end of life policies, procedures and pathways.
- To support the Specialist Nurses for Organ Donation (SNOD) and Clinical Leads for Organ Donation (CLOD).
- To identify and ensure delivery of educational programmes to meet recognised training needs.

4. Membership

4.1 The Membership of the Sub Committee is as follows:

Chair	Independent Member In the absence of the Committee Chair the Sub Committee Vice Chair will chair the meeting.
Vice Chair	Independent Member
Attendees	Executive Director of Nursing / Deputy Chief Executive Clinical Leads for Organ Donation (CLODs) Specialist Nurses for Organ Donation (SNODs) Consultant – Intensive Care Unit Senior Nurse for Critical Care Medical representative for Emergency Medicine Senior Nurse representative for Emergency Medicine Senior Nurse for Theatres- Prince Charles Hospital Senior Nurse for Theatres- Royal Glamorgan Hospital Senior Nurse for Theatres- Princess of Wales Hospital Consultant Palliative Care/Lead Nurse for Palliative Care Pathology Representative Communication Team Representative Spiritual Care Representative Local Donor Family Primary Care Representative

4.2 By invitation the Sub Committee Chair may invite any other officers from CTMUHB or those outside the organisation where appropriate. The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

4.3 Member Appointments - The membership of the sub Committee shall be determined by the **Quality, Safety & Experience** Committee, based on the recommendation of the Sub Committee Chair. The membership of the Sub Committee will be reviewed annually.

5. Quorum

- 5.1 A Quorum of a third of the whole number, including the Independent Member of the Health Board as Chair of the Sub-Committee or the Vice Chair of the Sub Committee.

6. Meeting Secretariat

- 6.1 The secretariat will be appointed via the Medical Directorate.

7. Frequency of Meetings

- 7.1 The Sub Committee shall meet at least four times per annum and as otherwise directed by the Chair.

8. Withdrawal of Individuals in Attendance

- 8.1 The Sub Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9. Circulation of Papers

- 9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10. Delegated Powers, Authority & Access

- 10.1 The Sub Committee is authorised to request legal advice via the Executive Medical Director without recourse to the Quality, Safety & Experience Committee.
- 10.2 The Chair of the Sub Committee shall have reasonable access to the Chair of the Quality, Safety & Experience Committee, Executive Directors and other relevant senior staff.

11. Accountability & Responsibility

- 11.1 The Sub-Committee is directly accountable to the Quality, Safety & Experience Committee, for its performance in exercising the functions set out in these terms of reference.
- 11.2 Due to the sensitivity of the patient information received, the Sub-Committee will at all times be aware of the importance of confidentiality, and ensure that they comply with the CTMUHB's policies within this area of work.

- 11.3 The Sub-Committee shall embed CTMUHB's values, vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.
- 11.4 The requirements for the conduct of business as set out in the CTMUHB's Standing Orders are equally applicable to the operation of the Sub Committee.

12. Reporting

- 12.1 The Sub-Committee, through its Chair and Members, shall work closely with the Quality, Safety & Experience Sub Committee and other appropriate forums to provide assurance in relation to:
- Joint planning and co-ordination of Board and Committee business; and
 - Sharing of information
- 12.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.
- 12.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive written update reports following each meeting which details the business undertaken on its behalf.
- 12.4 The Sub-Committee Chair, supported by the Sub-Committee meeting secretariat, shall:
- Report formally, regularly and on a timely basis to the Quality, Safety & Experience Committee on the Sub-Committee's activities. This includes the submission of a routine Committee Highlight report, as well as the presentation of an Annual Report within six weeks of the end of the financial year.
 - Bring to the Quality, Safety & Experience Committees attention any significant matter under consideration by the Sub-Committee.

13. Applicability of Standing Orders to Committee Business

- 13.1 The requirements for the conduct of business as set out in CTMUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum

14. Chairs Action on Urgent Matters

- 14.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub Committee need to be taken between

scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with at least two other members of the Sub Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Sub Committee for consideration and ratification.

- 14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

15. Review

- 15.1 These Terms of Reference shall be approved by the Quality, Safety & Experience Committee and subject to review at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.



Agenda Item

8.1.5

Quality, Safety & Experience Committee

All Wales IPFR Policy (2025)

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Tynan-Preece, Commissioning Manager
Cyflwynydd yr Adroddiad / Report Presenter	Sallie Davies, Deputy Medical Director (TBC)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health

Pwrpas yr Adroddiad / Report Purpose	For Approval
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
All Wales IPFR Policy Implementation Group – includes representation of all Health boards and AW TTC, QAG, Medical Directors, Board Secretaries and Velindre NHS Trust	November 2022 – July 2025	Supported
Head of Commissioning	08/09/2025	Supported
Assistant Director of Transformation	11/09/2025	Supported
Executive Director of Public Health	12/09/2025	Supported

Acronyms / Glossary of Terms	
AWTTC	All Wales Toxicology and Therapeutic Committee
CTMUHB	Cwm Taf Morgannwg University Health Board
IPFR PIG	Individual Patient Funding Request Policy Implementation Group
IPFR QAG	Individual Patient Funding Request Quality Assurance Group
NWJCC	New Wales Joint Commissioning Committee
QC	Queens Council
VUNT	Velindre University Health Trust
WHSSC	Welsh Health Specialised Services Committee
AWMSG	All Wales Medicines Strategy Group

1. Situation /Background

- 1.1 An Individual Patient Funding Request (IPFR) is defined as a *request to a Health Board or NWJCC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board has arranged to routinely provide, or commission*. This can include a request for any type of healthcare including a specific service, treatment, medicine, device, or piece of equipment.
- 1.2 The current version of the All Wales Individual Patient Funding Request policy was last reviewed 2017. In July 2022, the Welsh Government tasked the NWJCC (formally WHSSC) with undertaking a '*di minimis*' review of the policy and terms of reference. This was following a Judicial Review NWJCC (formally WHSSC) was subject to in 2021, and where a series of recommendations were made by the QC.
- 1.3 Following an extended period of engagement and consultation with key stakeholders including AWTTC, IPFR QAG, Medical Directors and Board Secretaries of each Health Board and Velindre University NHS Trust (VUNHST). This engagement was predominantly managed via the All Wales IPFR Policy Implementation Group (PIG) (which includes representation from all health boards, NWJCC and AWTTC), this group has been instrumental in ensuring the revised policy is fit for purpose. In August 2025, the final version of the revised policy was agreed by Health boards and the NWJCC (appendix 1).
- 1.4 This paper will provide a high level summary of the key changes within the updated IPFR policy.
- 1.5 Each health board is now required to obtain formal approval to endorse and implement the revised policy.

2. Specific Matters for Consideration

2.1 Outcome of Judicial Review

In December 2021 a judgment was handed down in a judicial review concerning MW – v- (1) WHSSC & (2) Aneurin Bevan UHB (ABUHB), which overturned a decision of the WHSSC (now NWJCC) IPFR panel to decline funding for treatment. This was largely because the court’s interpretation of the NHS Wales Policy for Making Decisions on IPFR’s was significantly different to that of the IPFR panel and indeed the original and intended meaning of the policy. Subsequent legal advice from a QC indicated that the policy would need to be revised if its original and intended meaning was to be reinstated.

3. All Wales IPFR Policy update

- 3.1 The NHS Wales IPFR PIG brings together representatives from Health Boards, the Joint Commissioning Committee, AW TTC, and Health Technology Wales to ensure the fair and consistent application of the Individual Patient Funding Request (IPFR) Policy across Wales. The group supports decision-making for treatments not routinely provided, promotes best practice, and helps shape national policy. It also works to improve understanding of the IPFR process, enhance data quality, and inform future commissioning. Through collaboration and stakeholder engagement, the PIG fosters a transparent, inclusive, and patient-focused approach to funding decisions.
- 3.2 The NHS Wales IPFR Policy has been updated collaboratively, following a robust development project. The proposed version is accepted by the All Wales IPFR PIG as being fit for purpose. This follows discussion and agreement at a meeting of the IPFR Chairs (or their representatives) in September 2024.

The main changes to note are:

- Revisions to the section explaining how IPFR decisions are made, with more explanation of the criteria to be considered, with particular reference to IPFR applications made under section 9B:
 - Primary criteria relate to whether available guidelines (e.g from NICE or AWMSG) recommend NOT to use an intervention; or if the intervention has NOT been appraised hence no guidelines are in place.



- Further criteria require the objective assessment of the clinical circumstances of the patient; the potential for significant clinical benefit; and whether the value for money of the intervention is likely to be reasonable (please refer to table 1).
- The 'decision making guide' has been retained, however is now an appendix rather than embedded with the core Policy, and is considered an 'aide' to assist panel discussion.
- Updated Terms of Reference for the NWJCC IPFR Panel to strengthen clinical representation.
- Inclusion of the Terms of Reference for the IPFR PIG.
- Removal of surplus, convoluted, passages referring to legal challenge.
- Simplification of references to Health Board complaints processes and referrals to Public Services Ombudsman for support.

Table 1, Revision of criteria for IPFR applications considered under section 9B:

Old IPFR policy (2017)	New IPFR policy (2025)
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population? and Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage? IPFR panel to: Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit	Does the presentation of the patient's condition mean they are likely to gain significant clinical benefit from the intervention requested? IPFR Panel to: Consider the evidence submitted in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Does the evidence provided explain why this patient is likely to gain a significant clinical benefit when compared to next best alternative for this patient, which may in some cases be best supportive care?



from the treatment than another patient with the same disease at the same stage?	
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3.3 With the oversight of the IPFR QAG, the application and adherence to the new All Wales IPFR policy will be monitored and any concerns regarding non-compliance with the new criteria will be reported to Health boards and NWJCC via their quarterly quality assurance audits.

4 Key Risks / Matters for Escalation

Following robust discussions with key stakeholders, there are no key risks or matters that require escalation.

5 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Choose an item.
	If more than one applies please list below: This policy spans all strategic areas
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / 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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) /	Person Centred
	If more than one applies please list below: Policy spans all quality domains



Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	
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: All Wales policy
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate): NEUTRAL Outcome for Welsh Language (delete as appropriate): NEUTRAL	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below) Changes to the All Wales IPFR policy are recommended following a Judicial Review for which NWJCC was involved.	
Enw da / Reputational	Yes (Include further detail below) The is risk of reputational harm if the policy is not approved and endorsed for use in CTM UHB.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

6 Recommendation

The Committee is asked to endorse the revised All Wales IPFR Policy (2025) and approve its implementation within CTMUHB.

7 Next Steps

No further action following endorsement and approval from the QSE Committee. The date on which the new IPFR policy will be implemented will be co-ordinated across NHS Wales, once all Health Boards and JCC have approved the policy for endorsement via formal governance channels. This is likely to be a date in October 2025.



NHS WALES POLICY MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)

Reference Number	Policy Reference (as per individual Health Board)	Version Number	FINAL July 2025
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Health Boards and Primary Care providers across Wales

NHS Wales Joint Commissioning Committee (JCC)
Public Health Wales (PHW)
Public Domain via Internet Sites

Policy Development: All Wales IPFR Policy Implementation Group
NHS Wales Joint Commissioning Committee

Consultation: Legal Advice from Welsh Health Legal & Risk Services
NHS Wales Medical Directors Stakeholder groups

Approved: July 2025

Date of Publication: TBC

Date of Next Review July 2028

Lead Health Board Contact: Contact details as per individual Health Board

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1 INTRODUCTION

1.1 Background

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All-Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

1.1.1 In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. An independent review group was established to explore how the current process could be strengthened.

1.1.2 In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

1.1.3 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being, and Sport agreed the time was right for a new, independent review of the IPFR process. The panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017.

1.1.4 Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review would be undertaken to put beyond doubt how the policy should be interpreted. In 2024 the commissioning responsibilities of WHSSC were transferred to the NHS Wales Joint Commissioning Committee (JCC).

1.2 Purpose of this Policy

1.2.1 To ensure an open, transparent, fair, clearly understood and easily accessible process is followed, the NHS in Wales has introduced this Policy on decision making for IPFR's. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

1.2.2 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.3 A comprehensive range of NHS healthcare services are routinely provided

locally by primary care services and hospitals across Wales. In addition, the JCC, working on behalf of all the Health Boards in Wales, commissions a number of more specialist and highly specialist services at a national level. However, each year, requests are received for healthcare that fall outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

1.2.4 Each Health Board in Wales has a separate Policy called 'Interventions Not Normally Undertaken' (INNU) setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because:

- There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
- The intervention has not been reviewed for the indication under consideration by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG); and/or One Wales Medicines process or Health Technology Wales.
- The intervention is considered to be of relatively low priority for NHS resources.

1.2.5 The INNU policy should be read together with this policy on making decisions

1.2.6 The challenge for all Health Boards and JCC is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board and/or JCC has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board and JCC's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board or JCC will have to make.

1.2.7 In line with the requirements of the Equality Act 2010 and the Welsh Government guidance 'Inclusive Policy Making' issued in May 2010, a detailed equality impact assessment has been completed to assess the relationship between this policy and the duties of the Act.

1.3 Explaining Individual Patient Funding Requests (IPFR)

1.3.1 IPFRs are defined as requests to a Health Board or JCC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board or JCC has arranged to routinely provide, or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device or piece of equipment.

Such a request will normally be within one of the three following categories.

- a patient and NHS clinician have agreed together that they would like treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition).

- a patient and NHS clinician have agreed together that they would like treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone).
- a patient has a rare or specialist condition that falls within the service remit of the JCC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

1.3.2 IPFRs should not be confused with requests for packages of care for patients with complex continuing healthcare needs – these are covered by separate Continuing Healthcare arrangements. Further information can be obtained from the Health Board’s Nursing Department.

1.3.3 IPFRs should also not be confused with treatments that have already been provided or administered outside of NHS funded care. Requests **will not** be considered for retrospective funding.

1.3.4 If the clinical circumstances for the specific individual patient have changed, an IPFR application form describing / explaining / justifying:

- i. why the patient is likely to gain significant clinical benefit from the proposed intervention; and
- ii. demonstrating that the value for money of the intervention for that particular patient is likely to be reasonable,

then a case may be submitted to the Health Board or JCC for consideration for further prospective funding. For example, if a patient funds a treatment themselves and their clinician believes they can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.

1.3.5 The three categories of treatment described in 1.3.1 will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare but equally the granting of funding in one case does not mean that funding will be provided for the same treatment for other patients. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.

1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient’s condition does not have substantially the same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made.

1.3.7 In practice, it is not always practical to determine the “benefit” of an intervention in numerical terms in the same way, for example as NICE or the AWMSG. In these situations, a description of the benefit should be used to

enable IPFR panels to compare the description of the incremental clinical benefit likely to be obtained.

In general, the clinician should compare the benefits of the intervention being requested with what he or she considers to be the next best alternative, which may in some cases be best supportive care.

1.3.8 Whether an intervention provides “value for money” is assessed conceptually in terms of the incremental cost per incremental quality-adjusted life year (QALY) of benefit. Whilst “reasonable” value for money is to be interpreted in the same way that “cost-effective” is used in the Health Technology Appraisal (HTA) process operated by NICE, AWMMSG and HTW.

1.3.9 Recognising that it can never be possible to anticipate all unusual or unexpected circumstances, this policy aims to establish a clear guide to making decisions on IPFRs to determine whether the evidence that the patient is likely to gain a significant clinical benefit, and the value for money of the intervention for that particular patient is likely to be reasonable, has been presented.

Please refer to the decision-making factors in Appendix one. These are factors the panel may consider when looking at the significant clinical benefit expected by the treatment, and whether the cost of the treatment is in balance with the expected benefits.

2 THE LEGAL CONTEXT OF THIS POLICY

2.1 Health Boards exercise functions delegated to them by the Welsh Ministers under various statutes and in particular under the National Health Service (Wales) Act 2006 and under secondary legislation made under that Act.

2.2 In addition to specific statutory obligations, Health Boards are public bodies, which are required to comply with their legal obligations to act in accordance with the rights of individuals under the European Convention of Human Rights as defined in the Human Rights Act 1998 and under common law.

2.3 Health Boards must therefore be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have considered all relevant issues in the decision-making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate.

Careful consideration needs to be given in relation to all decisions; particular care may need to be given in the following circumstances:

- when evidence is not clear or conclusive.
- when the issue is controversial and may not have the support of NICE, AWMMSG or HTW.
- when life or death decisions are involved.
- when limiting access to specific services or treatments.
- when setting priorities.
- when other Health Boards or JCC may have used their discretion to make a different decision on a specific topic.

- 2.4** It is lawful for JCC and Health Boards to adopt policies about which treatments will, and which will not, be routinely funded. It is also lawful for JCC and Health Boards to adopt this policy to define the circumstances in which a decision can be made to fund an intervention for a patient where the patients are lawfully
- 2.5** denied funding for the same intervention as a result of policies or as a result of an absence of a policy approving funding for that intervention.
- 2.6** Consistency in policy and approach, together with clarity about clinical criteria for treatment and a consistent approach to dealing with IPFR requests should reduce the need for patients to go through a review or appeal process at any level. This should be the desirable outcome as far as it is possible.

3 PRINCIPLES UNDERPINNING THIS POLICY

The principles underpinning this policy and the decision making of the Health Board are divided into five areas - the NHS Core Values, the Prudent Healthcare Principles, Evidence-based Considerations, Ethical Considerations and Economic Considerations.

- 3.1 NHS Core Values** are set out by the Welsh Government as;
- Putting quality and safety above all else: providing high value evidence-based care for our patients at all times.
 - Integrating improvement into everyday work and eliminating harm, variation and waste.
 - Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
 - Working in true partnerships with partner organisations and with our staff
 - Investing in our staff through training and development, enabling them to influence decisions and providing them with tools, systems, and environment to work safely and effectively.
- 3.2 Prudent Healthcare Principles**
- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.
 - Care for those with the greatest needs first, making the most effective use of all skills and resources.
 - Do only what is needed, no more, no less; and do not harm.
 - Reduce inappropriate variation using evidence-based practices consistently and transparently.
- 3.3 Evidence-Based Considerations**
- 3.3.1** Evidence-based practice is about making decisions using quality information, where possible, and recognising areas where evidence is weak. It involves a systematic approach to searching for and critically appraising that evidence.
- 3.3.2** The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently.

NICE issue Technology Appraisals and the All-Wales Medicines Strategy Group and Health Technology Wales issue guidance which Health Boards and JCC are required to follow.

3.3.3 Additionally, a central repository for evidence-based appraisals is available which provides support for clinicians making an application. This is located on the shared database. Users are able to upload and access the information

available which will continue to be developed over time as evidence /new reports are produced.

3.3.4 It is also important to acknowledge that in decision making there is not always an automatic “right” answer that can be scientifically reached. A “reasonable” answer or decision therefore has to be reached, though there may be a range of potentially reasonable decisions. This decision is a compromise based on a balance between different value judgements and scientific (evidence-based) input. Those vested with executive authority have to be able to justify, defend and corporately “live with” such decisions.

3.4 Ethical Considerations

3.4.1 Health Boards and JCC are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources (‘distributive justice’). They are expected to respect each individual as a person in his or her own right.

3.4.2 Resources available for healthcare interventions are finite, so there is a limit to what Health Boards and JCC can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost-effective intervention is one that confers a great enough benefit to justify its cost. That means policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process.

3.4.3 Welsh Government communications set out six ethical principles for NHS organisations and these underpin this policy. They are:

- treating populations and particular people with respect.
- minimising the harm that an illness or health condition could cause.
- fairness.
- working together.
- keeping things in proportion; and
- flexibility

3.5 Economic Considerations

3.5.1 It is a matter for Health Boards and JCC to use its discretion to decide how it should best allocate its resources. Such resources are finite and difficult

balancing decisions have to be made. Health Boards and JCC must prioritise the services that can be provided whilst delivering high-quality, cost-effective services that actively avoid ineffective, harmful, or wasteful care that is of limited benefit. The opportunity cost associated with each decision has also to be acknowledged i.e., the alternative uses to which resources could be put.

4 MAKING DECISIONS ON IPFR

4.1 In line with the principles set out earlier in this document, Welsh Government communications set out the key factors for 'good decision making'. These are:

- openness and transparency.
- inclusiveness.
- accountability.
- reasonableness.
- effectiveness and efficiency.
- exercising duty of care.
- lawful decision making; and
- the right to challenge and appeal

This policy aims to ensure that the Health Board and JCC has a clear and open mechanism for making decisions that are fair, open, and transparent. It enables those responsible for decision making to demonstrate that they have followed due process, considered the above factors, and have been both rigorous and fair in arriving at their decisions. It also provides a clear process for challenge and appeal.

4.2 In accordance with Welsh Government communications, NICE definitions, and the criteria set out in this policy, Health Boards and JCC should make decisions on IPFRs based on; the evidence presented to demonstrate the expected significant clinical benefit, and the evidence presented outlining the patient's individual clinical circumstances. Decisions should be undertaken whilst taking into reasonable account the evidence base, and the economic and ethical factors below:

- **evidence-based considerations** – clinical and cost effectiveness; service and policy implications.
- **economic considerations** – opportunity cost; resources available; and
- **ethical considerations** – population and individual impact; values and principles; ethical issues.

Non-clinical factors (such as employment status) will not be considered when making decisions on IPFR.

This Policy does not cover healthcare travel costs. Information on patients' eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Governments' healthcare costs website.

4.3 The following criteria must be used by all Health Board and JCC IPFR Panels when making IPFR decisions. It is the responsibility of the referring clinician to ensure that sufficient information is placed before the panel to allow the panel to be able to determine whether the criteria are satisfied.

A patient will only be entitled to NHS funding for the requested intervention or drug if the panel conclude that the criteria under **either (a) or (b)** below are satisfied:

(a) If guidelines (e.g. from NICE or AWMSG) recommend NOT using the intervention/drug, or the clinical access criteria of an applicable policy are not met:

- I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to other patients for whom the recommendation is not to use the intervention.
- II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and
- III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

(b) If the intervention has NOT been appraised (e.g. in the case of medicines, by AWMSG or NICE), and there is no applicable policy in place:

- I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and
- II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

4.4 An IPFR panel is required to decide whether the application fulfils Part A or Part B and then consider the application against the relevant criteria. A panel may only approve applications which meet all of the applicable criteria above. It is however the responsibility of the requesting clinician to demonstrate the clinical case for the patient in respect of the criteria outlined.

4.5 Considerations under Part A

4.5.1 Where a recommendation has been made not to use an intervention, the panel is required to consider whether the patients' clinical circumstances are significantly different to other patients for whom the recommendation is made not to use the intervention'. That process will usually require a comparison between the patient for whom treatment is being requested, and other patients with the same medical condition who could have been offered the requested intervention if the relevant guidance and/or applicable policy allowed.

4.5.2 The panel next should consider whether there is a significant difference between the clinical circumstances of the patient for whom funding is being requested, and the comparator group, and whether the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected for patients for whom the recommendation has been made not to use the intervention. If, but only if, both of these criteria are

met on the facts of an individual Part A case, the panel will then consider whether the intervention is deemed value for money as described at paragraph 4.7 below.

4.6 Considerations under Part B

- 4.6.1** In the absence of any appraisal or applicable policy, the panel need to consider whether the referring clinician has provided sufficient evidence to conclude that the patient is likely to gain significant clinical benefit from the intervention requested. If this criterion is met on the facts of an individual Part B case, the panel will then consider whether the intervention is deemed value for money as described below.

4.7 Value for money

- 4.7.1** The assessment as to whether the intervention provides “value for money” is a matter of judgement for the panel. The panel should reach a decision exercising its broad discretion to decide whether the value for money of an intervention for a particular patient is likely to be reasonable.
- 4.7.2** The panel should consider the likely overall costs to the NHS of the requested intervention compared with the next best alternative treatment that is routinely funded on the NHS. The panel should in a similar way consider the overall benefit (effectiveness) of the intervention compared with the next best alternative treatment that is routinely funded on the NHS. If the requested intervention is estimated to be more effective and less costly (than the alternative treatment) then it is likely to represent value for money. If the treatment is less effective and more expensive, then it is unlikely to be deemed value for money. If the treatment is more effective and more costly or less effective and less costly then the panel will need to make a judgement as to whether the treatment is likely to represent value for money. For any scenario, other factors may affect treatment choice, and these should be documented as part of the discussion.
- 4.7.3** Where presented as part of the evidence, an incremental cost effectiveness ratio (“ICER”) and quality- adjusted life year (QALY) may be considered by the panel provided this is relevant to the individual case and there is appropriate expertise by the group to do so. When assessing this evidence, the panel should consider relevant thresholds in relation to NICE and AWMSG when considering if the intervention is a cost-effective option.
- 4.8** When making decisions, the panel are entitled to have regard to the factors set out at Appendix 1 to this policy, if the panel consider that addressing those issues may assist the panel in coming to decisions on the criteria set out at paragraph 4.3 above. The panel is not obliged to consider all the factors set out Appendix 1 to this policy and may consider that some of the factors are not relevant to the facts of an individual case or do not assist the panel in coming to its decision on those criteria.

5 HOW TO MAKE A REQUEST FOR FUNDING UNDER THIS POLICY

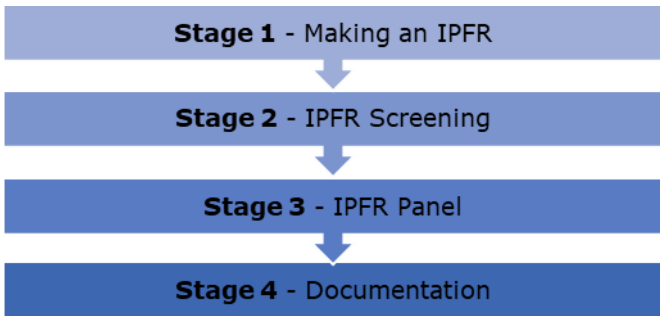
5.1 Information on how to make an IPFR

A patient leaflet is available explaining how an individual patient funding request (IPFR) can be made. These can be downloaded from the Health

Board, JCC or AWTTC website. Further information can be obtained from the IPFR Coordinator.

Copies of this policy and the IPFR application forms can also be obtained via the website, or by contacting the IPFR Coordinator.

5.2 Summary of the IPFR Process



5.3 Stage 1 Making an IPFR

The patient and their NHS clinician (agree together that a request should be made). The IPFR application form is completed by the clinician on the patient's behalf. This will ensure that adequate clinical information is provided to aid the decision-making process.

The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

Ideally, applications for specialised and tertiary services should be completed by the patient's secondary care clinician, unless extenuating circumstances dictate otherwise. This is to ensure that all pertinent information is included in the form thereby avoiding the delay that will arise from the need to request further information before the application can be processed. All IPFR applications should demonstrate support from the relevant clinical lead, head of department or multi-disciplinary team (MDT). Where relevant, advice may also be sought from the internal clinical team.

It is necessary for clinicians to provide their contact details as there may be times when additional clinical information is required during a panel meeting to aid a decision.

The application form is sent to the IPFR Coordinator electronically or in hard copy so that the authorised consent of the clinician is recorded.

The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision.

Should the IPFR Coordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or if the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

The requesting clinician is responsible for completing and re-submitting the application form **within ten working days**. Should this time elapse, a chaser letter will be sent providing a **further ten working days** to make a submission.

Where the information has still not been provided in the time set, the case shall be closed, and the requesting clinician notified accordingly.

5.4 Stage 2 Screening of the IPFR

The IPFR application will be considered by the IPFR Senior Officer to determine whether the application needs to be screened out because:

- a) The request meets pre-agreed criteria for a service already commissioned/provided and can automatically be funded
- b) an alternative and satisfactory clinical solution is found
- c) The request represents a service development which needs to be passed to the relevant Division or Directorate for action.

The IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician using a standard letter, **within five working days** of the decision being made. This letter will also include reasons for the decision and information on any further courses of action required.

5.5 Stage 3 Considerations by the IPFR Panel

Requests that are not screened out will be considered at a meeting of the IPFR Panel. The IPFR Coordinator will ensure that the panel has all of the information needed to reach a decision and will ensure that each case is anonymised before each meeting.

Panels will convene at least once per month in order to ensure that applications are dealt with in a timely manner. The volume and urgency of applications may require panels to meet more frequently as and when required.

The panel will consider each IPFR on its own merits, using the criteria set out in paragraph 4.3 of the Policy. Where possible, they should set out their assessment of the likely incremental clinical benefit and their broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent. The IPFR Coordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision.

A standard decision letter should be prepared to communicate the decision to the requesting clinician. Correspondence will also be sent to the patient to inform them that a decision has been made, and their clinician will contact them within 5 working days to discuss. If this has not happened, patients are encouraged to contact their clinician.

These letters will be sent **within five working days** of the panel's decision and will also include information on how to request a review of the process where a decision has been made to decline the request.

5.6 Who will sit on the IPFR Panel?

The Health Board will appoint core members of the IPFR Panel which will comprise:

- Executive Public Health Director (or deputy – Public Health Consultant)
- Executive Medical Director (or deputy - Associate/Assistant Medical Director)
- Executive Director of Nursing (or deputy – Assistant Director of Nursing)
- Director of Therapies & Clinical Science (or deputy - Assistant Director of Therapies)
- Director of Pharmacy and / or Chief Pharmacist or deputy; and
- Two lay representatives.

The Chair of the Panel will be selected from the group of core members and must have a clinical background (with the exception of JCC – see Terms of Reference at Appendix 3).

Each organisation may also wish to appoint up to a further two Panel members at the discretion of the Chair of the Panel, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning.

Please refer to the Terms of Reference at Appendix 2 and 3 for details of the Health Board and JCC IPFR Panel.

5.7 What about clinically urgent cases?

The IPFR Policy and process allows for clinically urgent cases, as deemed by the requesting clinician, to be considered outside of the normal screening and panel processes. In these circumstances, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel, within their delegated financial limits. Any such decisions will be made in line with the principles of this policy, considering the clinical urgency of the request outlined in the application form by the clinician. Those marked urgent will be considered within 24-48 hours (working days only) as per the application form.

5.8 Can patients and clinicians attend the IPFR Panel?

Patients are not permitted to attend IPFR Panels. The reasons are that it would make the process less fair because it would draw to the attention of panel members characteristics of the individual patient that should not influence their decision-making. The IPFR process is anonymous therefore allowing patients to attend would jeopardise this level of scrutiny. The IPFR Panel will normally reach its decision on the basis of all of the written evidence provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel. **Any information provided which relates to non-clinical factors will not be considered.** Local Liaison teams are able to support patients in making such statements if required.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on specific issues and/or request independent expert clinical advice for consideration by the panel at a future date. The Chair of the IPFR Panel, may also contact the referring clinician to get more clarification in respect of an individual referral.

The provision of appropriate evidence to the IPFR Panel will be entirely at the Chair of the IPFR Panels discretion.

5.9 Documentation

The IPFR Coordinator will maintain a confidential electronic record of all requests. A separate, confidential hard copy file may also be maintained. This information will be held securely in compliance with Data Protection requirements and with Caldicott Guidance.

The IPFR Administration Team retains a record of the IPFR application and subsequent decision and any outcome data that is provided by the clinician. Data will be retained to help inform future planning requirements by identifying patient cohorts both at a local and national level. Data will also be used for the production of an annual report on IPFR's every year as required by the Welsh Government. This will not include any identifiable data and will use aggregated data.

In addition, a central repository for clinical evidence will be available and will develop over time as and when new evidence reports are produced / become available.

Any information will be held in line with the NHS Information Governance Retention Policy

6 HOW TO REQUEST A REVIEW OF THE PROCESS

If an IPFR is declined by the panel, a patient and their NHS clinician have the right to request information about how the decision was reached. If they are unhappy with the decision the NHS clinician on behalf of the patient can either:

Resubmit an IPFR application, but only if there is either significant new clinical information or a significant change in clinical circumstances, or

If the patient and their NHS clinician feel the process has not been followed in accordance with the IPFR policy, a review hearing can be requested (see below).

The review process for an application for funding under the IPFR policy does not conflict with a patient's ability to make a complaint about the care that has been arranged in relation to a IPFR funding decision. This is best achieved through the Health Boards or JCC's Putting Things Right process which can be found at

<https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right> (see section 9).

6.1 The 'review period'

There will be a period of **25 working days** from the date of the decision letter during which they may request a review by the review panel ('the review period').

The letter from the Health Board or JCC that accompanies the original

decision will state the deadline for any review request. In calculating the deadline, Saturdays, Sundays, and public holidays in Wales will not be counted.

6.2 Who can request a review?

A review can be requested either (a) by the original requesting clinician on the patient's behalf or (b) by the patient with the original requesting clinician's support. **The review request form must be completed by the clinician.** Both the patient and their clinician must keep each other informed of progress. This ensures the patient is kept informed at all times, that the clinician/patient relationship is maintained, and review requests are clinically supported. Patients are able to access advocacy support at any stage during this process.

6.3 What is the scope of a review?

It does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds. A review request on any other ground will not be considered.

The 3 grounds are:

Ground One: *The Health Board or JCC has failed to act fairly and in accordance with the All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).*

Health Boards and JCC are committed to following a fair and equitable procedure throughout the process. A patient who believes they have not been treated fairly by the Health Board or JCC may request a review on this ground. This ground relates to the procedure followed and not directly to the decision and it should be noted that the decision with which the patient does not agree is not necessarily unfair.

Ground Two: *The Health Board or JCC has prepared a decision which is irrational in the light of the evidence submitted*

The review panel will not normally entertain a review request against the merits of the decision reached by the Health Board or JCC. However, a patient may request a review where the decision is considered to be irrational or so unreasonable that no reasonable Health Board or JCC could have reached that conclusion. A claim that a decision is irrational contends that those making the decision considered irrelevant factors, excluding relevant ones, or gave unreasonable weight to particular factors.

Ground Three: *The Health Board or JCC has not exercised its powers correctly.*

Health Boards and JCC are public bodies which carry out its duties in accordance with the Statutory Instruments under which it was established. A patient may request a review on the grounds that the Health Board or JCC has acted outside its remit or has acted unlawfully in any other way.

6.4 How is a review request lodged?

A review request form should be completed and logged with the IPFR Coordinator of the Health Board or JCC within the review period. The review request form must include the following information:

- The aspect(s) of the decision under challenge and
- The detailed ground(s) of the review request

The review request form should be sent to the IPFR Coordinator so that the signatures of both the patient and their clinician are recorded. A scanned version sent electronically will also be acceptable as long as signatures are present.

If the patient signature cannot be obtained in a timely manner or at all, the requesting clinician can sign to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

6.5 Initial scrutiny by the IPFR Senior Officer

The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more grounds of review, they will contact the referrer (patient or their clinician) to request further information or clarification.

