Quality, Safety & Experience Committee

Tue 20 January 2026, 09:00 - 12:00

Virtually via Teams

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Committee Chair*

09:05 - 09:10
5 min

2. CONSENT AGENDA BUSINESS

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

09:10 - 09:15
5 min

3. COMMITTEE GOVERNANCE ARRANGEMENTS

3.1. Action Log

Discussion *Carolyn Donoghue, Committee Chair*

3.1 QSEC Action Log QSEC 20 January 2026.pdf (2 pages)

3.2. Matters Arising not Contained within the Action Log

Discussion *Carolyn Donoghue, Committee Chair*

09:15 - 09:45
30 min

4. STAFF AND SERVICE USER EXPERIENCE

4.1. Shared Listening & Learning Story - Alcohol Services

Kyle Newton, Alcohol Care Team Lead

09:45 - 11:25
100 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Thematic Spotlight Presentation - Compassionate Care

Discussion *Becky Gammon, Interim Deputy Director of Nursing*

5.1 Patient stories overview update Compassion 26 QSEC 20 01 2026.pdf (3 pages)

5.2. Comfort Break

5.3. Clinical Executive Directors Update Report

Discussion *Clinical Executives*

5.3 Clinical Exec Directors Update Report QSEC 20 January 2026.pdf (12 pages)

5.4. Care Group Highlight Reports

5.4.1. Primary Care & Communities Care Group Highlight Report

Discussion *Zoe Ashman, Interim Care Group Nurse Director*

5.4.1 PCC Highlight report QSEC 20 January 2026.pdf (10 pages)

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

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

5.4.2 Highlight Report DTPS QSEC 20 January 2026.pdf (13 pages)

5.4.3. Mental Health & Learning Disabilities Care Group Highlight Report

Discussion *Lloyd Griffiths, Interim Care Group Nurse Director*

5.4.3 MHLD QSE Hightlight Report QSEC 20 January 2026.pdf (9 pages)

5.4.4. Planned Care Care Group Highlight Report

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

5.4.4 Planned Care Highlight Report QSEC 20 January 2026.pdf (9 pages)

5.4.5. Children & Families Care Group Highlight Report

Discussion *Carl Verrecchia, Service Director*

5.4.5 CF Highlight report QSEC 20 January 2026.pdf (9 pages)

5.4.6. Unscheduled Care Group Highlight Report

Discussion *Deborah Matthews, Care Group Nurse Director*

5.4.6 USC Care Group Highlight Report QSEC 20 January 2026.pdf (14 pages)

5.5. Stroke Services Report - Bi-Annual Update

Discussion *Unscheduled Care Leadership Team Gary Howell, Clinical Director of AHPs Claire Thompson, Exec Director Strategy and Transformation*

5.5 Stroke Update QSEC 20 January 2026.pdf (21 pages)

11:25 - 11:40
15 min

6. DELIVERING OUR PLAN

6.1. Patient Safety, Quality and Experience Dashboard (to include an update on Ombudsman Public Interest Reports)

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

6.1 Patient Safety and Quality Dashboard Report QSEC - January 2026 APPROVED RH.pdf (25 pages)

6.2. People’s Experience Activity Report

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

6.2 People's Experience Report QSEC 20 January 2026.pdf (9 pages)

11:40 - 11:50
10 min

7. Governance, Risk & Assurance

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

Discussion *Gareth Watts, Director of Corporate Governance*

- 7.1a Org RR QSEC Jan 2026 - Cover Paper.pdf (7 pages)
- 7.1b Appendix 1 - Org RR QSEC Jan 2026.pdf (5 pages)

7.2. Clinical Effectiveness Update 2025- 2026

Discussion *Dom Hurford, Executive Medical Director*

- 7.2 Clinical Effectiveness Update QSEC 20 January 2026.pdf (6 pages)

11:50 - 11:55
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the meeting held on 18 November 2025

Decision *Carolyn Donoghue, Committee Chair*

- 8.1.1 Unconfirmed Minutes Public QSEC 18th November 2025 QSEC 20 January 2026.pdf (15 pages)

8.1.2. Unconfirmed Minutes of the In Committee meeting held on 18 November 2025

Decision *Carolyn Donoghue, Committee Chair*

- 8.1.2 Unconfirmed Minutes In Committee QSE 18 Nov 25 QSEC 20 January 2026.pdf (2 pages)

8.1.3. Annual Cycle of Business for 2026

Decision *Gareth Watts, Director of Corporate Governance*

This will be shared at the March 2026 meeting

8.1.4. Organ Donation Sub Committee Annual Committee Report January - December 2025

Decision *Dom Hurford, Executive Medical Director*

- 8.1.4a Organ Donation Committee Annual Report January - December 2025.pdf (6 pages)
- 8.1.4b Letter from NHSBT QSEC 20 January 2026.pdf (1 pages)

8.1.5. Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents

Decision *Gareth Watts, Director of Corporate Governance*

- 8.1.5a Approval of the Policy on Policies - QSEC Jan 26 - CP.pdf (6 pages)
- 8.1.5b Appendix 1 - POL_CG06_PolicyonPolicies_FinalDraft_v5.pdf (14 pages)
- 8.1.5c Appendix 2 - Approval Process Clinical and Non Clinical WCD v8.pdf (3 pages)
- 8.1.5d Appendix 3 - NEW Policy Document Template v5.pdf (5 pages)

8.1.6. IM and Exec Walkabouts Operating Model

Decision *Richard Hughes, Interim Executive Director of Nursing*

- 8.1.6 IM and Exec Walkabouts 20 January 2026 v4.pdf (11 pages)

8.2. FOR NOTING

8.2.1. Non-Routine Committee Business (Forward Plan)

Information *Carolyn Donoghue, Committee Chair*

8.2.1 CTMUHB QSEC Non Routine Bus QSEC 20 January 2026.pdf (3 pages)

8.2.2. Health Inspectorate Wales (HIW) Improvement Plan Tracker Report

Information *Richard Hughes, Interim Executive Director of Nursing*

8.2.2a HIW Tracker Cover Report - QSEC Jan 26_v3.pdf (6 pages)
8.2.2b Appendix 1 - HIW Insp Recs Tracker_QSEC 20.01.2026v1.pdf (8 pages)

8.2.3. Human Tissues Act Compliance Progress Report

Information *Dom Hurford, Executive Medical Director*

8.2.3a HTA compliance Progress Report QSC 20 January 2026.pdf (9 pages)
8.2.3b Appendix 1 Royal Glamorgan Hospital inspection report (002).pdf (9 pages)

8.2.4. RADAR Update Report

Information *David Deekollu/Richard Jones*

8.2.4 RADAR Report QSEC 20 January 2026.pdf (7 pages)

11:55 - 12:00
5 min

9. CLOSE OUT BUSINESS

9.1. Committee Highlight Report to the Board

Discussion *Gareth Watts, Director of Corporate Governance*

9.2. Meeting Feedback

Discussion *Carolyn Donoghue, Committee Chair*

Is there anything we should do more or less of?

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

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

Have we received sufficient assurance from a range of sources?

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

9.3. Any Other Business

Discussion *Carolyn Donoghue, Committee Chair*

12:00 - 12:00
0 min

10. Private/Closed Session Business

Information *Carolyn Donoghue, Committee Chair*

There are no items requiring discussion in closed session on this occasion.

12:00 - 12:00
0 min

11. Date & Time of Next Meeting

Information *Carolyn Donoghue, Committee Chair*

The next meeting will be held on 24 March 2026 at 9:00am

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Committee Action Log

Name
Comm

Date action			/ Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	WAST produced Quality Report to be shared with Members at future meetings of the Committee to help Independent Members to triangulate data between WAST and the Health Board	Interim Executive Director of Nursing	Interim Executive Director of Nursing	20/05/2025 Now 22/07/2025 **Now November 2025**	Open	**In progress** Interim Executive Director of Nursing for CTMUHB to meet with Director of Nursing at WAST to discuss what quality data sets were now available within WAST that could be shared with Committee members.
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	Consideration to be given outside the meeting on the frequency of reporting on this matter to future Committee meetings. Deputy Director of Nursing to discuss further with Committee Chair to determine the level of information required moving forwards	Committee Chair	Interim Executive Director of Nursing	25/03/2025 Now 22/07/2025 Now November 2025 **Now January 2026**	Proposed for Closure	**Completed** Being proposed for closure owing to improved performance with WAST. Any future exceptions to feed through the USC Care Group Highlight Report
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	Interim Executive Director of Nursing	TBC	Open	**In progress** Date to be agreed with Team
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	Proposed for Closure	**Completed** Information shared with members by email on 18 November 2025
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	Interim Executive Director of Nursing	20.01.2026	Proposed for Closure	**Completed** An update on this has been included in the report being presented to the January Committee
22.07.2025	6,1	13	Patient Safety, Quality & Experience Dashboard	Response to be provided outside the meeting regarding inconsistencies reported in figure contained in paragraph 2.2 regarding number of incidents reported compared to bar chart graph contained later in the report	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	23.09.2025	Open	**In Progress** Interim Executive Director of Nursing plans to discuss the context of this action with Committee Chair
23.09.2025	5.2.5	10	Unscheduled Care - Care Group Highlight Report	Discussion to be held with DTPS Care Group to clarify any discrepancies and ensure understanding of the patient support model at YGT	Care Group Nurse Director, Unscheduled Care	Interim Executive Director of Nursing	18-nov-25	Proposed for Closure	**Completed** USC Care Group are holding an overarching action plan and includes the 35 cases raised as a concern by the therapy team. The review is ongoing, to date no harm has been identified. A review panel is being set up to include therapies to discuss each case and record a formal MDT outcome and any learning or further actions to be taken. There is a robust criteria to transfer to YGT, Pathway 1 and 3 patients and the ETOCS are quality assured by the Hub prior to agreeing transfer. Patients must not have any ongoing therapy needs and will have reached their threshold The Nurse Director for Unscheduled Care presented an update to ELG on the 10th November 2025 to provide assurances around improvement work.
23.09.2025	7,5	15	Health, Safety & Fire Sub Committee Highlight Report 4 September 2025	Further clarity on reporting routes to be obtained for nutrition and catering activity.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	18/11/2025 **Now 31 December 2025 Due to the review of Cycles of Business this action deadline has been extended to the end of December.**	Open	**In Progress** This action is being taken forward by the Corporate Governance team in their review of the Committee and Sub Committee annual Cycles of Business (timeframe to be complete by end of December 2025) Once a reporting route for nutrition and catering has been identified this will be fed back to the Committee.
18.11.2025	5.3.1	8	Unscheduled Care - Care Group Highlight Report	Next report to include more detailed performance data in relation to stroke performance, showing the trajectory of improvement.	Nurse Director, Unscheduled Care	Interim Executive Director of Nursing	20-jan-26	Proposed for Closure	**Completed** Data has been included in the report being presented to the January meeting
18.11.2025	6,1	11	Patient Safety, Quality & Experience Dashboard	Actual date of occurrence to be included in future reports in relation to the maternity adverse occurrence data in the table of reportable events by clinical area	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	20-jan-26	Proposed for Closure	**Completed** Addressed in the Patient Safety and Quality Dashboard for January's Committee.
18.11.2025	6,1	11	Patient Safety, Quality & Experience Dashboard	Clarity to be provided in future reports in relation to the variation between initial harm assessment and final outcome in relation to reported incidents	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	20-jan-26	Proposed for Closure	**Completed** Addressed in the Patient Safety and Quality Dashboard for January's Committee.
18.11.2025	6,2	12	Peoples Experience Activity Report	Further detail to be included in future reports in relation to how assurance was provided regarding actions taken from PALS queries	Interim Deputy Director of Nursing	Interim Executive Director of Nursing	20/01/2026 **Now May 2026**	Open	**In progress** It is proposed that a report outlining the revised model for the Patient Advice & Liason Service will be presented to the May 2026 meeting of the Quality, Safety & Experience Committee

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Committee Action Log

Nam
Com

Date from	acti	e / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
20.05.2025	4,2	4	Executive and Independent Member Walkaround Framework Cover Paper	Review of proposed frequency of walk rounds to be undertaken alongside a wider review of the new process once one round of walk rounds had been completed	Interim Executive Director of Nursing	Interim Executive Director of Nursing	18.11.2025	Open	**Completed** Review has been undertaken and a report containing details of feedback received from the latest round of walkrounds is on the agenda for the November meeting. The Interim Executive Director of Nursing will also be having a discussion with Independent Members on the future process at the Board Development session on 18 December 2025.
22.07.2025	4,1	4	Listening & Learning Story - Carers	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed, with further discussion required as to what could be done to address the issues	Head of Corporate Governance & Board Business	Interim Executive Director of Nursing	20.01.2026	Open	**Completed** This item has been added to the forward work programme
22.07.2025	6.1.1	14	Committee Referral - Details of the medical negligence claims from the losses and special payments report - Verbal Update	Detailed written update to be presented to the September 2025 meeting of the Quality, Safety & Experience Committee	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	23.09.2025	Open	**Completed** Report and explanation presented to the meeting held on 23 September. Audit, Risk & Assurance Committee Chair content that this referral has now been addressed.
22.07.2025	6,4	14	People Experience Forum Update	Review the statement made within the report in relation to underfunding to better reflect the intended message, focusing on concerns rather than asserting underfunding as fact.	Deputy Director of Nursing	Interim Executive Director of Nursing	23.09.2025	Open	**Completed** Response shared with Members by email on 5 November 2025
23.09.2025	4,1	3	Listening & Learning Story - Domestic Violence	Link up Head of Safeguarding with the Chair of the Women's Network in order to promote the work being undertaken by the Team to keep people safe	Executive Director of Allied Health Professionals & Health Sciences	Executive Director of Allied Health Professionals & Health Sciences	23.09.2025	Open	**Completed** Executive Director of Allied Health Professionals & Healthcare Sciences has confirmed this has been actioned.
23.09.2025	4,1	5	Listening & Learning Story - Domestic Violence	Head of Safeguarding to return to the Committee in one year to provide more evidence in relation to learning points	Head of Corporate Governance & Board Business	Head of Safeguarding	sep-26	Open	**Completed** This item has been added to the forward plan for September 2026
23.09.2025	5,1	6	Report of the Clinical Executives	Report on the current position regarding the proposed changes to the roles and remits for Physicians Associates to be developed and presented to a future meeting	Executive Medical Director	Executive Medical Director	jan-26	Open	**Completed** This item has been added to the forward work programme
23.09.2025	5,1	6	Report of the Clinical Executives	The position in relation to the risk of sustainable funding routes for key projects/services which were subject to short term funding to be included in the alert/escalate section of the Committee Highlight report to Board. Positive items for escalation to also be included in relation to the positive inspection carried out by the Human Tissue Act Authority and the recent HIW visits to the Emergency Department at Royal Glamorgan Hospital (RGH) and to Maternity services at Princess of Wales Hospital (POWH).	Assistant Director of Governance & Risk	Assistant Director of Governance & Risk	nov-25	Open	**Completed** The Highlight Report for the Committee which met on the 23rd September 2025 captured the agreed items and will be received at the November 2025 meeting of the Public Board.
23.09.2025	5.2.2	8	Diagnostics, Therapies, Pharmacy & Specialities Highlight Report	Update to be provided to the next meeting regarding the reasons behind the increased blood transfusion incidents	Executive Medical Director	Executive Medical Director	nov-25	Open	**Completed** Update has been included in the Highlight Report as to the reasons behind the increase
23.09.2025	5.2.4	9	Planned Care - Care Group Highlight Report	Outcome and impact of the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate to be presented to the Committee after the trial period of 12 Months	Head of Corporate Governance & Board Business	Care Group Nurse Director, Planned Care	sep-26	Open	**Completed** This item has been added to the forward work programme
23.09.2025	6,2	12	Committee Referral - Details of the medical negligence claims from the losses and special payments report	Summary report to be submitted back to the Audit, Risk & Assurance Committee confirming the review outcome discussed at the Quality, Safety & Experience Committee	Head of Concerns & Business Intelligence	Head of Concerns & Business Intelligence	13-nov-25	Open	**Completed** This report is on the agenda for information at the November Audit, Risk & Assurance Committee
23.09.2025	7,1	13	Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Stroke risk narrative risk description to be reframed from a sustainability to a performance perspective.	Chief Operating Officer	Chief Operating Officer	18-nov-25	Open	**Completed** In relation to Datix Risk ID 4632 regarding stroke services, the risk has been reframed to take into account feedback received from the September 2025 Quality, Safety & Experience Committee to capture the performance element of the risk and this can be seen in the Organisational Risk Register update on the agenda. The Unscheduled Care Group are currently reviewing the risk score as a result of these changes.
23.09.2025	2.3 (CLOSED SESSION)	3	Organisational Risk Register – Closed Risks	Review to be undertaken outside the meeting as to whether the Special School Nursing position should be included as a risk.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	18-nov-25	Open	**Completed** The Special School Nursing Risk is escalated to the Organisational Risk Register and was considered in the Public Committee session. The risk ID for reference is 5753 "Inadequate Special School Nurse Provision".