A review will only be referred to the review panel if, after giving the patient and their clinician an opportunity to elaborate or clarify the grounds of the review, the Chair of the review panel is satisfied that it falls under one or more of the grounds upon which the review panel can hear the review.

The Chair of the review panel may refuse to consider a review that does not include all of the above information.

6.6 What is the timescale for a review to be heard?

The review panel will endeavor to hear a review **within 25 working days** of the request being lodged with the Health Board. The date for hearing any review will be confirmed to the patient and their clinician in a letter.

This review process allows for clinically urgent cases, as deemed by the referring/supporting clinician, to be considered outside of the panel process by the Health Board's Chair together with a clinical member of the review panel. Any such decisions will be made in line with the principles of this policy.

6.7 Who will sit on the Review Panel?

The Health Board will appoint members of the review panel. The panel will comprise (see Terms of Reference at Appendix 4 for full details);

- Health Board Independent Board Member – Lay (Chair of the Review Panel)
- Health Board Independent Board Member (with a clinical background)
- Health Board Executive Director, or deputy (with a clinical background)

- Representative from Llais
- Chair of the Local Medical Committee, or deputy
- JCC Representative at Director level (where applicable)

The Health Board will intend to inform the patient and their clinician of the membership of the review panel as soon as possible after a review request has been lodged. None of the members of the review panel will have had any prior involvement in the original submission.

In appointing the members of the review panel, the Health Board will endeavor to ensure that no member has any interest that may give rise to a real danger of bias. Once appointed, the review panel will act impartially and independently.

6.8 Can new data be submitted to the review panel?

No, because should new or additional data become available then the IPFR application should be considered again by the original panel in order to maintain a patient's right to review at a later stage.

6.9 Can patients attend review panel hearings?

At the discretion of the panel, patients and/or their unpaid representative may attend review panel hearings as observers but will not be able to participate. This is because the purpose of a review hearing is to consider the process that has been followed and not to hear new or different evidence.

If new or different evidence becomes available, the case will automatically be scheduled for reconsideration by the IPFR Panel. Patients and/or their unpaid representatives are able to make their written representations to this IPFR Panel in order for their views to be considered.

It is important for all parties to recognise that review panel hearings may have to discuss complex, difficult and sensitive information in detail and this may be distressing for some or all of those present. Patients and/or their unpaid representatives should be aware that they will be asked to retire at the end of the review panel discussion in order for the panel to make their decision.

6.10 The decision of the review panel hearing

The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician. The review panel can either;

- uphold the grounds of the review and ask the original IPFR Panel to reconsider the request; or
- not uphold the grounds of the review and allow the decision of the original IPFR Panel to stand.

There is no right to further review unless new and relevant circumstances emerge. Should a patient be dissatisfied with the way in which the review panel carried out its functions, they are able to make a complaint to the Public Services Ombudsman for Wales.

6.11 After the review hearing

The Chair of the review panel will notify patients and their clinicians of the review panel's decision in writing. This letter should be sent **within five working days** of the panel and will also include information on how to make a complaint to the Public Services Ombudsman for Wales www.ombudsman-wales.org.uk.

6.12 How will JCC undertake a review?

As the JCC is a collaborative committee arrangement to support all Health Boards in Wales, it will not be able to constitute a review panel. JCC will therefore refer any requests it receives for a review of its decisions to the Health Board in which the patient resides. A JCC representative who was not involved in the original panel will become a member of the review panel on these occasions.

The Health Boards IPFR Senior Officer will be present at these review hearings to advise on proceedings as per their governance role. In the interests of transparency, and not to confuse the applicant, the JCC Senior IPFR Officer will be responsible for circulating the review documentation to review panel members, clerking the hearing, and preparing the standard decision letter to communicate the decision of the review panel to the patient and clinician.

7 QUALITY ASSURANCE

The IPFR Quality Assurance Advisory Group was established in 2017 to monitor and support all IPFR panels to promote quality in decision making and consistency across Wales. The Group meets quarterly to assess anonymised random sample IPFR reports in relation to their completeness, timeliness, and efficiency of communication in line with the NHS Wales IPFR policy process.

8 REVIEW OF THIS POLICY

8.1 This Policy should be reviewed every 3 years or as required to reflect changes in legislation or guidance. The review will be undertaken by the All-Wales IPFR Policy Implementation Group. Any changes made will be undertaken in line with the groups Terms of Reference (see appendix 5) and authorised by the responsible Health Board and JCC Committee. Any delay in conducting a review will not prevent JCC or a Health Board from being able to rely on this policy.

8.2 Any of the following circumstances will trigger an immediate review of the linked INNU Policy:

- an exemption from a treatment policy criterion has been agreed.
- new scientific evidence of effectiveness is published for all patients or sub- groups.
- old scientific evidence has been re-analysed and published suggesting previous opinion on effectiveness is incorrect.
- evidence of increased cost effectiveness is produced.

- NHS treatment would be provided in all (or almost all) other parts of the UK.
- a National Service Framework recommends care.

9 MAKING A COMPLAINT

9.1 Making an IPFR does not conflict with a patient's ability to make a complaint through the Health Boards or JCC's Putting Things Right process, details of which can be found at <https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right>

9.2 If it is not possible to resolve a concern through local resolution the person raising the concern can refer the matter to the Public Services Ombudsman for Wales (PSOW). Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

Patients are able to access advocacy support at any stage during this process.

APPENDIX 1: DECISION MAKING FACTORS

Panels may find it useful to consider these factors, but they are not required to look at every factor set out in the table. Furthermore, there may be factors in the table that are not relevant to the individual case. The factors in the table are optional and cannot change the meaning of the criteria under paragraph 4.3 of the Policy.

IPFR Panel Decision-Making Factors	IPFR Panel Evidence for Consideration in Decision-Making
PART 9A - SIGNIFICANTLY DIFFERENT AND SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population for whom the recommendation is not use the intervention? Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage and for whom the recommendation is not to use the intervention?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? This is in context of the population for whom the treatment is not recommended. • Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage? This is in context of the population for whom the treatment is not recommended.
PART 9B - SIGNIFICANT CLINICAL BENEFIT	
Does the presentation of the patient's condition mean they are likely to gain significant clinical benefit from the intervention requested?	Consider the evidence submitted in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Does the evidence provided explain why this patient is likely to gain a significant clinical benefit when compared to next best alternative for this patient, which may in some cases be best supportive care?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What does NICE recommend or advise? • What does the AWMSG recommend or advise? • What does the Scottish Medicines Consortium recommend or advise? • What does Public Health Wales advise? • Is there advice available from the One Wales Medicines process or Health Technology Wales? • Is there peer reviewed clinical journal publications available? • What information does the locally produced evidence summary provide? • Is there evidence from clinical practice or local clinical consensus? • Has the rarity of the disease been considered in terms of the ability for there to be comprehensive evidence base available? • Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.
ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the treatment and is the cost of the treatment likely to be reasonable? Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What is the specific cost of the treatment for this patient? • What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? • Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. • Is the treatment reasonable value for money?

ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the cost of the treatment requested, are there any ethical considerations that have not been raised in the discussions? • Is the evidence base sufficient to support a decision? • Is the evidence and analysis of the cost sufficient to support a decision? • Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? • Have non-clinical factors been excluded from the decision? • Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

APPENDIX 2

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (Health Board)

PURPOSE

The Health Boards IPFR Panel is constituted to act as a Committee of the Health Board and holds delegated Health Board authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy/commissioning decisions for the Health Board. Any policy proposals arising from the panels considerations and decision will ultimately be reported to the Health Board's Quality & Patient Safety Committee for ratification. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board structure. - Any decisions resulting in a financial cost in excess of this must be reported to the Health Board Chief Executive for budget authorisation.	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning. In Attendance: • IPFR Coordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

Quorum: Chair or Vice Chair plus 2 panel members with a clinical background.

Meetings: The IPFR Panel will normally be at least once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair or Vice Chair

of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.

Recording: The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.

Training: All Panel members will receive a local induction.

Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

Panel Interest: At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.

Consensus: IPFR panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision

APPENDIX 3

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (JCC)

PURPOSE

The NHS Wales Joint Commissioning Committee's IPFR Panel is managed by NHS Wales Joint Commissioning Committee and holds delegated authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will act at all times in accordance with the All-Wales IPFR Policy taking into account the appropriate funding policies agreed by JCC.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy/commissioning decisions for the Health Boards. Any policy proposals arising from the Panel's considerations and decisions will be reported to the JCC for ratification. Financial authorisation is as follows: Individual Patient Packages The JCC scheme of delegation states that financial approval is required for individual NHS patient treatment charges outside of LTS's and SLA's concerning one off treatment costs exceeding £750,000. Therefore, any approved IPFR treatment exceeding £750,000 needs to be reported to the Joint Committee. Lifetime costs The JCC scheme of delegation states that financial approval is	• Independent Chair (from open recruitment) • 2 Lay representatives** • Health Board nominated clinician or clinician deputy. • 2 Vice Chairs (appointed from within the panel membership) • JCC Medical Director or nominated deputy. • JCC Director of Nursing or nominated deputy. A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel in conjunction with the JCC Medical and/or Director of Nursing, for example a member of an ethics committee. In attendance from JCC • IPFR Coordinator • Finance Advisor (if required) • Governance Advisor (if required) • Other JCC staff as and when required to clarify on policy/commissioning arrangements/evidence evaluation For particularly complex cases the IPFR Panel may invite other individuals with clinical, pharmacy or commissioning expertise and skills, unconnected with the requesting provider to support decision making.

required for individual NHS patient treatment charges outside of LTS's and SLA's for lifetime costs exceeding £100,000,000. Therefore, any approved IPFR exceeding £1,000,000 needs to be reported to the Joint Committee. Any decisions resulting in a financial cost in excess of these limits must be reported to the Chief Commissioner for authorisation and the relevant Health Board for information and if over £1 million to the Joint Committee for approval or ratification (if a Chairs action was undertaken).	
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**** Definition: Not registered as a healthcare professional, either lay (not currently healthcare worker) or lay plus (no healthcare experience ever) (Health Research Authority 2014) will be eligible.**

PROCEDURAL ARRANGEMENTS

Quorum: The Panel will be quorate with 4 of the 7 Health Boards representatives, 1 JCC Clinical Director or deputy and the Chair or Vice Chair.

Meetings: The IPFR panel will normally be held as a minimum once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently.

Where possible, a virtual panel will be held to consider urgent cases. If this is not possible due to the urgency of the request, or availability of panel members, then the Chief Commissioner with either the Medical Director or Director of Nursing and Quality and the Chair of the JCC Panel (or a vice chair) are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

Urgent cases will be reported at the next scheduled IPFR panel. An electronic National IPFR database of all cases will be maintained by AWTTC.

Recording:

The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.

Training:

All Panel members will receive a local induction programme.

Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

Members Interest:

At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.

Consensus:

IPFR Panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision.

Reporting:

The IPFR Chair shall:
Report formally, regularly and on a timely basis to the Collaborative Commissioning Leadership Group (CCLG) on IPFR activities.
Bring to the CCLG's attention any significant matters and ensure appropriate escalation arrangements are in place.

Review of the TOR:

The Terms of Reference of the JCC Panel will be reviewed in line with the All-Wales IPFR Policy.

APPENDIX 4

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

The IPFR Review Panel are constituted to act as a Committee of the Health Board and holds delegated Health Board authority to review (in line with the review process outlined in this policy) the decision-making processes of the Individual Patient Funding Request (IPFR) Panel.

The Review Panel may uphold the decision of the IPFR Panel or, if it identifies an issue with the decision-making process, it will refer the issue back to the IPFR Panel for reconsideration.

The Review Panel will normally reach its decision on the basis of all of the written evidence which is provided to it and will not receive any new information.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The Review Panel has delegated authority from the Board to undertake reviews, limited to the purpose set out above. In exceptional circumstances, the Review Panel may also wish to make a recommendation for action to the Board. The action can only be progressed following its ratification by the Board (or by its Chief Executive in urgent matters).	• Independent Board Member – Lay (Chair of the Review Panel) • Independent Board Member (usually with a clinical background) • Executive Director or deputy (with a clinical background) • Representative from Llais • Chairman, Local Medical Committee, or deputy • JCC representative at Director level (as required) In Attendance: • IPFR Senior Officer (governance advisor) • JCC IPFR Senior Officer (as required)

PROCEDURAL ARRANGEMENTS

Quorum: As a minimum, the Review Panel must comprise 3 members (one of whom must have a clinical background, one must be an Independent Board Member, and one must be a Health Board Officer).

Meetings: As required.

Urgent Cases: It is recognised that provision must be made for occasions where reviews need to be heard urgently and before a full panel can be constituted. In these circumstances, the Health Board's Chair can undertake the review together with a clinical member of the Review Panel. This ensures both proper accountability of decision making and clinical input.

Recording: The IPFR Senior Officer will clerk the meetings to ensure a proper record of the review discussion and outcome is made.

See detail under section 6.12 on how JCC will undertake a review.

1. Purpose of the Group

The purpose of the NHS Wales IPFR Policy Implementation Group (PIG) is to facilitate the commitment made by Health Boards and the Joint Commissioning Committee (JCC) to adhere to the NHS Wales IPFR Policy, providing and developing assurances systems and guidance to aid the decision making process. This includes areas relating to IPFR's, requests for routine treatment out of area, Interventions Not Normally Undertaken (INNU) and requests for treatment in other parts of the European Economic Area (EEA). The group will:

- Provide strategic leadership for the development and implementation of the IPFR policy and supporting documentation across all Health Boards and the JCC.
- Share good practice across all Health Board areas and promote continuous improvement.
- Review all policies that refer to IPFR to ensure that the policies are up to date, consistent and coherent.
- Provide a forum in which to share advice, support and assistance to ensure deliverance of a consistent process across Wales.
- Explore opportunities to ensure the IPFR process is widely understood by patients and clinicians, providing support on the process and application of IPFR's.
- Use best efforts to ensure the quality of data collection is in line with local and national reporting requirements.
- Monitor identified and emerging risks and advise on their prevention, mitigation and management.
- Work with and support the All Wales Therapeutics and Toxicology Centre on the development of the annual report in relation to IPFR's.
- Utilise the IPFR process to help inform key issues relating to possible future regional and / or national commissioning opportunities.
- Ensure active participation of key stakeholders when and where appropriate.

2. Membership of the Group

The IPFR network group will comprise of;

- A senior IPFR co-ordinator or nominated deputy from each Health Board and JCC.
- A senior member or nominated deputy from the AWTC

Other members may be included in the group as and when required.

3. Chair

The group will be chaired by an appointed member of the group.

The Chair will provide direction on the implementation of all decisions made by the group in relation to the development of the All-Wales policy, related guidance and assurance mechanisms.

All activities carried out under the auspices of the IPFR Policy Implementation Group are to be undertaken with prior agreement from the group members.

4. Frequency of Meetings

The group will meet bi-monthly. However, due to the nature of the work, the group may be required to meet more frequently on occasions, with additional work being done between meetings via email whenever possible.

The Terms of Reference will be reviewed periodically and amended accordingly.

5. Quorum

The quorum will be made up of any 5 members of the IPFR Policy Implementation Group.



Agenda Item

8.1.6

Quality, Safety & Experience Committee

All Wales Prior Approval Policy (2025)

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Tynan-Preece, Commissioning Manager
Cyflwynydd yr Adroddiad / Report Presenter	Sallie Davies, Deputy Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Interim Executive Director of Public Health

Pwrpas yr Adroddiad / Report Purpose	For Approval
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
All Wales IPFR Policy Implementation Group	July 2025	Supported
Head of Commissioning	09/09/2025	Supported
Assistant Director of Transformation	11/09/2025	Supported
Executive Director of Public Health	12/09/2025	Supported

Acronyms / Glossary of Terms	
AWTTC	All Wales Toxicology and Therapeutic Committee
IPFR	Individual Patient Funding Request

IPFR PIG	Individual Patient Funding Request Policy Implementation Group
IPFR QAG	Individual Patient Funding Request Quality Assurance Group
PAR	Prior Approval Request
NWJCC	New Wales Joint Commissioning Committee
WHSSC	Welsh Health Specialised Services Committee

1. Situation /Background

- 1.1 The current version of the All Wales Prior Approval (PAR) policy was last reviewed in 2018.
- 1.2 The responsibility for reviewing the All Wales PAR policy rests with the All Wales IPFR Policy Implementation Group (IPFR PIG). Following discussion in 2024, it was agreed to review the PAR policy alongside the review of the All Wales IPFR policy.
- 1.3 This paper provides a summary of the key changes within the updated PAR policy.
- 1.4 Each health board is now required to obtain formal approval to endorse and implement the revised policy.

2. Specific Matters for Consideration

2.1 All Wales Prior Approval policy

A prior approval request (PAR) is normally defined as a request for a patient to receive routine treatment outside of local services or established contractual arrangements. Such a request will normally fall within one of the following categories: -

- Second opinion
- Lack of local/commissioned service provision/expertise
- Clinical continuity of care (considered on a case-by-case basis)
- Transfer back to the NHS following self-funding in the private sector
- Re-referral following a previous tertiary referral
- Students
- Veterans

2.2 Governance arrangements

The NHS Wales IPFR Policy Implementation Group (PIG) brings together representatives from Health Boards, the Joint Commissioning Committee, AWTTC, and Health Technology Wales to ensure the fair and consistent

application of the Prior Approval (PAR) policy and IPFR Policy across Wales. The group supports decision-making for treatments not routinely provided, promotes best practice, and helps shape national policy. It also works to improve understanding of the IPFR & PAR process, enhance data quality, and inform future commissioning. Through collaboration and stakeholder engagement, the PIG fosters a transparent, inclusive, and patient-focused approach to funding decisions.

The NHS Wales IPFR PIG has been instrumental in ensuring the revised PAR policy is fit for purpose.

2.3 Revisions to the Prior Approval Request (PAR) Policy

In parallel with the review of the All Wales IPFR Policy, the opportunity was taken for the IPFR PIG to review the All Wales PAR Policy. The proposed version is accepted as being fit for purpose (Appendix 1).

The main changes to note are:

- Organisational change from WHSSC to NWJCC
- Clarity on exclusions which will not be considered
 - retrospective requests;
 - requests for healthcare travel costs;
 - referrals related to (potential) participation in a clinical trial – these are included in the research costs, or facilitated via Health and Care Research Wales.

The PAR process is an established process and ensures health boards and JCC have a consistent approach to decision making across NHS Wales. The PAR process generally works well and is fully embedded in the day to day function of NHS Wales.

Following robust discussion and agreement at the All Wales IPFR PIG, there are no risks to report and matters for escalation. Should any issues or concerns arise, these will be escalated in the first instance to Commissioning Colleagues within CTM UHB.

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 /	Choose an item.
	If more than one applies please list below: This policy spans all strategic areas



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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: All Wales policy
Cydraddoldeb a'r Gymraeg	Yes: ☒	No: ☐



<i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Outcome for Equality (delete as appropriate): NEUTRAL Outcome for Welsh Language (delete as appropriate): NEUTRAL	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below) The is risk of reputational harm if the policy is not approved and endorsed for use in CTM UHB.	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Choose an item.	

4 Recommendation

The Committee is asked to endorse the revised All Wales PAR Policy (2025) and approve its implementation within Cwm Taf Morgannwg UHB with immediate effect.

5 Next Steps

No further action following approval and endorsement from the QSE committee.



NHS WALES PRIOR APPROVAL POLICY

Reference Number	Policy Reference (as per individual Health Board)	Version Number	FINAL July 2025
Linked Documents	Individual Patient Funding Request (IPFR) Policy Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Local Health Boards and Primary Care Providers across Wales
NHS Wales Joint Commissioning Committee (NWJCC)
Public domain via Internet sites

Development Group: All Wales IPFR Policy Implementation Group

Consultation: Commissioning / Planning Managers
IPFR Panel Members
NHS Wales Medical Directors

Date of Publication: July 2025

Lead Health Board Contact: Contact details as per individual Health Board

Review Date July 2028

1.0 INTRODUCTION

1.1 Background

1.1.1 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being and Sport agreed the time was right for a new, independent review of the Individual Patient Funding Request (IPFR) process. The review panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

1.1.2 The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017 and made a number of recommendations to support the IPFR process. This includes the development of a clear and consistent national process for dealing with requests to access routine services outside of Local Health Board's existing arrangements (including those of the NHS Wales Joint Commissioning Committee)

1.2. Purpose of this policy

1.2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.2 Health Board's in Wales have a statutory responsibility to provide healthcare that meets the needs of their local populations in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). They achieve this by either directly providing healthcare or by commissioning healthcare from other service providers. In addition, the NHS Wales Joint Commissioning Committee (NWJCC), working on behalf of all Health Board's in Wales, commissions a number of more specialised services at a national level. The use of the term 'Health Board' throughout this policy includes NWJCC unless specified otherwise.

1.2.3 Consequently, patients should not be able to access healthcare services elsewhere unless **all** treatment options available within locally provided services or those commissioned by Health Boards have been exhausted and it is **clinically appropriate** to do so.

1.2.4 Each Health Board in Wales has a separate policy setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because: -

- There is insufficient evidence of clinical and/or cost effectiveness

- The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG)'
- The intervention is considered to be of relatively low priority for NHS resources

The relevant policy for the patients' Health Board titled 'Interventions Not Normally Undertaken' (INNU) should be read together with this policy.

1.2.5 For the purpose of this policy, a prior approval is normally defined as a request for a patient to receive routine treatment outside of local services or established contractual arrangements. Such a request will normally fall within one of the following categories: -

- Second opinion
- Lack of local/commissioned service provision/expertise
- Clinical continuity of care (considered on a case-by-case basis)
- Transfer back to the NHS following self-funding in the private sector
- Re-referral following a previous tertiary referral
- Students
- Veterans

Further detail is provided in Section 5.

Requests **will not** be considered for retrospective funding.

1.2.6 This policy sets out to deliver the national context and provide clarity for referring clinicians and patients. Additional policy processes outlining specific commissioning, contractual and additional prior approval requirements may be in place and will vary across each Health Board.

1.2.7 For instances where funding is required for NHS healthcare for individual patients who fall outside the range of services and treatment that a Health Board has arranged to routinely provide, the Individual Patient Funding Request (IPFR) policy should be followed. Such a request would normally fall within one of the following categories: -

- A patient requires a treatment which is new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatment,
- A patient requires a treatment which is outside of existing clinical policy criteria,
- A treatment is required for a patient with a rare or specialist condition and is not eligible for treatment in accordance with the clinical policy criteria.

2.0 AIMS AND PRINCIPLES

2.1 Health Board's in Wales have a responsibility to secure services for their patients. Patients registered with a GP in Wales who are resident in Wales do not have a statutory right to choose which hospital they are referred to. The Welsh Governments view is that in general, Health Boards can best organise services to meet the needs of their patients when such services

are provided in Wales. This ensures equity in terms of access, convenience, and affords each Health Board the opportunity to strengthen and improve the quality of their local services thus providing a net gain for the whole community.

- 2.2 However, patients who are registered with a Welsh GP but are resident in England, or patients who are resident in Wales but registered with an English GP (Cross Border Patients) may have a specific right to choose their secondary care provider. The cross-border arrangements are specific to those Health Boards that share a border with England i.e. Betsi Cadwaladr University Health Board, Powys Teaching Local Health Board and Aneurin Bevan University Health Board the detail of which can be found in the Responsible Body Guidance for the NHS in Wales.
- 2.3 Each Health Board aims to ensure the establishment of simple uniform arrangements based around high quality, sustainable local services for their patients. Where these cannot be provided by the Health Board's own services for reasons such as resource, expertise or capacity, the Health Board will look to plan and secure necessary services with other appropriate NHS providers through its agreed care pathways. Where the service cannot be provided by the Health Board or contracted provider, the Health Board will plan to secure services from other appropriate providers.

The principles underpinning this policy include: -

2.4 **NHS Core Values** – set out by the Welsh Government as;

- Putting quality and safety above all else; providing high value evidence-based care for our patients at all times.
- Integrating improvement into everyday working and eliminating harm, variation and waste.
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partner organisations and with our staff; and
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

2.5 **Prudent Healthcare Principles**

- Achieve health and wellbeing with the public, patient and professionals as equal partners through co-production.
- Care for those with the greatest needs first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

2.6 **Cross Border Healthcare Arrangements**

- Enable Cross Border patients to exercise their right of choice to a secondary care provider either in England or within the Health Board.

3.0 SCOPE OF THE PRIOR APPROVAL POLICY

3.1 This policy applies to: -

- The registered population within the geographical catchment area of the Health Board to whom it has a statutory responsibility for arranging services as outlined in the Local Health Boards (Directed Functions) (Wales) Regulations 2009. (*The Who Pays? Determining Responsibility for payments to providers in August 2013 states that although the Health Board has commissioning responsibility for English resident Welsh registered patients, they are the legal responsibility of the relevant CCG*)
- Secondary Care referrals only made by General Practitioners, Consultants and other clinically qualified health professionals with referral rights within the Health Board area.
- Tertiary referrals only made by consultants and clinical gatekeepers.

Please note - it is the clinician's responsibility to complete the application form. This ensures that adequate clinical information is provided to aid the decision-making process.

4.0 EXCLUSIONS

4.1 This policy does not apply to the following services: -

- Emergency Treatment
- Urgent suspected cancer referrals. All referrals for urgent suspected cancer must be **referred by e-referral** into the appropriate Health Board's respective tumour sites which have been set up in accordance with NICE guidelines. If a Cross Border patient has requested to be referred to a local hospital in England, then the referral will be made.
- Community based services such as district nursing.
- Looked After Children
- Requests for treatment in countries of the European Economic Area.
- The specialised services pathways established as part of the arrangements under The National Health Service Joint Commissioning (Wales) Regulation 2024.
- Requests which are judged to fall under IPFR or INNU.
- Reimbursement for private treatment

4.2 This policy does not apply to the following cohorts of patients: -

- Patients diagnosed with HIV/AIDS as outlined in the Welsh Governments HIV Actions Plan for Wales 2023-2026.

4.3 This policy does not apply to the following factors: -

- Non-clinical factors (such as employment status) will not be considered when making decisions on prior approval requests.

- Waiting time factors will not be considered when considering prior approvals as this will theoretically prioritise some patients over others who are in the same clinical position.
- Patient choice. The NHS in Wales does not operate a system of patient choice. However, cross border patients may be able to choose their secondary care provider.

4.4 This policy does not cover healthcare travel costs. Information on patient eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the [Welsh Government's 'healthcare costs'](#) website.

4.5 Referrals related to **participation (or potential participation) in a clinical trial**

No Prior Approval, or Individual Patient Referral Funding (IPFR) application is required if the purpose of the referral is clinical trial related i.e. if a patient wishes to participate (or explore potential participation) in an 'interventional' research study outside of Wales i.e. studies where the research protocol includes a treatment or intervention not otherwise available to the patient outside of a trial. There should be no barrier to a patient being seen by the trial site for this purpose, and no funding needs to be exchanged or be provided for the site to accept the referral.

The [UK Policy](#) is that costs associated with the referral are a research cost and as such must be met by the trial site (via the study grant for non-commercial studies, or by the commercial Sponsor for industry funded studies). This includes visits to the trial site at pre-screening stages prior to commitment or recruitment to the trial being confirmed, including where referrals that are more speculative for a range of potential trials open at the provider site, and includes the consultation costs and associated travel costs. The referring clinician will need to be assured that the patient at least broadly meets (or has potential through further screening/assessment to meet) the eligibility criteria for one or more trials that are open to recruitment at the provider organisation before a referral is made.

Note: If any support is required to expedite the referral, or if provider site requires more information on the UK Policy position, please escalate to Research-FundingSupport@wales.nhs.uk

5.0 GUIDING PRINCIPLES AND CRITERIA

5.1 **Second Opinion**

If a second opinion is required for routine treatment out of area, the requesting clinician must demonstrate that the patient has exhausted all local options where possible. The patient should first receive a second opinion from a consultant colleague within the same Health Board and then from a Health Board or English NHS Trust with whom a contractual agreement is held.

Please note; if a second opinion is approved, this does not automatically mean that funding will be provided for additional appointments and/or treatment.

5.2 **Lack of local service provision/expertise**

The NHS secondary care consultant or other care provider, for example a GP or dentist, with the support of an NHS secondary care consultant where available, needs to demonstrate that all local and locally commissioned service provision has been exhausted in order for an external referral to be considered for an 'expert' opinion. In addition, for reasons due to lack of local expertise, the clinician must demonstrate that the referral being made is to an 'expert' within that specific clinical speciality.

5.3 **Clinical continuity of care**

Whilst the Health Board understands the importance of continuity, we must endeavour to deliver the patient's care locally. Where comparable services are available locally, the patient will be referred to those services in the first instance. Clinical advice will be sought to ensure local services meet the needs of the patient's clinical condition.

Consideration for a patient to remain with an existing provider will only be given if their specific clinical condition warrants continuity of care and that there are circumstances, which if unaddressed, are likely to have a serious impact on the patient's continuing health and wellbeing.

Before funding on this basis can be considered, a comprehensive report/letter from the existing clinician highlighting the specific clinical reasons why the patient should remain under their care would be required.

If a patient moves into a Health Board's area, they will be expected to access local services. However, in some instances, patients may request to remain with an existing care provider based on 'continuity of care'. As outlined above, clinical information will be required to support the reasons for this.

5.4 **Transfer back to the NHS following self-funding in the private sector**

If a patient has self-funded their own referral/treatment in the private sector, the Health Board cannot be expected to fund ongoing treatment in the private sector. To ensure equity, all such referrals will be declined and the clinician advised to refer the patient to local or commissioned NHS services.

If, however, there is no local or locally commissioned service provision for the proposed treatment, the request for a referral to an external NHS consultant will be considered, based on the clinical information provided. The patient will be expected to receive all treatment with an NHS provider and should be added to the appropriate waiting list accordingly.

5.5 **Re-referral following a previous tertiary referral**

If a service is not available locally or within existing commissioned services, the Consultant/Clinical Gatekeeper may wish to refer a patient to a specialist centre for clinical advice and/or potential treatment. Following the assessment/treatment, and when clinically appropriate, the patient should be discharged back to local services.

Patients frequently request to return to the same specialist centre for a 'new episode of care' based on 'clinical continuity'. When comparable

services are available locally, patients will be expected to access the local services.

5.6 **Students**

Students who register with a GP in Wales where they are receiving further or higher education become the responsibility of the Local Health Board in that area and should be treated in accordance with the principles outlined with the [Responsible Body Guidance](#) for the NHS in Wales.

5.7 **Veterans**

The treatment of veterans should be undertaken in accordance with the principles outlined within [WHC \(2023\) 022 Armed Forces Covenant – Healthcare Priority for Veterans](#)

6.0 **PROCESS UNDERTAKEN WHEN CONSIDERING A PRIOR APPROVAL REQUEST**

6.1 Prior approval requests can be sent to abb.priorapprovalteam@wales.nhs.uk

6.2 All prior approval requests are considered on their own merits using the guiding principles and criteria outlined in this document. Decisions are based on the clinical circumstances of the individual patient. It is therefore important to ensure that adequate clinical information is provided to aid the decision-making process.

6.3 Where the patient does not meet the guiding principles outlined above, the prior approval request will be declined.

6.4 Should an application be received which has not been completed sufficiently enough to determine whether or not the request meets the guiding principles and criteria, or the incorrect form has been completed, the form will be returned to the requesting clinician within five working days of receipt.

6.5 Prior approval requests made directly by a patient, or a patient representative will not be accepted. If a direct request is received, the patient will be advised to contact their GP or Hospital Consultant. Requests for referrals will not be accepted to private providers. The NHS cannot pay for or subsidise private hospital treatment.

6.6 A formal process will be held on a regular basis to ensure that correctly submitted and completed applications are considered in a timely manner. The volume and urgency of applications may require a decision more frequently as and when required.

6.7 A standard decision letter notifying the requesting clinician of the decision will be sent.

7.0 **HOW TO REQUEST A REVIEW OF THE PROCESS**

If a prior approval request is declined, a patient and/or their NHS clinician have the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, they can ask for that decision to be reviewed.

8.0 WHAT IS THE SCOPE OF A REVIEW

There will be a period of 25 working days from the date of the decision letter during which a review may be requested.

The request for a review form should be completed clearly outlining the grounds for the review and sent to the Prior Approval team. The review panel will endeavour to meet within one month of the request being logged by the Health Board. Following the review, a decision letter will be issued to notify the patient and their clinician of the review panel's decision.

If new or additional information becomes available, the application will be reconsidered.

9.0 REVIEW PANEL MEMBERSHIP

The review panel should comprise: -

- Chair
- Senior Clinical Representative
- Senior Management Representative

10.0 CONFIDENTIALITY AND INFORMATION GOVERNANCE

In operating the prior approval policy, the Health Board will have due regard to the need to ensure that patient confidentiality is maintained at all times.

Each Health Board must comply with the requirements of the Data Protection Act and Caldicott Principles of Good Practice.

11.0 REVIEW OF THIS POLICY

This policy will be reviewed every 3 years or as required to reflect changes in legislation and guidance.

12.0 MAKING A COMPLAINT

Making a request for a prior approval does not conflict with a patient's ability to make a complaint to the Public Services Ombudsman for Wales. Further information is available on the Ombudsman's website www.ombudsman-wales.org.

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

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

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

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
16 May 2024	Suggested at the 16 May 2024 meeting that report would be presented to a future meeting on this item	Chief Operating Officer	CTM Escalation Policy	Suggested at the 16 May 2024 meeting that report would be presented to a future meeting on this item	Chief Operating Officer	Chief Operating Officer	18 September 2024	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 – 22 July 2025 – Now 23 September 2025	In progress Verbal update provided at the meeting held on 22 July 2025. Agreed that written update would be presented to the meeting taking place on 23 September 2025
11 March 2025	Request made by an Independent Member at the January 2025 QSEC for this report to added to future meeting agenda's	Executive Director of Nursing	WAST Produced Quality Report	USC Care Group to provide a report on the joint working with WAST looking at the People's Experience and Quality of care as this is work that is undertaken jointly with the central team and sits within USC portfolio.	USC Care Group Nurse Director	Executive Director of Nursing	20 May 2025 22 July 2025 Now November 2025	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.
10 April 2025	Request made at the agenda planning session held on 10 April 2025	Committee Chair	Stroke Services Progress Report	Stroke Services report to be presented to the July meeting of the Committee	Executive Director of Allied Health Professionals & Healthcare Sciences	Allied Health Professionals & Healthcare Sciences	22 July 2025 – 23 September 2025 – Now November 2025	In progress Presentation received and discussed at the meeting held on 22 July 2025. Further report on progress to be presented to the meeting taking place on 23 September 2025. Following the agenda planning session held in August 2025, it was agreed that the USC Care Group Highlight report for September would include an update on Stroke KPI's with the next detailed update on Stroke to be presented to the November 2025 meeting
26 June 2025	Email request received from Director of Public Health requesting this item is discussed at future meeting	Executive Director of Public Health	Reducing Health Inequalities	Report to be presented to the September 2025 meeting for discussion	Executive Director of Public Health	Executive Director of Public Health	23 September 2025	Proposed for Closure – On agenda
17 July 2025	Email request received from the Medical Directors office	Executive Medical Director	Organ Donation Committee Terms of Reference	To be presented to the Committee for approval	Executive Medical Director	Executive Medical Director	23 September 2025	Proposed for Closure – On agenda

7 August 2025	Suggestion made at agenda planning session held on 7 August 2025	Deputy Director of Nursing	Quality focussed report on Commissioned Services	To be presented to Committee for discussion and awareness	Executive Director of Strategy & Transformation	Assistant Director of Transformation	18 November 2025	In progress
7 August 2025	Suggestion made at agenda planning session held on 7 August 2025	Thematic Spotlight Presentation - Inpatient Mental Health Improvement Programme	Report to highlight progress made since the update presented to the July 2024 meeting	To be presented to Committee for assurance purposes	Mental Health & Learning Disabilities Care Group Nurse Director	Mental Health & Learning Disabilities Care Group Nurse Director	23 September 2025	This has been deferred to 18 November 2025
Completed Items								
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	Completed Update included in the Clinical Executives report presented to the meeting held on 22 July 2025



Quality, Safety & Experience Committee – Annual Cycle of Committee Business

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

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: [Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](#)

The Quality, Safety & Experience Committee meets at **least 6 times per annum**.

Committee Chair: Carolyn Donoghue, IM University	Committee Vice Chair Kath Palmer, Vice Chair	Executive Leads for Agenda Planning Greg Dix, Executive Nurse Director / Deputy CEO
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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	R		R		R		R		R		R		R If all actions are complete	R 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	R		R		R		R		R		R		R	X
3. Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings	R		R		R		R		R		R		R	X
4. Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings	R		R		R		R		R		R		R Except for the annual review in November	R Annual Review only
5. Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually					R								X	R
6. Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually					R								X	R
7. Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually					R Defer to Sept 25				R Defer to Nov 25		R		X	R

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	R		R		R		R		R		R		X	R
9. Outcome reports - Executive and Independent Member Patient Safety Walkabouts	Executive Director of Nursing / Deputy CEO	Twice per annum.			R To be deferred to the May meeting		R				R Defer to Nov 25		R		X	R
Setting the Scene – Service Delivery																
10. Thematic Spotlight Presentation	Lead Clinical Executive	All Regular Meetings	R		R		R		R		R		R		X	R
11. Report from the Clinical Executives	Clinical Executives	All Regular Meetings	R		R		R		R		R		R		X	R
12. Care Group Highlight Reports	Care Group Nurse Directors/Care Group Medical Directors	All Regular Meetings	R		R		R		R		R		R		X	R
Delivering our Plan																
13. Quality Dashboard Report	Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	R		R		R		R		R		R		X	R
14. Stroke Services Progress Report <i>(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)</i>	Executive Director of Therapies & Health Science / Chief Operating Officer	Twice per annum	R						R						X	R
Governance, Risk and Assurance																
15. Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All Regular Meetings	R		R		R		R		R		R		X	R
16. Health Inspectorate Wales (HIW) Audit Tracker Report	Director of Corporate Governance & Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	R (consent)		R (consent)		R (consent)		R (main)		R (consent)		R (main)		R	R (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			R						R				X	
18. Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi Annually	R										R		X	R
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		R								X	R
20. Infection, Prevention & Control Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually									R				X	R
21. Infection, Prevention & Control Strategy Implementation Plan	Executive Nurse Director / Deputy Chief Executive	Annually					R								X	R
22. Putting Things Right Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually							R Defer to Sept		R				R	X
23. Non Clinical Policies for approval	Executive Portfolio determined.	As and when required													R	X
24. Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually					R						R		R	X
25. Safeguarding & Public Protection Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually											R		R	X
26. Nurse Staffing Levels Wales Act 2016	Executive Nurse Director / Deputy Chief Executive	Twice per Annum					R						R		R	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					R								X	R
28. Oversight on the delivery of the R&D Strategy	Executive Nurse Director / Deputy Chief Executive	Bi Annually					R Defer to July		R				R			

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.																
29. Cancer Services Annual Report	Executive Medical Director	Annually														X
30. RADAR Committee Highlight Annual Report	Executive Medical Director	Annually plus exception reporting			Removed from the March agenda whilst reporting arrangements are being finalised						Defer to Nov 25					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

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.																
42. Organ Donation Sub Committee Annual Committee Report	Executive Medical Director	Annually					R Defer to July 25		R Defer to Sept 25		R Defer to Jan 2026				R	X
43. Hosted Organisations Quality, Safety & Experience Updates	JCC Chief Commissioner NIAW Programme Director	TBD													R Unless there is an area for escalation	X
44. Anti-Microbial Resistance reports	Executive Medical Director	Twice Per Annum					R						R			
45. Harm Free Care Update	Executive Director of Nursing	Twice Per Annum					R						R		X	R
46. Annual Duty of Quality Report	Executive Director of Nursing	Annually					R Defer to July		R						X	R
47. Research & Development, Innovation & Improvement	Executive Director of Nursing	Bi Annually									R				X	R
48. Patient Experience Forum Update	Executive Director of Nursing	Bi Annually							R						X	R

Agenda Item

6.2.1

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Mandy Rayani, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 31 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC [Standing Orders](#).

The Quality and Safety Outcomes Committee Terms of Reference can be found [here](#).

3. HIGHLIGHT REPORT

RAG Rating	Highlight
Alert / Escalate	Members commented on the importance of developing a video tour for the Mother and Baby Unit and agreed to highlight this in the Chairs report, and to provide feedback to the HB that provides this service.
Advise	- Members were advised that further work was being undertaken on the Quality Newsletter to align it with the JCC communications strategy. This was close to being completed and will be referred to as a Quality Bulletin. - Members received an update on the escalation status of the Paediatric Critical Care Unit (PCCU) and the Neonatal Intensive Care Unit (NICCU) at the Children's Hospital for Wales. The following points were noted: - Improvements in the governance structure including key appointments and regular meetings to ensure clearer oversight and accountability. - Introduction of a dashboard to accurately capture activity and cot availability. - Key improvements demonstrated in neonatal mortality and national benchmarking in areas such as retinopathy, prematurity screening and infection rates. - Positive feedback from patient and families highlighting the improvements in care and the importance of ongoing work to maintain these improvements. - Clear expectations and requirements for de-escalation improved understanding of what was being asked and once established the service was able to provide the necessary information and assurance. - Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current Quality and Patient Safety issues within the WKN commissioned services. The following points were noted: - Oxa 48 e-coli infection identified on a kidney ward and the challenges related to this outbreak. Although this primarily affects kidney patients, it may become a broader infection control concern. It was noted that the environment had been a contributing factor. An

RAG Rating	Highlight
	infection prevention and control meeting is arranged to discuss and agree a consistent approach across Wales. ○ The WKN meetings with the three providers of BCUHB, CVUHB and SBUHB and how the wider JCC will be made aware and kept informed of this issue. This would be highlighted in the QSO Chairs report to the JCC. ○ The diversity of dialysis providers and whether this poses any challenges in terms of applying a uniform approach to protocols and standards. It was confirmed that the renal community work very closely, sharing clinical input and that infection prevention and control issues are driven by the clinical teams within the renal centres. • The Director of Commissioning for Specialised Services provided updates on various specialist services including: ○ The continued challenges in engagement with Salford Royal Hospital obesity services. This will continue to be escalated. Meanwhile, additional capacity has been secured in South Wales. ○ Improvements in plastic surgery waiting times, the data for March 2025 was still pending, but the target of 104 weeks is likely to be achieved. There was insufficient capacity to make any significant in-roads into achieving 52 weeks targets. ○ Prostate-Specific Membrane Antigen (PSMA) due to the ongoing production challenges with Positron Emission Tomography Imaging Centre (PETIC) in CVUHB. A clinical update was provided advising that undertaking clinical revalidation with all the PMSA PET requests has been agreed with a view to shared decision making, noting that these scans were not mandated according to NICE guidance, therefore, the suggested triage involves categorising patients into high, intermediate, and lower risk groups. This positive progress was welcomed. ○ South Wales Specialist Auditory Implant Device Service and the continued lack of progress. This will form part of a broader conversation however there was an action plan in place and the requirements were more visible. • A report for the Commissioning for Ambulance and 111 services was received. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. In addition: ○ The establishment of a new clinically led 'National Ambulance Patient Handover Improvement Implementation Group.' The work of this group will be

RAG Rating	Highlight
	a key enabler in supporting the JCC in reducing its emergency ambulance services associated risks around utilisation of capacity. ○ The new ambulance performance framework and introduction of new categories was noted which included a purple category for incidents of cardiac and respiratory arrest. ○ High rate of 111 call abandonments and whether the service can cope with demand. The JCC has yet to assess whether it provides sufficient or effective call handling and clinical capacity as a formal strategic demand and capacity review of the 111 system has not yet been conducted. A detailed analysis of the GDPR breaches within the Ambulance and 111 report was requested to understand the causes. ○ A deep dive on Ambulance services, including a patient story, was scheduled for June 2025 where several issues can be addressed. • The Director for Mental Health and Vulnerable Groups report was presented. The following points were highlighted: ○ Improvements in High Secure services through the introduction of positive interaction program (PIP) at Ashworth, reducing long-term segregation numbers, noting that Broadmoor and Rampton were implementing similar strategies. ○ Environmental issues at Caswell Medium Secure Unit and Ty Llewellyn, including lack of seclusion facilities. SBUHB has appointed an independent assessor to undertake an independent review of their mental health services. The JCC needs to stay cited on the work of this review to help with informing strategic commissioning decisions. ○ Inpatient numbers have risen within eating disorder services. Noting ongoing discussions to enhance gatekeeping processes. ○ Plans for two newly commissioned perinatal beds for North Wales patients located in Chester, by October 2025.
Assure	• Members heard a story from a patient's specific experience of the Tonna Mother and Baby Unit stating the challenges she faced as a mother with physical health disabilities. It was noted that the Unit worked hard to address the environment and accessibility issues and the staff's willingness to listen and adapt. To minimise anxiety for patients, the Unit is now planning to produce booklets with

RAG Rating	Highlight
	photographs of the unit and to introduce phone calls between staff and patients prior to admission to discuss and prepare for their stay. A video tour was also planned, however due to resources this has not been possible. The Chair thanked her for her sharing her personal story and wished her well for the future. - Members received the risk register as at 31 January 2025, highlighting the risks relating to the Quality Safety and Outcomes assigned for monitoring and scrutiny purposes. The following areas were highlighted: - Cardiac Device Services, the Chair inquired whether this risk was specific to North Wales or if it represented a broader issue concerning engagement within the service. It was clarified that the service was safe, and the engagement issues relate to the provider. The risk was likely to be resolved by the next meeting. - Paediatric Intensive Care Beds and Neonatal Infection Control which had been covered in the earlier presentation. Whilst these remain on the Risk Register as risks scoring 20, these should also be updated by the time of the next meeting. It was noted however there appeared to be some underlying issues that could be related to the environment. The infections rates appeared to be higher than national averages despite good compliance with infection control measures. - Neurosurgery Sustainability, noting that this risk had been de-escalated from 16 to 8. It was queried if this was premature as the funding had been allocated but the overall sustainability of the service was dependent on successful recruitment. The matter around when a risk is mitigated from a commissioner perspective and becomes a provider risk/issue was discussed. It was suggested that this topic could be addressed in a JCC strategy session since the JCC still needed to conclude their discussions around risk appetite. - C&VUHB Neurosciences Staffing issues/level was queried as the description around the risk being addressed by the rehabilitation strategy was due for consideration by the JCC in Quarter three 2024/2025 but this has now passed. It was agreed to review this outside of the meeting and provide an update at the next meeting.
Inform	The forward plan of business for the next twelve months was presented noting that it was a work in progress and would be used to support Agenda planning for future meetings.

RAG Rating	Highlight
	- A report outlining recent incidents and concerns reported to the JCC from provider and commissioned services covering the period January 2025 – February 2025 was received. - An update on the Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) regulatory activity was provided noting the ongoing collaboration with HIW to improve reporting and assurance processes.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health
	Ensure Quality
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
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i>	Person Centred
	If more than one applies please list below: Equitable

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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality 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: 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 Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.



Agenda Item

8.2.4

Quality, Safety & Experience Committee

Infection, Prevention & Control
Annual Report 2024/2025

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Nursing for Infection Prevention & Control
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Richard Hughes, Deputy Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Forum Individuals	Date	Outcome
IPCC	03/09/2025	Approved

Acronyms / Glossary of Terms	
IPCC	Infection Prevention and Control Committee

1. Situation / Background

The Infection Prevention and Control (IPC) Annual Report for 2024–2025 provides a comprehensive overview of the activity, achievements, and ongoing challenges in the prevention and management of healthcare-associated infections (HCAIs) across Cwm Taf Morgannwg University Health Board (CTMUHB). The report aligns with the Welsh Government’s Code of Practice for the Prevention and Control of Healthcare Associated Infections and reflects the Health Board’s ongoing commitment to patient safety, staff education, and infection risk reduction across all care settings.

2. Specific Matters for Consideration

2.1 Key Achievements

During the reporting period, CTMUHB made demonstrable progress in several key areas:

- A reduction in healthcare-onset Methicillin-Sensitive Staphylococcus aureus (MSSA), Pseudomonas aeruginosa, Klebsiella spp., and E. coli bacteraemia, achieving the majority of Welsh Government improvement targets for these indicators.
- Ongoing implementation of a new centralized IPC Hub model to enable streamlined communication, improved responsiveness, and extended hours of IPC support, including on-call cover during weekends and bank holidays.
- Securing of significant capital and strategic funding to enhance IPC capacity, including over £400,000 to establish a community IPC team, with the aim to expand surveillance and training support in nursing homes and primary care.
- Progress on strategic infrastructure improvements, such as sterile services upgrades, decontamination modernization, and forthcoming development of negative pressure isolation rooms.

2.2 Ongoing Challenges

Despite notable gains, the Health Board continues to face key challenges:

- A marked increase in Clostridium difficile infections, with CTMUHB falling short of national reduction targets despite maintaining a lower rate than the all-Wales average.
- Suboptimal compliance with IPC training—particularly Level 2—among clinical groups, with medical and dental staff demonstrating the lowest rates (28.6%). This poses a significant risk to safe clinical practice.

- Fragmentation in microbiology access, testing methodology, and estates collaboration, including water and ventilation safety, affecting consistency and service equity across sites.
- Testing inconsistencies (e.g., use of PCR at POW vs immunoassay at other sites) complicating inter-site benchmarking, especially for C. difficile.
- The Health Board ceased having epidemiologist support from PHW.

2.3 Strategic Enhancements

To address these challenges and sustain progress, several key strategic developments have been implemented:

- Introduction of a dynamic “areas of concern” audit model with the aim of replacing the static annual programme, enabling better targeted IPC oversight and rapid intervention.
- Ongoing work to strengthened multidisciplinary collaboration with patient flow, antimicrobial stewardship, estates, decontamination, and microbiology teams to improve situational awareness and integrated response.
- Ongoing implementation of the Hub Centralized model
- Start planning on community team
- Development of a practice development framework to support the development of IPC staff and lay the ground for a future implementation of a link workers program.

3. Key Risks / Matters for Escalation

- Low compliance with IPC training across the HB
- Need to strengthen review processes and implementation of lessons learned with wider HB learning matrix to inform strategy
- Increase on C. diff cases across Wales, IPC part of the Learning C. diff collaborative to explore all Wales strategies that can support reduction across CTM

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☐
	Outcome for Equality (delete as appropriate): 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** Members of the Quality, Safety & Experience Committee are asked to **NOTE** the contents of the IPC Annual Report

6. Next Steps

6.1 Priorities for 2025–2026

Building on the foundations laid this year, the Health Board will prioritise:

- Improving mandatory IPC training compliance, with targeted strategies for high-risk staff groups and alignment with performance and appraisal systems.
- Addressing rising community-onset infection rates (especially MSSA, C. difficile, and ARIs) through closer collaboration with Public Health Wales, antimicrobial teams, and primary care services.
- Implementing the Development Framework aligned with IPS and WHO standards to build internal IPC capability, resilience, and succession planning.
- Improve incident/RCA reviews, in particular regarding C. diff, to improve responsiveness and better dissemination of lessons learned and themes
- Creation of lessons learned matrix to increase visibility of wide learning requirements across the HB, to better guide future IPC actions/projects
- Continue the OCP process in place to ensure full implementation of the Hub model, with extended hours of IPC support, including on call.



GIG
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WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Annual Report 2024/25



June 2025
Draft V1

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Executive Summary

This Infection Prevention and Control (IPC) Annual Report for 2024–2025 provides a comprehensive overview of the activity, achievements, and ongoing challenges in the prevention and management of healthcare-associated infections (HCAIs) across Cwm Taf Morgannwg University Health Board (CTMUHB). The report aligns with the Welsh Government’s Code of Practice for the Prevention and Control of Healthcare Associated Infections and reflects the Health Board’s ongoing commitment to patient safety, staff education, and infection risk reduction across all care settings.

Key Achievements

During the reporting period, CTMUHB made demonstrable progress in several key areas:

- A reduction in healthcare-onset Methicillin-Sensitive *Staphylococcus aureus* (MSSA), *Pseudomonas aeruginosa*, *Klebsiella* spp., and *E. coli* bacteraemia, achieving the majority of Welsh Government improvement targets for these indicators.
- Ongoing implementation of a new centralized IPC Hub model to enable streamlined communication, improved responsiveness, and extended hours of IPC support, including on-call cover during weekends and bank holidays.
- Securing of significant capital and strategic funding to enhance IPC capacity, including over £400,000 to establish a community IPC team, with the aim to expand surveillance and training support in nursing homes and primary care.
- Progress on strategic infrastructure improvements, such as sterile services upgrades, decontamination modernization, and forthcoming development of negative pressure isolation rooms.

Ongoing Challenges

Despite notable gains, the Health Board continues to face key challenges:

- A marked increase in *Clostridium difficile* infections, with CTMUHB falling short of national reduction targets despite maintaining a lower rate than the all-Wales average.
- Suboptimal compliance with IPC training—particularly Level 2—among clinical groups, with medical and dental staff demonstrating the lowest rates (28.6%). This poses a significant risk to safe clinical practice.
- Fragmentation in microbiology access, testing methodology, and estates collaboration, including water and ventilation safety, affecting consistency and service equity across sites.
- Testing inconsistencies (e.g., use of PCR at POW vs immunoassay at other sites) complicating inter-site benchmarking, especially for *C. difficile*.
- The Health Board ceased having epidemiologist support from PHW.

Strategic Enhancements

To address these challenges and sustain progress, several key strategic developments have been implemented:

- Introduction of a dynamic “areas of concern” audit model with the aim of replacing the static annual programme, enabling better targeted IPC oversight and rapid intervention.
- Ongoing work to strengthened multidisciplinary collaboration with patient flow, antimicrobial stewardship, estates, decontamination, and microbiology teams to improve situational awareness and integrated response.
- Ongoing implementation of the Hub Centralized model

- Start planning on community team
- Development of a practice development framework to support the development of IPC staff and lay the ground for a future implementation of a link workers program.

Priorities for 2025–2026

Building on the foundations laid this year, the Health Board will prioritize:

- Improving mandatory IPC training compliance, with targeted strategies for high-risk staff groups and alignment with performance and appraisal systems.
- Addressing rising community-onset infection rates (especially MSSA, C. difficile, and ARIs) through closer collaboration with Public Health Wales, antimicrobial teams, and primary care services.
- Implementing the Development Framework aligned with IPS and WHO standards to build internal IPC capability, resilience, and succession planning.
- Improve incident/RCA reviews, in particular regarding CDiff, to improve responsiveness and better dissemination of lessons learned and themes
- Creation of lessons learned matrix to increase visibility of wide learning requirements across the HB, to better guide future IPC actions/projects
- Continue the OCP process in place to ensure full implementation of the Hub model, with extended hours of IPC support, including on call.

Governance and Assurance

The Infection Prevention and Control Committee (IPCC) has provided ongoing assurance to the Health Board throughout the year via quarterly reporting, trend analysis, and performance updates against national goals. This governance structure supports the Board's duty to ensure IPC measures are effective, evidence-based, and aligned with national and local risk profiles.

0 - INTRODUCTION

This Annual Infection Prevention and Control (IPC) Report for 2024-2025 provides a comprehensive review of our activities, achievements, and ongoing challenges across Cwm Taf Morgannwg University Health Board (CTMUHB). It reflects our continued commitment to safeguarding patients, staff, and the community from preventable healthcare-associated infections, ensuring alignment with the Welsh Government's Health and Care Standards and the established targets for healthcare-associated infection reduction.

The year under review has presented significant challenges, notably the persistent increase in *Clostridium difficile* (*C. difficile*) cases across both hospital and community settings. This uptrend underscores the critical importance of effective antimicrobial stewardship, vigilant medication review, particularly regarding Proton Pump Inhibitors (PPIs), and rigorous adherence to IPC practices, including prompt detection, isolation, and rigorous environmental decontamination processes.

The report makes a review of the HB position regarding the Compliance with the Code of Practice for the Infection Prevention and Control of Healthcare Associated Infections for Wales.

The report highlights significant progress in other areas, including reductions in MSSA and *Pseudomonas aeruginosa* bacteremia, demonstrating the positive impact of targeted IPC initiatives and enhanced staff engagement. Conversely, it also identifies areas for improvement, such as the continued need for robust training, adherence to standardized IPC practices, and greater clinical visibility of the IPC team across all health board sites.

Capital and infrastructure projects, such as the refurbishment of sterile services and enhancements in decontamination procedures, illustrate ongoing investments aimed at improving patient safety and compliance with national standards. Additionally, innovations including the deployment of an IPC outbreak management toolkit and the ongoing planning to roll-out of an IPC Champions program highlights our commitment to embedding IPC best practices into everyday healthcare delivery.

Effective infection prevention and control remains a shared responsibility—from frontline staff to senior leadership—demanding ongoing multidisciplinary collaboration and alignment with national guidance. The IPC team continues to engage proactively with internal stakeholders, Public Health Wales, Health Protection and other internal and external stakeholders to drive improvements and achieve targeted reductions in infection rates.

This report encapsulates our collective achievements, ongoing initiatives, and future strategies to enhance patient safety, reflecting our unwavering commitment to maintaining the highest standards in infection prevention and control across Cwm Taf Morgannwg University Health Board.

The reporting period has also seen significant changes within the IPC team, including the appointment of a new Head of Infection Prevention and Control. Under this new leadership, the Health Board has begun implementing a new IPC strategy, featuring a centralized Hub model designed to streamline IPC communication, facilitate staff mobility, and extend service availability from 8 am to 8 pm on weekdays, with on-call coverage during weekends and bank holidays.

Recognizing the significant burden of community-onset infections, the IPC team has received additional funding to expand its efforts into the community. This expansion will initially focus on auditing and establishing a robust network of IPC link workers in nursing homes, supported by the Health Board, with further development plans contingent on initial outcomes.

The IPC team has recruited a new Decontamination Specialist/Officer, a crucial role within the team to address decontamination challenges.

Despite facing capacity challenges due to staffing shortages and sickness, the ongoing recruitment, Organizational Change Process (OCP), and IPC workflow reviews are anticipated to significantly enhance our capacity to support clinical areas effectively.

Decontamination practices remain an essential component of our overall IPC strategy, with significant efforts made to ensure compliance with national guidelines and quality standards. This

chapter details key developments, challenges, and recommendations concerning decontamination processes, including sterile services, endoscope management, and the implementation of a centralized endoscope decontamination unit. Continuous improvement in decontamination practices remains essential, and this chapter outlines the steps undertaken and future actions planned to achieve the highest standards of patient safety and compliance.

1-COMPLIANCE WITH THE CODE OF PRACTICE FOR THE PREVENTION AND CONTROL OF HEALTHCARE ASSOCIATED INFECTIONS - WALES

The table below sets out the actions taken by the HB to evidence compliance with the code of practice and actions for 2025/26 work plans to be monitored by IPPC.

Compliance Criterion	What the Registered provider will need to demonstrate	Evidence of compliance	Recommendation/action for 2025-26 work plan
1	Appropriate organizational structures and management systems for IPC must be in place	• Infection Prevention and Control Committee (IPCC). • Annual Program of Work. • Annual Audit Program • Annual Report to the Health Board. • Risk Register review. • Training provision to the HB staff and mandatory training program • Policy review program • Water Safety Group. • Ventilation Safety Group • Decontamination Group • Health Board Infection Prevention and Control Team. • Access to expert advice by Consultant Microbiologist. • Access to microbiological testing through accredited laboratory • Outbreak recording database (on excel spreadsheet) and ICNet • ICNet as electronic surveillance and case management system • Recording of Multi-resistant microorganism infections • RCA's undertaken • On-call 24-hour microbiology support • IPC level 1 and 2 training as well as ANTT mandated to relevant staff • Decontamination expert available (1) •	• Ensure that there is equality of access to testing on all acute sites. • Ensure that microbiology support is the same across all acute sites • Develop and implement link workers program across acute sites of the HB • Ensure full implementation of Hub model across the organization • Extend IPC support to from 8 am to 8 pm and on-call weekends and bank holidays • IPC annual auditing program to be replaced by monthly reviewed "areas of concern" to ensure more targeted IPC surveillance • Improve outbreak recording – ICNet Outbreak module to be used by IPCt on all outbreaks to ensure accurate data is recorded. • IPC databases on review as well as IPC processes to ensure there is continuity across the 3 acute sites • Strengthen the collaboration between IPC and antimicrobial pharmacist • Ensure adequate compliance with IPC training (95% and above) across all the HB • Stop presential IPC training level 2 and move IPC training resource to targeted training activities (training, roadshows, etc.) • Explore with Comms alternate ways of

			communicating IPC to staff, patients and visitors - Only one decontamination expert for the HB – strengthen the organization's position with funding for training other members of the IPC team to ensure support and resilience - Currently issues with samples being sent previous to antimicrobial prescription/start, this has been identified from the snapshot audits, an action plan has been drafted – work to focus on this goals to ensure reduction of multi-resistant microorganisms.
2	All care equipment, including medical devices is decontaminated effectively and safe the point of use	- Quarterly reports by estates and facilities to IPCC - Cleaning Policy - Decontamination Policy. - Waste Management Policy - Decontamination auditing program in place set by the decontamination expert and with support from the IPC team - Availability of cleaning stickers to be used after cleaning/decontamination of equipment - Decontamination and sterilization electronic traceability system - Decontamination site meetings and Decontamination committee meetings - Decontamination expert reporting to IPCC through the IPC report - HB Decontamination policy	- Increase resilience of decontamination expertise on the HB with funded training to IPC team members - Support training needs for the decontamination expert - Support ongoing capital projects such as endoscopy sites to improve compliance with decontamination best practices - Ensure comprehensive training program to support sterile services and endoscopy
3	The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimizes the risk of infection	- Estates and facilities report to the IPCC - HB cleaning policy - IPC Environmental audits - SITE audits by the facility team - Emergency response, resilience and recovery plan for domestic service - System to monitor compliance with National	- Explore joint work streams with facilities and estates - Support implementation of new cleaning standards once published - Ensure facilities and estates are invited for outbreak meetings when there are related concerns - Ensure that there is uniformity on the cleaning

		Standards of Cleanliness with NSC • HPV available to all acute sites as well as UV • IPC alerts requesting HPV cleaning when deemed needed and reporting produced by the equipment mailed to all relevant parts • Hand hygiene facilities in all clinical settings • Pest control policy	responsibilities as well as schedules (currently there are different arrangements across the organization with different products and names) • Consider impact when boarding in wards regarding proximity to Hand Hygiene sinks due to risk of contamination
4	Suitable, timely and accurate information on infections is available to staff, service users and their visitors, and those responsible for providing care to others.	• IPC presence on Safe to Start meetings • IPC locality meetings chaired by HoN for each locality • Hand washing notices. • Isolation notice at patient doors when required • IPC daily site plan sent to HoN. • IPC presence on daily meetings with Patient Flow teams • Information leaflets for patients available in both English and Welsh language • IPC annual report publicly available through the organization external web page (once approved) • Letters to patients and GPs when positive results of CDiff or CPE • IPC alerts on ICNet regarding admission of patients with CPE, previous CDiff as well as contacts of patients with CPE that were discharged without full screening • Information on antimicrobial resistance is made available to staff and patients through public release of Q&S reports.	• Continue IPC presence on safe to start meetings • Continue IPC presence on Site escalation meetings • Develop guidance to trigger Universal mask use and also when to stand it down • Continue to provide training to patient flow teams and explore ways of closer cooperation to improve on decision making • Improve work with comms to ensure adequate messages and information are available on internal and external sites when required. • Ensure more robust update of IPC information in both intranet and internet sites
5	All staff employed to provide care in all settings are fully engaged in preventing and controlling infection.	• IPC mandatory level I and II training and monitored through ESR • IPC ANTT training available • Implemented targeted trainings along the year such as IPC training for	• Move face to face level 2 training to on-line only and focus on ad-hoc focused training. • Promote join initiatives with other departments to make IPC agenda visible (e.g. road shows, etc)

		patient flow teams, use of new outbreak toolkit, etc. • Infection Control responsibilities included in job descriptions • Oc. Health service available the oversees staff vaccination • RCA done on Hospital onset cases of Multi resistant organisms or bacteremia associated with invasive devices such as catheter or IV line • Datix system to record and review incidents across the HB • Uniform Dress Code in line with All-Wales guidance and monitored at clinical area by managers and part of IPC auditing	• Ensure strengthening of IPC visibility in clinical settings with more clinical area based work • Joint work across HB with leads for different professional groups to ensure compliance with mandatory training • Ensure that there are more robust processes to review infection processes to ensure that the reviews are done as quickly as possible to ensure that the learning points can be promptly acted upon with benefits as earlier as possible
6	Suitable and sufficient isolation facilities are provided to support effective IPC.	• All acute settings have single rooms available • IPC support on management of single rooms with direct contact with clinical area and as part of discussion with patient flow teams • Daily site IPC plan sent to patient flow and HoN to support decision making • IPC training sessions targeted to patient flow teams deployed during the last 2 quarters of the year • Failure to isolate patients documented in Datix system • IPC communicates with clinical areas (during office hours) any relevant results and advises on transmission-based precautions and discusses mitigation strategies when isolation is not immediately possible • Patients waiting for CPO screening are isolated until waiting for results. Due to the scarcity of side rooms, this is not always immediately possible, in these cases, contacts are screened in line with national guidance and	• IPC to continue to be present at safe to start meetings • IPC to continue to be present at site escalation meetings • Ensure IPC and patient flow teams continue to work closely to support decision making and optimize patient safety and patient flow • IPC support to be extended from 8 am to 8 pm as well as support on-call during weekends and bank holidays (limited hours) • There are no negative pressure rooms available in the HB Emergency departments, which limits the capacity to deal with HCID's and other highly infectious diseases such as measles. Funding has been made available during Q4 by the WG to create 2 negative pressure rooms – POW and RGH

		incident is recorded through Datix • ICNet alerts for admissions/readmissions of patients known to be carriers of multi drug resistant organisms and IPC alerts clinical area • HCID response policy being developed and table top exercises as well as visits to areas have been done • Practice development staff from A&E were given 2 places to attend HCID training for the new PPE suite, also HCID trolleys set by PHW due to be deployed to ED	
7	Evidence based IPC policies are made accessible and reviewed regularly	• IPC policies in place and on review scheduled – circulated and discussed at IPCC • Outbreak management toolkit deployed with training across the HB • Internal Legionella training provided to the IPC team • IPC audits done through AMaT system and fed back to clinical teams with request of action plan • IPC access during office hours week days and microbiology support 24/7	• Continue to monitor IPC policies and if needed develop new policies to deal with known or new challenges in line with National Guidance • Deployment of joint letter between IPC, microbiology and estates informing clinical areas when positive outlets with legionella are identified (to be agreed with the chair of the WSG before presentation to IPCC) • Strengthen monitor and support for audit action plans following audits – explore ways to ensure action plans completion are monitored with the support of HoNs • Move auditing to targeted audit on “areas of concern” based on reported scoring on AMaT based on specified criteria • Integrate information regarding “areas of concern” with other HB teams (e.g., cross information with safeguarding team, health and safety, etc.) to ensure that there is better share of information and quicker detection of areas to be monitored more closely

			- Extend IPC support to 8-20h weekdays and on-call weekend and bank holidays during the morning (OCP ongoing) - Put in place program to praise examples of excellency regarding IPC practices in clinical areas (currently being discussed in the team)
8	Organisational systems and processes are in place that protect staff from the risk of exposure to infections that can be transmitted in the workplace	- IPC mandatory Training - PPE available - Occupation Health Service available - Oc. Health supports IPC from a staff health perspective when required during outbreaks - FFP3 face fitting being led by Health and Safety team - HCID train the trainer course attended by practice development nurses from E.D. to be cascaded to relevant staff - Staff has access to adequate PPE equipment and are trained on safe use through IPC training as well as FFP3 face fitting program (managed by OC. Health) - Polices in place to support staff at risk assessing the precautions required for IPC to protect themselves. - Provision exists outside of OH working hours for Staff to access. An example is the access to the Emergency Unit for the acute and timely management of a Needle Stick Injury - OH has a Duty Line and a generic email account for staff to access for general enquiries	Strengthen staff knowledge on IPC and in particular PPE usage with activities developed jointly with clinical leads (e.g. ad-hoc training, road shows, etc.)
9	All staff are trained, educated and competent in IPC as appropriate for their role	- IPC Level 1 and 2 training for clinical staff mandated from induction - ANTT training being moved to mandated again to staff which have to perform it under their role - Ongoing IPC training – online and face to face,	- Fundamental IPC level 1 and 2 training compliance needs to be increased among staff – Currently 74% with some professional groups around 28% - IPC training more focused areas of need and ensure

		also targeted training has been offered to specific areas such as Legionella awareness, Patient flow and IPC, IPC in management, or ad-hoc when necessary. - Records of staff IPC mandatory training through ESR and reported to IPCC through the IPC report - QI team in the HB to support on QI projects or methodology training - AMS training provided by AMS pharmacist as well as AMS mandated through ESR requirements	attendance from the clinical areas - Comms involvement in IPC awareness and education actions - Promote IPC through alternate ways and as part as a multidisciplinary team (e.g. roadshows with IPC and other partners such as HoN, medical, H&S, estates and facilities, etc.
10	There is an organisation wide antimicrobial stewardship programme in place.	- Antimicrobial Stewardship Group in place from Q3, also AMS pharmacist and medical microbiologist meeting every week, with the purpose of review and update antimicrobial guidelines. - AMS pharmacy strategy in place and adopted as HB AMS strategy - AMS expertise 24/7 available through microbiology - AMS guidelines hosted by Eolas. Available on app and through sharepoint - Snapshot audits of all antimicrobials on all DGH sites in Nov 24, Gentamicin audit on May 25, PPS – UTI - Acquisition of HCAI associated with antimicrobial is reported on Datix and investigated, with lessons learned shared with the wider clinical team	- Explore joint work with Antimicrobial Pharmacist and microbiology with support from medical directorate - Ensure review of bloodstream infections for multi-resistant organisms and action of learned actions as swiftly as possible - Establish network of link workers and include in the training themes such as Abx Stewardship and Sepsis Awareness - Produce leaflets/Cards to give to patients with infections such as CPE and CDiff - No AMS Lead in the HB, but work ongoing to ensure that the local AMS as well as community stewardship is lead through the AMS board. - Ensure “lessons learned” matrix is created to inform actions/interventions - Review of antimicrobial prescribing in primary care – Development/strengthen primary care RCAs for CDI
11	The organization’s strategy to deliver a net zero health service is compatible with maintaining the prevention and control of infection	- IPC being part of discussions to reduce carbon foot print strategies - IPC open and supportive of alternative that are evidence based equally safe but more sustainable	- Put training and support actions in place to ensure adequate and rational use of PPE to avoid misuse or overuse - Deploy link workers program to support on local

		- IV to oral switch of antibiotics uses less plastic – Pharmaceutical services working towards a 48h review as part of the HB AMS policy	IPC support, in particular on staff understanding of PPE so work can be moved towards rational use
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Table 1 - Compliance Review with The Code of Practice for the Prevention and Control of Healthcare Associated Infections - Wales

2-TRAINING ACTIVITY

This chapter will present and discuss both the training provided (formal training) during the financial year as well as training attended by the IPC team members.