Agenda Item	20th January 2026	Quality Safety and Experience Committee	

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Becky Gammon – Interim Deputy Director of Nursing
Presented By:	Becky Gammon – Interim Deputy Director of Nursing
Approving Executive Sponsor:	Richard Hughes – Interim Executive Director of Nursing and Midwifery
Report Purpose	For Noting
Engagement undertaken to date:	Patients and Relatives directly Care Groups Discussion Board presentations previously

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Shared learning
Related Health and Care Standard	e.g. Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes (include date) No (Explain why)
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No If Yes please include brief detail.
Link to Strategic Goals	Improving Care

You Said	We Did
Extending Kindness and Compassion in Practice	• Sessions on person-centred care, dignity and respect have been implemented in all new starter nursing and midwifery programmes. • Nursing staff have been released to attend compassionate leadership training delivered by Health Education Improvement Wales (HEIW) (initially aimed at Band 7 and above, with a plan for roll-out) • Supporting conversion in relation to professional behaviours as part of a Just culture
Focus on professional standards, civility and respect.	• Use Alan's and Rhian's patient and family stories to illustrate the impact of compassionate care. This has been shared widely across the Improving Care Board, professional forums, clinical education and via safe to start daily huddles. • reviewing feedback from attendees to influence changes to the program • Encourage short, meaningful check-ins with patients and families at key points in the care journey
Use patient, carer and staff feedback for learning	• Digital story framework approved and available on CTM UHB SharePoint. • Training sessions delivered for "how to collate a patient story", including partner agencies such as Llais • Aligned the futures patient stories to the strategic drivers to ensure shared learning across the Health Board • Development of people's experience strategy – due to launch – March 26 • Review concerns/complaints to identify themes that relate to communication or attitude in a no-blame way and agree on simple behaviour changes • Explore how the PALS care to share clinics can be supported by the ward manager

You Said	We Did
Provide targeted training for clinical and non-clinical staff	• In collaboration with the Learning and Organisational Development team, implement workshops on empathic communication, active listening and difficult conversations – Due to start April 26 • Linking in with Health Education Improvement Wales (HEIW) to release staff to attend the difficult conversation training.
Support staff wellbeing and reflective practice	• Promote access to staff wellbeing services and peer support to reduce burnout and sustain compassionate care • Launch of the speaking up safely guardians
Recognise and reward compassionate practice	• Launch of the Viva Engage communication platform • Implementation of the Seren award • Exploring how public nominations can be submitted to the Seren Awards • Scoping Promptly system to understand if it can record mentions of thanks from the public for wards and departments • Discussion with iCTM on how to recognise and celebrate contributions made by staff to improve patient experience for People's as part of People's Experience Week 2026

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
5.3

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes-Interim Executive Director Nursing, Midwifery and Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes-Interim Executive Director Nursing, Midwifery & Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	1. Richard Hughes-Interim Executive Director Nursing, Midwifery & Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels-Executive Director of Public Health

Pwrpas yr Adroddiad / 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	
IPC	Infection Prevention Control
PPE	Personal Protective Equipment
LNC	Local Negotiating Committee
BMA	British Medical Association
IMTP	Integrated Medium Term Plan
AHA	Advancing Health Awards
AHP	Allied Health Professionals
MDT	Multi-Disciplinary Team
LAs	Local Authorities

1. Situation /Background

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

- Richard Hughes-Interim Executive Director Nursing, Midwifery & Patient Care
- 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-Richard Hughes

This section of the paper provides an overarching update on the remit of Nursing & Midwifery.

Maternity and Neonatal Services

The data pack for the national Maternity and Neonatal Assessment has been fully submitted, followed by panel interviews involving both Board representatives and clinical colleagues. The outcome of this national assessment is anticipated in January 2026.

In addition, visits are planned during January with the Chief Midwifery Officer for Wales, hosted by the Interim Executive Director of Nursing and Midwifery.

Executive-led support meetings have been convened with the Care Group in the absence of the Director of Midwifery, alongside direct support for Heads of Midwifery provided by the Interim Deputy Director of Nursing.

A walkabout with the Vice Chair and Maternity Board Champion is scheduled for mid-January 2026.

All reporting processes remain in place, including weekly touchpoints with the Care Group and their respective Head of Quality & Patient Safety.

A detailed report summarising the performance of Maternity and Neonatal services for 2025/26, together with the outcome of the national assessment, will be presented to the Quality, Safety and Experience Committee in March.

These measures reflect a continued commitment to robust governance, collaborative leadership, and assurance across maternity and neonatal care during this critical assessment period.

IPC and PPE precautions

The latest executive briefing provides assurance regarding the current epidemiological position of respiratory viruses within Cwm Taf Morgannwg (CTM), with a particular focus on influenza.

Surveillance data indicates a stabilisation of the situation. The anticipated post-festive surge in cases did not materialise, and CTM no longer reports the highest number of influenza inpatients in Wales.

Sentinel GP consultation rates for influenza-like illness have decreased to low intensity, and critical care impact remains limited. Other respiratory viruses, such as RSV, are being managed locally and do not currently necessitate the continuation of universal mask mandates.

Targeted infection prevention and control (IPC) measures, including mask use, will remain in place for outbreak and high-risk areas.

In light of this evidence, the universal mandatory requirement for mask wearing across CTM clinical settings will be stood down from 12th January 2026. This decision is proportionate and evidence-based, aligning with national trends, and is contingent upon robust communications to reinforce responsible visiting, hand hygiene, and the continued use of masks where clinically indicated or during outbreaks.

The position will remain under active review, with clear operational plans in place to respond swiftly to any localised increases in respiratory virus activity. Ongoing surveillance and strong leadership messaging will ensure that infection prevention remains a priority, and that measures can be rapidly re-escalated should the epidemiological situation change.

Ambulance Handover and associated matters

The most recent Health Board Area Report for CTM, covering the period 1st to 5th January 2026, provides a detailed overview of incident demand, response times, and hospital handover performance.

During this period, CTM recorded 846 verified incidents, with a breakdown across categories including arrest, emergency, and amber calls.

The median response time for emergency incidents in CTM was 7 minutes and 13 seconds, with handover data indicating that a significant proportion of ambulance arrivals at CTM hospitals were managed within the 45-minute standard. However, there remain instances where handover and turnaround times exceed this threshold, reflecting ongoing operational pressures within the system.

It is noteworthy that CTM has demonstrated sustained and notable performance over recent months, as previously highlighted by the Chief Operating Officer. These improvements have been recognised at Board level, with particular reference to the collective efforts across CTM sites in delivering against key operational standards, including ambulance handover performance.

Regular updates and assurance reports have been provided through established governance forums, ensuring that the Board and its committees remain informed on progress and areas for continued focus.

In recognition of ongoing challenges and the need for continuous improvement, the Interim Executive Director of Nursing and Midwifery has commissioned a focused review within the Unscheduled Care Group.

This work will examine quality, safety, and experience within the emergency department footprint, with particular attention to boarding status and any potential unintended consequences arising from efforts to improve ambulance handover performance.

The March meeting of the Quality, Safety and Experience Committee (QSEC) will serve as a winter wrap-up, hosting a series of detailed reports on quality standards and boarding activity across the organisation, providing further assurance and oversight as the Health Board continues to address these critical areas.

2.2 Medical Directorate-Dom Hurford

Section 2 Medical Directorate

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

Achievements
This section covers the following achievements:

1. Medical Examiner Service Update
2. Individual Patient Funding Request (IPFR) Quality Assurance (QA) Group Audit
3. Policy on allocation of Supporting Professional Activities (SPA) for Consultants in CTM

Medical Examiner Service Update

QR codes have been developed within the health board, to notify both the medical examiner service and coroner's office. This has been a huge achievement and is a key part of our strategy to reduce times families are waiting for death certificates. We also have access to the medical examiner's database and receive regular updates. This is particularly useful to look for delays and address these quickly.

A winter escalation plan has been agreed at board recently.

Individual Patient Funding Request (IPFR) Quality Assurance (QA) Group Audit

The latest IPFR Quality Assurance Group meeting was held on 10 November 2025.

The group reviewed one randomly selected IPFR application considered between July and September 2025 from each IPFR panel in Wales.

The group noted the excellent evidence summary provided by CTMUHB's pharmacy team to support the panel discussion.

They highlighted that the work has always been to an excellent standard and it is great to see this recognised by the national team.

Policy on allocation of Supporting Professional Activities (SPA) for Consultants in CTM

This has been agreed by the LNC (BMA and the Health Board) and standardises the approach across CTM allowing for transparency and parity for all consultants. The allocation includes provision for key roles within each department to enable stronger governance processes (such as mortality reviewer roles and appraisal lead allocations). This new policy will be phased in alongside Job Planning over the next year.

Areas of Focus

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

1. Physicians Associates Roles and Remits
2. Community Health Pathways
3. Resident Doctor Contracts

Physicians Associates Roles and Remits

There has been some uncertainty and unsettlement amongst the Physician Associates (PAs) since new guidance was released in Q3.
The Medical Directorate organised a guidance meeting for CTMUHB's PAs in October 2025.

The meeting was an opportunity for this group of colleagues to raise issues that have affected them. This valuable feedback has helped us to develop actions in areas such as registration, support, training, and development of the lead PA role. The meetings will continue in 2026.

Community Health Pathways

This is a nationally sponsored initiative that now has been moved to the HB to continue funding (we are expected to fund the clinical editor posts for the next year). However, due to the financial situation we must make difficult decisions and at present do not have the resources to maintain this.

We need to establish the impact that having these pathways are having, such as: reductions in overall outpatient referrals and appropriate referrals in line with guidance only.

We are in the process of starting these audits.

At present we have added the programme to the IMTP for review.

Resident Doctor Contracts

Positive news in that agreement with the BMA Resident Doctors' Committee has been met, making the likelihood of industrial action less in Wales.
However, the new contract will take time to implement fully and does contain some areas of potential financial risk as it requires all rosters to be compliant and full.

We have until August 2026 to have in place and that will take a lot of the focus of the People team and AMD Workforce's focus to meet that deadline.

2.3 Allied Health Professions and Healthcare Science-Lauren Edwards

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

Successes

Staff Survey

DTPS Care Group achieved the highest Staff Survey response for 2025**,** with a 54.6% completion rate across the specialities. This was above the 40% target set by the Health Board and demonstrates the ongoing commitment of managers and teams to engage and improve.

Meetings with teams will be arranged once feedback from the survey has been received, to discuss trends and plan ongoing improvements.

Speech and Language Therapy (SLT) access

Access to specialist Speech and Language Therapy (SLT) for patients experiencing late onset swallowing difficulties following head and neck cancer treatment has been significantly enhanced.

An increasing number of this patient group are presenting with late radiation-induced dysphagia, often many years after their initial discharge. This poses complex treatment challenges and can severely affect both quality of life and healthcare resources.

In response, a dedicated late radiation dysphagia pathway has been developed and implemented. This pathway ensures that patients receive timely and appropriate specialist intervention, while also reducing the need for unnecessary invasive investigations, thereby improving both patient safety, experience, and the overall quality of care.

Recognition

There has been significant success and recognition of AHP services recently:

- The AHP Community Rapid Access and Admission Prevention (RAAP) Service Model won the Advancing Health Awards Cymru (AHA) 2025 Award for New Ways of Working.
  The AHP Community RAAP model is an MDT service designed to prevent avoidable hospital admissions and provide rapid access to AHPs in the community. It combines rapid OT response via the Navigation Hub and profession-specific "hot clinics" for urgent needs, and a falls prevention programme. This model
  strengthens system flow, reduces conveyance to hospital, and has been recognised nationally for innovative practice.

- One of our Physiotherapy HCSWs, won the Rising Star Award at the AHA Cymru awards with one of our Physiotherapists, winning Clinical Educator of the Year, with 2 other members of the physiotherapy service being finalists at the CTM Clinical Student and Educator awards.

- The inpatient podiatry service was a finalist in the Quality in Care Awards for "implementation of a dedicated inpatient podiatry service for people with acute diabetic foot disease"

- The Public Health Dietetic team were recognised across 5 different awards categories for the CTM Food and Fun Programme.

- A newly qualified Speech and Language Therapist winning the most inspiring student award at the AHA Awards.

Awareness

- Following the approval of 3 new SOP to support practices around dysphagia (Mouth Care, Acute Dysphagia referrals and Eating and Drinking at Acknowledged Risk) the Speech and Language Therapy Department have been rolling out awareness training to support staff and improve outcomes and experience for our patients.

- As part of the psychological model of care project being undertaken across the adult mental health directorate that links with the Community Mental Health Team redesign work, 90 places for frontline staff across the adult directorate have been awarded via HEIW funding.

  Training is applicable to all frontline clinical staff:
  - to provide a relational understanding of trauma and complexity
  - to develop skills in mapping interactions and the relationship between staff and patients
  - to enable reflection on dynamics that staff may get involved in
  - to reflect on how ways of interacting might elicit certain responses

- to consider different ways of responding to achieve a different outcome
- to increase awareness of our own personal relational patterns (what is going on within us)
- to increase awareness of relational dynamics in the team/ organisation (what is going on between us and around us)
- developing a common relational language for understanding interactions on a day-to-day basis to aid reflective practice.

- Previous vacancy rates were over 50% across the adult psychology directorate at the start of 2025.
  This has been reduced to less than 20% through recent successful recruitment.

- Three audiology screeners have now started roles within CTM, following movement of the School Entry Hearing Screening to Audiology, aligning with the pathway set out in the Welsh Health Circular 2021. For the first-year, screening will be undertaken in collaboration with School Nursing team, with full Audiology provision commencing in quarter 3 of 2026.

- As mask wearing is currently mandatory (at the time of preparing this update report) within CTMUHB, audiology have developed and shared communications reminding colleagues of the impact mask wearing can have on individuals who rely on lipreading to communicate and ways in which the negative impacts can be mitigated.

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 UHB has the highest rate of drug misuse deaths in Wales

The annual Public Health Wales report on drug-related deaths was released in December 2025, showing that rates of drug misuse deaths have increased in Wales to 9.7 deaths per 100,000 people in 2024.

Cwm Taf Morgannwg (CTM) University Health Board has the highest rate of drug misuse deaths of any health board in Wales, at 15 deaths per 100,000 people for 2024 – more than 5 extra deaths per 100,000 people compared to the Welsh average.

When broken down by local authority (LA) area, all three LAs in CTM fall into the highest five LA rates of drug-related death across Wales.

- Merthyr Tydfil: 21.2 per 100,000 – the highest rate of any LA in Wales
- Bridgend: 16.6 per 100,000
- Rhondda Cynon Taf at 12.8 per 100,000

All three LA areas remain in the top five rates when looking at three year rolling averages, indicate that this is representative of ongoing trends.

CTM stands out for particularly high rates of deaths involving heroin/morphine with death rates (7.5 per 100,000), more than twice the Welsh average (3.7 per 100,000). Similarly, rates of deaths involving benzodiazepines are higher (5.2 per 100,000), than the Wales average (2.8 per 100,000).

Approximately 58% of individuals were in contact with services in the 12 months prior to their death, and 31% within 1 month. Rapid access to drug treatment services which sustain engagement is key to reducing drug-related deaths.

The full report can be found here: Drug Related Mortality Annual report 2025

Drug-related deaths review project

A project is underway led by the CTM UHB public health team working with the Area Planning Board and the Community Drug and Alcohol Team (CDAT).

A project is underway led by the CTM UHB public health team working with the Area Planning Board and the Community Drug and Alcohol Team (CDAT).

This project has four key aims:

To provide a detailed overview of patterns in drug poisoning deaths in CTM between 2022-2024 and identify opportunities for intervention

To understand the impact of drug-related deaths on the community and services

To review how the learnings from the Western Bay Drugs Commission[1] apply to CTM

To develop a coordinated strategic approach to decreasing drug-related deaths in CTM

The findings and recommendations of this project will be reported back via the CTM Area Planning Board for the prevention of drug-related deaths in CTM with a focus on effective use of data, short term interventions, and long-term system change.

A key area of focus for the project is identifying opportunities to recognise people at high risk of drug-related deaths, especially in the case of non-fatal drug poisonings, where there is potential for preventative intervention.

[1] The Western Bays Drugs Commission was formed in response to the high rates of drug-related deaths in the Western Bays APB area, including Swansea, and engaged with more than 250 people including lived experience and invited experts: Turning the Tide – steering a new course towards hope and recovery

3 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Improving Care
	If more than one applies please list below:

Link to CTMUHB Strategic Goal(s)	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 *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Quality of patient care is at the forefront of improvements and decisions made and individual quality impact assessments are completed at the right time by the right team. This paper is presented for information and noting purposes.

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

4 Recommendation

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

5 Next Steps

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

Agenda Item
5.4.1

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Bradley, Service Director for Primary Care & Community Zoe Ashman, Interim Care Group Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Zoe Ashman, Interim Care Group Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
PCC Quality, Safety, Risk and Experience Meeting	15/12/2025	Noted

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

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

1. Situation /Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience Primary Care and Communities Care Group at its meeting on the 15th December 2025.

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

2. Specific Matters for Consideration

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

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

- Put the needs of patients, carers and the public at the centre of all its business.

- Provide evidence based and timely advice to the Primary Care and Community Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.

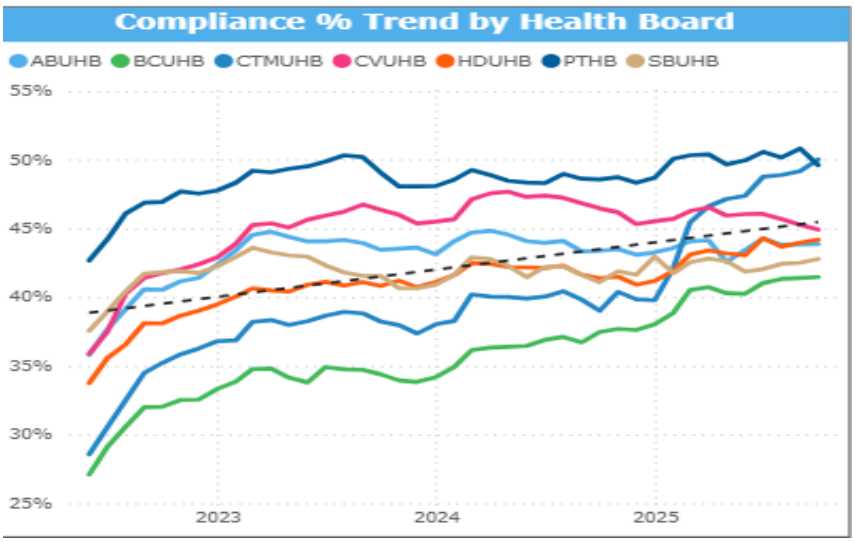
- Provide assurance to the Primary Care and Community Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.

- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

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

3. Highlight Report

Alert / Escalate	**District Nursing** Over the festive period the District Nursing service in Bridgend and Merthyr Localities faced significant workforce challenges due to several absences in the team resulting from maternity leave, long term sickness and circulating flu. This negatively impacted ability of the team to respond to urgent requests. Bank and agency were explored as well as cross cover and redistribution of 'caseloads' but this had limited success. The teams have been prioritising end of life and palliative care patients as well as those on their caseloads. Continuous review of the absences and impact on the service is being undertaken and action being taken to address the issue. **Dental Contract** A new General Dental Service contract is due to be implemented across Wales from the 1 April 2026. The new contract will change how the dental contract is remunerated and the metrics that need to be achieved by practice. Unfortunately, not all dental practices are happy with the changes being made and there is a likelihood that some may choose not to continue providing NHS dental services under the new model from the 1 April but will switch to private dentistry. CTM UHB has already received NHS termination notices from 3 contracts across the CTM area. The practices have a 3-month notice period under their current contract terms and the risk is others will follow, an impact assessment is currently being assessed across the Localities. **Shift Fill for GP OOH/Nav Hub - Risk ID 6397 – Score 16** Due to the ongoing discussions at a national level around the GP OOH contract / worker status the Health Board has had a hold on GP recruitment. This decision has been taken to limit the possible financial risks associated with the contractor status.

	Historically OOH GPs are recruited through 'rotamaster' where they can book 'shifts' they chose to work, sometimes on a short notice and adhoc basis. Many of the experienced GPs do this as they work elsewhere during the day or in the week. The impact of this has been unfilled shifts, especially for the overnight home visiting shifts over the festive period. To mitigate this risk a new process of recruitment has been introduced via Locum Nest. However, this has not proved to have a positive impact as the process is not flexible and does not to suit the needs of GPs. Further work continues to explore recruitment options whilst national discussions concluded. **8 Core Diabetes Processes** Positive news that Cwm Taff Morgannwg is now the best performing Health Board in Wales for completion of All 8 Care Processes at 50.02%. Graph below illustrates improvement made. Merthyr South and Bridgend East are still the poorest of our performing 'Clusters' but assurances have been given by the practices that they are working to improve the position. 
Advise	**Death in Custody – Update** Four deaths have occurred (two in prison, one post-release, and one during temporary home release). One inquest has been completed, confirming a drug-related cause of death, and three further inquests are scheduled between January and March 2026. A new Death in Custody Review Group met for the first time in November to strengthen governance, monitor actions, and ensure lessons learned are implemented. Key priorities include clarifying governance processes, updating the SOP,

auditing health screening compliance, and preparing for upcoming inquests.

Dental Services Parc Prison:
A reduced dental service has been in place for over a year due to there being insufficient accommodation space in the facility to deliver the number of dental sessions required to meet demand. This together with the high demand for urgent care means that the service is only providing urgent care and access to full course of treatment is limited. A second surgery needs to be included in the expansion plans for Parc Prison, but it has recently been decided by G4S that there is no space to fit a second surgery. A joint risk paper is in development between primary care and the Dental provider to inform G4S/HMPPS of the risk if no further space is found for further consideration. This will be considered in early January 2026.

Cessation of Cellulitis Service
Notice is being served with effect from the end of March 2026 to the cellulitis service delivered by the National team. This was originally funded by the Value Based Health Care Programme up to the end of March 2025 since this time it has not been funded but continues to deliver in community venues. Plans are being made by the Care Group to mitigate the loss of this service and this will involve patients being absorbed into the core community nursing service. An assessment of skills is being undertaken to assess the nursing skills and core competencies and implementation of a training programme.

Consent for Flu process change in Schools
A new process was implemented within Schools by the School Nursing Team where consent had to be provided 48 hours in advance of a school flu appointment. This was introduced without consultation with the Health Protection Operational Team or Public Health Colleagues. An unknown number of children presenting in school, with consent, and were turned away, despite vaccines on site. To mitigate this, children will be picked up by the central CVC team. The Health Protection Operational Team are now liaising with School Nursing Colleagues to re-visit the schools with the highest numbers and utilise the new Mobile Outreach Unit.

Welsh Immunisation System (WIS 2.0)
A new clinical recording system was launched 1st September 2025. The new platform has had several performance bugs including a problem with the expected write-back of Flu, Covid & RSV vaccinations into Primary Care (EMIS & Vision) as well as

	the Child Health system (CYPRIS). These issues have been reported back to DHCW for urgent resolution. There have been concerns relating to stock limitations and inconsistencies in recording stock levels and twice-daily fridge temperatures. These issues have also been reported across other Health Boards and escalated by the Directors of Primary Care and Mental Health centrally. **Parc Prison** Operational Staffing and Estate Challenges which are due to fluctuations in staffing and regime changes continue to impact healthcare resource allocation and service delivery. To mitigate this, the Care Group is working with G4S to explore wing-based medicine administration, reducing reliance on healthcare runners. A pilot initiative will engage Peer Step Mentors to remind prisoners of appointments, collect disclaimers from those unwilling to attend, and provide feedback to improve scheduling and communication.
Assure	**Comprehensive Special Dental Care – Risk 5416** There are 27 patients in system awaiting dental care. This service has now been given an all-day theatre list once per fortnight in PCH since the beginning of December 2025 and the positive impact on waiting list is already being seen. Alongside this waiting list discussions have taken place to repatriate this service from Cardiff & Vale (C&V). It is anticipated that the service will be transferred back to CTM in January 2026. *This risk has therefore been de-escalated from level 16 to 12 but will continue to be reviewed.* **Paediatric GA Risk 5417** There are approximately 466 children on the waiting list for a General Anaesthetic Assessment (GAA). The Care Group has been escalating the growing backlog Paediatric GAs as a risk for several months, but assurance can be given now that the additional theatres are now up and running and this is having a positive impact on the waiting list. *The risk has been reduced from a 20 to a 12 but will continue to be reviewed.*
Inform	**Policy on the Venepuncture Pathway** A clinical policy covering venepuncture pathways between the Navigation Hub to the Hospital@Home service was considered and in principle supported pending full completion of the documentation. **YCC Ward 5:** No update is available as the funding has yet to be identified for the recruitment of the nursing establishment together with associated costs of facilities etc.

Parc Prison: expansion Plan HMPPS and G4S have secured planning permission to expand the prison's capacity by an additional 345 individuals by October 2028. The Care Group is in the process of finalising a workforce plan which will be required to support the additional Prisoners for submission in the first week of January 2025.

Planned HIW visits to GP Practices

Foundry Town – 8th December 2025

New Surgery Pencoed - 11th December 2025

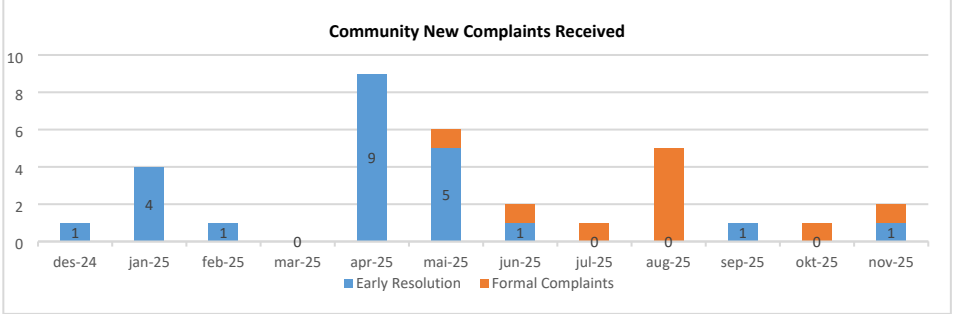
HIW Visits & Dental Practice Advisor (DPA) Support Visits:

The Primary Care Team have established a rolling DPA support visit schedule to visit those practices that have not had a HIW in the last 5 years. DPA support visits provides assurance that practices are providing quality care in safe environments if HIW have not inspected within the required timeframe. To date during 2025/26 the DPAs have visited 8 practices.