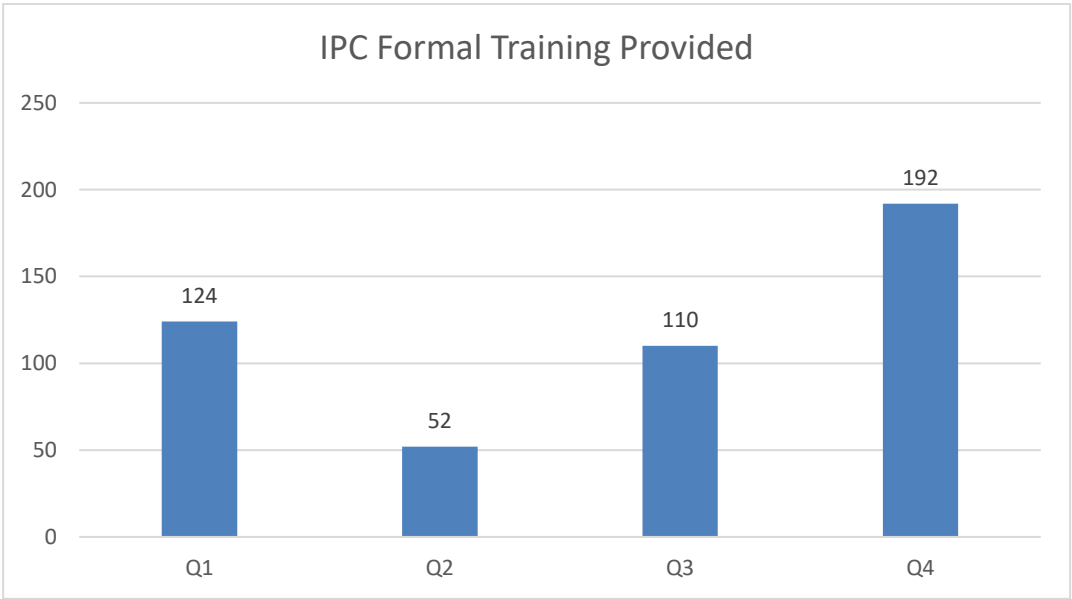
Another point being discussed in this report is the staff compliance with IPC training.

2.1-TRAINING DELIVERED

Q1	Q2	Q3	Q4
PCH Level 2 - PCH - 7 (44) - POW – 2 (20)	IPC Level 2 - PCH - 3 (10) - POW – 1 (6)	IPC Level 2 - PCH – 5 (38) - POW – 2 (15) - RGH – 2 (24)	IPC Level 2 - PCH – 5 (58) - POW – 2 (21) - RGH – 1 (7)
ANTT - PCH - 1 (6) - POW – 1 (6)	ANTT PCH - 2 (15)	ANTT PCH - 3 (25)	ANTT - PCH - 3 (12) - POW – 1 (4) - RGH – 1 (5)
Ward Based POW - 2 (21)	Ward Based	Ward Based	Ward Based
Students PCH -1 (17)	Students	Students	Students
HCSW	HCSW PCH - 1 (21)	HCSW	HCSW
Care Bundles PCH - 1 (10)	Care Bundles	Care Bundles PCH – 1 (8)	Care Bundles
DNA POW – 3 (23)	DNA POW – 1 (8)	DNA PCH – 3 (13)	DNA - PCH – 6 (24) - POW – 1 (4) - RGH – 1 (7)
			Outbreak Toolkit 8 – (60)
			Patient Flow 5 – (25)

Table 2 - IPC training provided per quarter

During the financial year the IPC team provided formal IPC training to 384 staff members with 79 DNA (20.57%) along the 4 quarters as shown in the following graphic:



Graphic 1 - IPC Formal Training Provided per Quarter

The highest training activity occurred in Q4, driven by the introduction of targeted training sessions, including the Outbreak Toolkit and Patient Flow training programs. Notably, only 18 staff members participated in care bundle training throughout the entire year. Improving attendance at these sessions is crucial for the upcoming financial year, as incomplete or incorrect care bundle documentation consistently emerges as a common issue identified in RCAs associated with healthcare-related infections.

Address this requires increasing awareness among Heads of Nursing at the various sites, as well with other clinical managers. Additionally, exploring strategies to enhance the visibility and accessibility of care bundle training sessions is necessary to boost participation and ultimately achieve improved compliance across the Health Board.

The data also indicates an increase in ANTT training attendance during Q4, attributed to clarifying its ongoing necessity as mandated training. Although ANTT training was removed from the list of mandatory requirements earlier in the year, it continued to be provided, albeit with fewer training opportunities initially offered – This has the implication that we currently do not have a baseline of the staff requiring this training have done it and also not being mandate poses a challenge to ensure that staff doing techniques that require ANTT are adequately competent, which brings significant risks of HCAI.

2.2-TRAINING ATTENDED

The IPC team continues to be an expert service to the Trust and have worked towards keeping their professional development up to date with the latest knowledge, enabling the team to provide a high level of support to the Health Board. It is essential that investment continues during this new financial year, to support the IPC team regarding it’s knowledge development. For the new financial year, training should look into (not exclusively) preparing members of the team in key aspects such as water safety, decontamination and ventilations safety, due to the lack of expertise across the IPC team on this key areas. The IPC team will continue to endeavor to be present in other initiative such as National and Regional conferences and then ensure that all the learning is brought back to the organization, shared within the IPC team as well a broader audience and informs the IPC practices and advice.

Another internal initiative that has been put in place to ensure the team’s knowledge is up to date and that all the team members possess the essential knowledge to be able to develop its role was the creatin of meeting every 2 months were several IPC teams are presented either by members of the team, other health experts within the Health Board and with some external speakers.

2.3- IPC TRAINING COMPLIANCE

The following gauge shows the overall compliance with IPC mandated training across CTM:

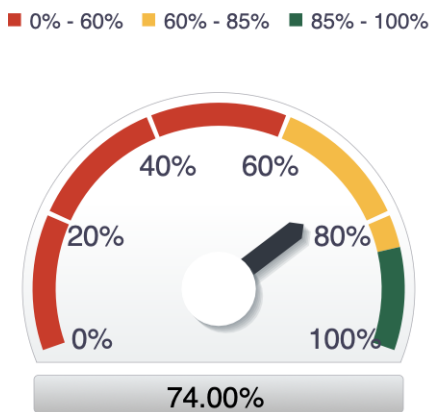


Figure 1 - Overall compliance with IPC mandatory training

As can be seen in above gauge, we have a sub-optimal compliance across both Level 1 and Level 2 training, leaving us in amber with only 74% with our staff completed the IPC training, if we look at both training levels in separate:

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
NHSICSTFIInfection Prevention and Control - Level 1 - 3 YearsI	3983	3983	3302	82.90%	54	83.03%
NHSICSTFIInfection Prevention and Control - Level 2 - 1 YearI	8291	8291	5781	69.73%	319	71.14%

Table 3 - Compliance with IPC mandatory training per Level

We can see that the lowest compliance is at Level 2, which is particularly concerning, because it is aimed to those staff that will be doing more invasive techniques with the patients and therefore will incur in higher risk of both causing infection or getting themselves infected.

To further understand this information, it is important to look at the compliance per staff group:

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic	404	413	253	61.26%	18	61.50%
Additional Clinical Services	2470	2470	1897	76.80%	106	78.54%
Administrative and Clerical	2365	2383	2043	85.73%	19	86.53%
Allied Health Professionals	812	812	625	76.97%	14	79.06%
Estates and Ancillary	1270	1271	975	76.71%	35	74.74%
Healthcare Scientists	205	205	167	81.46%	1	83.90%
Medical and Dental	808	808	231	28.59%	15	29.70%
Nursing and Midwifery Registered	3902	3902	2885	73.94%	165	75.29%
Students	10	10	7	70.00%	0	70.00%

Table 4- Compliance with IPC mandatory training per Staff Group

The data clearly highlights that the Medical and Dental staff group has the lowest compliance by a significant margin, with only 28.59%, followed by the Professional, Scientific, and technical group at 61.26%. Conversely, the Administrative and Clerical staff demonstrate the highest compliance, despite their typically lower risk of patient interaction. Nurses and Midwives also show suboptimal compliance at 73.94%.

If we look at the data from a care group perspective:

Care Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Bank Care Group	2	2	2	100.00%	0	100.00%
110 Chief Operating Officer Care Group	1189	1190	870	73.11%	39	71.01%
110 Children & Families Care Group	1411	1420	999	70.35%	65	70.07%
110 Corporates and Hosted Care Group	1324	1327	1131	85.23%	15	85.38%
110 Diagnostics, Therapies, Pharmacy & Sciences Care Group	1756	1757	1323	75.30%	39	77.06%
110 Mental Health & Learning Disabilities Care Group	1181	1186	944	79.60%	39	80.10%
110 Planned Care Care Group	2017	2023	1415	69.95%	71	70.44%
110 Primary & Community Care Group	1567	1569	1207	76.93%	48	80.62%
110 Unscheduled Care Care Group	1799	1800	1192	66.22%	57	68.67%

Table 5- Compliance with mandatory training per Care group

With exception of Bank Care Group and Corporate and Hosted care group, all the other areas have low scores, in particular Unscheduled care and Planned care.

This overall compliance picture is concerning. Without a robust understanding of their responsibilities and effective infection prevention practices, staff are inadvertently placing patients, themselves, and the wider community at unnecessary risk, contravening the fundamental Hippocratic principle of '*Primum non nocere*' (First, do no harm).

While promoting IPC training is a core function of the IPC team, achieving comprehensive compliance requires a collective effort across all levels of staff. It is essential that CTM management prioritizes increased awareness and adherence to IPC training in the upcoming financial year, ensuring IPC principles are consistently integrated into everyday clinical practice. Without establishing strong IPC foundations, the Health Board will struggle to effectively manage and reduce the incidence of healthcare-associated infections.

3 – STAFF ORGANIZATION- CHANGES AND NEW MODEL OF WORK

The new Care Group model, approved by the Board in July 2022, has already seen the establishment of services around Care Groups focused on;

- Planned Care,
- Unscheduled Care,
- Children and Families,
- Diagnostics and Therapies,
- Primary Care & Community and Mental Health.

In line with the agreed, the IPC team has been working towards deploying the new work model to the IPC organization and practice.

The proposed new model is designed to streamline processes and improve operational efficiency, looking at freeing up resources and capacity to provide IPC advice and expertise. The current workforce has been mainly site-based working mostly on the acute sites of Princess of Wales, Prince Charles and Royal Glamorgan Hospital with touchpoints into the wider community hospitals and HMP Prison. The recent changes and implementation of care groups have required a wider input across the Health Board to all in-patient and community care facilities. In order to meet the needs of the service it is necessary to use the experience and skills of those who currently provide a site-based function in a centralized system implementing and working through a hub model. This is crucial to the success of a safe, sustainable and fit-for-purpose IPC service and can provide an equitable service across the health board promoting patient safety and prevention of infection.

The new structure requires a single IPC team that has a contact person in a “hub” who coordinates daily IPC information, monitoring and communication. The Contact person (CP) will lease closely with the Local contact practitioners (LCP) to facilitate specific site IPC communication.

As reflected in the model below the CP communicates widely across the HB.

Communication Hub

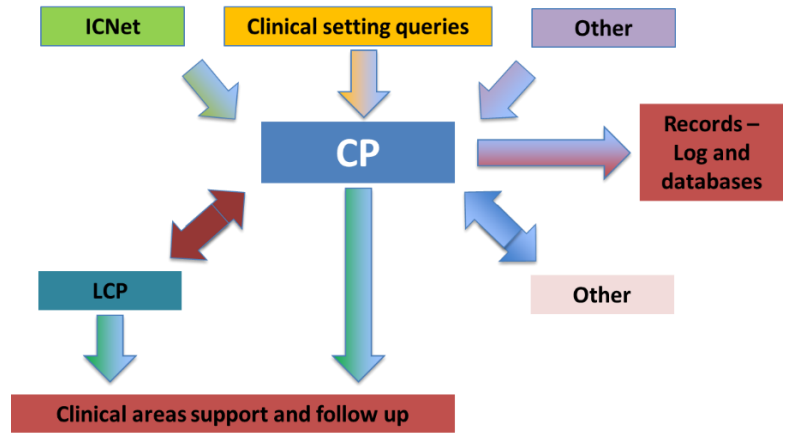


Figure 2- Hub Communication structure

To ensure the service is fit for purpose, an OCP was started to enable the service to be extended from its current 9-5 Monday to Friday hours of service to 8-8pm Monday to Friday with an on-call service at weekends.

To ensure oversight and robust governance there is the aim of ensuring weekly reports from Senior IPC nurses and IPC leads to the HoN and monthly highlight reports with infection trends and compliance against the 10 national IPC goals which will be scrutinised through the Quality and Safety committee and monthly to Welsh Government through Integrated Quality, Planning and Delivery (IQPD) meetings.

The new work strategy was introduced to the IPC team in Quarter 3 and began its implementation in Quarter 4, initially appointing a designated HUB coordinator. Given the fragmented nature of IPC services across the Health Board (HB), ongoing task and finish groups have been established to identify and standardize IPC procedures and documentation. This task has proven particularly challenging due to parallel fragmentation in related services, such as microbiology and laboratory support, resulting in difficulties interpreting data, inconsistent access to equivalent testing methods, and variations in IPC recommendations.

The rollout of this new strategy will continue into the next financial year, becoming increasingly vital with the recent funding secured to establish a community IPC team. To support and facilitate this strategy, creating a Development Framework aligned with the Welsh IPC Framework, WHO guidelines, and IPS competency standards is essential. This IPC Framework will be presented at the Q1 IPCC meeting for discussion and approval, aiming for broad implementation across the HB. An induction package for new IPC staff will complement this framework. Additionally, efforts are underway to identify external training opportunities to enhance team expertise, focusing on both general IPC competencies and specialized areas like Water Safety, Decontamination, and Ventilation Safety.

By the end of Quarter 4, the IPC team faces capacity challenges due to existing vacancies and the ongoing practice and process reviews. Recruitment efforts continue, though finding suitably qualified staff remains difficult. This further underscores the importance of deploying the Development Framework to enable existing and future IPC staff to achieve their full potential, encourage professional growth, and ultimately strengthen the HB's resilience.

Community IPC Team: The Health Board secured £403,155.77 in funding during Quarter 4 (January 2025) to establish a community IPC team. Initially, this team will focus on collaboration with local authorities to review IPC compliance in Nursing Homes and establish a network of IPC link workers to enhance IPC compliance and support within these settings. In the next phase, the team aims to extend its connections to GP surgeries, replicating the Nursing Home model by developing another network of link workers and actively supporting IPC practices.

To achieve these objectives, recruitment for the community team is ongoing. The previously mentioned Development Framework will be crucial to ensuring the formation of a skilled, cohesive team capable of operating seamlessly between primary and secondary care settings. Currently, the IPC team is developing supportive resources, including training packages and auditing tools tailored for community use, alongside establishing an effective reporting system to ensure transparency, oversight, and appropriate support.

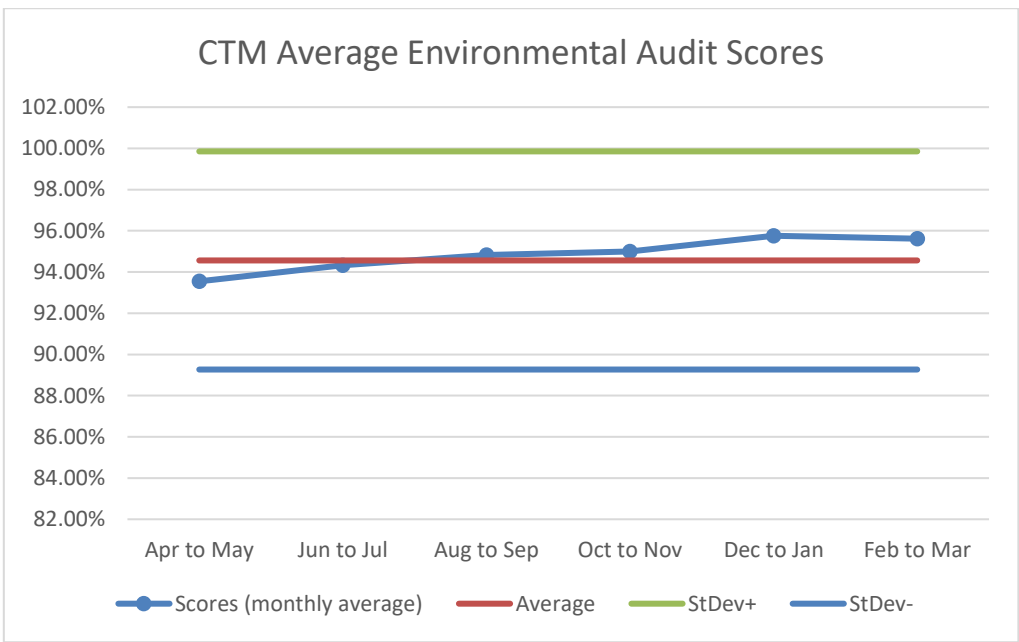
4-ANNUAL AUDIT AND INSPECTION PROGRAM

This has been a year of change across the IPC team, working towards the exclusive use of the AMaT tool to record audits done both by clinical settings as well as by the IPC team. There are some auditing still being done on excel spreadsheets, such as audits regarding catheter bundles, etc., but the plan is to also move those to the IT tool in use and stop using excel spreadsheets. This will have the advantage to centralize the information, making analysis and decisions based on this information easier and more accurate. Also facilitates the auditing of the quality of the audit execution.

The IPC team is transitioning to a new paradigm where they will review selected IPC audits submitted by clinical areas on a monthly basis. A set of criteria was created and embedded on the monthly locality reports to ensure we can identify and target on the following month areas identified as “areas of concern”.

Currently, clinical areas submit regular audits through the IT tool for Environmental IPC, PPE, Hand Hygiene and Bare below the elbows, care bundles (urinary, PVC and CVC). Currently there are some audits not in the electronic tools such as endoscopy, mortuary, CSSD (IPC and Decontamination) and opening of new areas sign off IPC audit.

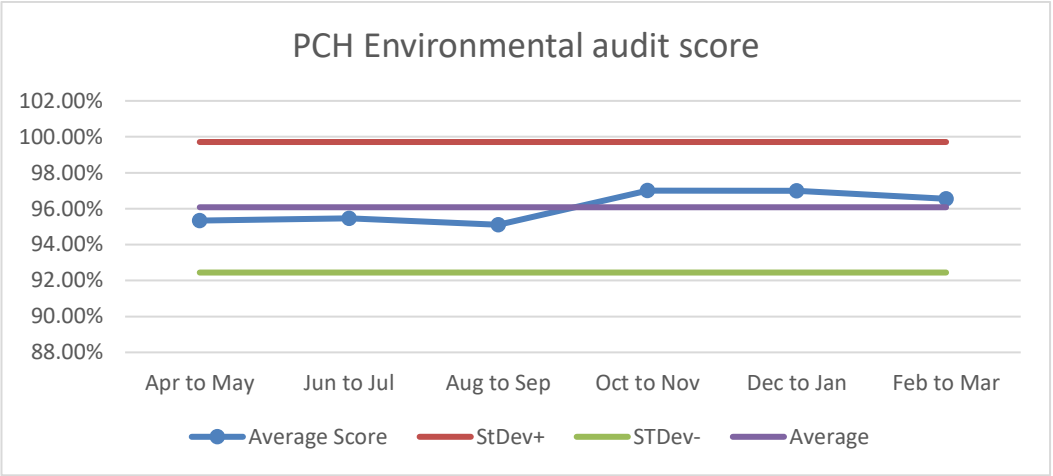
Looking at the current HB position regarding the Environmental IPC audit, submitted by the clinical areas:



Graphic 2 - All CTM average Environmental audit score - clinical area submitted

We see that we have an average score of 94.5% and an upper trend regarding the scores across the organization, if we remove all non-submitted scores.

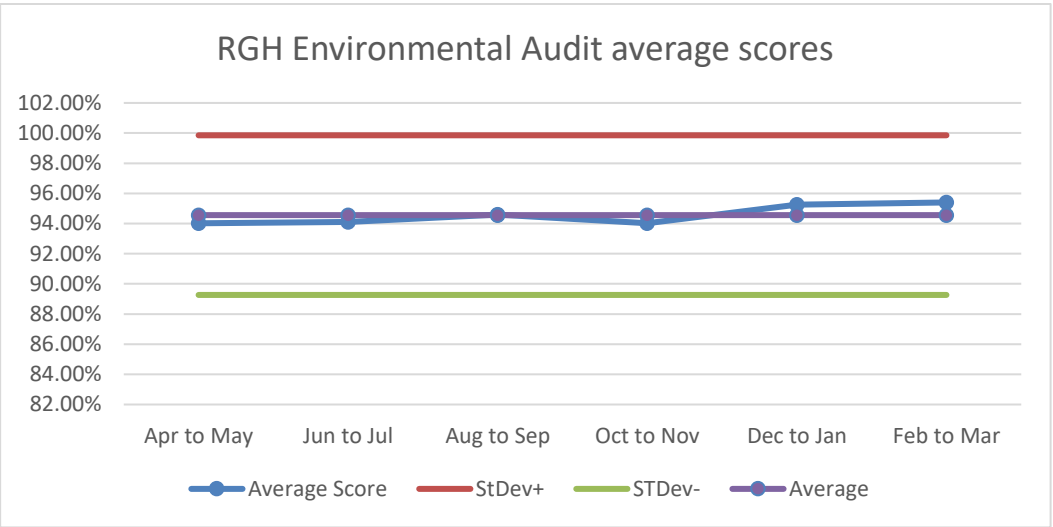
Looking at the main clinical areas:



Graphic 3- PCH CTM average Environmental audit score - clinical area submitted

PCH has an average of 96% so slightly higher than all CTM score with the same trend for increase of the scores from November onwards as seen on the all CTM data.

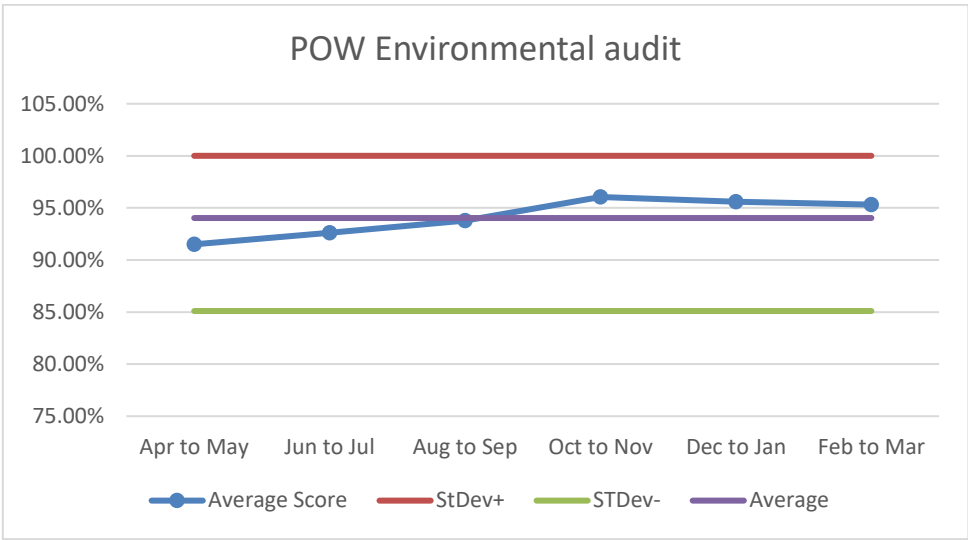
If we look at RGH:



Graphic 4 - RGH CTM average Environmental audit score - clinical area submitted

We have an average of 94.56%, so in line with CTM overall but while the data shows some improvement on the scores from October onward, this tendency is less evident. It is important to highlight that this data was calculated removing non-submissions

Looking at POW data:



Graphic 5- POW CTM average Environmental audit score - clinical area submitted

We can see an average of 94% with an improvement across the year.

While these figures place us within the high amber range (85% to 95%) or green range ($\geq 95\%$), they contrast with the IPC annual audit score, which has an average of 84.7% and a significant standard deviation of 14.91%. It is important to note that this discrepancy may partly arise from differences in the auditing tools used, as the annual audit tool is broader and more comprehensive, making direct comparisons challenging.

This discrepancy highlights the need for adopting a new auditing strategy to ensure the accuracy and reliability of the submitted data. IPC must actively ensure that staff are effectively trained in auditing techniques and remain vigilant against complacency and routine oversight of non-conformities.

Several strategies could address this issue, but as discussed throughout this report, we believe the most effective approach is to shift away from a static, resource-intensive annual audit program. Such programs typically fail to provide continuous support or develop clinical staff capacity to promptly identify and address compliance issues. Instead, implementing an "areas of concern" strategy—where clearly defined criteria highlight specific areas requiring focused auditing—is recommended. Over time, this approach could be expanded to integrate concerns identified by other departments, such as Health and Safety. This strategy would target resources and attention effectively, ensuring increased compliance and competent auditing.

Given the limited IPC resources, embedding a resilience component is essential. This would involve cross-auditing by clinical staff from other settings, offering fresh perspectives less affected by familiarity with the environment. The establishment of IPC link workers across the organization, supported actively by clinical area managers, would further bolster this strategy.

5-External Inspections and Audit

The were no external inspections and/or audits to report

5-SURVEILLANCE OF ALERT ORGANISMS AND OUTBREAKS

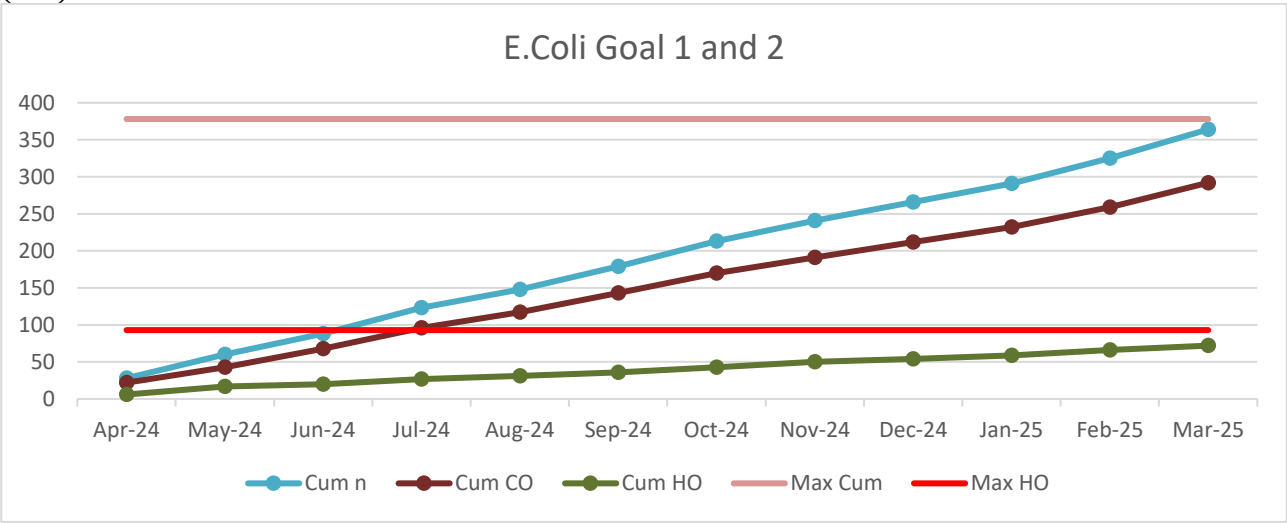
The IPC team have responded to numerous inquiries on the management of potential and actual infectious organisms; the following is a summary of the infections detected, in particular the position of the Health Board regarding the goals set by PHW for the reduction of HCAI.

5.1 – INFECTION PREVENTION AND CONTROL – EPIDEMIOLOGICAL REVIEW AGAINST WELSH GOVERNMENT TARGETS

The Infection Prevention and Control (IPC) team during 2024-2025 concentrated on acute care with minimal community support, resulting in challenges in managing community-onset infections. The AMR&HCAI Improvement Goals for 2024-25 have been released by the Welsh Government in October 2024. This report will explore the Goals 1 to 10 since Goals 11 and 12 are part of the Antimicrobial Lead Pharmacist reporting.

5.1.1 - IMPROVEMENT GOALS 1 AND 2 – E.COLI BACTERAEMIA

The WG improvement goal for reducing *E.coli* bacteremia is 10% reduction of HO cases from 2023/24, which equates to no more than total 378 cases and no more than 93 Hospital Onset Cases (HO):

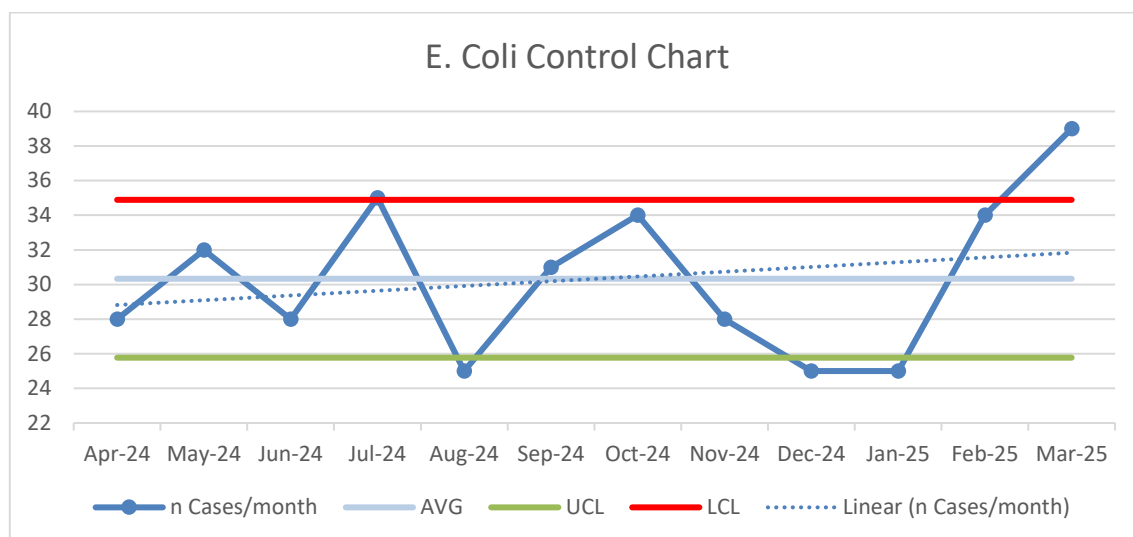


Graphic 6 - E.Coli Bacteraemias

In line with the information in graphic 6, we can see that the Health Board has achieved the target of reduction set by the Welsh Government. The Total number of Hospital Onset cases was lower than 93 cases. The same was found regarding the total number of cases where the threshold of 378 cases was not breached (total 364 cases).

It is important to point that most cases were community onset – 80% with 20% being HO.

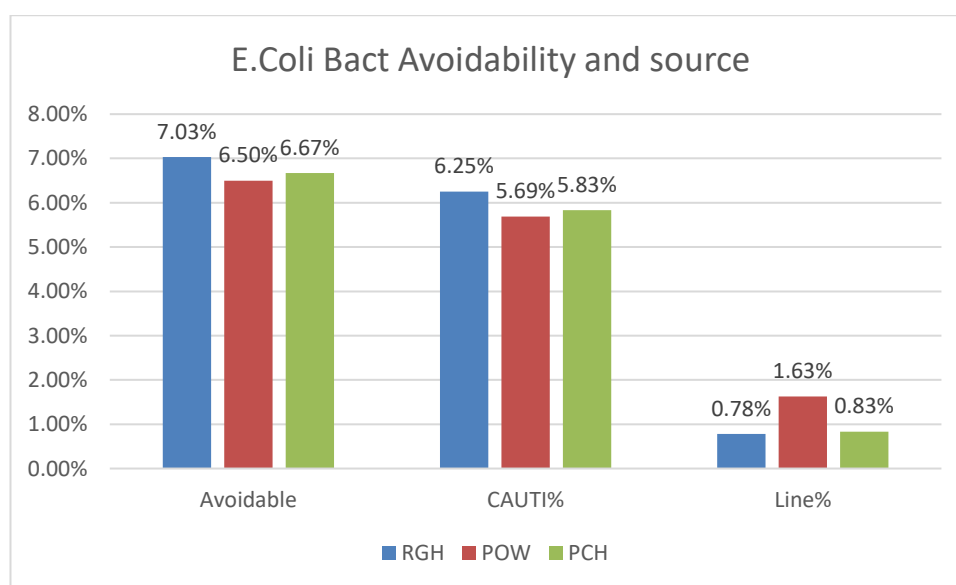
If we look at the SPC Chart for the *E. Coli* cases along the financial year:



Graphic 7 - SPC E.Coli chart

We can see that there are 4 points outside the standard deviation lines, with a trendline showing a tendency to increase albeit the reduction this year.