Type of visit	Scheduled	Completed	Remaining
DPA	18	10	8

Common themes identified:
IRMER policy, audit, checklist
RADAN registration
Midazolam Policy updates / dosage instructions
Audits (smoking cessation/MMD/SOSET)
Resus face masks / policy updates
Welsh language standards/ active offer
Complaints policy updated to include Llais

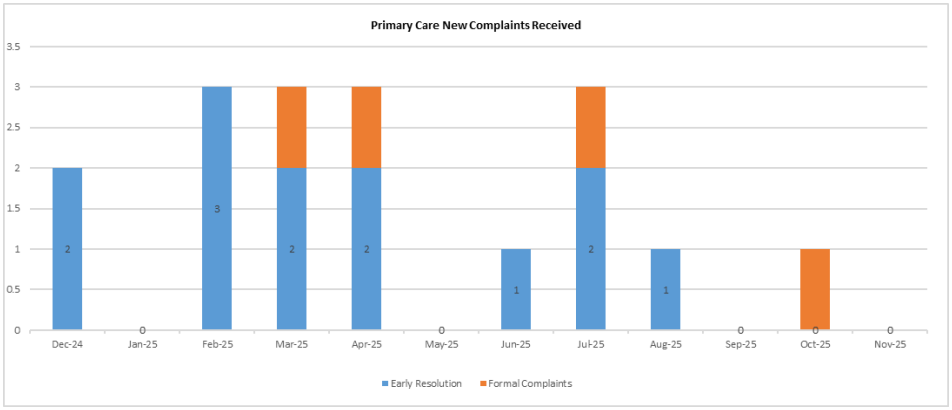
Headline Governance Information
Community



For the reporting period as at November 2025 the governance sit rep is as follows:

Community
New complaints received -2 (1 ER and 1 Formal)
Inquests – 9 open and 2 new added. 3 inquests concluded in November.
Open Redress Cases: 28
Personal Injury 0
Clinical Negligence 0
RIDDOR Incidents reported 0
Never Events – 0
Open Nationally Reportable incidents – 0
Nationally Reportable Incidents reported – 1
Falls Incidents – 38
Pressure Area Incidents - 243

Primary Care



Complaints received – 0
Enquiries received – 4
Incidents reported – 24 (22 of which patient safety and 1 non patient safety and 1 total organisation incident)
34 incidents closed in November
RIDDOR Incidents – 0
Nationally Reportable incidents – 0
Open Nationally Reportable incidents - 0
Never events – 0
Falls incidents – 0
Pressure Area Incidents – 4
Open Redress Cases - 2
New Inquests Received – 0
Total Number of Inquests Open - 2

Parc Prison (reported separately)

	Open Incidents - 74 Incidents with status of 'awaiting closure' - 8 A meeting date set with GP colleagues on 16th January 2025 to review and close the 12 GP Medication incidents. Open ER's – 16 Formal Complaints (managed under PTR)
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 *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies, please list below: Culture and valuing people Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies, please list below: Efficient, Person centred, Equitable, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies, please list below:

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

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

5. Recommendation

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

Agenda Item
5.4.2

Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Hannah Wilton, Director of Pharmacy and Medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AHP	Allied Health Professionals
CDs	Controlled Drugs
CT	Computed Tomography
DHCW	Digital Health and Care Wales
DI	Designated Individual
DRL	Diagnostic Reference levels
DTPS	Diagnostics, Therapies, Pharmacy and Sciences
FUNB	Follow Up Not Booked
HB	Health Board

HTA	Human Tissue Authority
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
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 and Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 15th December 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 DTPS 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 DTPS 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**
	LIMS2.0: The Programme remains in RAG Status Red.
	• Tranche 1: Sign off, data migration (legacy data) has been completed by Health Boards.
	• Tranche 2: Cellular Pathology go live, originally planned for Dec 2025, has been pushed to 9th Jan 2026
	  ○ National User Acceptance Testing (UAT) sign off by CTM has been completed.
	  ○ Next step is for Health Boards to test the system locally in the live LIMS environment
	  ○ Final go live is dependent on resolution and testing of an outstanding defect.
	• Financial implications and risk, in relation to extending the current LIMS beyond product end of life and support, has been shared with the Health Boards.
	• CTM teams remain focussed on delivery of Cell Path in Jan 2026
	
	Healthcare Science
	Neurophysiology
	Deficit continues between demand and capacity, with backlogs continuing to rise for both testing and reporting, which has been further exacerbated by HSC (external company) onboarding work, with higher rates of conversion than expected from neurology to neurophysiology. Plans to increase neurology consultant capacity within the HB is also expected to increase activity and consequently waiting times.
	Planned Care Recovery funding is currently being utilised to hold additional weekday clinical sessions to increase activity.
	Further mitigations in the form of outsourcing activity could rapidly reduce current waiting lists. Currently a procurement exercise is underway with the intention of holding additional weekend sessions in Q4. Dates will be confirmed once the contract is awarded.
	
	Radiology
	
	Radiology-supported endoscopy services at PCH have been temporarily suspended because of critical faults in the endoscopic equipment at RGH. This has required transfer of equipment to RGH site to satisfy demand. Consequently, the service has been reconfigured, with procedures redirected to alternative sites. Inpatient cases are now being managed at RGH using equipment transferred from PCH, while outpatient activity has been relocated to POW. This reconfiguration has reduced overall service capacity, which may impact access and lead to longer waiting times. A capital

	bid to replace all faulty equipment and restore the service at PCH has been submitted to Welsh Government, and an update is awaited. There is currently an insufficient number of support staff at HCSW Band 2/3 level, and a staffing review is underway to mitigate this risk, including the introduction of fixed term posts. This shortage has a significant impact on the ability to provide ultrasound services, particularly due to the requirement for chaperones during intimate examinations. **Medicines Management** Pharmacy fridge temperature monitoring auto-dialler not working. Within hours, the fridges are constantly monitored by the team so there is no risk; out of hours, the lack of auto-dialler function means no alerts would be raised in the event of temperature deviations. There is no risk to patient safety, as deviations would be picked up in working hours and appropriate action taken to dispose of or adjust expiry dates of stock. However, there is significant stockholding of significant value. Therefore, the risk register updated to 16 to reflect the increased risk. An interim solution in place to alert the on-call pharmacist via email, and work continues with the external provider to ensure a permanent solution is in place ASAP.
Advise	**Radiology** **RGH MRI – lone working concerns received by HIW** Current MRI staffing consists of one radiographic assistant (9am–5pm) and two Band 6 radiographers (7:30am–8pm) covering both scanners operating seven days a week. Despite a review and mitigation efforts, patient safety risks remain due to remote waiting areas and limited emergency response capability. Plans to relocate the MRI booking desk and create an adjacent waiting room are underway, with construction expected to finish by May 2026. A vulnerability assessment highlighted the absence of cardiac arrest and affray alarms, which will be addressed in future builds. Business cases for additional Band 6 Radiographers and support staff are pending review; however, budget constraints mean only three extra assistants can be recruited from the clinical budget for coverage from 7:30am–8pm daily. Current support worker resources remain focused on ultrasound lists. **Pathology** **Cellular Pathology – Transfer of reports from outsourcing**: currently all reports received from the outsourcing company are manually transferred from the results portal to the Pathology system. This has resulted in incidents where reports have been incorrectly

transcribed, and the risk score has been increased to reflect this. Cellular Pathology is currently working with the outsourcing company to implement an automated solution which will enable results to be electronically transmitted directly to the pathology system. Implementation of this system cannot commence until post-LIMS implementation. In the interim, incidents are being monitored to support assessment of the current risk and all possible actions are being taken to minimise the risk of error.

Microbiology Respiratory Testing:
Currently the CTM Microbiology department only has capacity to deliver the respiratory testing service between 8am-10pm, this is due to insufficient staff resource to support a 24/7 service. At present, there is no overnight emergency respiratory testing available, leading to delays in testing and potential impact on patient flow. There is a long-standing risk recorded in relation to Microbiology staff resource which has now been escalated in light of the increased incidence of flu throughout the Health Board.

Assure

Medicines Management

CD audits: Target= 100%. Current figures for completion of CD audits are:

	RGH	PCH	POW	YCR/YCC
Current compliance with CD ward Audits %	**94**	**100**	**100**	**100**
Previous months compliance %	97	100	82	YCR 100% YCC 85%

AMaT team building dashboard to assist with planning and reporting on compliance. Not yet finalised

Pathology

Community Body Stores

On 3rd November, a pilot commenced transferring management of Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon body stores to the Mortuary department management, supported by facilities and nursing colleagues. This is in line with Welsh Government recommendations following the publication of the Fuller Report. The pilot is now live and will be reviewed in April 2026 to ensure Mortuary policies and procedures have been effectively embedded.

Medical Examiner Service (MES) QR Code:
New MES Regulations came into force in September 2024, whereby all non-coronial deaths are now independently scrutinised by the Medical Examiner Service. This has resulted in a number of

administrative changes to the death certification process, leading to delays in death certification and increased length of stay for the deceased (impacting Mortuary capacity). CTM has developed and launched a local QR code in October 2025, which supports improvements in the death certification process by enabling the qualifying attending practitioner to nominate suitable colleagues to complete death certification. This has had a positive impact in some areas and improves data capture to help understand where delays occur. However, there are still some areas of concern around delays in completing actions and so work continues to address these.

Infected Blood Inquiry: implementation of recommendation 7e – implementing SHOT reports:

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

Following on from the report, the Serious Hazards of Transfusion (SHOT) Transfusion Safety Standards were introduced July 2025. Health Boards were tasked with completing a gap analysis to the standards and submitting to the Blood Health National Oversight Group (BHNOG) by31st December 2025.

The Gap analysis has been completed for CTM and is either compliant or partially compliant (improvements could be made) for the majority. There were 2 areas of non-compliance, and these were in relation to

- Paediatric and neonatal transfusion training: although transfusion training is provided to staff working in paediatrics, there is currently no evidence of specific training in relation to the requirements for paediatric patients. The transfusion team will undertake a benchmarking exercise to understand how this is achieved in other health organisations and initiate discussion with CTM Paeds Teams to determine how we can take this forward in CTM.
- Support & education for patient partners: there is currently no evidence of Health Board policies/procedures in place in relation to provision of appropriate support and education for patients involved in co-production. This has been discussed at the people's experience group, and a side meeting will be arranged to discuss what is in place in different areas throughout the HB. Organisational support may be needed if there is a requirement for policy development.

An action plan has been developed with the objective of meeting full compliance by December 2026; fortnightly meetings have been arranged with the Transfusion Team to monitor progress.

Radiology

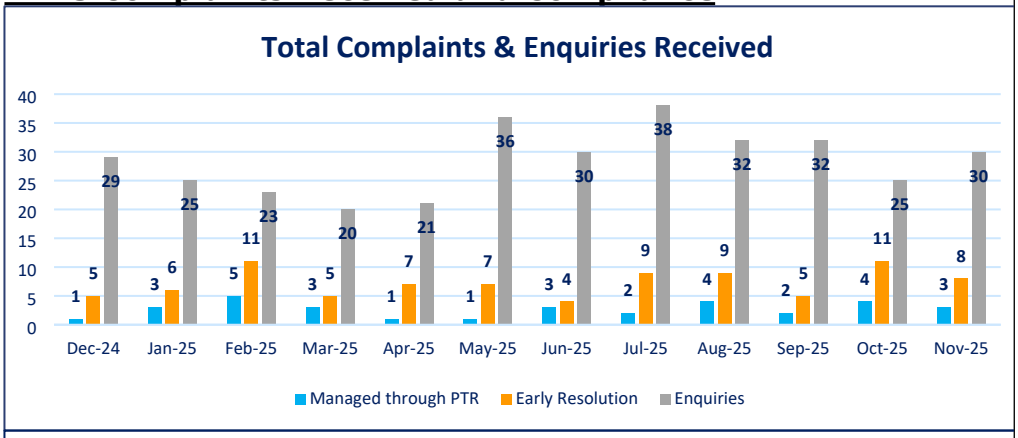
The Radiology Information System Programme (RISP) is progressing well, with a cross-section of staff having completed Super User training in preparation for implementation in March 2026.
A meeting with Simply Do is scheduled to engage frontline staff in developing service improvement projects.
Additionally, a Radiology IPC Audit has been developed, and results are being submitted on AMaT. Initial findings show positive results at POW while audit results for PCH and RGH are awaiting submission.

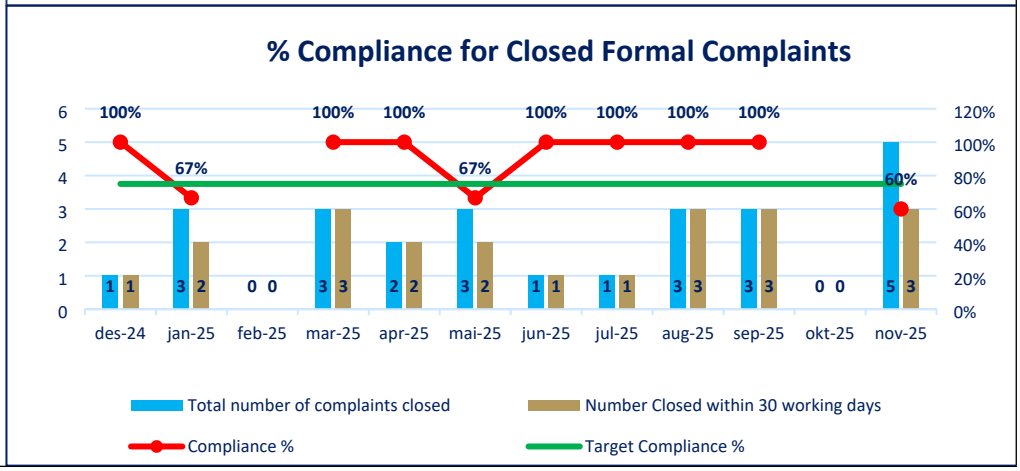
Allied Health Professionals

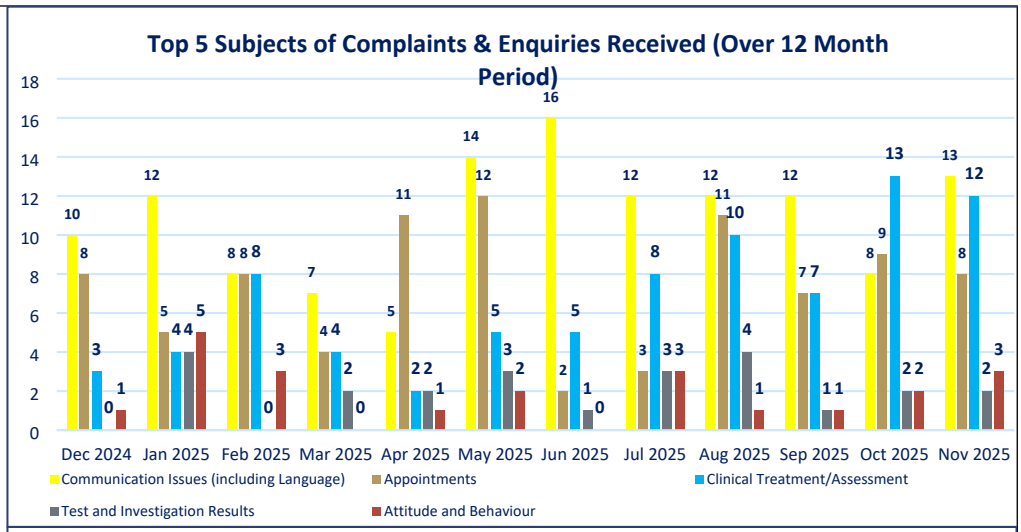
- Following the approval of 3 new SOPs to support practices around dysphagia (Mouth Care, Acute Dysphagia referrals and Eating and Drinking at Acknowledged Risk), the Speech and Language Therapy Department have been rolling out awareness training to support staff and improve outcomes and experience for our patients.

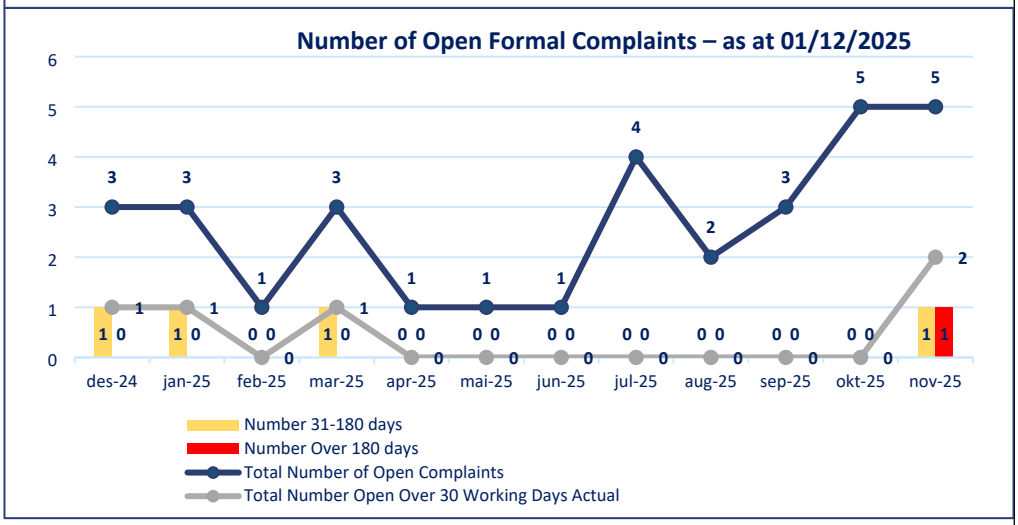
Inform	**<u>Radiology</u>** The POW mini-C-arm IR(ME)R employer procedures are currently under review. During this process, issues have been identified around legislative compliance with IR(ME)R, particularly concerning clinical audit, entitlement and consent. These challenges are being addressed collaboratively, with a deadline for completion set for the end of January 2026. **<u>Pathology:</u>** Pathology SimplyDo challenge was launched in October/November focussing on specimen receptions, where there is the highest incidence of error. The challenge has allowed frontline staff to provide ideas and innovations to help make improvements to workflows, communication and their work environment, with the goal of reducing the number of errors, and leading to improvements in patient care. The challenge has now closed: some ideas have already been implemented, many of the ideas will require additional support and planning, but all feasible ideas will be taken forward. In terms of benefits analysis, it is expected that there will be a decrease in the number of specimen reception incidents reported. This data will be collected to evidence impact of the project. **<u>Allied Health Professionals</u>** The AHP Community Rapid Access and Admission Prevention Service Model won the AHA Cymru 2025 Award for New Ways of Working.

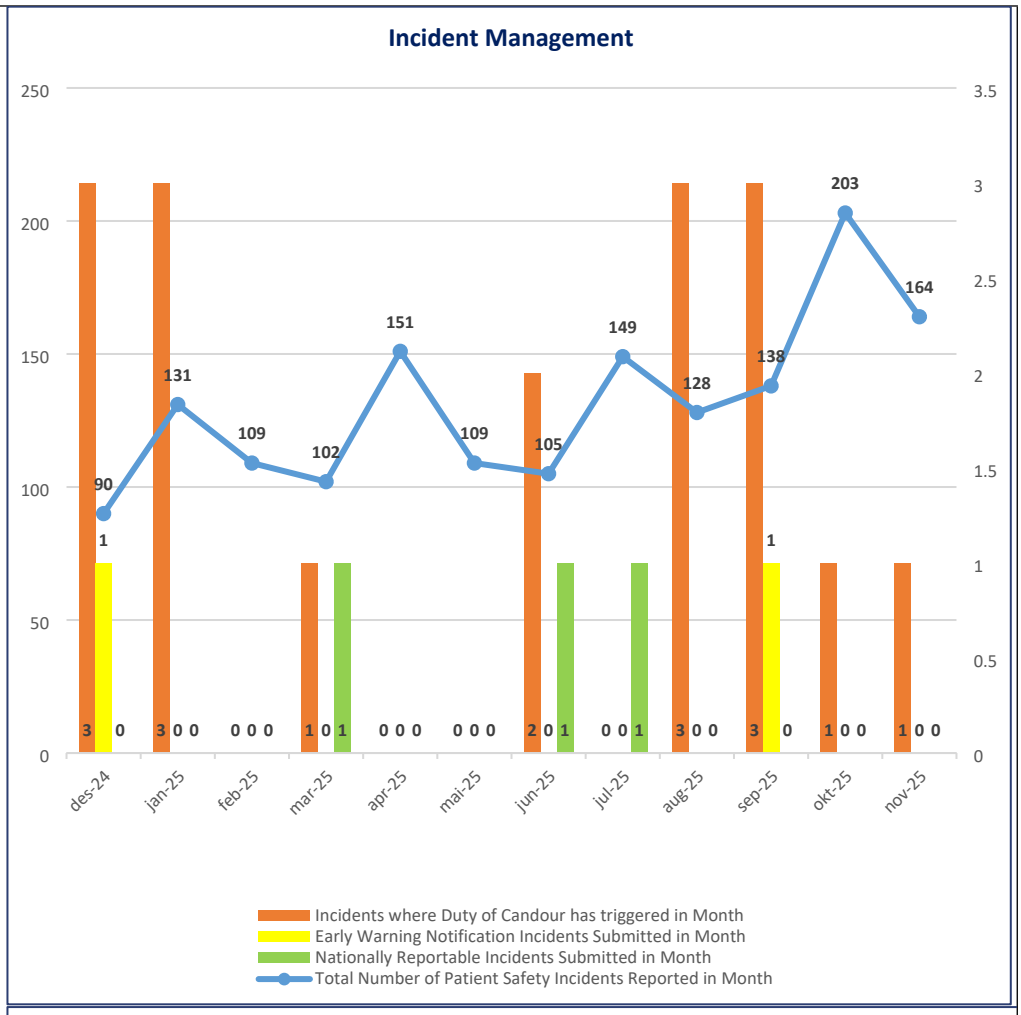
DTPS Complaints Received and Compliance

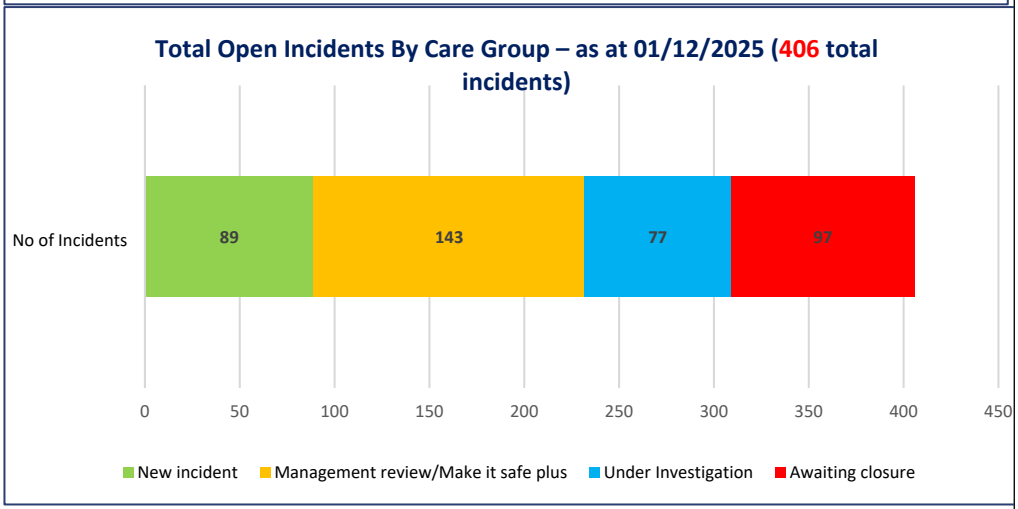


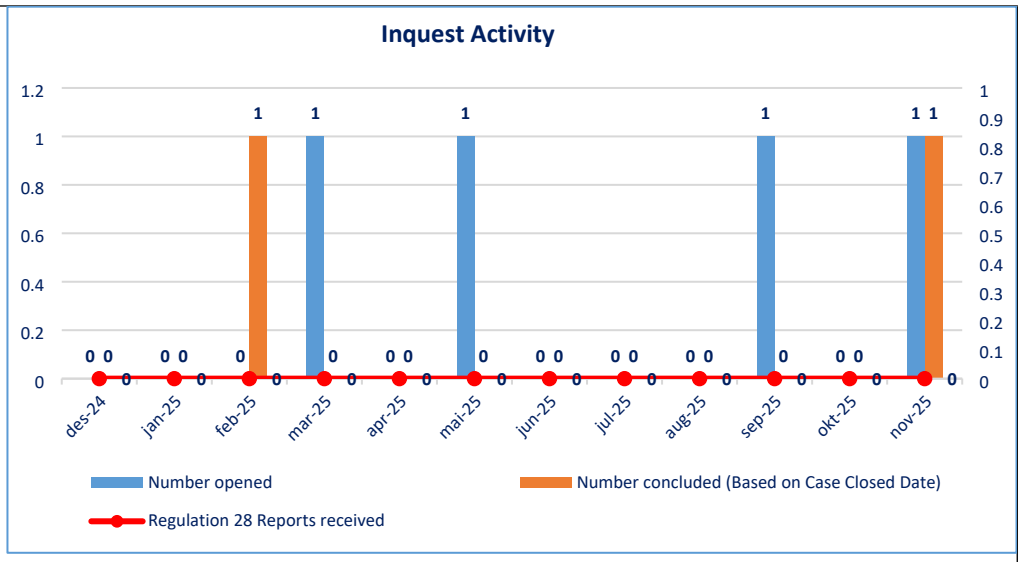



Top 5 Subjects of Complaints & Enquiries Received (Over 12 Month Period)
Dec 2024
Jan 2025
Feb 2025
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
Sep 2025
Oct 2025
Nov 2025
Communication Issues (including Language)
Appointments
Clinical Treatment/Assessment
Test and Investigation Results
Attitude and Behaviour


Number of Open Formal Complaints – as at 01/12/2025
des-24
jan-25
feb-25
mar-25
apr-25
mai-25
jun-25
jul-25
aug-25
sep-25
okt-25
nov-25
Number 31-180 days
Number Over 180 days
Total Number of Open Complaints
Total Number Open Over 30 Working Days Actual


Incident Management
250
200
150
100
50
0
3.5
3
2.5
2
1.5
1
0.5
0
90
131
109
102
151
109
105
149
128
138
203
164
3 0
3 0 0
0 0 0
1 0 1
0 0 0
0 0 0
2 0 1
0 0 1
3 0 0
3 0
1 0 0
1 0 0
des-24
jan-25
feb-25
mar-25
apr-25
mai-25
jun-25
jul-25
aug-25
sep-25
okt-25
nov-25
Incidents where Duty of Candour has triggered in Month
Early Warning Notification Incidents Submitted in Month
Nationally Reportable Incidents Submitted in Month
Total Number of Patient Safety Incidents Reported in Month


Total Open Incidents By Care Group – as at 01/12/2025 (406 total incidents)
No of Incidents
89
143
77
97
0
50
100
150
200
250
300
350
400
450
New incident
Management review/Make it safe plus
Under Investigation
Awaiting closure



Appendices	

3. Assessment

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

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

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

4. Recommendation

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

Agenda Item
5.4.3

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths Interim Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths Interim Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AMAT	Audit Management and Tracking system
CMHT	Community Mental Health Team
CTM	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
CVUHB	Cardiff and Vale University Health Board
IMTP	Integrated Medium Term Plan
IT	Information Technology
LPMHSS	Local Primary Mental Health Support Service
MHA	Mental Health Act
MH	Mental Health
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
SHED	Service for High Risk Eating Disorders
SLT	Senior Leadership Team

1. Situation /Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the MHLD Care Group at its QSE meeting on 03/12/2025.

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

2. Specific Matters for Consideration

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

2.2 The MHLD Care Group QSE Board will:

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

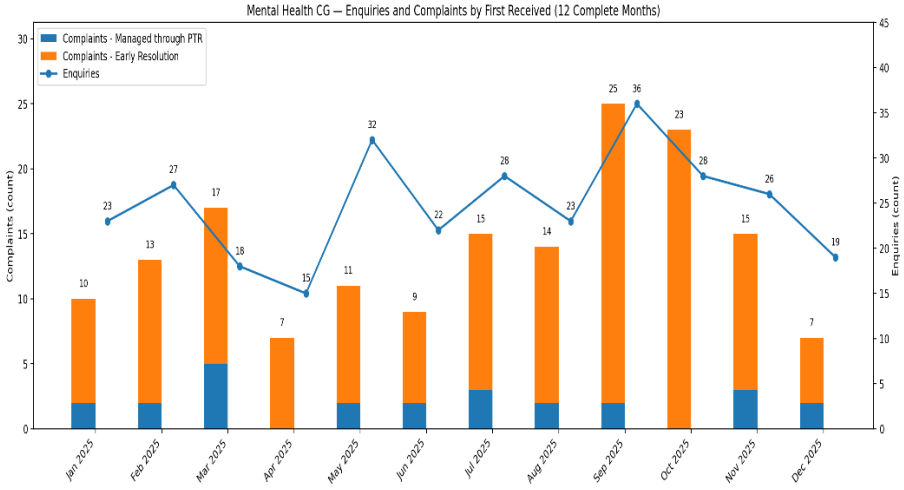
3. Key Risks / Matters for Escalation

Alert / Escalate	• The Local Primary Mental Health Support Service (LPMHSS) provides assessment, brief psychological interventions, advice, and signposting for individuals presenting with mild to moderate mental health difficulties. The service delivery requires a consistent team of administrative and business support staff, however, current staffing shortages have resulted in a marked operational deficit. In the short term the Care Group are continuing to monitor the mitigations implemented to ensure the service remains safe, prioritised, and clinically effective until full staffing

	establishment is restored, in weekly meetings between the Directorate and Care Groups SLTs. The Directorate are presenting a proposal to the next MHLD OMB to correct the operational deficit and clear the backlog of people waiting for psychological interventions.
Advise	• Medical staffing remains fragile across Adult MH services and has been added to the organisational risk register with a score of 16, this has been compounded by recent professional issues highlighted in the previous paper. The Care Group has implemented robust mitigation to manage medical staffing and ensure the wards have senior medical cover. • CTM commissions the Tier 3 Eating Disorder Service (SHED) from Cardiff and Vale University Health Board (CVUHB). The CVUHB service is currently experiencing significant and sustained operational pressures, characterised by high levels of staff sickness and multiple vacancies. As a result, the service is unable to deliver the full scope of specialist provision which presents clear clinical risks for the small cohort of CTM patients. The Care Group has met with CVUHB colleagues and implemented a series of mitigating actions including, a temporary appointment of a nurse practitoner, drop in clinics, physical health monitoring and staff training. • 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. The in-house training ended in March 2025 to maintain training compliance the Care Group continues to spot purchase individual courses. The procurement of an external provider is nearing the later stages and a provider has been identified, a sustainable programme of training should be in place in the coming months when the formal contract is issued.

Assure

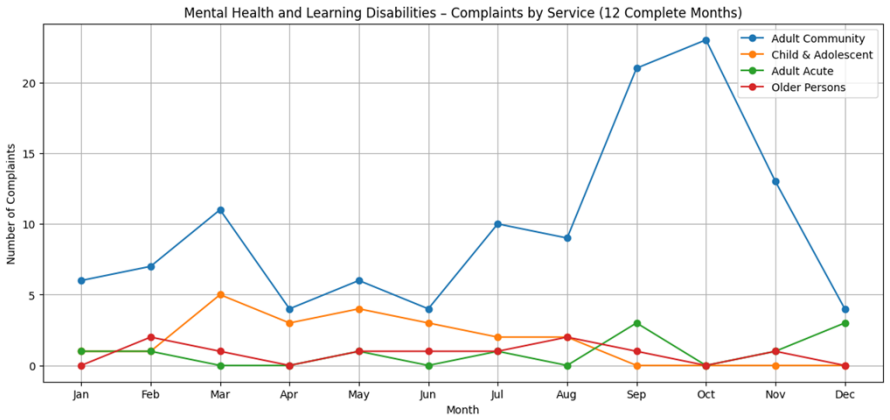
- The number of complaints received by the Care Group during this reporting period (15 in November, and 7 in December) was lower than the 2 year monthly mean of 18. The vast majority of complaints were managed through the Early Resolution process with the number of formal complaints received during this period (5 in total) being lower than the monthly mean of 5.