When we look at avoidability and sources:



Graphic 8 - E.Coli - Avoidability and Source

The profile of *E. Coli* bacteraemia shows less variation across sites:

- Avoidable cases ranged narrowly from 6.5% (POW) to 7.03% (RGH).
- CAUTI-related infections also showed minor differences, ranging from 5.69% (POW) to 6.25% (RGH)
- Line-associated infections were notably lower, with the highest being 1.63% at POW.

This relatively uniform profile suggests consistent performance across the Health Board, though continued efforts are needed to drive down CAUTI incidence, especially at RGH and POW.

More work will need to be put towards continue the reduction of Gram-negative blood stream infections and in particular *E. Coli*. such as:

- Increase on PPE awareness across the organization – The IPC team will look at doing a point prevalence evaluation during Q2 regarding PPE understanding, to identify the main gaps, share it

with the clinical leads of the organization and discuss with comms strategies to raise awareness across the organization, findings and actions will be presented at Q2 IPCC

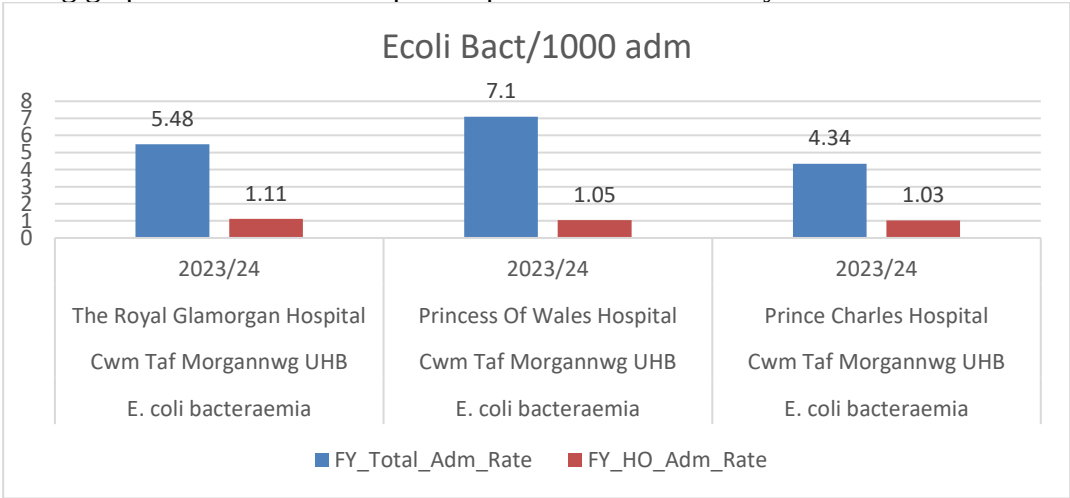
- Strengthen ANTT training – ANTT training is due to be re-instated as mandatory and it is essential to ensure that we achieve a high rate of compliance across CTM. Because this training was taken off from ESR, it is not possible to evaluate our base line to inform our progression and future strategy. IPC will continue working towards the deployment of the mandated training, while continues to provide training. It will be included in this report for future committees the compliance data and targets for improvement as soon as a baseline is identified.
- Continue improving catheter insertion and management across the organization – IPC will focus on increase the monitor of compliance with insertion and maintenance bundles and will seek support from Comms to launch initiatives to raise awareness. A point prevalence will be done to identify our gaps regarding the compliance of the bundles and an action plan will then be created, the IPC team aims to present the first findings and associated actions during Q2 IPCC. This will require a multidisciplinary approach to ensure that all clinical staff involved are included and motivated to improve practices.
- Continue to improve canula and other invasive line insertion and maintenance
- Increase compliance with IPC training level 1 and 2- Currently IPC training levels 1 and 2 are low, but above all, regarding gram negative bacteremia, it is essential to focus in particular on the level 2 training, this will require a multidisciplinary approach, with clinical leads involved, to ensure awareness and compliance. The target goal for CTM will be to achieve at least an average compliance of 85% by the end of Q3. This is an ambitious goal, having in mind that there are clinical groups such as medical and dental with compliance around 25%.

This will require a continuation of a joint effort between IPC and the clinical areas as well as the commitment of professional groups such as medics and nurses to ensure IPC best practices are always adhered. It is essential that staff training compliance is increased and maintained across the organization.

Also, it is important to continue the rollout of the catheter passport across CTM to ensure better care in hospital and in the community regarding the prevention of catheter associated infections. Hydration awareness project would still be important towards a sustainable reduction.

5.1.1.1 – E. Coli rates per acute setting

The following graphic shows the rates per hospital for the financial year 2024/25:



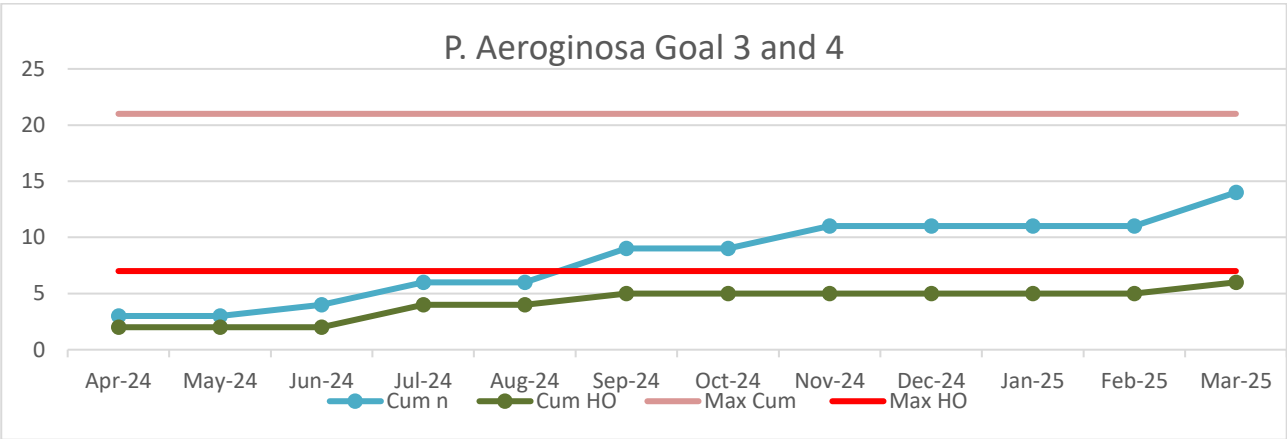
Graphic 9 - E.Coli Rates - Acute settings/1000 admissions

As we can see, the highest rate was on Princess of Wales Hospital (PoWH), nonetheless, the high value is connected with acute admissions, since the rate for HO cases is very similar across the 3 settings, being the lowest Prince Charles Hospital.

The overall conclusion of the separate analysis for the 3 localities is that HO rates continue to represent a small portion of the overall number of cases and to achieve significant reductions, it is essential to look at more detail to the contributing factors in the community that may support a sustainable reduction to CO cases.

5.1.2 - IMPROVEMENT GOALS 3 AND 4 – P. AEROGINOSA BACTERAEMIA

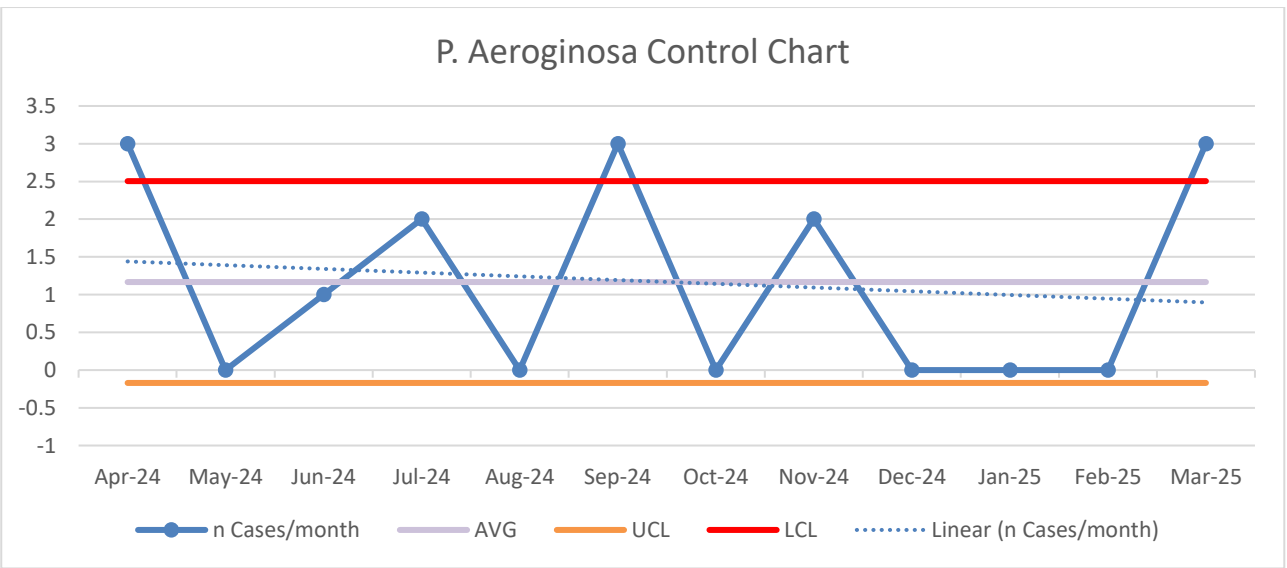
The WG improvement goal requires a 10% reduction in HO cases compared to 20123/24 which equates to no more than 21 cases (<7 HO and <21 total):



Graphic 10 - P Aeruginosa Bacteraemia

In line with graph 3, we have not passed the threshold of infection regarding the HO cases we have achieved the reduction goal, not breaching the threshold of 7 HO cases as well not breaching the threshold of maximum 21 cases for cumulative HO and CO cases. The results reveal a reduction on the number of cases across the year.

If we look at the SPC chart:



Graphic 11 - SPC Chart - P Aeruginosa

It comes in line with the information provided before. While we only see 3 points (April, September and March) falling outside the average deviation lines, there is step downward trendline, which reveals that we are currently on a controlled process but achieving a significant reduction on the overall number of cases. Nonetheless work will need to continue to focus on actions to reduce the rate of infections for the new financial year to ensure that this is a sustained reduction.

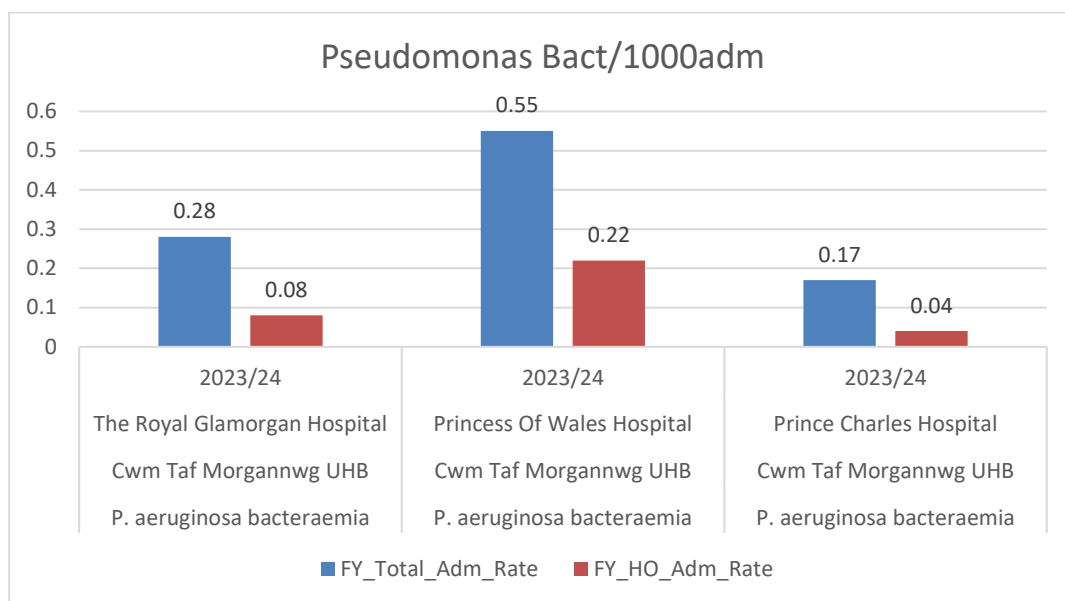
These are some of the key actions to support the sustainable reduction of *Pseudomonas aeruginosa* bacteraemias:

- Regular audits of staff compliance with WHO's 5 Moments for Hand Hygiene
- Work towards establishing a link workers network to increase awareness across the HB – It is an objective for IPC to during the new financial year deploy a link workers program. We are currently developing a training package to support the link workers and is being presented to this IPCC the proposed Development Framework Document that will support the link workers on the development of their competencies. It is essential that we focus on getting motivated staff to join the link workers programs and that they are supported by their managers to ensure they can perform the IPC activities and attend to IPC training initiatives/training.
- Reinforce education and training programs on proper hand hygiene practices for clinical and support staff, through the presence of IPC, clinical settings ownership.
- Ensure a robust insertion and maintenance bundle for all invasive devices (e.g., central venous catheters, peripheral cannulas, urinary catheters, endotracheal tubes) and promote a promptly removal of unnecessary devices; regular daily review with clear clinical justification documented – Monitor through auditing.
- Ensure strict adherence to water safety and hygiene management aligned with WHTM 04-01 guidelines and follow water testing in line with the Water Safety Plan and Effective multidisciplinary collaboration involving infection control teams, estates/water management teams, microbiology, pharmacy, nursing, medical staff, and hospital management.
- Ensure clinical areas are alerted of positive findings in water systems as soon as possible.
- Ensure clinical areas are aware and compliant with the identification of low usage outlets and inform estates as well as start water running protocols for low-use taps and showers, with clear records maintained – This must be moved towards an all Health Board approach since currently we have differences regarding who is responsible for doing the water running.
- Ensure compliance with mandatory training and compliance monitoring of ANTT when accessing invasive lines or performing clinical procedures and ensure that there are regular competencies assessment of staff performing procedures to ensure compliance.
- Root cause analysis (RCA) or post-infection review (PIR) on confirmed bacteremia to identify and address contributing factors.
- Increase compliance with IPC trainings level 1 and 2 across the HB
- Ensure all reusable medical equipment is appropriately decontaminated, cleaned, disinfected, or sterilized according to manufacturer and local infection control guidelines

By systematically applying these evidence-based interventions, you can effectively reduce the incidence of *Pseudomonas aeruginosa* bacteremia within your hospital.

5.1.2.1 – *P. Aeruginosa* rates per Acute Setting

The following graphic shows the rates per hospital for the financial year 2024/25:



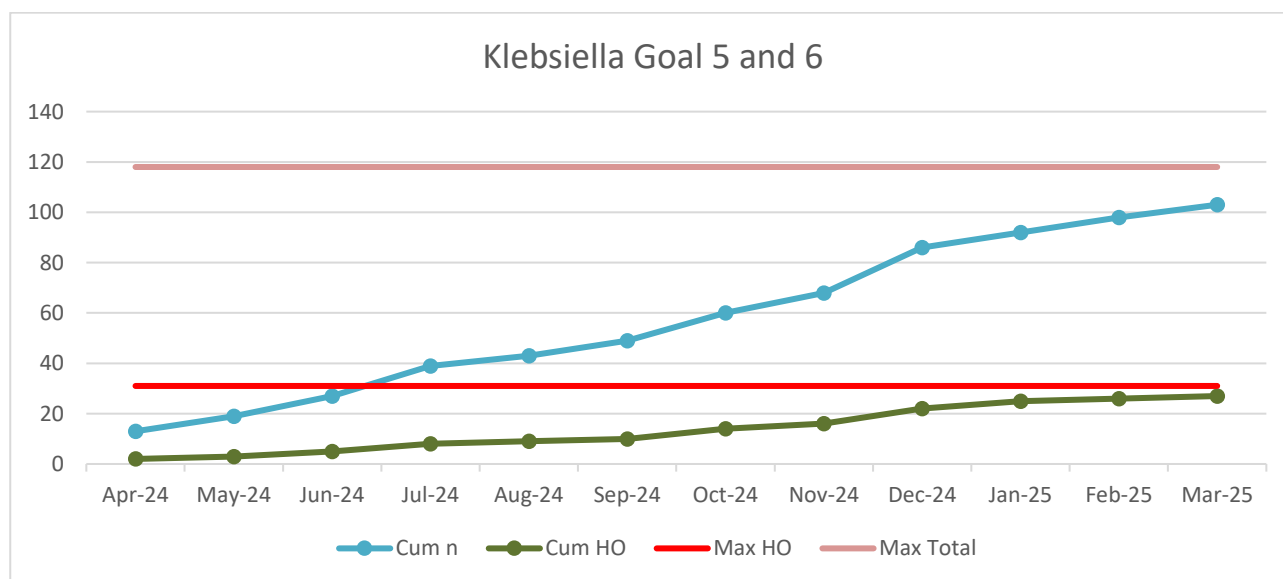
Graphic 12 - *P. Aeruginosa* rates per acute site

The Princess of Wales Hospital had the highest overall rate, followed by The Royal Glamorgan Hospital, being the lowest Prince Charles Hospital. While the rates remained very low, it will be important to try to understand the lower rate found at Prince Charles Hospital.

It is positive to see a reduction on the community and would be beneficial to further explore the reasons for this as well as understanding what reasons are driving the highest rates at POW hospital.

5.1.3 - IMPROVEMENT GOAL 5 AND 6 – *KLEBESIELLA SPP.* BACTERAEMIA

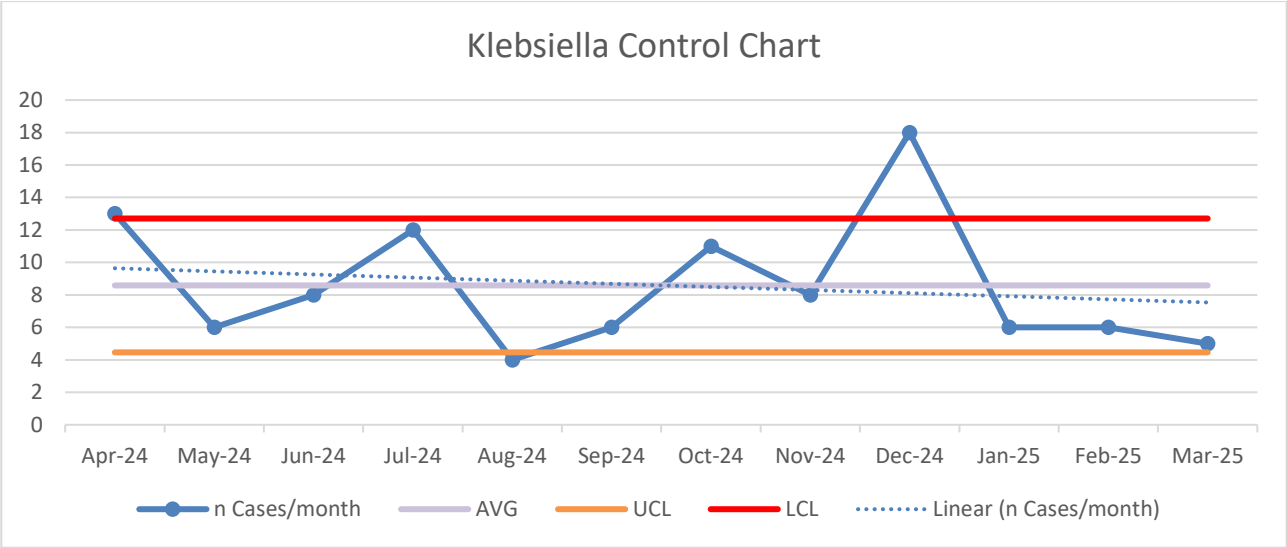
The WG improvement goal requires a 20% reduction of HO compared to 2023/24 figures. This equates to no more than 118 cases (HO<31 cases):



Graphic 13 - *Klebsiella Spp.* Bacteraemia

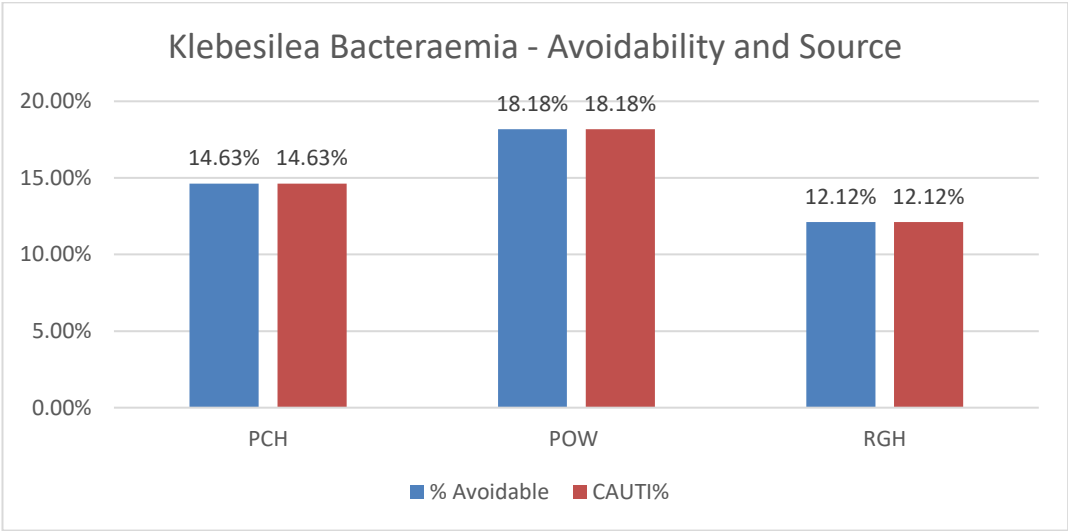
In line with graphic 13, we can see that we have achieved the reduction on HO cases not passing the 31 cases threshold

Looking at the SPC chart:



Graphic 14- Klebsiella SPC chart

We can see that there were no significant changes in the situation along the financial year with 2 deviation points, the first slightly negative on August 2024 and a deviation on a positive on December 2024, nonetheless the majority of the number of cases stayed within average deviation interval with a very slight decrease trendline. While this is a positive outcome, it alerts that we need to continue to work towards the reduction goal since the data does not fully support the reduction as a stable trend in light with current data. To ensure we can continue with a sustainable reduction we need to continue to target our actions towards reducing Gram negative infections as described to the *E.Coli* (6.1.1) When we look at avoidability and source:



Graphic 15 - Klebsiella Bacteraemia - Avoidability and Source

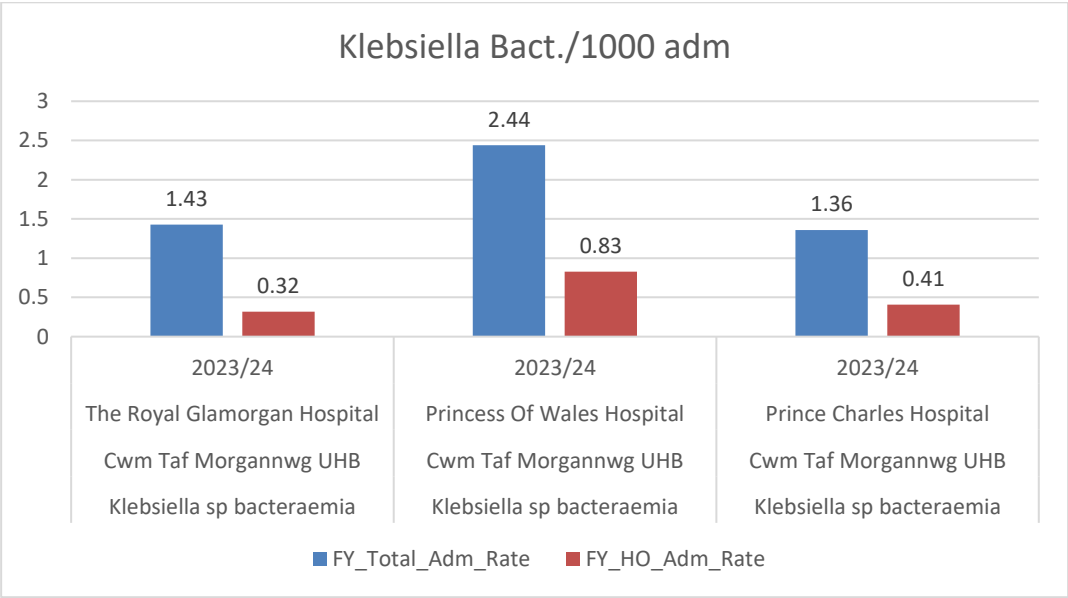
The data on Klebsiella spp. bacteremia presents a consistent picture across all three sites:

- PoWH exhibited the highest percentage of avoidable infections (18.18%), identical to the proportion attributed to CAUTI.
- PCH reported 14.63% for both avoidable cases and CAUTI-related infections.
- RGH had the lowest percentage for both indicators at 12.12%.

The findings underline the strong association between CAUTI and Klebsiella bacteremia. Interventions to improve catheter care, particularly at POW and PCH, may significantly reduce Klebsiella-related infections

5.1.3.1 – Klebsiella spp. rates per Acute Setting

The following graphic shows the rates per hospital for the financial year 2024/25:

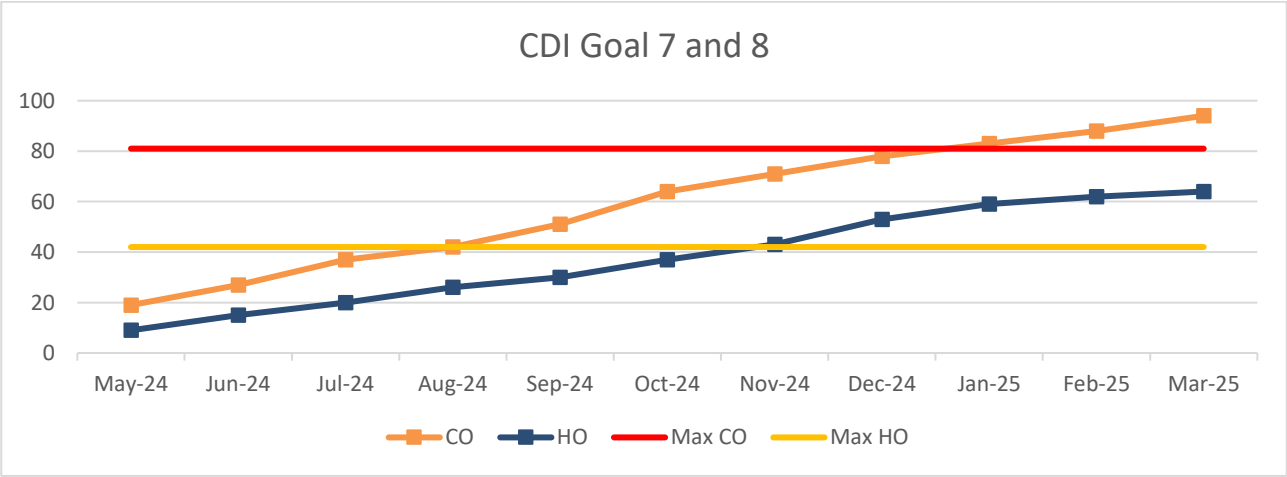


Graphic 16 - Klebsiella rates per acute setting

As we can see on graphic 16, the highest rate of *Klebsiella spp.* Bloodstream infections is in POW, followed by PCH, having the highest burden on CO cases. When looking at HO cases the highest rate is also POW hospital and the lowest PCH, which is similar to the findings for *E. Coli* Bacteremia, another Gram negative microorganism. For the new financial year it would be important to try to understand the reasons for the highest rates in POW compared to the other 2 acute settings.

5.1.4 - IMPROVEMENT GOALS 7 AND 8– C DIFFICILE

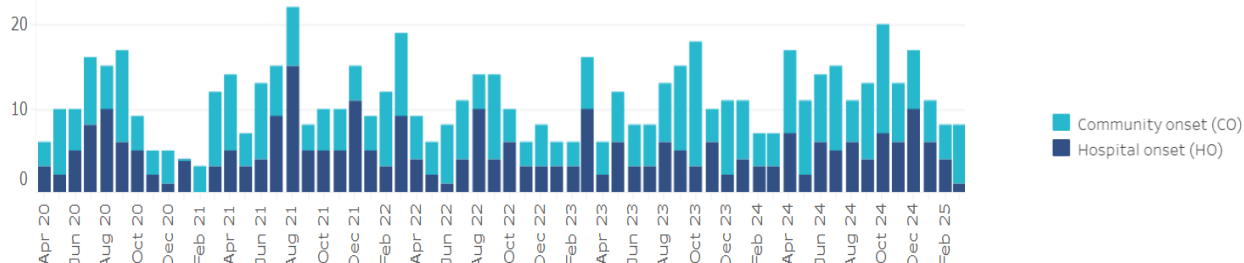
The WG improvement goal for *C.Difficile* for 2024/25 is 10% reduction from 2023/24 which equals < 42 cases HO and <81 CO:



Graphic 17 - Clostridium Difficile infections

The graphic clearly shows that the HB has failed to achieve the reduction goal. Similar situation has been seen across Wales with increased rates of *Clostridium Difficile*. Albeit the increase, CTM continues to show a lower rate than all Wales – CTM-35.58/100,000 population and all Wales – 47.39/100,000 population, therefore 24.92% lower.

The following graphic illustrates the distribution burden between Hospital Onset (HO) Cases and Community Onset (CO) as mentioned, at the moment of this report being produced, 59% of all *Clostridium Difficile* cases reported are CO.



Graphic 18 - CDI infections - Ratio CO/HO

The increase in *Clostridium Difficile* infections has been consistently observed throughout the financial year and continues to date. While part of this rise may relate to increased antibiotic usage during the COVID-19 pandemic, we are also currently experiencing a significant surge in respiratory infections. These combined factors highlight the critical need to strengthen our review processes and apply lessons learned from previous C. diff cases.

Key learnings from RCA's include:

- Prescription of Proton Pump Inhibitors (PPIs): There is a need for thorough review and documentation of both dosing and indications for use.
- Antimicrobial Stewardship: It is crucial to ensure that antimicrobial prescriptions are appropriately made and reviewed, extending this oversight into community settings.
- Need to increase visibility of previous positive cases in the clinical areas.
- Early Detection and Isolation: Prompt detection and isolation of C. diff cases at the earliest opportunity are essential to controlling outbreaks.
- Environmental Decontamination: Environments must be cleaned and disinfected using sporicidal agents, followed by hydrogen peroxide for further decontamination. This process can be particularly challenging in high-traffic areas like Accident & Emergency (A&E), where patient placement may hinder the effective use of hydrogen peroxide.
- Ensure good Hand Hygiene, Bare below the elbows and adequate use of PPE – to achieve this will need to ensure better compliance with mandatory training, local training and increased IPC presence in the clinical settings.
- Low compliance of staff with IPC training.

IPC Actions:

- Monitor Hydrogen Peroxide Vapour (HPV) disinfection – Ensure it is used as gold standard for post CDiff cases.
- Alerts in ICNet for the admission of patients with known C. Diff cases have been implemented, allowing clinical areas to early identify symptom development and early medication review.
- Enhance the robustness of Root Cause Analysis (RCA) by exploring immediate actions for quick wins – Ensure to continue to review the current process and that a robust revision is in place by no later than the end of Q2 and trialed during Q3
- Encourage early reviews of PPI prescriptions in collaboration with pharmacy services.

- Implement sampling and isolation protocols for patients presenting with the first loose stools – To action this, agreement between IPC and microbiology from POW and RGH/PCH will need to be reached on a same testing regime. It will need to be considered if sample should be taken at any first opportunity or if should be underpinned by the presence of risk factors. IPC to support these discussions and to present at the next IPCC a proposal testing regime to be used across all CTM.
- Back to basics – Deploy awareness initiatives such as Hand Hygiene promoting, etc.
- Ensure that low compliance with mandatory training is escalated to HoN and managers, including Medical Directorate, discuss with Comms strategies to raise awareness – To be reviewed quarterly at IPCC.
- Ensure that *Clostridium Difficile* infection review meetings are done at first opportunity possible, with full support from clinical area, Microbiology, IPC, medical staff and Antimicrobial Pharmacist and ensure that lessons learned are swiftly applied and create a “matrix” of lessons identified as recurrent themes for wider development of support and corrective strategies – This is ongoing work as part of the review of IPC workstreams but will require wider support from microbiology, clinical setting management, pharmacy and medical directorate to ensure that review meetings are not delayed and done at the first opportunity – Average time for reviews and outstanding reviews to be included in future IPCC reports.

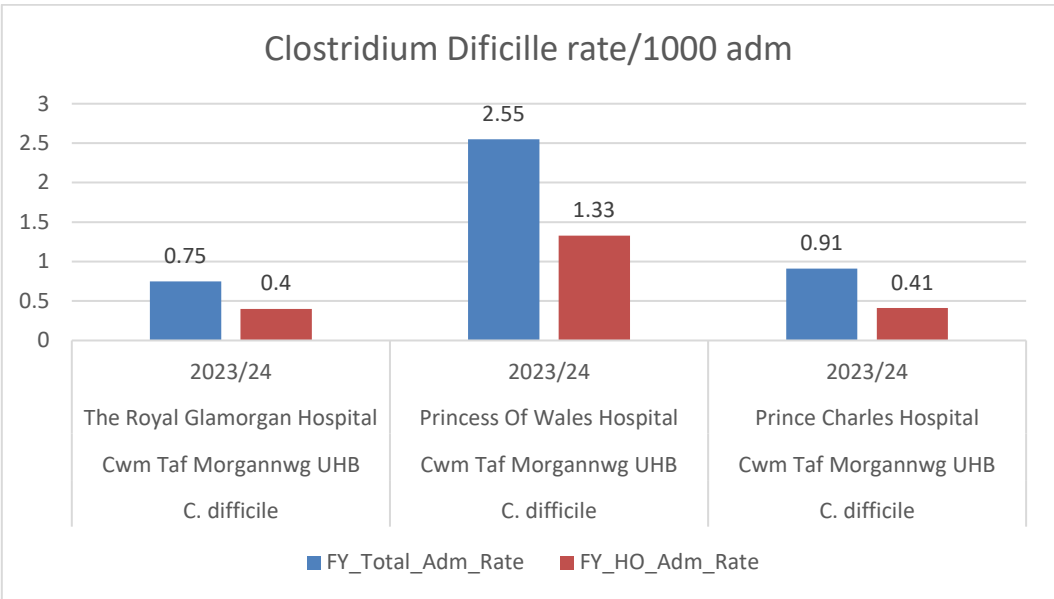
While these actions can significantly influence *C. diff* rates in secondary care, it is equally important to extend support to primary care, particularly from an antimicrobial stewardship perspective. Reviews of *C. diff* toxin-positive cases should be broadened to include community settings, necessitating the establishment of a robust review system.