The top 3 subject areas for complaints and enquiries have remained consistent over the past 12 months;

1. Clinical Treatment/Assessment
2. Communication Issues
3. Appointments

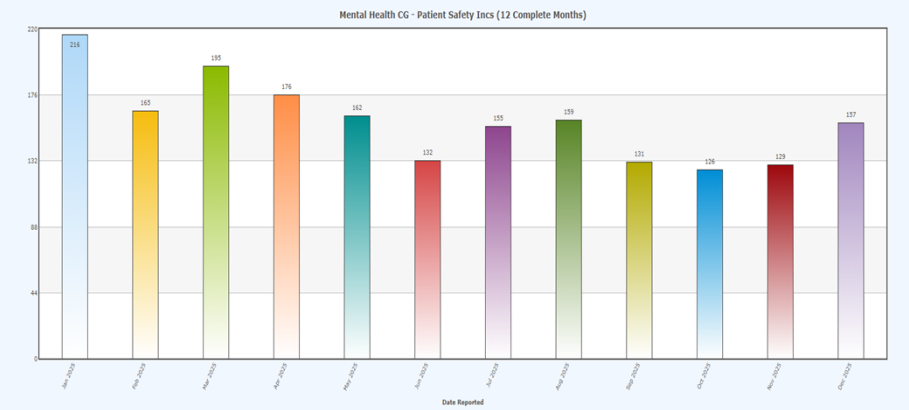
The graph below shows the directorate breakdown of complaints. The Adult Community Directorate has the highest number of complaints, however this is to be expected as it is the directorate with the largest number of service users in areas such as outpatients and LPMHSS. The spike in complaints in September and October 2025 is directly linked to the administrative and business support staff challenges that have been highlighted in previous reports to committee. It is pleasing to note that these are now returning to within the mean due to the mitigation actions implemented.



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

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

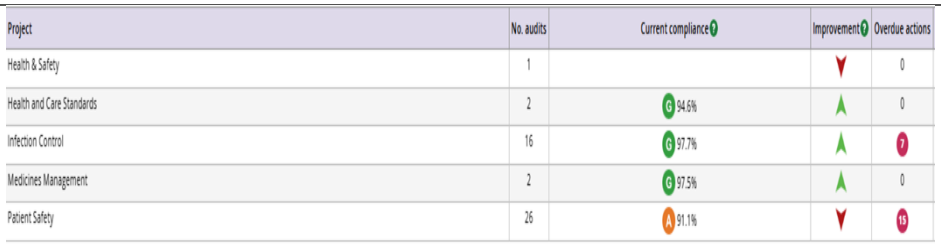
- The Datix incidents reported this period, 129 in November and 157 in December are lower than the 2-year mean of 198 per month and lower than the last reporting period.



- There are 3 open NRIs which is consistent with the 2-year mean. All of these are overdue but are in the final stages of approval.

  There were no new NRIs reported during this period.

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

	 The overdue actions have gone down from 34 to 22. Of the 22 14 are RAG rated green with 3 RAG rated as amber and 5 as red, all 5 relate to CTP compliance. Performance against these audits is monitored in the individual directorate's QSE meetings. • The Care Group continues to run a programme of quality assurance reviews which are coordinated by the Senior Nurse of Quality Assurance and Improvement and are designed to replicate HIW inspections. They also offer staff the chance to experience a process similar to a Healthcare Inspectorate Wales (HIW) inspection, helping to build confidence and prepare for future assessments. Additionally, these reviews enable early identification of quality and improvement needs within community and inpatient settings.
Inform	• In December the Chief Nursing and Medical Officers visited Ty Llidiard, they toured the unit and met staff and young people. They gave positive feedback on the impact and sustainability of the improvement work at Ty Llidiard. • In November the leadership team in the OPMHS Directorate attended a leadership and problem solving study day facilitated by the British Army. • Maesteg CMHT held a Christmas party with lunch for the people who use their service and their carers.
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:
	Ageing Well

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:

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

5. Recommendation

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

Agenda Item
5.4.4

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
STAR	Surgical, Trauma Acute Rehabilitation
OMB	Operational Management Board
ODP	Operating Department Practitioner
DTPS	Diagnostics, Therapies, Pharmacy & Scientists

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience meeting on 15th December 2025.

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

2.1 Purpose of this Meeting

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

2.2 The Planned Care/Surgery QSRE Group will:

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

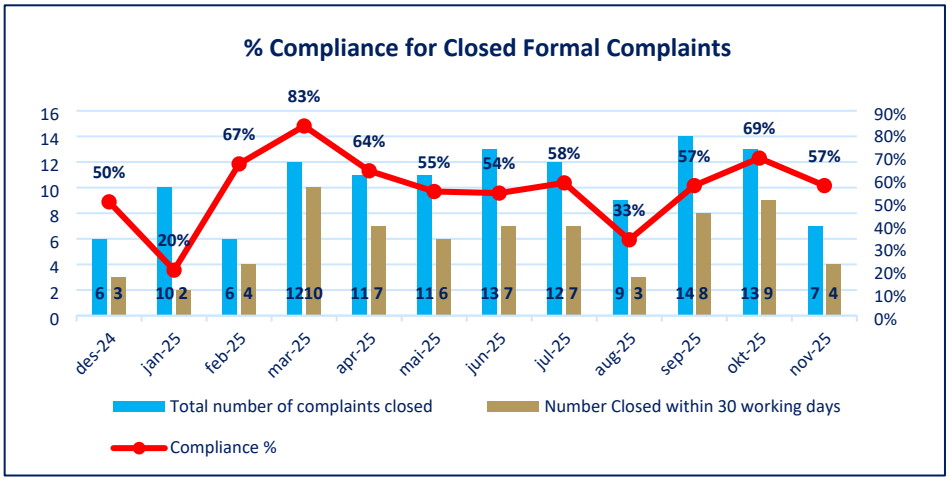
3.0 Highlight Report

Alert / Escalate	Laser Protection Officer (LPO) for Princess of Wales Hospital (POWH). • Planned Care Group are working with DTPS Care Group to ensure allocated LPO cover at POWH Trauma demand in the Royal Glamorgan Hospital (RGH) • Inpatient trauma demand across RGH. Resulting in a high number of trauma outlier patients on surgical wards impacting on surgical flow. • Reduced community rehabilitation capacity and local authority placements impacting on discharges. Mitigation • Care Group plan to run Big Room event with all key stakeholders involved in a trauma patient journey in January to follow patient pathway, constraints and challenges to then enable a 'optimal fortnight'.

- Orthogeriatric in-reach service in RGH has commenced. Team consists of an Orthopaedic Registrar, Orthogeriatric Consultant and Advanced Clinical Practitioner (ACP).
- Additional ACP appointed onto the STAR ward in POW to support patient rehabilitation.
- Care Group Directors from Planned Care and Therapies leading Boardrounds over the WG sprint fortnight initiative.

Advise

Concerns

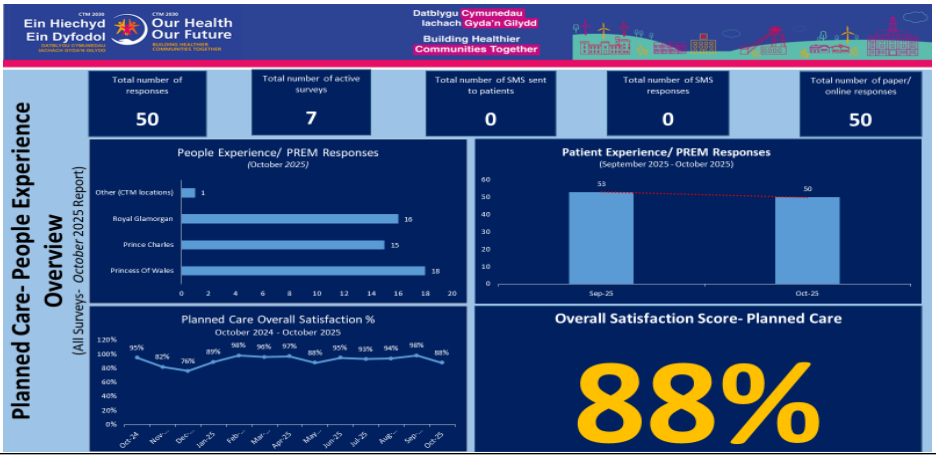


Themes

- Waiting list times in Trauma & Orthopaedics (T&O)
- Adherence to clinical pathways for transfers

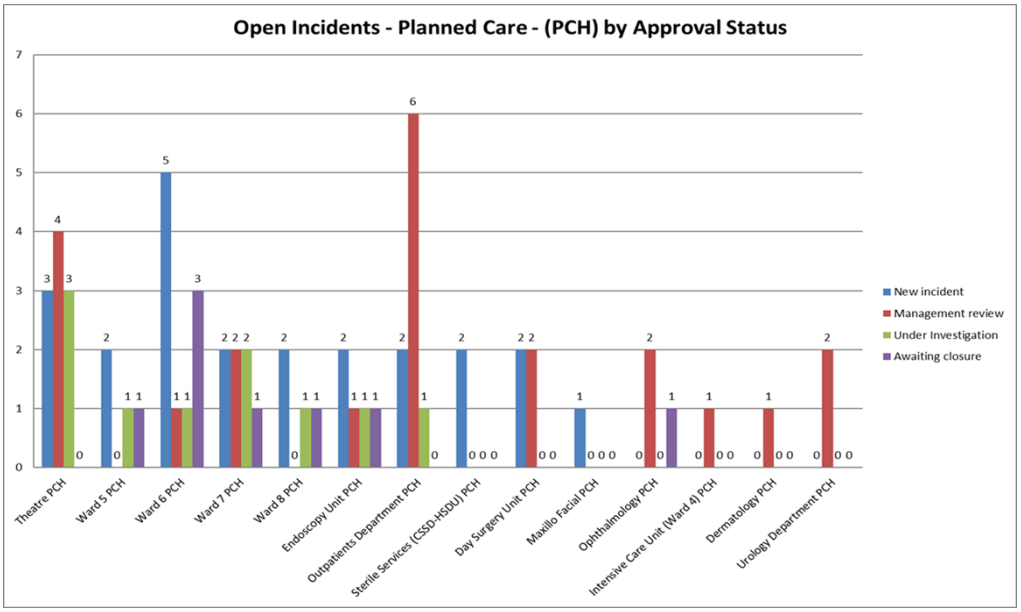
Newly appointed Lead Nurse for Concerns commenced in role December 2025. Key areas of focus initially are Early Resolutions within T&O.

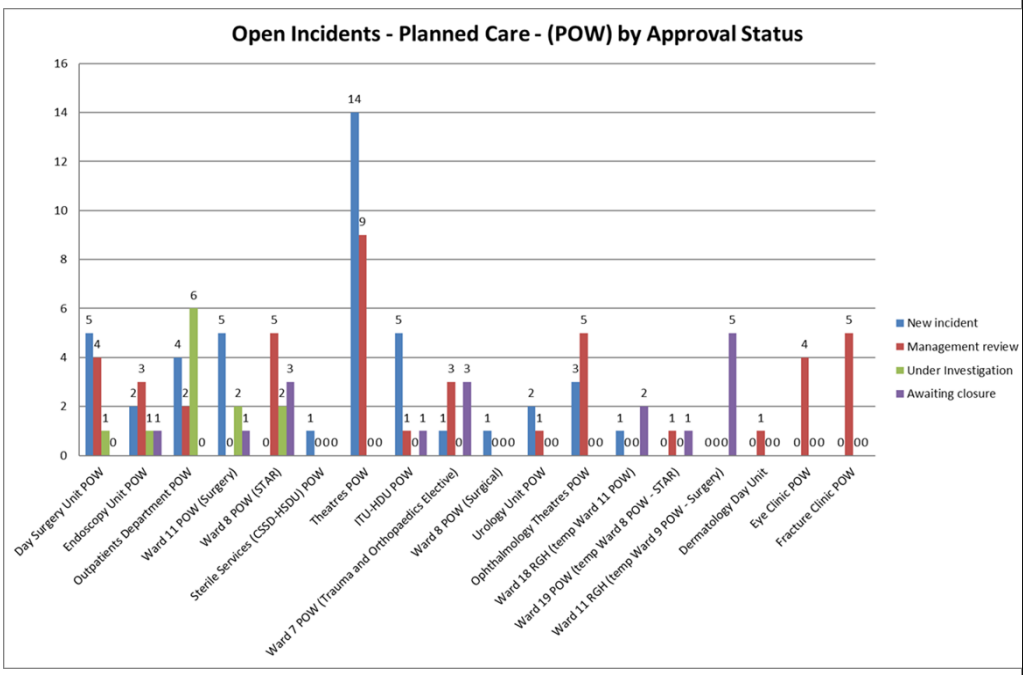
People's Experience (October 2025)



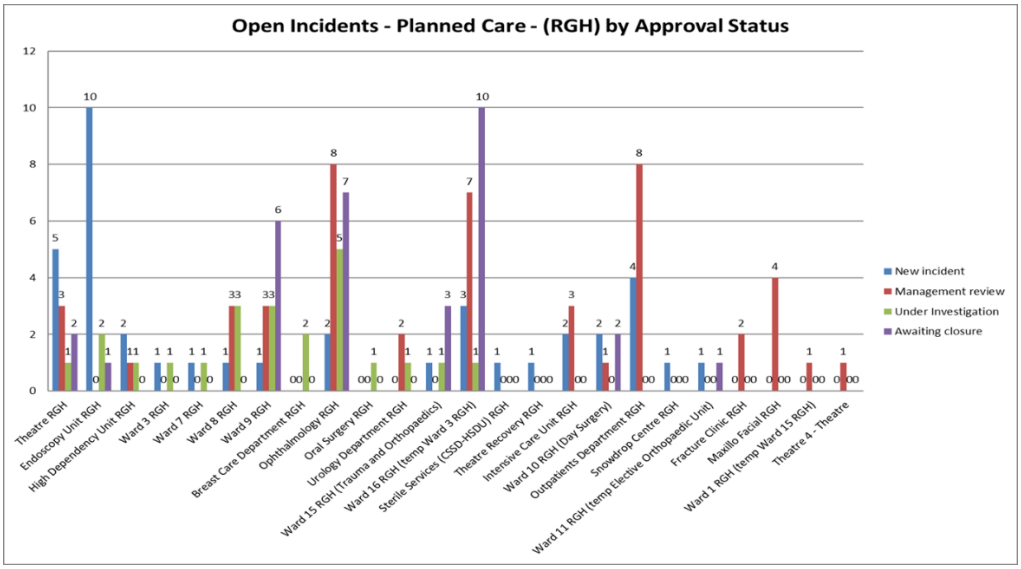
Incidents

Summary of Planned Care Incidents by hospital site (Nov 2025)



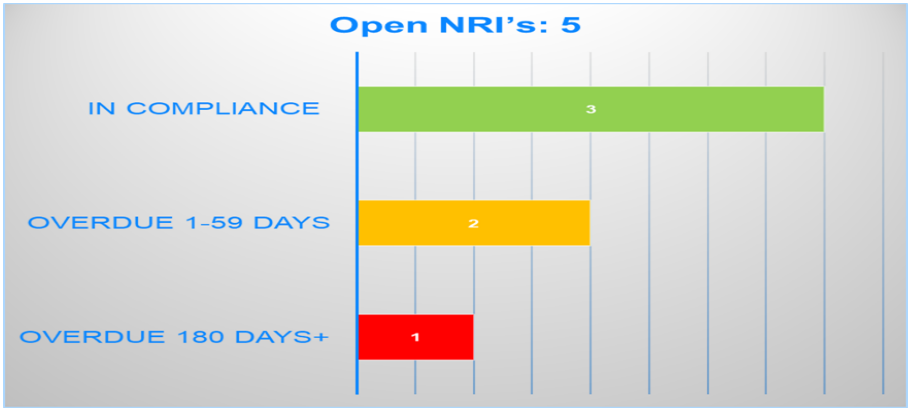


Theatres in POW high number new incidents relating to estates and newly installed air handling units in theatres. Ongoing communication with the air handling unit company and estates regarding monitoring and ensuring compliance with national standards.