Additionally, collaboration with Public Health Wales (PHW) and the epidemiology team is vital for identifying areas with a higher infection burden, ensuring that resources are directed appropriately.

A notable challenge lies in the inconsistency of testing approaches across Cwm Taf Morgannwg. Different testing methods are employed at various locations—immunoassays at PCH and RGH, while PCR is used at POW. Although all methods are viable for identifying *C. diff* cases, variations in sensitivity may impact the rates, making benchmarking unviable.

C. diff is a complex infection that requires a coordinated multidisciplinary approach to ensure that all areas work together effectively and that resources are allocated efficiently to meet our infection control goals.

5.1.4.1 – Clostridium Difficile rates per acute site

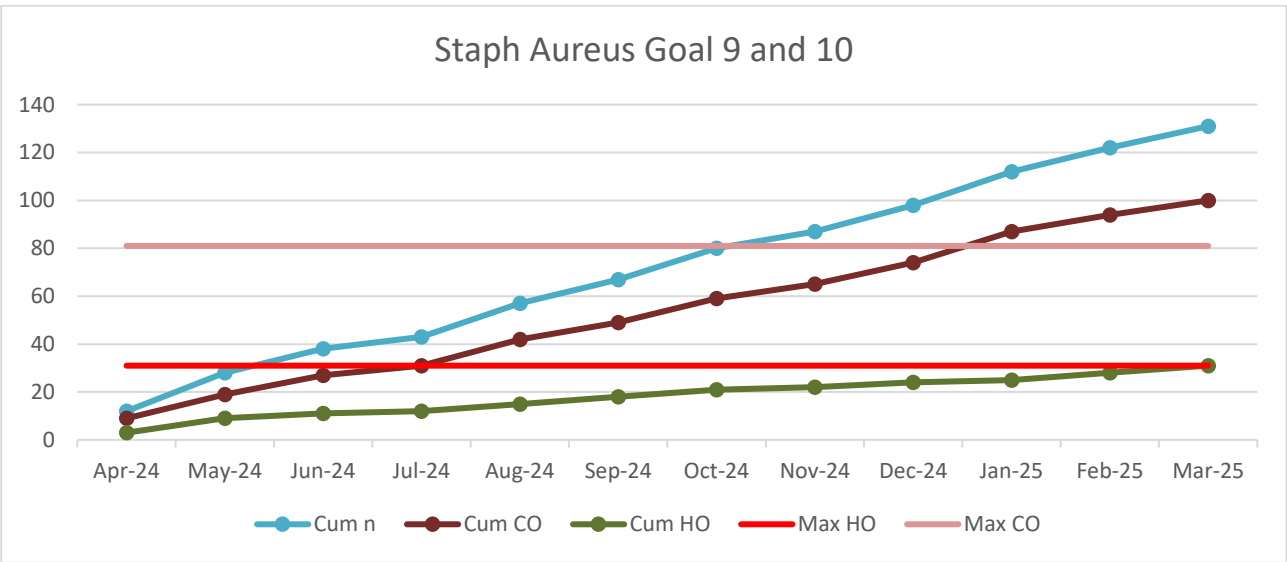


Graphic 19 - CDI rates per acute site

Graphic 19 shows that when we look at the different acute sites, we can see that the rates are significantly higher at POW Hospital. Unfortunately, it is not possible to clearly establish if this represents the reality, since the testing methodology at POW is more sensitive since PCR is used on testing instead of immunoassays. This stresses the importance to progress to a system where the same testing methodology is used to enable us to better understand if we are under-reporting cases in the 2 other acute settings.

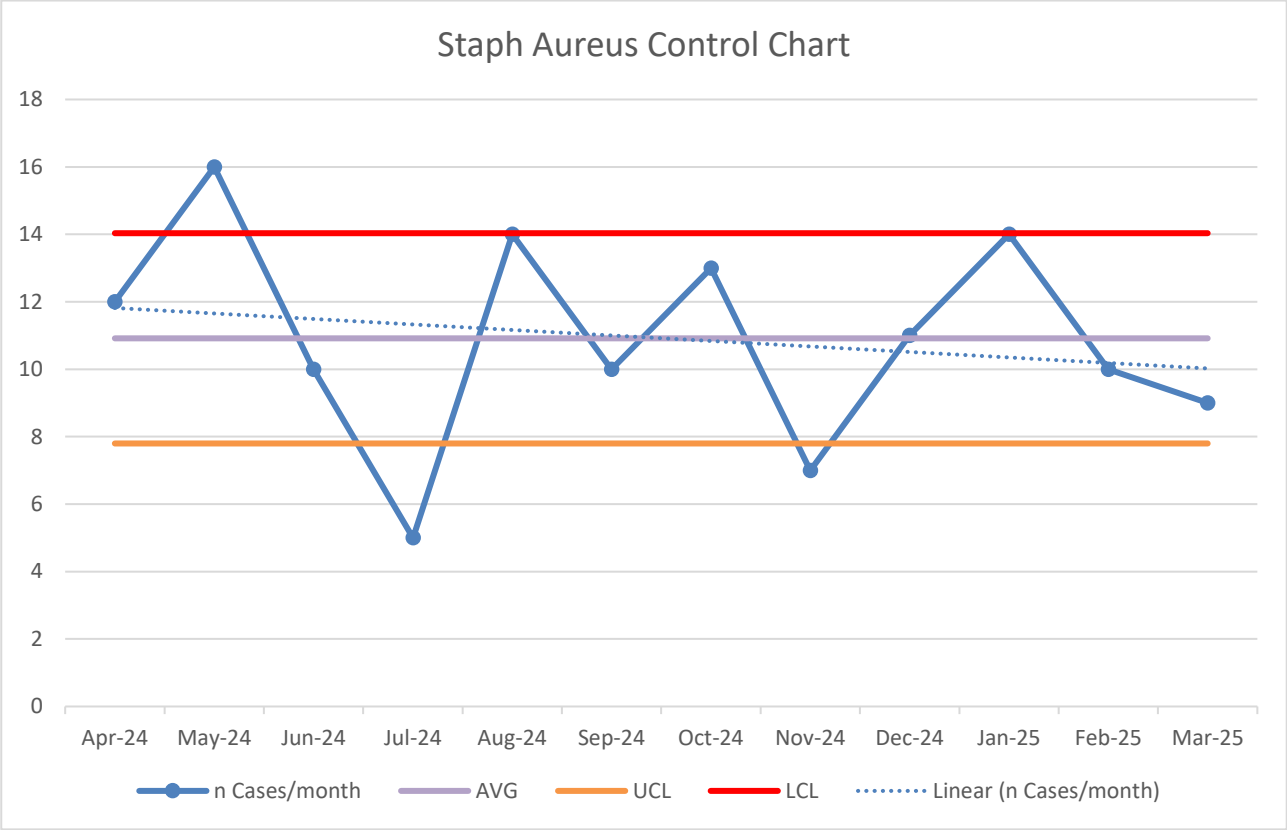
5.1.5- IMPROVEMENT GOALS 9 AND 10 – STAPHYLOCOCCUS AUREUS BACTERAEMIA (MMSA AND MRSA)

The WG improvement goal for *S.Aureus* bacteraemia for 2024/25 is now at 25 per 100,000 population with reduction of community onset and no more cases than 2023/24 of HO, which equals to a combined total of 112 cases (<31 HO and <81 CO)



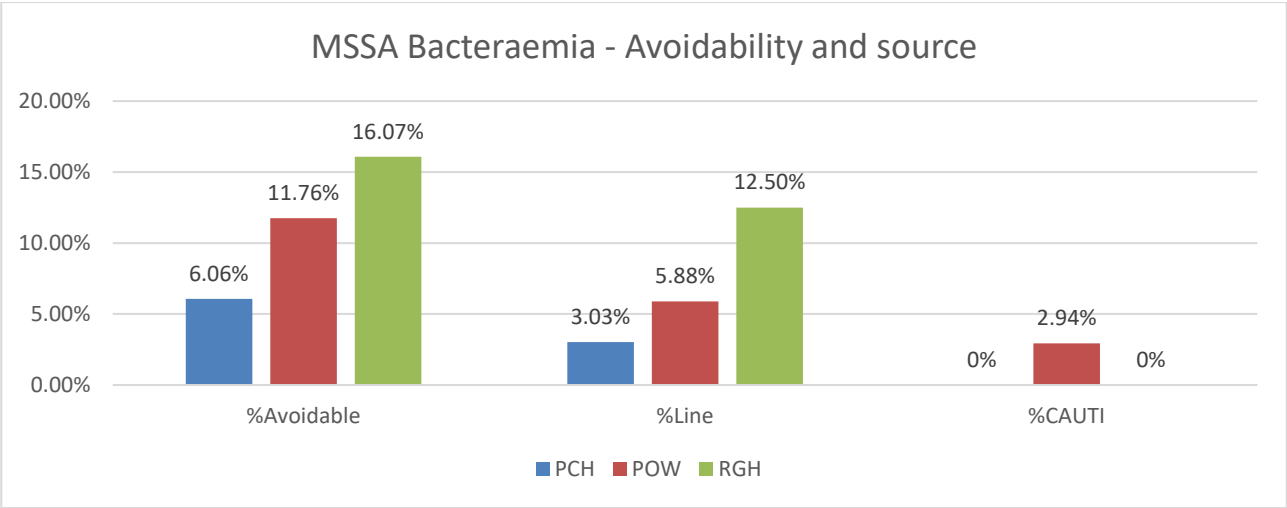
Graphic 20 - Staph. Aureus Bacteraemias

Regarding this goal, the HB did not achieve the goal reduction for CO cases with more 19 cases than the maximum set by the Welsh Government. Regarding HO onset cases the total number of cases was 31, falling on the maximum number to achieve the reduction goal. If we look at the SPC Chart:



Graphic 21 - Staph Aureus SPC Chart

The chart reveals that the processes in place have remained stable across the year, with a slight trendline of reduction, nonetheless the data shown on Graphic 20 reveals that while there was a reduction on HO cases, the CO cases continue to have the biggest weight on the overall number of cases, hindering the possibility of fully achieve the reduction goal. If we look to avoidability and sources for MSSA:



Graphic 22 - MSSA Bacteraemia - Avoidability and Sources

The analysis of MSSA bacteraemia across the three acute sites reveals variation in avoidability and source-related factors:

- RGH reported the highest percentage of avoidable cases at 16.07%, followed by POW at 11.76%, and PCH at 6.06%.
- Line-associated infections represent a significant proportion at RGH (12.50%), followed by POW (5.88%) and PCH (3.03%).
- CAUTI-related MSSA infections were identified only at POW (2.94%), with PCH and RGH reporting no cases.

This data suggests a degree of avoidable and line-associated MSSA bacteraemias at RGH, highlighting the need for improved line insertion and maintenance practices. AT POW will be advised to strengthened urinary catheter surveillance as well as in all other sites, invest in ANTT training.

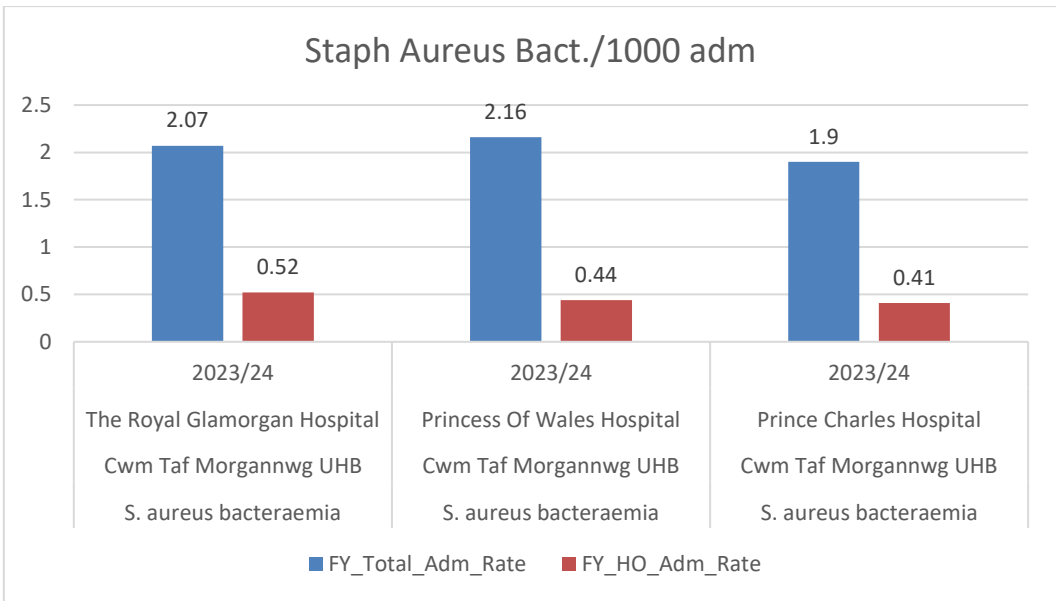
Preventable MSSA (Methicillin-sensitive *Staphylococcus aureus*) bacteraemia is currently categorized as a moderate risk. The Patient Care and Safety team has initiated rapid review meetings to evaluate these preventable infections and assess whether there have been breaches in the duties of candour and quality standards. The findings and lessons learned from these discussions are subsequently shared during site IPC meetings; however, additional efforts are needed to meet the established targets. Presently, 76% of *S. aureus* bacteraemia cases are classified as community-onset (CO), with only 24% identified as Hospital onset.

While it is crucial to focus on staff education regarding lessons learned and adherence to Aseptic Non-Touch Technique (ANTT) in the context of hospital-onset (HO) cases—especially concerning the insertion, maintenance, and removal of invasive devices—it is equally important to investigate the situation within the community. This should be conducted with the assistance of Public Health Wales (PHW) and the epidemiology team, particularly to identify the prevalence of infections in high-risk groups such as:

- Individuals with chronic wounds
- Diabetic patients
- Intravenous (IV) drug users
- Others at risk

These factors may contribute to the elevated incidence of community cases.

5.1.5.1 – *S. Aureus bloodstream infections per acute site*



Graphic 23- *Staph Aureus Bacteraemia rate per acute site*

All 3 sites had similar rates HO but POW shown the highest overall rate, followed by the Royal Glamorgan Hospital. As seen on Graphic 20, community represents the highest burden of *S. Aureus* infections, as shown in the final graphic, highlight the need to invest in and investigate the community factors driving these infection rates.

5.1.6 - POSITION OF THE HEALTH BOARD AGAINST ALL WALES

The following table shows the position of the HB against all Wales for HCAI monitored through the reduction goals

Microorganism	CTM Cases (YTD)	CTM Rate (/100k)	All Wales Rate (/100k)	CTM vs Wales
C. difficile	158	35.58	47.39	↓ 11.81 (24.9%)
MRSA bacteraemia	10	2.25	2.27	↓ 0.02 (0.88%)
MSSA bacteraemia	121	27.25	28.16	↓ 0.91 (3.2%)
S. aureus bacteraemia (MRSA+MSSA)	131	29.5	30.43	↓ 0.93 (3.06%)
E. coli bacteraemia	364	81.98	69.64	↑ 12.34 (17.72%)
Klebsiella sp. bacteraemia	103	23.20	22.64	↑ 0.56 (2.47%)
P. aeruginosa bacteraemia	14	3.15	5.24	↓ 2.09 (39.89%)

Table 6 - HB position on HCAI against all Wales

A we can see in Table 6, the HB has a lower rate of infections across all HCAI with exception of *E.Coli* and *Klebsiella*, which highlights the importance to invest on the reduction of Gram negative bacteremia for this new financial year with the measures that have been discussed in 6.1.1 – Goals 1 and 2. Albeit having lower rates of *Cdiff* compared to all Wales, it important to remind that the HB did not achieve a reduction on the number of infections during the financial year, therefore, it is essential that the HB also looks at strategies to reduce the number of cases for the new financial year.

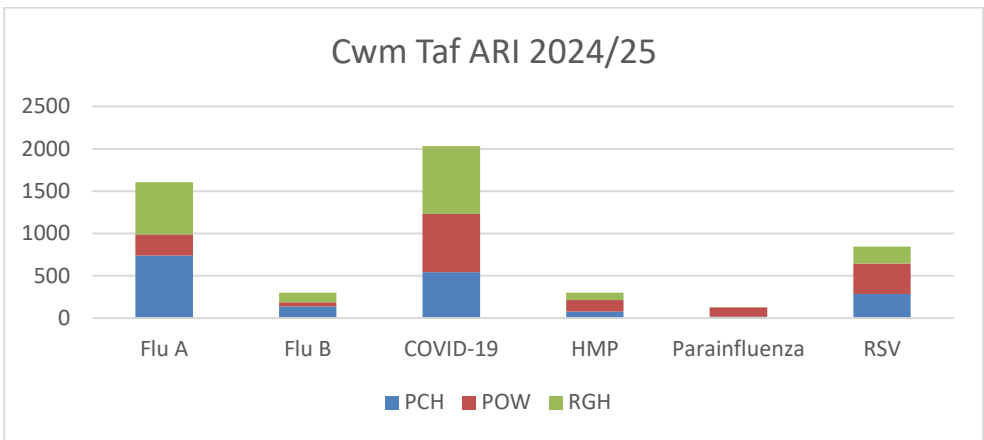
5.2 – ACUTE RESPIRATORY INFECTIONS (ARI)

Acute Respiratory Infections (ARI) significantly impact healthcare service capacity across the Health Board (HB). During the 2024/25 financial year, COVID-19 was the most common diagnosed ARI, totaling 2031 positive results. Influenza A (Flu A) followed closely, with a total of 1604 positive results:

Site	Flu A	Flu B	COVID-19	HMP	Parainfluenza	RSV
PCH	738	137	543	79	15	286
POW	249	49	688	134	112	358
RGH	617	113	800	87	2	200
TOTAL	1604	299	2031	300	129	844

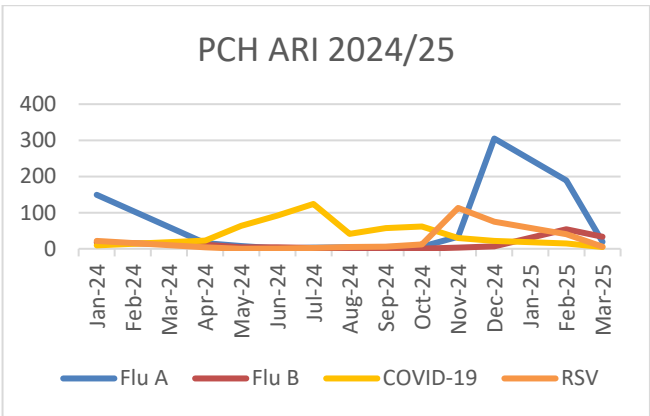
Table 7 - ARI totals 2024/25

We can see the same information in the following graphic:

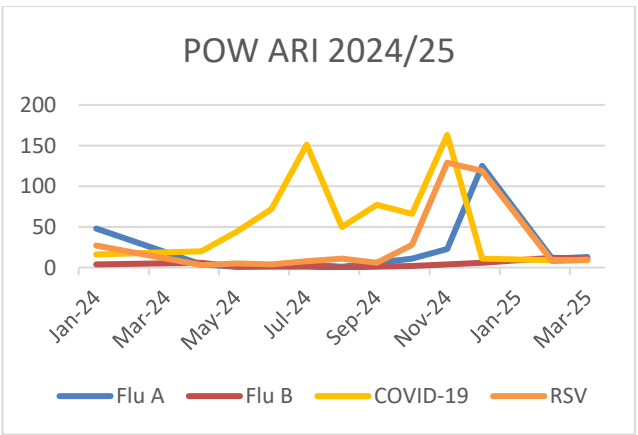


Graphic 24 - ARI positive 2024/25

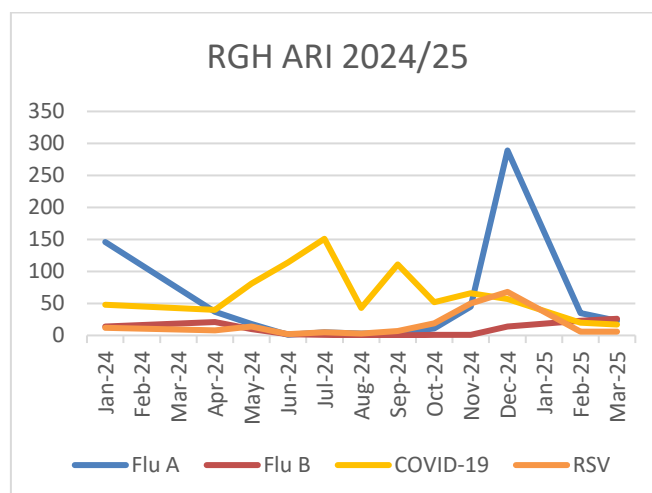
If we look in more detail to the distribution of results across the months:



Graphic 25 - ARI PCH 2024/25



Graphic 26- ARI POW 2024/25



Graphic 27 – ARI RGH 2024/25

COVID-19 showed the highest prevalence overall, especially notable at the RGH site, while the reason is unclear, it will very likely be associated with the move of patients from POW with an increase in activity across RGH.

Flu A peaked mostly at the PCH site, indicating a significant seasonal burden at this location, followed by POW (likely due to the reduced activity). Besides not being the ARI with more positive results, it was the one that caused higher disruption due to the peaks in all 3 sites during December.

RSV also had substantial numbers, particularly at POW, suggesting a localized issue that may require further exploration or preventative strategies specific to vulnerable populations in this catchment area, this data will need to be further investigated with the support from epidemiologists, to try to understand if there was any reason that explains the disparity in numbers

Monthly Distribution and Trends:

As explained before, all three acute sites (PCH, POW, and RGH) exhibited similar trajectories for Flu A, marked by a peak in December and a rapid decline through January. This aligns with expected seasonal patterns, reinforcing the need for proactive seasonal preparedness, including vaccination drives and enhanced winter pressure planning.

COVID-19, while being the most frequent infection over the year, did not demonstrate such a clear seasonal pattern as Flu A, underlining its persistent impact across the year. Continuous preparedness, robust infection prevention controls, and vigilance remain critical.

Recommendations for Action:

Enhance Seasonal Preparedness:

Strengthen influenza vaccination outreach.

COVID-19 Vigilance:

Maintain consistent, high-level vigilance and resource allocation to manage ongoing COVID-19 infections effectively.

Evaluate site-specific infection control practices, especially at RGH, to reduce the higher incidence observed.

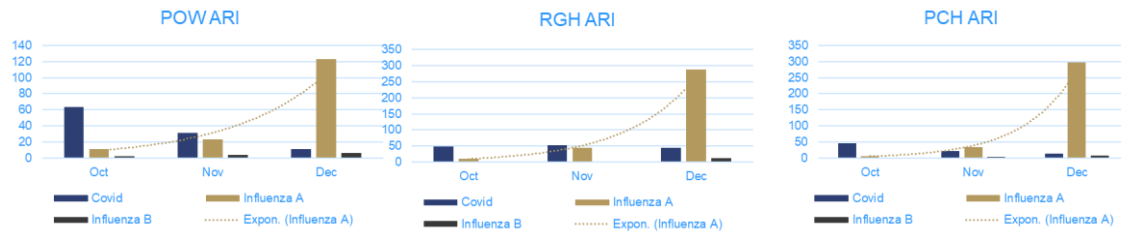
Targeted RSV Interventions:

Investigate the elevated RSV levels at POW and implement targeted interventions, particularly among vulnerable populations like paediatric and elderly groups.

This analysis and subsequent recommendations aim to inform strategic planning for infection prevention and control, optimize resource allocation, and mitigate the healthcare impact of ARIs within the Health Board.

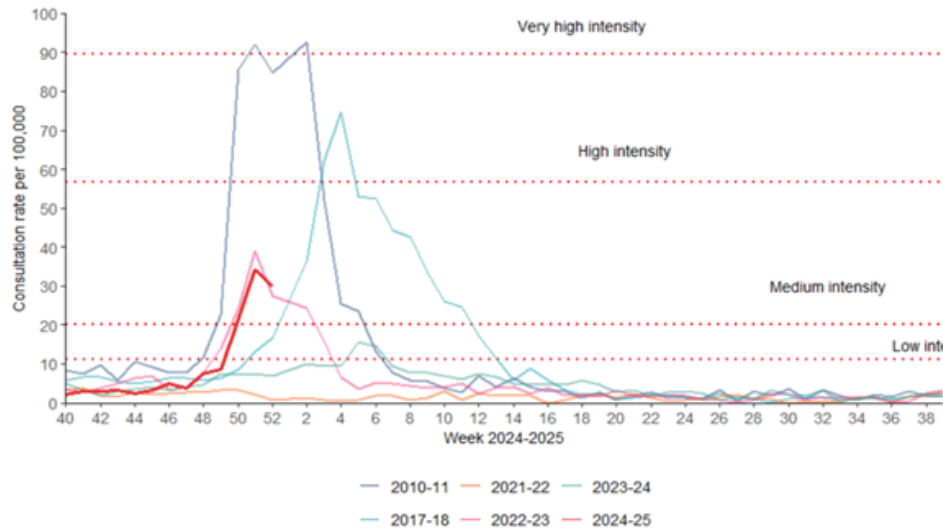
5.2.1 - INFLUENZA A AND B – IPC SUPPORT

As explained before, influenza A emerged as the second most frequent Acute Respiratory Infection (ARI) within CTM, with a notable surge in cases during December. This rapid increase significantly impacted operational capacity across the region. A small number of dual infections involving Influenza A and COVID-19 were promptly identified and managed through immediate isolation. The provided graphs illustrate the monthly distribution of cases during Quarter 3, a period characterized by heightened operational pressures due to increasing case numbers:



Graphic 28 - Influenza A and B last 3 months of 2024

The observed trajectories closely align with the winter projections from Public Health Wales (PHW), as demonstrated by:



Graphic 29- PHW winter projections - Flu

During the peak influenza period in Q3 (December), IPC was actively involved in the Patient Safety Support Cell, providing daily updates on infection control status and advising the Health Board (HB) on infection prevention and control strategies and bed capacity management. During this critical period, IPC commenced daily IPC plans with a focused oversight on cases requiring isolation. Additionally, universal mask usage was introduced across the HB, later discontinued in January. To strengthen organizational resilience, it is essential that the HB establishes clear criteria for initiating and ceasing universal mask use swiftly across CTM. Maintaining a daily IPC list remains critical, as it aids patient flow management by offering clear insights into the infection prevention burden, facilitating better bed capacity planning and informed patient movements. Moreover, investing in closer collaboration between IPC teams and patient flow management is crucial to enhance decision-making efficiency, especially during periods of high operational demand, as well as throughout the year. Implementing the Hub model, featuring extended IPC support, including on-call availability during weekends and bank holidays, is anticipated to significantly improve resilience and decision-making capabilities during future peak activity periods.

It is essential that in preparation for the next winter, the HB focus on initiatives to increase vaccination uptake within the various staff groups, in particular staff with patient facing roles. The following table shows the current rate of vaccination uptake in staff:

Vaccinations By Group					
2023/2024 Permanent Staff Vaccines by Group					
Staff Group	Had Vaccine	%	Not Had Vaccine	%	Permanent Staff
Add Prof Scientific and Technic	214	51.07%	205	48.93%	419
Additional Clinical Services	867	34.34%	1658	65.66%	2525
Administrative and Clerical	1035	39.06%	1615	60.94%	2650
Allied Health Professionals	445	52.48%	403	47.52%	848
Estates and Ancillary	553	40.36%	817	59.64%	1370
Healthcare Scientists	88	40.74%	128	59.26%	216
Medical and Dental	467	54.94%	383	45.06%	850
Nursing and Midwifery Registered	1530	37.56%	2543	62.44%	4073
Students	1	5.00%	19	95.00%	20
Total	5200	40.09%	7771	59.91%	12971

Table 8 - Permanent Staff Flu Vaccines by Group

As we can see the overall vaccination coverage is lower than the 83% required to achieve Herd immunity (Mertz & al., 2016)¹. The numbers are even more concerning if we include the non-permanent staff:

Vaccinations By Month					
2023/2024 All Staff Vaccines by Group					
Staff Group	Had Vaccine	%	Not Had Vaccine	%	All Staff
Add Prof Scientific and Technic	219	48.67%	223	49.56%	450
Additional Clinical Services	1017	27.24%	2684	71.90%	3733
Administrative and Clerical	982	37.45%	1550	59.12%	2622
Allied Health Professionals	448	48.28%	455	49.03%	928
Estates and Ancillary	548	40.00%	814	59.42%	1370
Healthcare Scientists	81	39.51%	117	57.07%	205
Medical and Dental	768	35.51%	1347	62.27%	2163
Nursing and Midwifery Registered	1529	37.07%	2494	60.46%	4125
Students	1	5.00%	19	95.00%	20
Total	5593	35.82%	9703	62.13%	15616

Table 9 - All staff Flu Vaccines by group

Here we can see that the overall coverage is 35.82%, with the lowest uptake on the Additional Clinical Services group, followed by Medical and Dental and Nursing and Midwifery (we are not considering the 5% coverage for students, since it is unclear if this is due to no reporting from vaccination done through the University).

From a resilience point of view, this is very concerning, since can strongly impact the workforce as well as, the staff can themselves become vectors spreading influenza to our service users.

It is essential that for this financial year, there is a robust discussion around the experiences of previous years vaccination campaigns and explore any lessons learned towards supporting a

¹ [Herd effect from influenza vaccination in non-healthcare settings: a systematic review of randomised controlled trials and observational studies - PMC](#) – Accessed on 24/04/2025 at 12:44h

sustainable increase on the vaccine uptake, either by dealing with myths or any other found barriers preventing to achieve an adequate vaccination coverage.

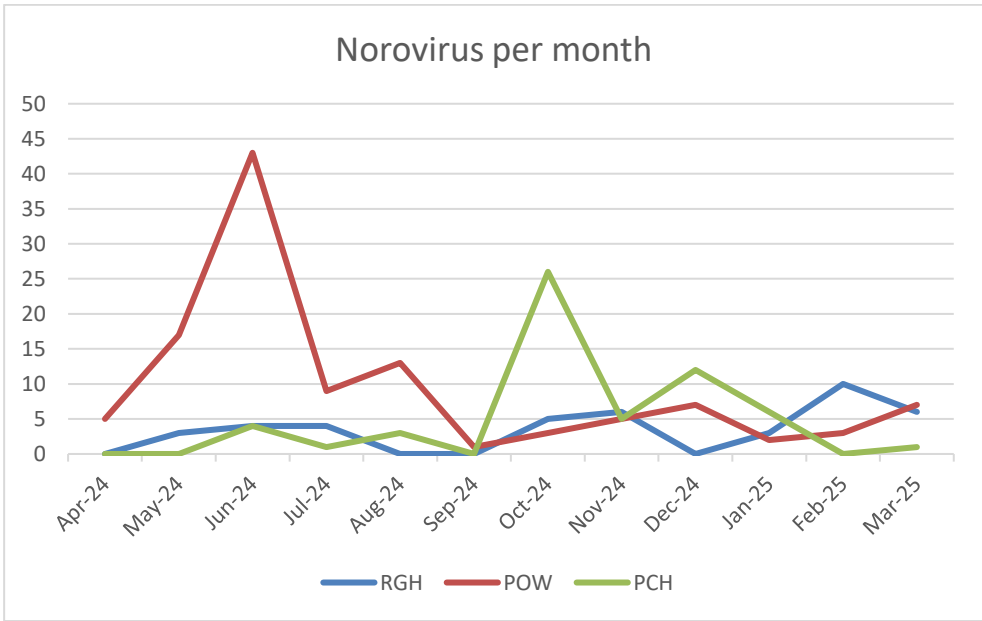
5.3 - NOROVIRUS INFECTIONS

Over the financial year 2024/25, a total of 41 cases were reported at RGH, 115 at POW, and 58 at PCH. The highest number of monthly cases was observed at POW in June 2024 (43 cases), followed by a significant peak at PCH in October 2024 (26 cases). RGH showed greater consistency throughout the year, with a notable increase in February 2025 (10 cases). These fluctuations suggest the need for further analysis of local epidemiology and service pressures during peak months.

Please see next table and graphic:

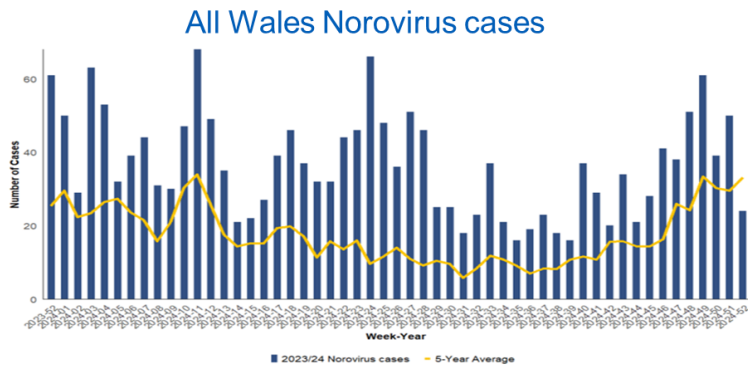
Month	RGH	POW	PCH
Apr-24	0	5	0
May-24	3	17	0
Jun-24	4	43	4
Jul-24	4	9	1
Aug-24	0	13	3
Sep-24	0	1	0
Oct-24	5	3	26
Nov-24	6	5	5
Dec-24	0	7	12
Jan-25	3	2	6
Feb-25	10	3	0
Mar-25	6	7	1
Total	41	115	58

Table 10- Norovirus cases per Month and acute setting



Graphic 30 - Norovirus cases per Month and acute setting

As we can see by the all-Wales profile graphic, norovirus infections had a sinusoidal pattern across the entire year, nonetheless with an increase starting on week 46 of the civil year (from November) with the peak between weeks 49 and 52 (based on 5 years average).