Ward 16 in RGH, ward manager is not on the ward therefore senior nurse has a plan in place to support the review of open incidents and incidents that are awaiting closure.

Nationally Reported Incidents (NRI)



- 180 days Overdue case has been reviewed and approved by Planned Care and is waiting Pharmacy Approval.
- 1-59 days overdue, one is waiting Executive approval and the 2nd is waiting on finalisation of a member of staff's statement

Critical Care

- New Senior Nurse has been appointed from early January 2026 into Critical Care in RGH.
- Demand and Capacity data mapping is being undertaken in RGH to ensure right bed numbers to meet demand.

	• CTM UHB Critical Care Surge Capacity has also been created to support this work and has been approved via Care Group Q&S Committee and CTM UHB OMB. Theatres & Recovery • All Wales Band 2/3 job description validation has commenced in CTM UHB with Theatre & Recovery being the first cohort of staff to be reviewed. • Due to large amount of change in relation to Speciality surgery and theatre activity on all 3 sites, a theatre workforce mapping exercise is being undertaken to ensure right ODP and Scrub Practitioner workforce on each acute site to support these changes. • Theatre refurbishment is ongoing on the RGH site. Continued use of Vanguard theatres to support this and enable full theatre activity to be delivered. Specialist Services. Glaucoma diagnostics hub at Ysbyty Cwm Cynon being created. Workforce posts out to advert. All equipment has been delivered.
Assure	Arthroplasty 7 day working model commenced in POWH from the 13th December until March 2026 using Bridgend Clinic for the weekend operating lists. Aiming to have 0 patients on 104 week waiting times by March 2026. ➢ 343 cases performed in POW since 1st September of which: ➢ 134 hips average length of stay 2.86 days ➢ 148 knees average length of stay 2 days ➢ 10 shoulders average length of stay 1.1 days Plan to create an elective arthroplasty enhanced care bay on Ward 7 (elective arthroplasty) in POW to deliver enhanced care to patients post operatively reducing the demand into HDU at PoW. **Single Cancer Pathway Diagnosis and Treatment Performance** CTM UHB 1st in Wales in Sept 25, with the highest number of patients starting their first definitive treatment in month within 62 days of first suspicion and CTM UHB was 2nd in Wales in October with the best performing services being Dermatology and Breast during these months. **Insourcing Outpatient (OP) Clinics Weekend Activity**

	Between September 2025 to December 2025 11,189 patients within CTM UHB have attended their OP appointments over the weekends for review, assessment and treatment in the following specialties: • Ear Nose & Throat • Orthopaedics • Ophthalmology • Urology • Gynaecology • Dermatology • Gastroenterology • General Surgery • Cardiology Following these appointments 4149 patients have now been discharged from further OP clinics. 13,000 patients remaining to be seen between January 2026 and March 2026
Inform	• STAR ward (ward 8 in POW) manager, has implemented a 'How to guide' for documenting correct mattress selections and presented in POW ward managers meetings, and this has now been embedded across the site. • Trauma coordinator for PCH has been appointed and commenced on the 8th December. • Trauma Unit, RGH taking part in UHB 'Enhanced Supervision Risk Assessment' pilot. Quality Improvement Critical Care • Pilot of a new Correndo Shower Chair within ITU. This will provide a for a more dignified hygiene experience for patients recovering from critical illness. Staff training to commence January 2026.
Appendices	

2. **Assessment**

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

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language**	Yes: ☐	No: ☐
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	Not applicable as CTM board papers are prepared in English
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	

3. Recommendation

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

Agenda Item
5.4.5

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Angharad Oyler, Head of Midwifery, Lucy Collins, Head of CYP Nursing Carl Verrecchia, Service Director Mohamed Elnasharty, Medical Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Carl Verrecchia, Service Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms

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

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Children and Families Care Group at its last meeting on the 11th December.

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	• Special School Nursing (Risk ID 5753) remains the highest Care Group risk within Children & Families (Risk score 20). Vacancy in Heronsbridge out to advert, staff member appointed for Ysgol Ty Coch (YTC), awaiting start date. Risk score reviewed but remains at 20 due to fragility of services. Request from YTC to revise Service Level Agreement (SLA) invoice due to lack of fulltime cover. Increased request from education for SLA to support CYP with health needs in mainstream schools. Service Director and Head of nursing will be meeting with Head of school in Q4 to re-establish SLA. • Unite are currently balloting their members in the Health Visiting Service, on decision to vote to take industrial action in early 2026 around discrepancy on band 6 job description. Ballot is running until 26th January 2026. No further dates from NHS Employers around All Wales job descriptions. • Badger net implementation - The current status, risks, and resource requirements for the implementation: critical gaps in technical delivery, training, infrastructure, and governance, have the potential to cause delay in the proposed safe and successful go-live in March 2026. Further meeting held in December with Executive colleagues where a phased approach is suggested. Further meetings in January to clarify actions underway. • Maternity Priority Unit. - The Maternity Priority Unit is an assessment unit for women in pregnancy requiring Urgent attention and care. The BSOTS (Birmingham Symptoms specific Obstetric Triage System) model is used to standardise the assessment and prioritisation process, it aims to improve the overall efficiency of the maternity unit and enhance patient safety. Using the BSOTS model is also a directive from Welsh Government. Risks and Mitigation escalated in November QS&E committee. Scoping regarding alternatives and options to enhance the environment continues. Further walkabout of footprint in PCH arranged for 8.1.26. This risk is on the risk register (6249) • **PROMPT**. The annual PROMPT report was published in December 2025. For the first time since implementation in 2019, CTMUHB have not achieved Standard 4.2 - the overall attendance for staff identified as being required to participate in PROMPT Wales training was 89%. This has been due to unprecedented sickness absence and challenges with having

a full Multi-Disciplinary Team (MDT) to deliver the training which is an essential criterion. An action plan was developed in 2025 and escalated through directorate, care group and board QSE and IQPD, the reduction in compliance during this period has impacted on the overall compliance picture.

In respect of the performance of the Health Board in relation to the PROMPT Wales Standards, it is noted that:

- Standard 1 Identify required participants – Is achieved
- Standard 2 Development of local syllabus – Is achieved
- Standard 3 Multi-professional faculty – Is achieved
- Standard 4.2 95% multi-professional participation in PROMPT Wales training – Is not yet achieved

1. Midwifery attendance was 89% down from 97.5%,
2. Obstetric doctors remained at 93%
3. and attendance by Obstetric anaesthetists decreased from 92% to 79%.

The number of obstetric doctors and anaesthetists who are eligible to participate is less than midwives so for context this equates to 12 doctors and 30 midwives who did not attend PROMPT Wales during this reference period.

The report highlights that whilst the PROMPT Wales standards drive sustainability and adherence to the PROMPT approach, the quality of the training experience is undeniably of equal importance, and we were pleased to report that the annual quality assurance reviews undertaken at CTMUHB during the 2024-25 programme year were of a high standard with feedback well received and addressed. The PROMPT Wales National Team commended the local PROMPT Wales faculty leads and the wider faculty team for their commitment to the delivery of PROMPT Wales/Community PROMPT Wales training.

An action plan had already been developed to address earlier this year to mitigate the risks and improve compliance with PROMPT training, which has significantly improved compliance and address sustainability of delivering of the programme in the future. Actions are ongoing, and compliance is reported monthly through directorate Quality and Safety and Experience Forum. Significant improvement is anticipated for Q4.

Advise	• National Maternity and Neonatal Assurance Assessment completed. Awaiting feedback and report (which is anticipated at the end of January/ early February 2026. • Birth rate + report under review, suggestive of requirement of significant additional staffing and funding in clinical and specialist/management workforce to align with the standard. Business justification case is being developed. • The National Perinatal Mental Health network has been disbanded, local MDT forums are being developed to ensure oversight. Initial meeting has taken place and ToR are being developed. • Waiting time performance for Neurodevelopment children (RISK ID 2808) currently remains at a risk score of 12. This is being reviewed to see how the Neurodivergence Improvement Programme (NDIP) funding received is likely to affect the trajectory. NDIP 25/26 – total budget for region and for ND team was reduced from what was expected. This will limit our improvement opportunities and our aim to get below 78 weeks at March 2026. Raised at Welsh Government IQPD in July and again in November. Monthly trajectory meetings with Performance and Escalation team continue. Current wait at just under 102weeks. • Menopause service review has taken place. The review has shown that provision within CTM was not adequate to meet the demand in accordance with national standards and guidance. Additional activity has been allocated to the service and we are working further with Primary Care on including this in the Womens Health Hub pathfinder project. • Welsh Government report on Allergy Services across Wales published, joint working group for paediatrics & adult services being led by the Head of Commissioning. • Working group set up to look at respiratory/allergy and atopic services within paediatrics due to rising pressures. • 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). (SON submitted for Welsh Government approval. Awaiting capital approval confirmation)

	• External review of previous four nationally reportable incidents – midwifery review completed. No additional issues identified which reassures us our internal process of review and learning is robust, this will now come off the corporate risk register. • Discussion continues with anaesthetics and perioperative services regarding provision for elective theatres lists for maternity services in PoW. Currently midwifery workforce are undertaking scrub duties which is impacting on midwifery staffing on the units. There is no dedicated Anaesthetics team for obstetrics, currently anaesthetics are covering maternity and the site resus bleep. • Review of plan for Midwifery sonography service underway to evaluate alternative approach to progress essential services to improve outcomes for women and babies and enhance consistent governance across sites which will include: 1. Electronic U/S/S referrals 2. Establish prematurity clinic 3. Establish Rainbow Clinic 4. Establish Placental site/complications clinic 5. Establish in house training and governance for Midwifery and Medical teams undertaking ultra-sound scanning.
Assure	• Work underway establishing Vulnerable families team, Teenage pregnancy midwife and Wellbeing Midwife now in post. Conversations ongoing with local authority regarding collaboration and alternative models of care to support this cohort of mother and babies. • Resolution to school hearing screening service progressing. School entry hearing screening service will move to audiology. School Nursing Service commenced transition year pupils in December. • Gynaecology Cancer action plan underway to deliver significant improvement in cancer treatment for our population. October Performance dipped to around 31% and should continue to improve as we work on both the triage at single point of access and the treatment stages. Risks to this outside our direct control are for the patients who require tertiary level treatment. Letter has been sent from the COO and Exec Medical Director to Swansea Bay in

early January, asking for their plans to improve pathology turnaround times to help patients through the pathway.

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

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

- Healthcare support workers at PoW Maternity and Paediatrics continue to be responsible for hostess trolley / mealtimes. Concerns raised by the team as this task continues to detract from providing clinical care to women. Work underway organisationally with band 2 & 3 Healthcare Support Worker (HCSW) roles. Maternity support workers roles will feature as part of the BR+ and workforce planning.

- Recruited Lead Nurse for women's health (18.75hrs) recruited to lead on the Women's Health Plan (WHP). Funding available allowed for increase in hours to full time until the end of March 2026 to progress WHP.

Risk Register

There is currently two risks scoring high with 16 or more. Discussed with executive colleagues

Risk ID	Description	Score
5753	Inadequate Special School Nursing provision	20
3576	No Therapy and Psychologist Provision for Neonatal services across CTM	16

Inform

- 30,313 fluenz vaccinations delivered by the school nursing team and health visiting service in CTMUHB:-
  48.64% uptake

- Ward 18 at Royal Glamorgan Hospital handed back to paediatrics in December and back in use for Paediatric Assessment Unit (PAU) beds and Surgical post operative care (post dental treatment).

- Health & Safety have recently supported the review of environmental monitoring in PCH labour ward. 4 rooms tested

	with no red flags. Complete testing expected by end of January 2026. Any issues raised will be remedied. • Consent training within maternity has commenced across sites for obstetricians and midwifery staff and included into Induction programme for all new staff into maternity. Training also provided for Gynaecology. • Sickness absence among nursing workforce within special care baby units at PCH and PoW is showing signs of improvement.
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: • Creating Health • Inspiring People • Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: • Growing Well • Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below: • A Globally Responsible Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below: • Culture and Valuing People • Leadership • Learning, Improving and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Safe
	• If more than one applies please list below: • Timely

(Duty of Quality Statutory Guidance (gov.wales))	• Equitable • Efficient • Effective • Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce If more than one applies please list below: • Repurpose • Reuse • Refine • Recycle

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

5. Recommendation

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

Agenda Item
5.4.6

Quality, Safety & Experience Committee

Highlight Report from the Unscheduled Care – Care Group.

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows, Operational Director for Unscheduled care. Deborah Matthews, Unscheduled Care Nurse Director Owen Weeks, Unscheduled Care Medical Director Robin Martin, Unscheduled Care Deputy Medical Director Victoria Healey, Head of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Deborah Matthews, Unscheduled Care Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Choose an item. Richard Hughes, Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Quality & Safety Committee	20/01/2026	

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

1. Introduction

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

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

2. Purpose of this Meeting

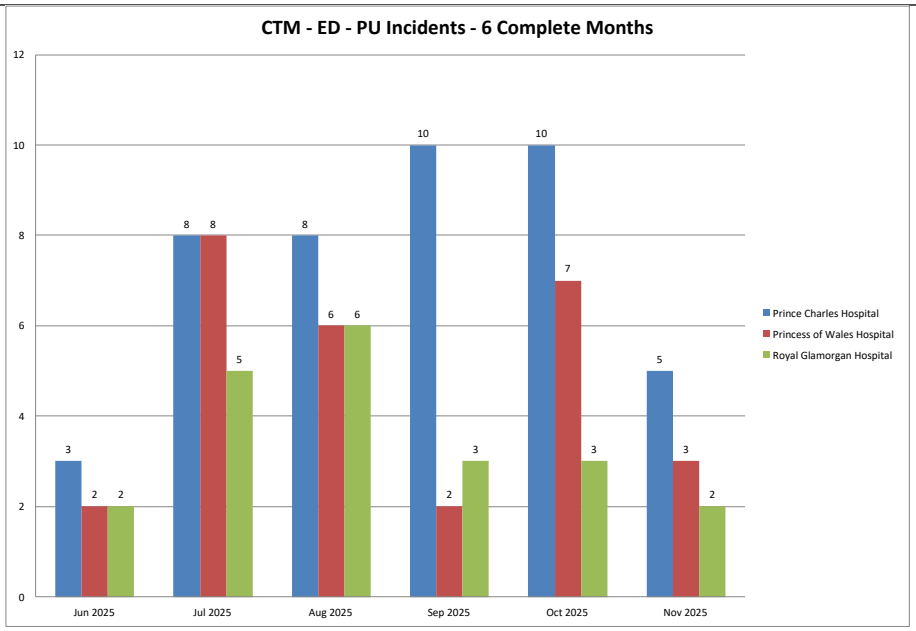
2.1 The purpose of the Quality, Safety, Risk and Experience meeting is to provide assurance to the Care Group and the Health Board's Quality, Safety & Experience (Q&S) Committee on the provision of safe and high-quality patient care and experience to the population we serve.