Graphic 31 - All Wales Norovirus infections

The CTM Norovirus trend deviates from the typical seasonal pattern described by PHW.

- June 2024 saw an unusually high spike (43 cases at POW alone), which does not align with the national data.
- The expected rise in late November and peak in December was modest only happening at POW.

IPC has worked closely with all clinical settings to ensure adequate management of all found cases and adequate management to avoid spread of infection.

It is important to highlight some challenges in RGH regarding norovirus testing where there is no availability of rapid testing, which limits the capacity to quickly confirm the positive cases. In some cases, there has been the need to divert samples to PCH for rapid testing.

The limitations on testing, create challenges on making the adequate management of cases as also increases the number of samples that are being sent to the laboratory, since samples continue to be sent from every new case until we have confirmed positive results to establish a period of increased incidence/outbreak.

6 – SURGICAL SITE SURVEILLANCE

CTMUHB participate in the mandatory surveillance of Surgical Site Infections (SSI) for Orthopedic and C. Section surgery. Using standardized methods, allows the Health Boards across Wales to analyze their SSI data and improve the quality of the care delivered. National surveillance also allows hospitals/Health Boards to benchmark performance indicators.

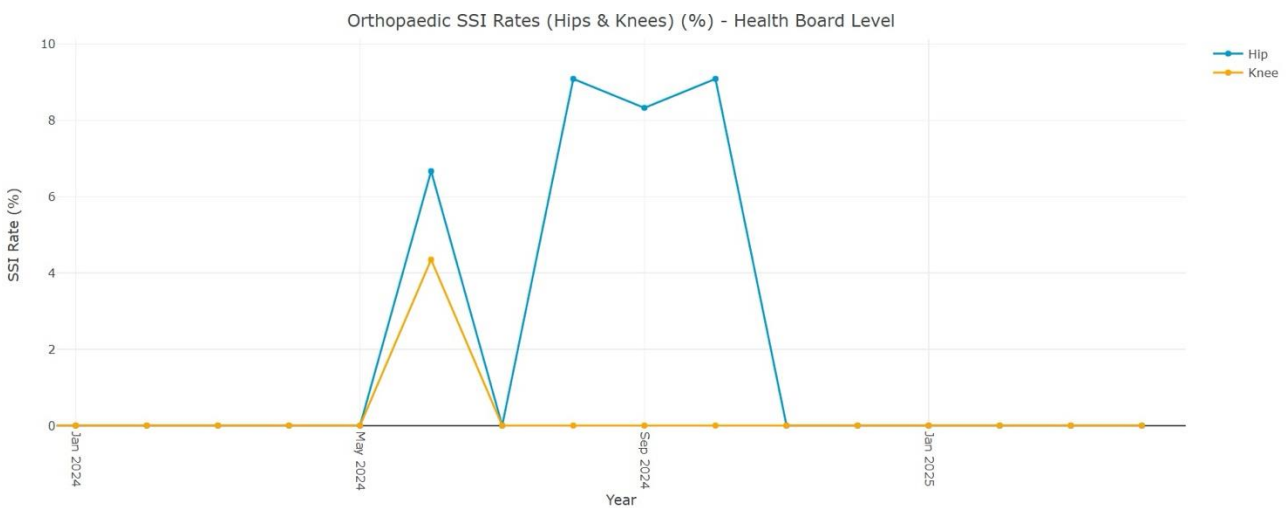
6.1 – ORTHOPEDIC SSI SURVEILLANCE

The annual surveillance data for Orthopaedic Surgical Site Infections (SSI) within CTMUHB highlights several key trends and areas for attention. The SSI rates for hip and knee surgeries have demonstrated variability across the reporting period. A noticeable peak was observed around May and September 2024, particularly for hip procedures, reaching SSI rates close to 10%. Knee surgery SSI rates peaked around May 2024 but remained lower compared to hips, approximately 6%. Encouragingly, SSI rates for both hip and knee surgeries returned to baseline by early 2025.

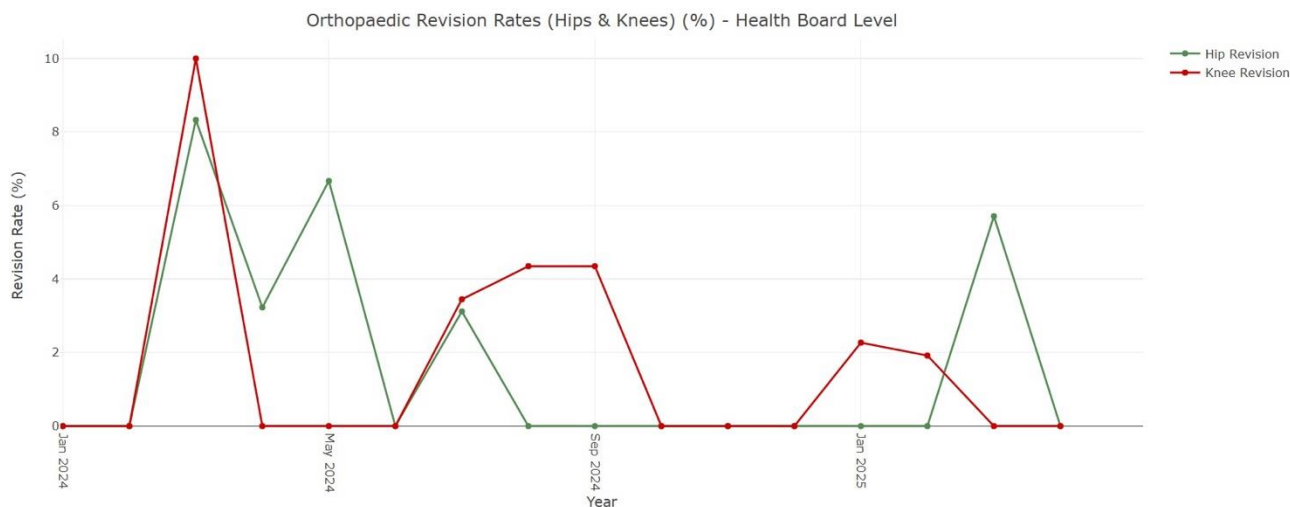
Parallel analysis of Orthopaedic Revision Rates for hips and knees also revealed fluctuations throughout the year. Knee revisions exhibited a significant spike in early 2024, with a peak of approximately 10%, followed by gradual stabilization toward the year's end. Hip revision rates peaked slightly lower, around 8%, but showed a fluctuating pattern throughout the year. Both hip and knee revision rates stabilized towards early 2025, correlating positively with the reduction in SSI rates.

This data underscores the importance of continued vigilance and proactive infection prevention strategies within orthopaedic surgical practices. Ongoing education, rigorous adherence to surgical protocols, and responsive intervention planning remain central to maintaining low SSI and revision rates moving forward.

The information can be seen in more detail on the following graphics:



Graphic 32 - Orthopaedic SSI rates (Hipes & Knees) CTMUHB



Graphic 33 - Orthopaedic Revision Rates (Hips & Knees) (%) - Health Board Level

6.2 – CESAREAN SECTION SSI

The Caesarean Section Surgical Site Infection (SSI) surveillance reports for Prince Charles Hospital (PCH) and Princess of Wales Hospital (POW) for Q1 to Q3 of 2024 indicate significant improvements and fluctuations across both sites. Q4 information is still outstanding while the report was being produced.

At Prince Charles Hospital, the overall SSI rate from Q2 2023 to Q1 2024 was 4.9%, reflecting a slight increase from the baseline of 4.6%. However, this rate decreased to 3.9% by Q2 2024, demonstrating an improvement compared to previous years. The hospital's data completeness remained consistently high, around 99-100%, facilitating accurate surveillance and reporting. Notably, most infections were classified as late community onset, indicating they occurred after hospital discharge, necessitating enhanced community care and patient education post-discharge.

Princess of Wales Hospital showed a notable reduction in SSI rates from 3.1% in the previous three-year baseline down to 1.9% by Q1 2024, further improving to 1.4% by Q3 2024. This reduction does not necessarily reflect an improvement on care since the previously detected high rates were deemed to over-reporting by the midwives. This has been discussed with PHW to understand and try to correct the data and currently a package of training is being planned to ensure that in the future there is consistency on the reporting of SSI.

Demographic analysis across both hospitals highlighted obesity as a significant risk factor, with higher SSI rates recorded among patients classified as obese (BMI 30+). Both hospitals primarily used dissolvable sutures for skin closure, which maintained a low complication rate. Emergency procedures had marginally lower SSI rates than elective procedures.

Overall, the data from both Prince Charles and Princess of Wales Hospitals indicate successful strategies in reducing Caesarean SSI rates, emphasizing the continued need for vigilance, targeted interventions in high-risk groups, and comprehensive post-discharge support to maintain and further improve patient outcomes.

7 – CAPITAL WORKS, DEVELOPMENTS AND REFURBISHMENT

Main hospital sites

At POW works are ongoing to fix the roof, with some services being deployed off-site to RGH and community hospitals. The IPC team has moved the allocation of staff to match the changes on workforce requirements.

The IPC team supported the opening of other sites during the move of clinical services from POW. The IPC team has been supporting the planning of the new cataract theatre in POW with the plan to install a surgicube to enable the availability of a clean laminar flow over the operating field in a room with no central air handling unit for theatres. An SOP will need to be developed by the surgical team with IPC support, regarding the prepping of the surgical trays due to the low air changes in the room. This has been added to the risk register.

Regarding sterile services at PCH, an unusually high particulate count was recorded in the air of the clean room during September. Once testing and rectifications were done, there was a stepped approach on increasing staff working on site accompanied with measurements of particulates in the air. While there was a progressive increase, the numbers remained within the limits required to maintain class 8 clean room classification.

The IPC team has been involved in multiple other capital projects such as the deployment of the Vanguard Endoscopy Unit and the still ongoing deployment of the Vanguard theatres at RGH, as well other projects such as SCBU at POW, the refurbishment of the maternity services and the Llantrisant Health Park project.

8 – DECONTAMINATION

8.1 - PRINCE CHARLES CSSD REFURBISHMENT

PCH CSSD is due to close for refurbishment at the end of 2025 or early 2026. This is part of the ground and first floor major project. The funding has not been guaranteed by Welsh Government at present and a decision on funding is due spring/summer 2025. Service will be split between RGH and POW HSDU. The plans will include a mobile endoscope decontamination unit for PCH which will cover the recently refurbished endoscopy department. No decision on a unit has been made yet. It is important to develop a robust specification for this unit. Estates and the CTMUHB appointed Authorizing Engineer Decontamination will be required to contribute to this specification. This provides the health board with assurance that any mobile unit will be fit for purpose and compliant with WHTM's and HBN's

8.2 - STERILE SERVICES MANAGEMENT STRUCTURE

The current Sterile Services management structure has changed due to the PCH CSSD Manager being on long term sickness absence. Currently there is sharing joint responsibility for all three sites by 2 managers. The Princess of Wales Hospital sterile services AE (D) audit was carried out on the 13/02/2025. The audit report is still outstanding. Sterile services audits carried out by the decontamination Officer in 2025 will be done using the CTMUHB approved audit tool.

8.3 - ENDOSCOPE DECONTAMINATION

8.3.1- PRINCESS OF WALES HOSPITAL

The built environments for endoscope decontamination at the Princess of Wales Hospital require significant investment. Urology endoscope decontamination is a significant risk due to the issues with the discontinued Getinge POKE YOKE machines. The built environment has manual and automated cleaning rooms but does not comply with HBN 13. The Endoscopy department requires investment and the last IHEEM JAG audit produced a red/amber rating. The room is a single room decontamination area with the potential for cross contamination. The area is considered very well managed by the decontamination officer/specialist, but the built environment does not meet JAG standards. Currently due to roof issues at the POWH, endoscopy have been moved to the Vanguard Endoscopy Unit at the RGH.

Nasoendoscopes

Non-Channeled Nasoendoscopes are reprocessed within ENT, Speech and Language Therapy. The method used is the Tristel Trio (3 Step) manual process. Traceability is carried out using the Tristel paper based book. ENT have controlled environment storage cabinets to increase the storage capacity of endoscopes. It is planned to move all Nasoendoscopes decontamination to the centralized facility when this is completed.

Channeled Nasoendoscopes are manually decontaminated in ENT then transported for HLD using endoscopy Endoscopic washer disinfectors.

ENT have controlled environment storage cabinets to increase the storage capacity of endoscopes. It is planned to move all Nasoendoscopes decontamination to the centralized facility when this is completed.

8.3.2 - ROYAL GLAMORGAN HOSPITAL

The Vanguard Endoscopy Unit went live on the 04/03/2025.

The Healthedge HESA traceability system which is what is used throughout CTM is being used, with no paper based traceability system, unless in the event of the electronic track and trace system being out of use. The Vanguard unit was procured for 48 weeks.

Nasoendoscopes

Nasoendoscopes are used within Outpatients ENT clinics and Maxillofacial Departments. The Tristel Trio process is used to decontaminate the endoscopes in both departments. The ENT scopes were previously reprocessed within HSDU at the RGH after the 2018 Welsh Government Endoscope Decontamination Survey. ENT and Maxillofacial only have three endoscopes for each department. There needs to be consideration given to purchase endoscopes for ENT which will allow centralized decontamination.

Recommendations from the 2018 WG Survey was for ENT decontamination to be moved to an automated high level disinfection process. Maxillofacial will be more difficult due to a high number of patients scoped in clinics twice a week.

TOE probes are reprocessed within HSDU at the RGH. The built environment is HBN 13 compliant and would be JAG compliant.

8.3.3 - PRINCE CHARLES HOSPITAL

CSSD at PCH decontaminates endoscopes for Endoscopy and TOE probes for cardiology. The unit was constructed in 2019 to centralize the endoscope decontamination activity. There is a planned closure of CSSD in December 2025

ENT have one Nasoendoscope. Tristel Trio product is used for the decontamination method. Maxillofacial are using single use at present.

8.3.4 - YSBYTY CWM RHONNDA

Outpatients ENT have three Nasoendoscopes. Tristel Trio is used as the decontamination method. Ysbyty Cwm Cynon Outpatients ENT have one Nasoendoscope. Tristel Trio is used as the decontamination method.

8.3.5 - YSBYTY CWM CYNON OUTPATIENTS

ENT have one Nasoendoscope. Tristel Trio is used as the decontamination method.

8.4 - LLANTRISANT HEALTH PARK

The decontamination expert has not yet got involved with design or discussion for Llantrisant Health Park. This has been signposted and currently the AE for decontamination has been added to the design group for this facility. We currently do not have a decontamination expert on the Health Board but are in the process of recruitment, once in post we will ensure that the new Decontamination expert will also take part in the design group to ensure we guarantee adequate compliance.

8.5 - WELSH GOVERNMENT TARGETED ESTATES FUNDING (TEF)

Welsh government targeted estates funding decontamination requests have been submitted for CTMUHB. Notification of approved requests has not been provided yet. Submissions include improvements as below.

- POWH centralized endoscope decontamination scheme
- Traceability system for community dental units and Podiatry.
- Decontamination equipment for SSD.
- ENT endoscopes to move RGH ENT decontamination to the HSDU.
- Storage systems for medical devices.
- Departmental improvements such as IAP room wall coverings. Continuous improvements to decontamination facilities requires involvement from the Decontamination Officer. Audits of the built environment often produce areas of improvements.

9 -WATER SAFETY

Water safety is paramount in a Health Care environment, in particular when it concerns to *Legionella* infections and in augmented care also *Pseudomonas aeruginosa*.

Elevated cold-water temperatures can result in legionella bacterium present in water systems becoming active. *Legionella pneumophila* is a waterborne bacterium and is spread via exposure to aerosols of water containing the bacteria.

Legionnaire's diseases are severe pneumonia caused by exposure to *Legionella pneumophila* symptoms, including muscle aches, tiredness, headaches, dry cough, and fever.

The WSG continues to respond to the findings of both legionella and pseudomonas in our water systems.

There are some key areas such as Dewi Sant clinical were significantly elevated, moving the HB to extensive remedial works and install a dosing system, which successfully controlled the risk and reduced the legionella findings to safe levels, nonetheless, across the organization more findings have been done across the year. It is essential that the HB has good governance processes and procedures in practice to ensure that issues are promptly identified, the risks are assessed and any mitigation measures are put in place while remedial works are ongoing. This is a multidisciplinary approach that is fundamentally headed by the RP (responsible person) for water safety, through the water safety group and is guided by the HB Water Safety Plan.

IPC has expressed concerns regarding the current WSP and proposed several changes to clarify not just the processes in place but also the roles and responsibilities of the various members of the water safety group. This review is at the moment waiting to be approved by the water safety group.

Another workstream that has been noted during this year is the inconsistency across the organization regarding the responsibility on flushing the low usage outlets. Some clinical areas this falls into the clinical staff (such as POW) and in the others it falls under the domestic staff. It is essential that there is one system across the organization. IPC had conversations with the managers of the domestic teams and has been agreed to move to a domestic running option, since putting this to the clinical staff would be too honourous. Nonetheless it is still essential to ensure that there is more awareness across the organization regarding the need to notify estates of low usage outlets and remove barriers to access water points. This is a risk when we see across the organization some of the bathrooms being transformed into storage rooms. While this falls into a clear need of storage for the clinical are, it is essential that provision is made to ensure the outlets are regularly opened and run as well as aim at the removal of the outlet and adjacent pipes.

One concern for IPC is also the fragmentation of the support on microbiology regarding water safety. Microbiology works closely with IPC to ensure that the risk for patients in areas with known legionella counts, is done and adequate awareness is shared with the clinical staff as well as guidance on testing when dealing with atypical pneumonia. Currently PoWH has a different arrangement from the other sites and is covered by PHW microbiology, where the Service Level Agreement, does not account for their representation and support in matters related with water safety. This is a significant gap that will need to be addressed to ensure adequate safety. In the interim, estates, IPC and microbiology have been working together towards improving communication and cooperation.

Another important aspect is ensuring that we are able to effectively communicate with the clinical areas when high counts of legionella are identified. It is essential that this is made in a comprehensive way, ensuring that both the aspects that relate with IPC as well as estates are covered. To respond to this need, the IPC team has worked with estates and microbiology to produce a joint letter to be sent to the clinical areas explaining the findings and what will be happening from an estates intervention as

well as what the clinical area needs to be aware (sign and symptoms of legionnaire’s disease, testing, etc.). This letter is seeking approval from the IPCC on Quarter 1 of 2025/26.

10 – VENTILATION SAFETY

The IPC team is a member of the ventilation safety group and works in partnership with estates and RP to ensure the ventilation systems across the organization as well as new developments are safe and used adequately.

IPC has been concerned with the fact that we do not have negative pressure rooms in our A&E to accommodate patients with suspected HCID or other highly infectious diseases such as measles or active TB (in particular multiresistant). On Q4, a bid was put to the Welsh Government for funding regarding these rooms and funds have been granted to build a negative pressure room at RGH and another at POW. This will be an ongoing project for the new financial year.

Another important point is ensuring that the IPC team, as a member of the ventilation safety group, has adequate training to fulfil an active role. Ventilation systems are not the core of IPC expertise and require specialized training. With the aim of ensuring this is achieved, the IPC team will seek funding for specialized training for some of its members during the new financial year. The learning will then be widely shared with the team.

11-CONCLUSION: LESSONS LEARNED AND PRIORITIES FOR 2025/26

The 2024/25 annual review of Infection Prevention and Control (IPC) across Cwm Taf Morgannwg University Health Board (CTMUHB) has highlighted significant progress as well as persistent challenges, shaping the strategic and operational focus for the coming year. This conclusion consolidates key lessons learned from data analysis, stakeholder feedback, and service developments, and maps the priorities required to strengthen IPC outcomes in 2025/26.

Lessons Learned

Strength of Targeted Interventions

Impact of Community-Onset Infections

The consistent growth in community-onset *Clostridium difficile* and *Staphylococcus aureus* underscores that hospital-based interventions alone are insufficient. Addressing prescribing practices, PPI use, and community care standards is vital to reducing the overall infection burden.

Significance of Training Compliance

Suboptimal IPC training adherence, particularly among staff, poses a fundamental risk to patient safety. Data show that staff knowledge and adherence to core IPC practices—especially around line maintenance, catheter care, and hand hygiene—are directly linked to avoidable infections.

Importance of Consistent Testing and Data Integrity

Variations in testing methodology (e.g., PCR vs. immunoassay for *C. difficile*) and laboratory services lead to inconsistent data across sites, undermining effective benchmarking and swift outbreak containment. This highlights the need for standardized diagnostic pathways and consistent epidemiological practices.

Value of “Areas of Concern” Auditing

Replacing static annual audits with a dynamic “areas of concern” approach has will allow more accurate, timely identification of non-compliance, strengthening local accountability. Continued staff support in auditing is necessary to maintain reliability of results.

Critical Role of Infrastructure and Capital Investments

Upgrades in sterile services, progress in decontamination processes, and forthcoming negative pressure rooms demonstrate that physical environments will significantly influence infection control. Sustained capital investment and robust project management remain crucial to embedding IPC best practices.

Resilience and Rapid Response

Seasonal surges (e.g., influenza, respiratory viruses) and unexpected outbreaks (e.g., Norovirus

spikes) reaffirm the need for real-time communication, and flexibility that can adapt to acute changes in patient flow.

Priorities for 2025/26

Enhance Training Compliance and Competency

- Focus on achieving at least 95% compliance with Level 2 IPC training among clinical staff, with particular emphasis on medical and dental groups.
- Ensure Aseptic Non-Touch Technique (ANTT) training becomes mandatory and has high compliance, to reduce line- and catheter-associated infections.

Strengthen Community IPC Strategies

- Deploy and further develop the newly funded community team to audit and support community settings starting by nursing homes.

Advance the New IPC Hub Model

- Finalize the Organizational Change Process (OCP) to establish fully extended IPC support from 8am to 8pm weekdays and on-call coverage during weekends.
- Refine communication pathways to ensure rapid escalation of potential outbreaks and consistent guidance across all clinical areas.
- Develop the Hub's capacity for real-time surveillance and analytics to provide proactive alerts and targeted interventions.

Improve Outbreak Management and Lessons-Learned Processes

- Adopt an enhanced outbreak documentation system, including ICNet outbreak modules, ensuring lessons learned are swiftly collated, shared, and acted upon.
- Create a formal "lessons learned matrix" to address recurring themes (e.g., decontamination lapses, device-related infections) and direct future IPC projects.

Maintain and Expand Infrastructure Projects

- Prioritize the timely creation of negative pressure rooms at POW and RGH, and ensure existing refurbishments (CSSD and endoscopy units) align with IPC standards.
- Monitor new and ongoing capital works (e.g., roof repairs at POW, Vanguard units at RGH) with strong IPC oversight to mitigate infection risks during construction.

Closing Statement

By embedding these priorities into day-to-day clinical practice, and by continuing to foster a culture of safety and shared responsibility, CTMUHB aims to consolidate its progress in reducing healthcare-associated infections. The lessons learned throughout 2024/25 illuminate the necessity of collaboration, consistency, and continuous improvement—values that will guide CTMUHB’s IPC strategy in the coming year and beyond. Through strengthened governance, evidence-based interventions, and equitable service provision, the Health Board remains committed to safeguarding patients, staff, and the wider community against preventable infections.

INFECTION CONTROL DOCTOR – ANNUAL STATEMENT FOR 2024-2025

It is my privilege, as the designated Infection Control Doctor and Microbiologist for the Health Board, to provide an annual overview of our collective Infection Prevention and Control (IPC) endeavours for the 2024/25 period. This statement reflects both the successes and ongoing challenges within our Health Board, and underpins the renewed priorities necessary for safeguarding patients, staff, and the broader community from healthcare-associated infections (HCAIs).

Throughout the past year, we have observed achievements, particularly in the reduction of key Gram-negative bacteraemias—including *E. coli*, *Pseudomonas aeruginosa*, and *Klebsiella* spp.—as well as a stabilization of *MSSA* rates across our acute sites. These improvements are largely attributable to strengthened collaboration among the IPC team, clinical leads, and allied services, as well as the adoption of targeted measures such as the centralized IPC Hub model. The dedicated work of our frontline staff, who have embraced more robust antimicrobial stewardship and adhered to standardized line- and catheter-care protocols, has significantly contributed to these gains.

However, we also face significant obstacles. Most pressing is the persistent rise of *Clostridium difficile* (*C. difficile*) infections, especially in community settings, which has prevented us from fully meeting Welsh Government reduction targets. We have identified factors such as the overuse of proton pump inhibitors, inconsistent testing methodologies, and suboptimal compliance with mandatory IPC training as areas requiring urgent attention. The fragmentation of microbiological services and variations in testing platforms among our sites also remain a challenge, complicating accurate benchmarking and timely outbreak management.

Looking ahead, it is clear that sustained vigilance and a shared responsibility for IPC must remain paramount. Our Health Board's strategic priorities for 2025/26 will focus on accelerating staff training compliance, further integrating community outreach efforts, and unifying diagnostic pathways for consistent surveillance. The deployment of negative pressure isolation rooms and ongoing modernization of sterile services likewise demonstrate CTMUHB's dedication to building a resilient, future-proof infrastructure. Crucially, we must continue to enhance governance and accountability mechanisms—for example through RCAs and refining our IPCC reporting.

In fulfilling my responsibilities as Infection Control Doctor, I am committed to championing evidence-based practice, guiding continuous quality improvement, and facilitating open communication between microbiology, clinical teams, and Health Board leadership. By aligning our operational activities with strategic oversight, and by fostering an environment where learning from adverse events is routine, we can optimize patient safety and sustain our progress in reducing HCAIs.

On behalf of the IPC Service, I would like to express my appreciation to our multidisciplinary colleagues for their dedication, agility, and clinical excellence over the past year. There is much to be proud of, yet also a clear imperative to embed IPC best practices even more deeply across our system. With a unified approach, underpinned by robust microbiological support and a culture of transparency, we can continue to meet future challenges and uphold the highest standards of care for those we serve.

Dr. Alexandra Tsitsopoulou
Infection Control Doctor / Consultant Microbiologist Cwm Taf Morgannwg University Health Board



Agenda Item

8.2.5

Quality, Safety & Experience Committee

Research and Development Bi-Annual Update Report

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Prof. John Geen, Assistant Director for R&D Mrs Rhian Beynon, R&D Manager
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Mrs Rhian Beynon, R&D Manager Prof. John Geen, Assistant Director for R&D
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
N/A		

Acronyms / Glossary of Terms	
CTIMP	Clinical Trial of an Investigational Medicinal Product
CTMUHB	Cwm Taf Morgannwg University Health Board



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

eISF	Electronic Investigator Site File
GCP	Good Clinical Practice
HCRW	Health and Care Research Wales
HDRC	Health Determinants Research Council
MHRA	Medicines and Healthcare Products Regulatory Agency
NIHR	National Institute for Health and Care Research
R&D	Research and Development



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

1. Situation /Background

This report provides the Quality, Safety & Experience Committee with a bi-annual update on R&D performance, funding, infrastructure and national and local strategic developments.

2. Specific Matters for Consideration

2.1 Cwm Taf Morgannwg UHB R&D Strategy 2025-20

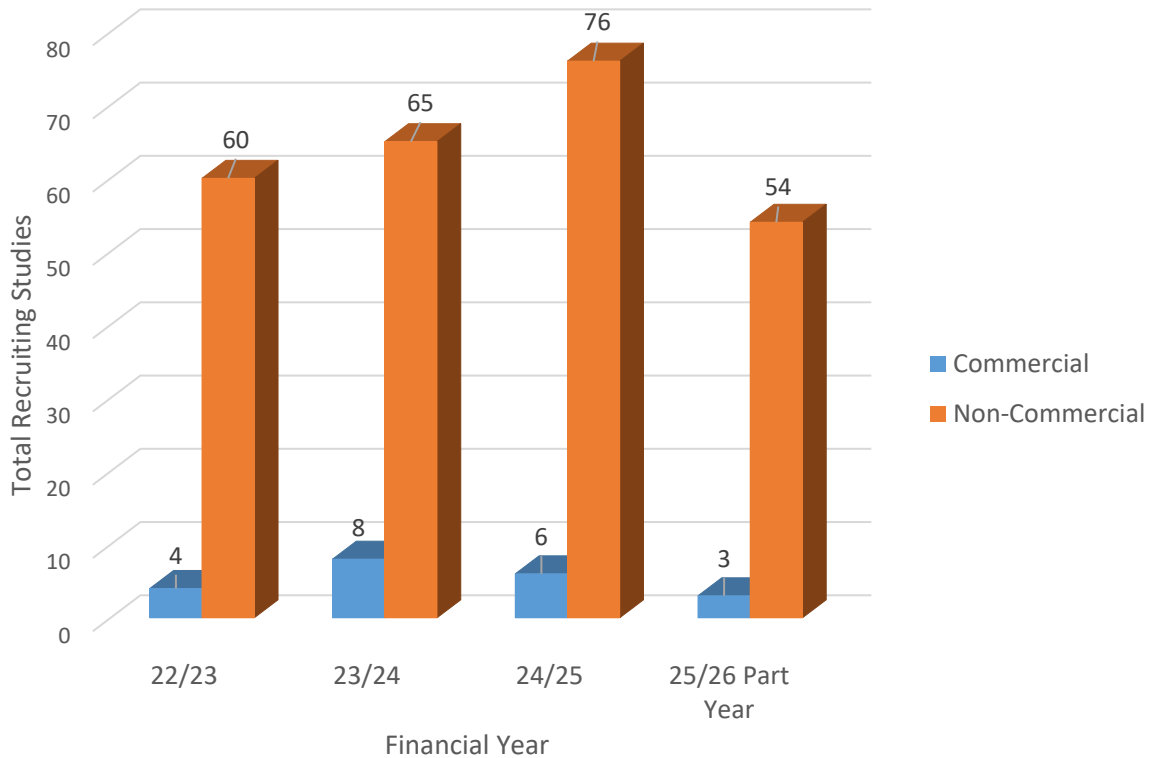
CTMUHB's R&D Strategy 2025-30 outlines how CTMUHB will further develop its visibility, infrastructure and research culture to embed research as a core function of the organisation, in alignment with key UK, national and CTMUHB policies and strategies. Following feedback received by the R&D team from the R&D Group and wider consultation to include Health and Care Research Wales and Welsh Government R&D Division, the R&D Strategy was endorsed at the Quality Safety and Experience Committee on July 22nd and approved by the Board on 31st July, 2025. 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 Board. The R&D team are currently working with CTMUHB's Communications Department to officially launch the strategy across CTMUHB and our academic, industry and third sector partners.

2.2 CTMUHB's Research Activity

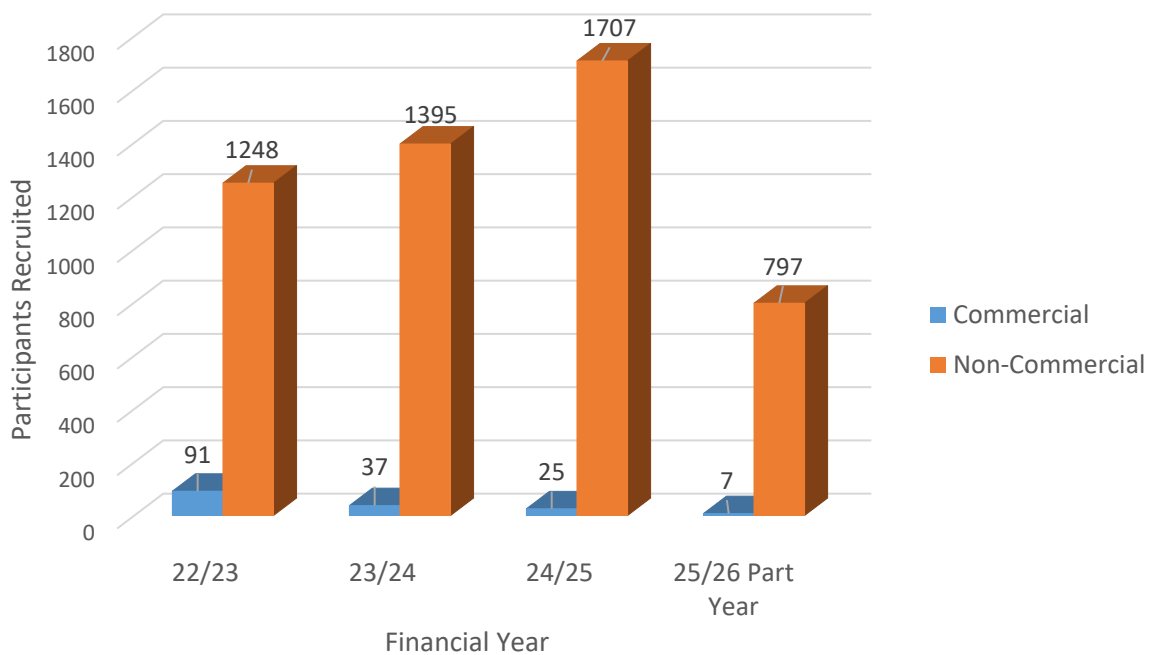
CTMUHB's R&D Department continues to prioritise the set-up and delivery of Clinical Research Portfolio (CRP) and commercial research across the UHB. The R&D Department circulates information on studies in need of recruiting sites, trawling the CRP for open studies in specific areas of interest and working with our academic and industry partners in the development of collaborative research studies. The current research portfolio spans across many specialties in primary, secondary and community care to include cardiology, dermatology, rheumatology, gastroenterology, paediatrics, critical care, anaesthetics, stroke, oncology, surgery, mental health, midwifery, diabetes, endocrinology, respiratory, population health, social care, physiotherapy, diagnostics and audiology. The graphs below outline the total number of open commercial and non- commercial CRP studies and participants recruited across CTMUHB between 2022-25.



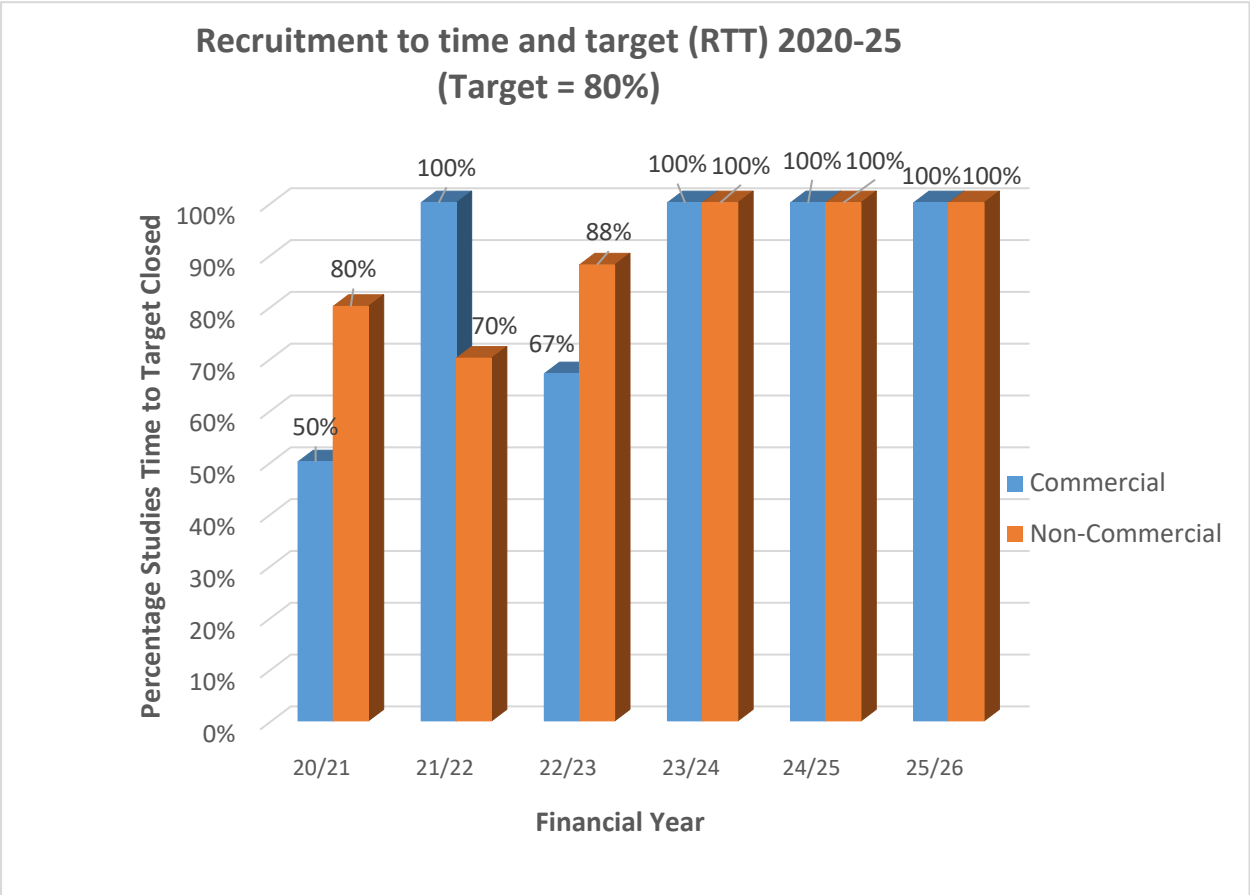
Open and Recruiting Studies by Financial Year 2022-2025



Recruitment by Financial Year 2022-2025



A key national metric from Health and Care Research Wales continues to be for 80% CRP and 80% commercial studies to close having met their recruitment to time and target (agreed number of participants recruited over an agreed timeframe). Meeting this metric can attract research sponsors to use the organisation as a recruiting site and is also key to the organisation maintaining autonomy on the management of the Support and Delivery budget received from Health and Care Research Wales. The graph below outlines the percentage of studies meeting recruitment to time and target between, 2020-21 to 2025-26.



2.3 R&D Funding

Health and Care Research Wales has a total Delivery funding budget of £15.8 million (2024-25) for the NHS and distributes this funding to each NHS organisation in Wales using a needs-based approach, whereby funding is allocated based on the actual resource required by the organisation to support study delivery needs. This funding enables the provision of a core R&D infrastructure to support the set up and delivery of research across the NHS organisations. Expenditure of this funding is closely performance managed in line with the All-Wales NHS R&D Finance policy, with specific guidance on its appropriate use and a requirement for NHS R&D departments to submit monthly returns detailing all expenditure to Health and Care Research Wales.

An updated NHS Research and Development Finance Policy was circulated by Health and Care Research Wales in July 2025 for consultation in use until 4th October 2025. The final updated policy will then be published in October 2025, underpinned by a revised Welsh Health Circular, mandating implementation by all NHS organisations in Wales.

In addition to the core research financial resources provided through Health and Care Research Wales Delivery funding, there are a number of mechanisms by which other research funding streams can be secured. The overall budget for Local Support and Delivery funding in Wales is insufficient and under significant pressure so it is imperative that all other funding opportunities are maximised to secure the sustainability and further development of the required research infrastructure.

CTMUHB's R&D team identifies and circulates potential grant funding calls to all research active professionals across CTMUHB, with the offer of support to help with the costing and submission of funding applications and assistance in sign posting to academic colleagues to develop joint applications. Securing external grant funding provides capacity to develop and deliver research through cost recovery for existing infrastructure or the appointment of additional fixed term posts. Securing external funding through a competitive process also enables research projects to be adopted onto the Clinical Research Portfolio, attracting delivery support from the CTMUHB R&D team. Recent grant successes include an SBRI Award (£125,626) in collaboration with Cansense Ltd to undertake a project investigating the use of AI and blood testing to reduce colonoscopy demand on cancer pathways and a Kidney Research UK Allied Health Professional Fellowship (£181,467.50), in collaboration with Cardiff University.

Following the successful award of £5million to Rhondda Cynon Taf Local Authority in collaboration with Cardiff University, CTMUHB and Interlink as part of a Health Determinants Research Collaborations from the National Institute of Health Research (NIHR), the R&D team are also collaborating with and supporting Rhondda Cynon Taf Local Authority (LTA) to develop their own research infrastructure with a view to undertaking joint research studies at the health and social care interface.

The UHB provides £15k development funding per annum for CTMUHB's R&D Department to release an annual funding call for up to 6 collaborative research projects with our academic partners to address specific health care challenges, with the aim that the resulting partnership will lead to the development of collaborative grant applications. 2024/25 funding was used to support 6 projects with Cardiff Metropolitan University, University of South Wales and Swansea University in the fields of infection, laboratory Sciences / ICU (long covid), Parkinson's disease, paediatric diabetes, breastfeeding provision for CTMUHB's workforce and Vitamin D binding protein and stroke.

Following the award of funding from Moondance for 0.2 wte Consultant for 18 months to act as a Research Champion to further increase and support cancer related research, the UHB has continued to fund 0.2 wte consultant sessions (0.1

WTE Colorectal and 0.1 WTE Obstetrics and Gynaecology) to progress this work. This work will be in partnership with CTMUHB's R&D Department and will help support the Tackling Cancer through research national initiative.

2.4 Commercial Research

Undertaking commercial research is crucial to increasing the UHB's research capacity as it enables the re-investment of overheads and capacity building funding paid by pharmaceutical and medical device companies for the UHB to act as a recruiting research site. This funding is in addition to the recovery of the necessary costs for the study to be undertaken and potential cost avoidance / savings through the provision of medications for clinical trials. Increasing the commercial research portfolio remains a key priority for CTMUHB, with Cardiology, Dermatology and Primary care being areas of success. The R&D Department circulate the details of potential studies across primary, secondary and community care, providing support to clinicians in completing feasibility questionnaires, attending site selection visits and the subsequent set up and delivery of the study. The R&D team are currently supporting research active colleagues in Rheumatology, Medicine (neurology), Endocrinology, ENT, Dietetics, Physiotherapy, Gynaecology and Psychiatry (Dementia) to develop their commercial research portfolios.

A new UK-wide process for Commercial Site identification is being implemented across Wales, which will involve the use of an app to facilitate health and care organisations across the UK to view potential commercial research studies seeking participating organisations and express an interest in taking part. This will streamline the existing email process, which is resource intensive and be UK wide, enabling Welsh sites access to commercial research studies. CTMUHB's R&D team is currently compiling a market profile for CTMUHB to highlight the organisation's research strengths, infrastructure and track record in the delivery of research, to attract potential research sponsors to open CTMUHB as a research site.

Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG)

A 5-year voluntary scheme for branded medicines pricing, access and growth (VPAG) initiative was agreed by the UK Government, NHS England and the Association of the British Pharmaceutical Industry (ABPI) to provide £22.1 million investment for Wales (£400million across the UK) between 2024/25 to 28/29 to develop capacity to deliver commercial research, with a view to developing a network of clinical research facilities, research delivery and a re-investment plan.

VPAG Stream 1&2 Funding

An application for VPAG Stream 1 funding was submitted from CTMUHB on January 31st, 2025 to increase commercial interventional research delivery capacity by expanding on and enhancing existing dedicated commercial clinical research facilities that will form part of the Wales Commercial Research Delivery Centre (Wales CRDC). The application was unsuccessful for Stream 1 funding. Funding was awarded to C&VUHB, Velindre and the Clinical research facility at Wrexham. These sites now constitute the CRDC in Wales. Review of the application against Stream 2 criteria, was unsuccessful for Stream 2 funding.

CTMUHB were successful in their application to the first equipment call, in support of Commercial research in early 2025 to the value of £170,000.

Commercial Research Delivery Wales Equipment Funding 2025/26

A rolling call is open for NHS organisations to submit a request for equipment during 2025/26 to support the delivery of commercial pharmaceutical interventional research. CTMUHB's R&D Department is awaiting the outcome of a recently submitted application to the value of £20.917.63.

Workforce Fellowships Call 2025/26

A rolling call is open for staff in the NHS and HEIs to submit a request for funding (costs incurred July 1st 2025 to 31st March 2026) to support workforce development by increasing exposure to commercial research through mentorship, training and shadowing. CTMUHB's Clinical Trials Pharmacist submitted a successful application, to the value of £1507.

Commercial Clinical Trial Capacity and Capability Short-term Funding

A rolling call is open to stakeholders from all health and care specialties, services and the clinical research infrastructure within health and social care in Wales to bolster clinical trial capability, by increasing workforce capacity and infrastructure as well providing agility relevant to the set up and delivery of commercial clinical research. CTMUHB's R&D Department is awaiting the outcome of a recently submitted application for 1.0 WTE Senior Research Fellow in Cardiology for an eighteen-month period.

Florence Electronic Investigator Site File (eISF)

Florence is a centralised cloud-based system which is accessible anywhere to allow organisations to manage their study documentation. It allows for master delegations of authority, remote monitoring, and/or multi-centre or multi-site trial management. It allows electronic signatures to be collected, as well as providing an area for non-study documentation to be managed and stored. Florence can be configured specifically to meet existing workflows and SOPs, including archive management SOPs and eSignature workflows. It can also be used for eArchiving. A funding proposal was submitted as a group application from all commercially active Health Boards and Trusts in Wales, to seek funding from the VPAG funding available, for the Florence eISF System implementation. Funding (£49,454.28) has been provided to CTMUHB's R&D Department to cover the cost of implementation, support package costs and full use of Florence eISF for two years (2025/2026 and 2026/2027). Following qualified approval from CTMUHB's Project Portfolio Board (PPB) and the relevant approvals from IT, Information Governance and Procurement, the contract has been signed and an implementation meeting has been scheduled for 10th October with CTMUHB's R&D team.

2.5 Annual Review Meeting

The annual review meeting with Welsh Government and Health and Care Research Wales was held on 7th March and was attended by the Executive Director with R&D in their portfolio (Executive Nurse Director and Deputy CEO), the Assistant Director for R&D, the Research Champion (Independent Member), Executive Director for Public Health, Executive Director of Allied Health Professions (AHPs) and Health Science and R&D Manager. Positive feedback regarding the UHB's performance in research was received.

2.6 Other National Developments

Forthcoming changes to clinical trial legislation and approvals processes

On 28 April 2025, the United Kingdom (UK) Parliament and Northern Ireland Assembly approved [The Medicines for Human Use \(Clinical Trials\) \(Amendment\) Regulations 2025](#) which govern the regulation of clinical trials involving investigational medicinal products (CTIMPs) in the UK. The new regulations will come into force on 28 April 2026. A new version of ICH GCP (ICH GCP E6 (R3)) was published on 06 January 2025 and these will be implemented in these new regulations. The upcoming changes include the update and introduction of new terminology, the addition of professions who can act as investigators, new legal requirements for data transparency, changes to the approvals process for CTIMPS and simplified arrangements for consent in clinical trials.

Strategic Action Plan for building research capacity for nursing, midwifery and allied health professions in Wales June 2025

The AD for R&D for CTMUHB contributed to the PRIORITY project, which was commissioned by Wales' Chief Nursing Officer, Chief Allied Health Professions Adviser and Director of Health and Care Research Wales to develop an action plan to build research capability in the nursing, midwifery and 13 allied healthcare professions. Conversation cafés, ethical dilemma café (EDC) workshops and citizens juries were held to inform the action plan. The Action Plan was published in June 2025 and outlines 12 actions with a proposed owner to oversee its implementation. [Improving research skills for nursing, midwifery and allied health professions](#)

The AD for R&D also continues to contribute to the Embedding Research in the NHS programme of work, as a member of the programme group, being overseen by Health & Care Research Wales.

CTMUHB are also part of the national discussions following an approach to all NHS R&D Directors by Moondance, to raise support for CADARN, an initiative seeking to promote more cancer research in Wales.

Health and Care Research Wales Inclusivity Action Plan 2025-30

This Action Plan was published in March 2025 to embed inclusive practice across Health and Care Research Wales, with actions set against 6 themes (an inclusive organisation, inclusive research funding, inclusive participation. An inclusive workforce, evidence-informed inclusion and impact for all). The delivery of the

plan will be overseen by the Research and Development Division, Welsh Government and annual progress updates will be provided to the Health and Care research Wales Advisory Board.

[Inclusivity Action Plan 2025 - 2028](#)

Health and Care Research Wales "Discover Your Role in Health and Social Care Research Public Involvement Action Plan 2025-29"

Further to the publication of the Discover your Role in Health and Social Care Research in 2020, the Public Engagement and Involvement Forum undertook engagement sessions with researchers and public contributors to establish what the plan had achieved and what was outstanding, in order to develop the next version of the action plan. Following a public consultation period, the new Action Plan was recently published and outlines 7 key focus areas (resources, inclusivity, ongoing support and learning for public contributors, accessible opportunities – helping shape research, payments and administrative barriers, impact, discover your role evaluation). [Discover Your Role - Public Involvement Action Plan 2025-2029](#)

NHS R&D Framework - Letter from Judith Paget and Suzanne Rankin - February 2025

A letter was sent by the Director General Health, Social Care & Early Years/NHS Wales Chief Executive and CEO Research Champion for Wales on February 25th, 2025 to NHS Executive Leads for Research regarding the Embedding Research in the NHS Programme and the NHS R&D Framework.

National Cardiovascular Research Network

The Assistant Director for R&D has accepted the invitation to become a member of the Leadership Team of the National Cardiovascular Research Network to provide input from an NHS perspective to progress research opportunities and facilitate collaborative working in the field of cardiovascular disease.

2.7 Medicines and Healthcare Products Regulatory Agency (MHRA) Good Clinical Practice (GCP) Investigator Site Inspection

CTMUHB underwent an MHRA GCP Investigator Site Inspection from 26th to 28th August 2025 in relation to a non-commercial CTIMP being undertaken in Princess of Wales Hospital investigating the use of Gaviscon Advance for the treatment of persistent throat symptoms (TALGITS). A written report outlining the findings of the inspection by the MHRA is expected within 25 days of the inspection.

2.8 R&D Placements and Training

The R&D Department continues to work with academic partners to offer clinical placements for health care professionals in training. Placements to date include one-week and two-week placements for University of South Wales student nurses, a two-week placement for a Trainee Clinical Scientist (AWMGS), a three-day placement for a Cardiff University student midwife and a two-day placement for an Audiology STP trainee.

The Assistant Director for R&D continues to present the CTMUHB and national strategic approach, agenda and ambitions to staff groups both within and outside the UHB with clear messaging that undertaking research is a key activity for all. Recent examples include presentations at the National Cardiovascular Research Network meeting and Enhanced, Advanced and Consultant Forum. The R&D Manager continues to present to the F1 Doctors and Band 6 & 7 Development programme.

The R&D Department continues to support the development of our researchers, through enrolment on the Associate Principal Investigator (PI) Scheme. Currently, there are 6 Associate PIs supporting research across the Health Board.

The R&D Department also continue to signpost CTMUHB staff to the NIHR and Health and Care research Wales training programme.

2.9 Communications and Dissemination

CTMUHB's R&D Department continues to work closely with the communications teams at CTMUHB and Health and Care Research Wales and its academic partners to share examples of research best practice and successful grants awarded to CTMUHB's researchers. Recent examples of dissemination include a Cardiff Metropolitan University news piece outlining a collaborative study being undertaken by CTMUHB and Cardiff Metropolitan University investigating the IL-6R genotype and incidence of long-covid ([2025 | New research on long-COVID offers hope for patients living with condition | Cardiff Metropolitan University](#)), a news piece from CTM outlining a collaborative study being undertaken by Cansense and CTMUHB investigating the use of AI and blood testing to reduce colonoscopy demand on cancer pathways ([CTM researchers running study to improve bowel cancer diagnosis - Cwm Taf Morgannwg University Health Board](#)) and a news piece from CTMUHB outlining a Cardiff and Vale UHB led study being undertaken at CTMUHB on the integration of liquid biopsies into the lung cancer diagnostic pathway ([CTMUHB delivering QuicDNA lung cancer study - Cwm Taf Morgannwg University Health Board](#)).

CTMUHB's R&D Department holds an annual R&D conference to showcase and disseminate the high quality multi-disciplinary and multi-professional research being undertaken across the Health Board, which also provides a networking opportunity for delegates from the NHS, academia, industry, Welsh Government and patient representatives. Last year's R&D conference took place on 26th November 2024 at the Vale Resort, Hensol. In addition to the keynote speaker, Prof Rob Orford, CEO of Moondance, there were 10 oral and 60 posters presentations documenting the considerable range of research being undertaken by all professions. This event had the highest attendance to date, with 224 delegates from the NHS, academia, industry, Welsh Government and patient representatives. The event was shared through Cwm Taf Morgannwg R&D and Health and Care Research Wales' social media. Planning is now underway for this year's conference, which will be held on **Wednesday, November 26th, 2025 at the Vale Hotel, Hensol**. The call for abstracts is open with an extended closing deadline of Monday 29th September 2025.

2.10 Patient access to participate in research

A key strategic objective is to ensure that CTMUHB supports a portfolio of research that provides inclusive and equitable access to its diverse population. The R&D Department recently undertook an evaluation to ascertain a baseline of the demographic and socio-economic profile of participants recruited to research studies in secondary care supported by the delivery team in CTMUHB between 1st April 2023 to 31st March 2024. Results indicate that participants were representative of CTM’s population in terms of age, gender and deprivation quintile. The R&D Department plan to extend this work further by recording additional data for analysis (e.g. ethnicity, health status) and by evaluating the barriers and facilitators to participants who undertake research in CTM. The R&D Department is also exploring ways to further support the set up and delivery of research in under-represented populations in CTM. Recent examples include a research project exploring the barriers and facilitators to breastfeeding infants among the gypsy and traveller population and a research project exploring attitudes to vaccination in prison residents.

3.0 Key Risks / Matters for Escalation

3.1 Increasing clinical and administrative space at Prince Charles and Princess of Wales Hospital

The development of the Clinical Research Centre at Royal Glamorgan Hospital has transformed the types of research that can be undertaken, and has enhanced our reputation with our academic and industry partners. This development has also reduced the reliance on the need for outpatient space to accommodate participant recruitment and research visits. In order to ensure the equitable access to research for CTM’s patients and clinicians, additional clinical and administrative space is required at both Prince Charles Hospital (2026) and Princess of Wales Hospital. Initial discussions took place with the previous site managers and further discussion is required to progress. It has been confirmed that PoW and PCH have the requirements for research as part of their accommodation review. There has been support for the provision of appropriate clinical and administrative space at PCH and PoW from the Executive team.

3.2 Health and Care Research Wales delivery Funding Shortfall 2025/26

Health and Care Research Wales delivery funding is used to cover the cost of R&D salaries, to include on-costs. Annual pay awards are paid in year by WG Health and Social Care Finance and then the pay award is added to the Health and Care Research Wales Delivery budget the following financial year but Health and Care Research Wales do not fund the pay award for 2018/19, 2019/20 and 2020/21. CTMUHB R&D was advised that funding for the pay awards for these three years is paid separately to the Health Board by WG Health and Social Care Finance, but CTMUHB’s finance team have confirmed that this is not the case for posts that were not in existence for those three financial years. A £62k shortfall was identified in 2024/25 in relation to the three year pay awards and this shortfall was covered by the Health Board. This was raised with R&D Division, Welsh Government, who agreed to the review the position for all NHS organisations in Wales. The shortfall

of £62k for 2025/26 has been raised to Health and Care Research Wales also and is reflected in the CTMUHB R&D Spending Plan (shared monthly with HCRW) for 2025/26.

The Delivery Funding for 2025-26 is currently showing an overspend in relation to the increased Employers National Insurance cost for 2025/26 but confirmation has been sought from Health and Care Research Wales that this cost will be covered in-year by Welsh Government.

There are additional cost pressures in the Delivery Funding budget during this financial year due to incremental drift and maternity leave cover. All avenues to increase other funding streams (grant funding, commercial income, charitable funding) are being actively explored as a priority as is the in-year management of the R&D budget received from HCRW.

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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: To be completed once final draft confirmed.
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5 Recommendation

The Quality, Safety & Experience Committee are asked to **NOTE** the contents of this report.

6 Next Steps

6.1 The R&D team will continue to work hard to deliver its strategic objectives with support from CTMUHB's Executive team and Care Group Directors and Management teams to embed research at a clinical, strategic and operational level, to include the development of designated clinical and administrative space at PCH and PoW and increasing commercial research activity.



Agenda Item

8.2.6

Quality, Safety & Experience Committee

Cwm Taf Morgannwg Individual Patient Funding Requests
(IPFR)
Annual Report 2024/25

Dyddiad y Cyfarfod / Date of Meeting	23/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Commissioning Support Officer, Commissioning Manager
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Philip Daniels, Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Forum Individuals	Date	Outcome
N/A	Click or tap to enter a date.	N/A



Acronyms / Glossary of Terms

AWTTC	All Wales Toxicology and Therapeutic Committee
EU	European Union
HTW	Health Technology Wales
IPFR	Individual Patient Funding Request
JCC	Joint Commissioning Committee
NICE	National Institute of Clinical Effectiveness
PIG	Policy Implementation Group
QA	Quality Assurance
TOR	Terms of Reference
OWMAG	One Wales Medicines Assessment Group

1. Situation /Background

1.1 This report briefs Board members of the decisions made by the Cwm Taf Morgannwg University Health Board (CTM) Individual Patient Funding Request (IPFR) panel during 2024/25.

1.2 The All Wales IPFR Policy was introduced in 2011 and revised in 2015 and 2017 following Ministerial reviews. The aim is to ensure there is a fair, transparent and consistent approach to decision making across Wales for medicine and non-medicine treatments not routinely commissioned on the NHS as they are new, novel or experimental. Where a medicine or treatment has not been appraised or approved for use in the NHS in Wales, a clinician can apply for it to be made available under the IPFR process. This process allows access to treatments where there is clear evidence a patient will derive significant clinical benefit from the treatment compared to other patients and that there is evidence that the treatment will be clinically effective and represents a cost effective use of NHS resources. Following a further review in 2023, the IPFR policy is being revised to ensure that the wording in the policy and associated documentation is clear, consistent and fit for purpose.

1.3 The membership of health boards IPFR panel is outlined in the All Wales IPFR policy. Within CTM, the panel membership is as follows:

- Deputy Medical Director (Chair- under delegated authority from the Medical Director)
- Senior Public Health Medicine Consultant (Deputy Chair - under delegated authority from the Director of Public Health)
- Head of Medicine Management
- Director of Nursing
- Director of AHPs and Health Science
- AMD Quality and Governance
- Assistant Director of Transformation
- Lay representative (2 vacant posts)

Each member now has a delegated deputy.

The CTM IPFR panel is scheduled to meet every fortnight to ensure applications are considered in line with the required timescales requested in the application. The CTM panel will be cancelled if there are no IPFR applications to consider. There is also an established mechanism to consider urgent applications within 24-48 hours. For urgent/life threatening applications and when a panel cannot be convened or discussion facilitated virtually within 24-48 hours, the Chair of the IPFR panel can undertake Chairs Action. During 2024/25, the CTM IPFR panel was convened on 26 occasions, while Chairs Action was undertaken for 2 cases.

- 1.4** There are strict process and timescales for IPFR case management for which the health board is audited, on a quarterly basis by the Quality Assurance panel. The QA selects an IPFR case chosen at random from the All Wales IPFR database. After each QA panel, the health board will receive a formal update. For 2024/25, the health board has performed well and has been consistent in its approach in terms of process and timelines.
- 1.5 Governance Structures related to the All Wales IPFR Process**
Following the independent review of the IPFR process in Wales in 2017, a key recommendation was to 'establish a national IPFR quality function to support IPFR panels to ensure quality and consistency in decision making'. This includes facilitation, advice training and auditing of the IPFR process and has an obligation to report on the quality of processes, highlighting any concerns through the existing quality and clinical governance processes in Wales. The QA panel was therefore established to undertake this function and is hosted by The All Wales Therapeutics and Toxicology Centre (AWTTC).
- 1.6** The governance structure for the established QA panel is clearly laid out in the terms of reference which were approved as part of the IPFR review through existing health board governance structures, including Welsh Health Specialised Services Committee (WHSSC), now Joint Commissioning Committee (JCC) and by the Deputy Chief Medical Officer for Wales for whom the group reports to. The group's role is to scrutinise a randomly selected IPFR from each IPFR panel to ensure the process had been followed in line with the All Wales IPFR Policy.
- 1.7** The AWTTC plays a pivotal role in supporting IPFR panels, ensuring consistency in approach via the QA group, establishing an All Wales IPFR database which seeks to identify any cohorts thus enabling a rapid review of the evidence and possible early access to treatment, for both medicines and non-medicines, and supporting the requirement for ongoing IPFR training events.

1.8 When a patient cohort is identified through cases submitted to the All Wales IPFR database, this links with the One Wales Commissioning Process.

1.9 Health Technology Wales (HTW) forms part of the QA group and are alerted to any non-medicine cohorts identified via the All Wales database thus enabling them to carry out an evidence appraisal. They also provide support for rapid evidence appraisals to IPFR panels when required. During 2024/25, CTM requested 5 rapid appraisals to assist the IPFR panel decision making process. Individual clinicians can also submit a topic for consideration. In addition to rapid appraisals, HTW considered more than 80 new topic referrals from across the health and care communities and published six new HTW guidance documents in 2021/22, including its first social care guidance, as well as nine new evidence appraisal reports.

1.10 One Wales Medicine Assessment process

The IPFR cases considered by the CTM IPFR panel and other health boards across NHS Wales including JCC, are also used to inform other aspects of the AWTTC work programme, in particular the One Wales Medicines Assessment process (OWMAG). This process has been developed to facilitate one single agreed decision for NHS Wales on access to particular medicines for a group of patients (a patient 'cohort'). Medicines and patient cohorts are identified for consideration by the OWMAG by signals from activity in the IPFR panels, from JCC, the Chief Pharmacist Peer Group or clinician groups.

1.12 Ongoing monitoring of the IPFR data has shown that soon after publication of an OWMAG positive decision, applications are no longer submitted for these indications. This positively demonstrates that the process effectively reduces the burden on IPFR panels and encourages equity of access to these medicines across Wales. During 2024/25, there was a single One Wales appraisal completed that was identified as an IPFR cohort; Dabrafenib with trametinib for treatment of BRAF V600E mutated anaplastic thyroid cancer (OW27). In addition to this, 13 IPFRs were considered across Wales for Bevacizumab with tipiracil/trifluridine (Lonsurf®). NICE published a positive recommendation in September 2024 (TA1008) after which there were no further IPFR requests that were submitted for consideration.

1.13 This demonstrates that overall, the IPFR route is being correctly used by clinicians; for those individual patients who may have clinical presentations that are different to the general patient cohort. The majority of the assessments are being triggered by requests from the service or individual clinicians rather than through collection of IPFR cohort data. This may in part be due to the diversity of requests coming through IPFR but it also shows more awareness by the service of the One Wales Medicines process.

In 2024-25 there were 4 new medicines assessed:

- dabrafenib and trametinib for anaplastic thyroid cancer;
- infliximab for treatment of immune checkpoint inhibitor (ICI) induced colitis;
- vedolizumab for treatment of ICI induced colitis;
- and nivolumab for treatment of oesophageal and gastric cancers with dMMR/high microsatellite instability [the nivolumab was negative]).

There are currently 21 positive One Wales decisions enabling access to medicines for the treatment of patients with conditions where there is unmet clinical need. All of these medicines are off-label (not licensed for the indication specified).

2. Specific Matters for Noting

2.1 IPFR data 2024/25

The requests submitted to the CTM IPFR panel vary in terms of complexity. The majority of applications relate to non-NICE approved/unlicensed drugs. The number of non-medicine requests received has been historically low, however an increase in the number of requests was noted in **2024/25** (table 1) compared to **2023/24** (table 2). IPFR decisions are recorded centrally on the All Wales IPFR database.

Table 1: Requests submitted to the CTM IPFR panel 2024/25

2024/25	Approved	Not Approved	Total
Medicine	31	10	41
Non medicine	8	3	11
Total	39	13	52

Table 2: Requests submitted to the CTM IPFR panel 2023/24

2023/24	Approved	Not approved	Total
Medicine	26	12	38
Non medicine	3	1	4
Total	29	13	42

Table 3: IPFR applications considered by the CTM panel by year.

	Approved	Not approved	Total
2021/22	21	7	28
2022/23	17	6	23
2023/24	29	13	42
2024/25	39	13	52

2.1.2 The number of IPFR applications the Health Board has considered in 2024/25 has totalled 52. It is not known at present whether the increase in the number of IPFR applications received is similar to that in other health boards across Wales. The AWTTTC IPFR Annual report (2024/25) is due for publication in Autumn 2025, when an assessment will be undertaken to understand if there has been an increase in the number of IPFR cases at an All Wales level.

2.2 Amendment to Directions concerning Cross Border Directive (2011/24/EC) and the S2 funding route process

2.2.1 Following the UK's withdrawal from the European Union (EU) on 31st December 2020, the EU Directive funding route ceased. Welsh Government issued the Welsh Health Circular (2021/005) instructing Health Boards that the EEA Directive can no longer be used by UK citizens to access healthcare treatment in the EU.

2.2.2 Whilst the EU Directive funding route has ceased, S2 arrangements will continue as part of agreed reciprocal healthcare arrangements with Europe post Brexit. The S2 route enables CTM patients to apply to have their planned treatment in another EEA country at the expense of their home

state. This can be in state provider or private healthcare provider that accepts an S2 certificate for which treatment will be provided under the same conditions and payment as for a resident of the country of treatment.

2.2.3 For the period of 2024-25 (January to December) CTMUHB considered less than 5 S2 requests. For information governance purposes and due to the low number of requests considered; the true number of requests is generally not reported due to being potentially patient identifiable. The Commissioning team will continue to closely monitor the number of S2 applications in 2025/26 and escalate appropriately if the number of requests increase.

3. Key Updates

3.1 All Wales IPFR policy update

An IPFR request considered by the JCC was subject to a judicial review in 2021 as due process had not been followed. The JCC were tasked with undertaking a '*di minimis*' review to address the recommendations made by the QC at the time. Following a prolonged process, the revised IPFR policy is due to be circulated in the near future. All health boards will be required to obtain endorsement and approval via their respective internal governance channels for endorsement. A date for implementation across Wales will be agreed once all Health Boards and JCC have completed internal sign off. This will ensure the IPFR policy is implemented across Wales and that IPFR applications adhere to the correct policy consistently across Wales.

3.2 CTMUHB representation on the All Wales IPFR panel

In the revised All Wales IPFR Policy (2025), the JCC have updated their TOR for the All Wales IPFR Panel to strengthen clinical representation from health boards.

3.3 CTMUHB IPFR panel membership

Following the retirement of The IPFR Chair in March 2025, The Deputy Medical Director is now the formal chair of the IPFR Panel. A clinical representative from Public Health Wales has also been confirmed as Deputy Chair and the AMD of Quality & Governance has recently joined the IPFR Panel to further strengthen clinical representation.

3.4 Lay Representation on the CTM IPFR panel

CTMUHB is required to recruit two lay representatives to the local IPFR panel as per the IPFR TOR. There has been great difficulty in attracting suitable candidates to the role for a number of years across Wales. Renewed efforts will be made to link with external stakeholders to recruit suitable lay members.

3.5 All Wales IPFR Workshop

AWTTC hosted the seventh annual IPFR workshop in May 2024 at Cardiff City Stadium. The workshop was open to IPFR panel members, IPFR teams, clinicians who complete IPFR application and those interested in learning more about the IPFR process. A total of 72 attendees were present on the day and all health boards were represented. CTMUHB were well represented with 6 colleagues attending from Pharmacy and Commissioning. The event provided delegates the opportunity to network and develop links across health boards. Delegates could also find out more information about the work of AWTTC and Health Technology Wales, by visiting stands throughout the day. A series of presentations were made to delegates and topics covered included:

- Medicines access in Wales – new initiatives
- IPFR QA feedback and updates
- Clinician training session on completing IPFR application forms
- Patient experience of IPFR
- Assessing value for money
- Comparators
- IPFR Panel cases; giving delegates the opportunity to form 'panels' to consider examples of IPFR cases.

AWTTC plan to host a virtual All Wales IPFR Workshop in the Autumn period of 2025, dates are yet to be confirmed.

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	Data to Knowledge



<i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: There are no specific quality and safety implications related to the activity outlined in this report.
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: EQIA undertaken on an All Wales basis.
Cyfreithiol / Legal	Yes (Include further detail below)	



	Healthcare (International Arrangements) Act 2019
Enw da / Reputational	Yes (Include further detail below)
	Activity where performance falls short of the Health Board's performance measures may result in impact to the trust and confidence in the Health Boards service provision.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)
	Workforce and financial resources are required to process and implement IPFR applications within the Health Board.

5 Recommendation

5.1 The Quality, Safety & Experience Committee are asked to **NOTE:**

- The contents of this report; and
- The need to recruit lay representation to the CTM IPFR panel;

6 Next Steps

6.1 No further action required.