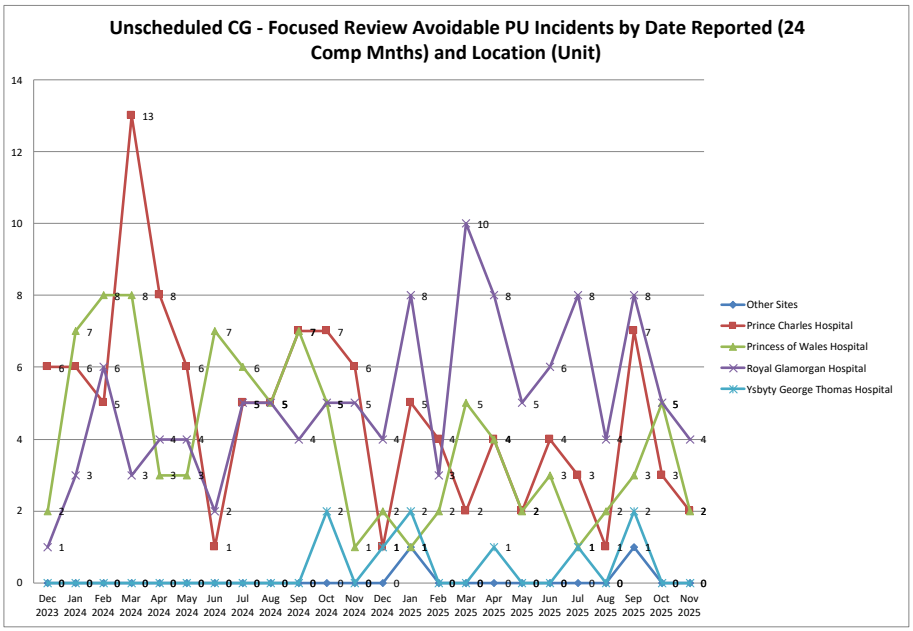
2.2 The Committee is requested to **NOTE** the report

Highlight Report

Alert / Escalate	**Ysbyty George Thomas (YGT;54 Bedded Unit)** The formal YGT OCP concluded on 20th October 2025 to progress the transfer of service from Unscheduled Care to Primary and Community Care, date to be confirmed. An overarching improvement action plan is in place with Senior Leadership oversight following concerns raised by the Therapy Team in September 2025 regarding care and deconditioning at YGT. In addition, concerns have been raised following an incident out of hours on the unit in relation to leadership and behaviours. An update was provided to ELG on the 10th November 2025 and provided assurances around improvements and the specific incident raised was deemed "No Harm" following a Rapid Review meeting. Due to the nature of the concerns raised, the Nurse Director for Unscheduled Care commissioned a retrospective review of 34 previous admissions to the unit. 40% of the cases have been reviewed to date with 'No Harm' identified. For further assurances, arrangements are underway to set up a MDT panel to review all the investigations completed and will include Safeguarding, Therapies and Patient Safety. To note there have been independent reviews undertaken by Llais, Executives and Independent Members with positive feedback to date. The care group have situated a senior nurse to be based in the Unit, with the Nurse Director for Unscheduled Care and Lead Nurse visiting regularly.

	There are a number of Lateral Move requests to return to POWH and with support from our Peoples Directorate we are actively engaging with staff to facilitate the requests noting there are limited vacancies on this site. **Influenza A Outbreak RGH 21st November 2025-** The number of positive cases peaked to 56 within the first week. There was an immediate MDT response. Mandatory mask wearing across CTM UHB in place from the 25th November and to remain as a minimum until 2nd January 2026 in line with winter surveillance. An Early Warning Notification has been completed, noting there have been 5 deaths where Influenza A is recorded as part 1a of the death certificate with 2 outstanding reports (as of the 6th December). In line with the UHB's investigation process, an MDT panel has been arranged for 17th and 23rd December 2025 to review the cases and identify any avoidable harm. To date: 1 case has been identified as avoidable, NRI completed. 1 Moderate Harm (Duty of Candour) 1 awaiting WHOCAT score to determine the level of investigation required.
Advise	**Stroke** See agenda item 5.5. Stroke Services Report - Bi-Annual Update
Assure	**<u>Pressure Area Management</u>** Pressure area management remains a key priority across all areas of Unscheduled Care, the graph below shows incidents reported as developed in the Emergency Departments over the past 6 months, and notably a decreasing trend. Since, the introduction of the 45-minute ambulance handover October 1st 2025, the 12 hour patient delays have increased in the last 3 months (see detail below; page 9). The delays are attributed to patient flow challenges across both Unscheduled and Planned Care including incidents such as the Influenza outbreak in the RGH, the Norovirus outbreak in POWH and the continued challenges of patient clinical transfers especially in POWH (patients for both Unscheduled and Planned Care waiting transfer to the RGH). Thus, the Unscheduled Care Clinical Service Group will continue to monitor unintended consequences and implement any necessary mitigation to prevent avoidable harm.





During the period October 2024 to November 25 in comparison to the previous 12 months the data illustrates the following trends for each respective site:

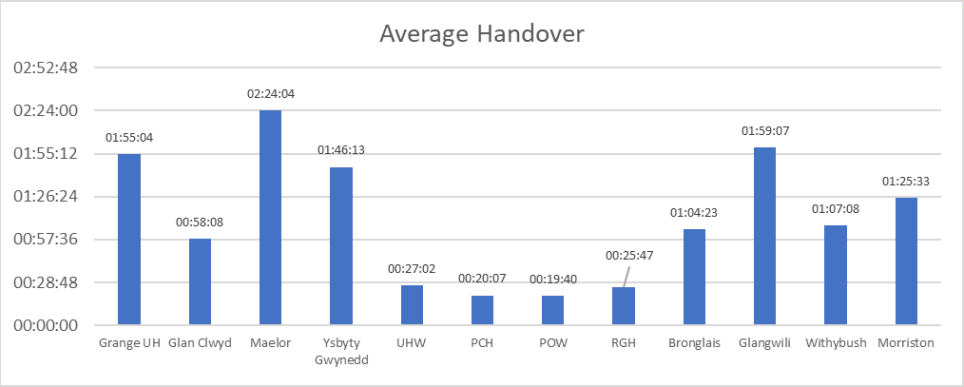
Site	Incident Trend
Royal Glamorgan Hospital	Reducing
Prince Charles Hospital	Reduction
Princess of Wales Hospital	Noticeable Reduction

NB: It is important to note that the bed base increased in RGH in October 2024 and significantly reduced in POW due to the Critical Incident.

Therefore, there are variables in the data when comparing with the previous 12-month prevalence in both RGH and POW sites.

USC Performance and 30-Day Action Plan Update

Performance metrics show CTMUHB achieving the fastest ambulance handover times in Wales (average time PCH 16 minutes, RGH 18 minutes, POW 27 minutes), with all 3 sites leading nationally.

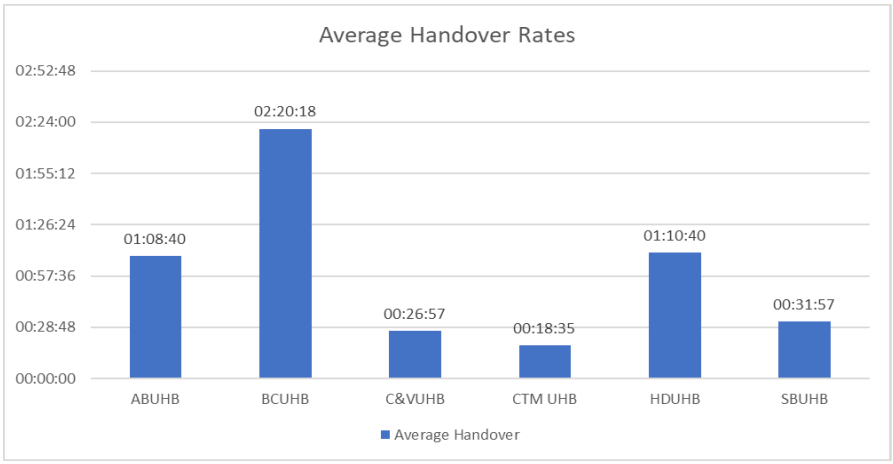


Despite challenges like reduced inpatient capacity and a critical incident at POW, CTMUHB maintained low lost hours and improved conveyance rates.

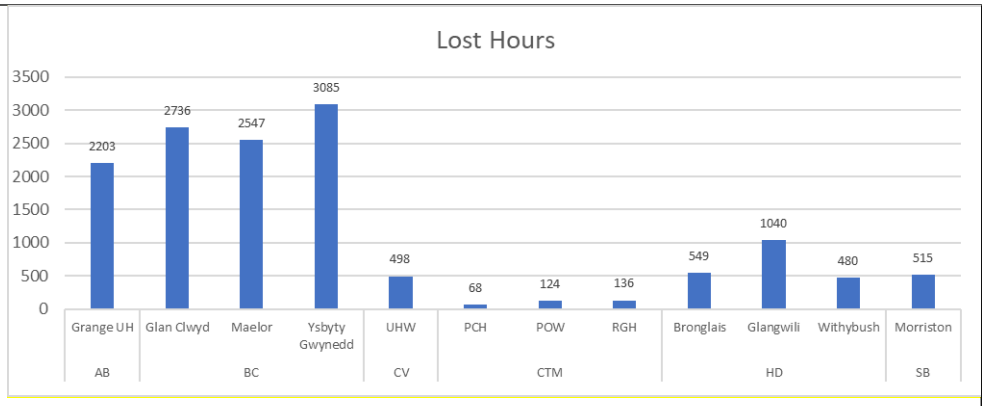
The 30-day deliverables focus on operational enhancements such as defining roles, improving diagnostics access, and refining discharge processes. Transformational goals include discharge protocols and care home admission avoidance. Outcome targets aim for zero tolerance to extended ED waits and improved discharge timings. The 60-day and 90-day plans build on these foundations, targeting further reductions in wait times, enhanced patient flow, and expanded community care capacity; Hospital@Home being key. The overarching goal is to achieve zero tolerance for 12-hour ED waits and 45-minute ambulance handovers commenced formally 1st October 2025, supported by trajectory-based planning and system-wide coordination.
The Unscheduled Care CG has undertaken a local resilience assessment for automated 45 minute handover, a ministerial directive to be in place from the 1 January 2026.

Please see below graphs relating to November's Ambulance performance:

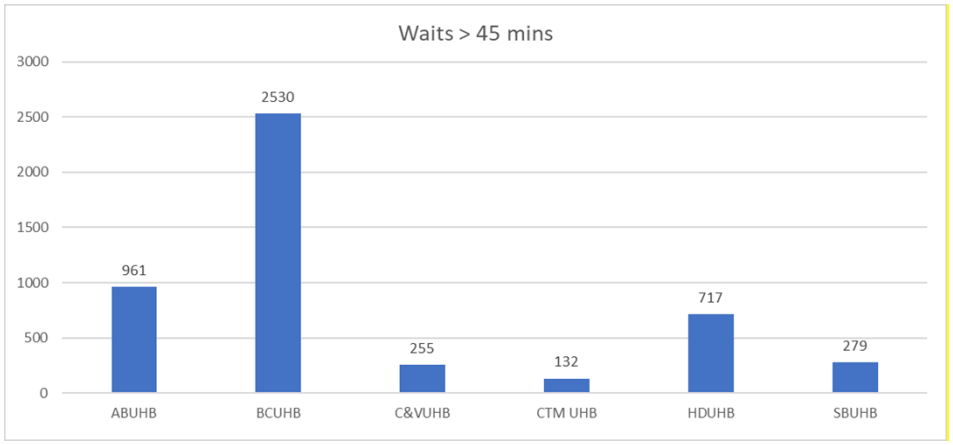
45 Minute Handover RAG		>90% handovers taking <= 45m	75%-90% handovers taking <= 45m	50% - 75% handovers taking <= 45m		>50% or over taking <= 45m
		2 ACUTE SITES	3 ACUTE SITES	2 ACUTE SITES		5 ACUTE SITES
Acute Sites Order based on % HO <= 45 mins	Ambulance Arrivals at ED	Average H/O	H/O <= 45 mins ED	% H/O <= 45 mins ED	% H/O <= 45 mins ED Year to Date	Lost Hours
Prince Charles Hosp Merthyr	725	00:16	706	97.4%	78.2%	68
Royal Glamorgan Hosp Pontyclun	818	00:18	767	93.8%	75.4%	135
Princess Of Wales Bridgend	447	00:27	399	89.3%	75.1%	120
University Hospital Of Wales	1553	00:32	1329	85.6%	75.2%	470
Morriston Hospital Swansea	1199	00:37	978	81.6%	71.2%	498
Withybush Hosp Haverfordwest	601	00:58	427	71.0%	55.8%	480
Glangwili Hospital Carmarthen	828	01:26	504	60.9%	53.2%	1020
Grange University Hospital Cwmbran	1441	01:42	717	49.8%	47.9%	2146
Bronglais Gen Hosp Aberystwyth	335	01:38	165	49.3%	56.1%	470
Glan Clwyd Hosp Bodelwyddan	1446	02:06	540	37.3%	45.4%	2697
Maelor General Hosp Wrecsam	1061	02:36	315	29.7%	32.6%	2515
Ysbyty Gwynedd Hosp Bangor	1160	02:53	313	27.0%	30.9%	3076



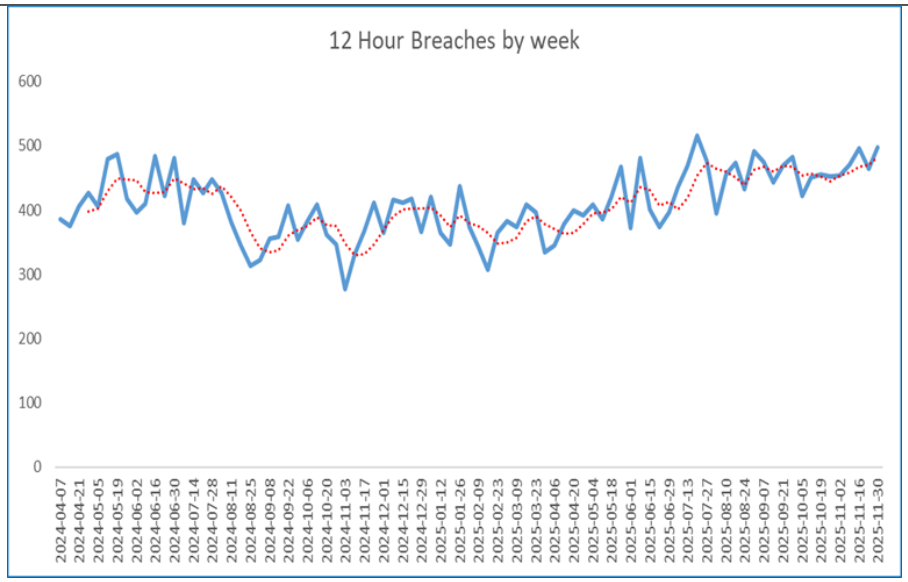
The above graph illustrates CTMUHB performance in handover efficiency in the month of November, with an average handover rate of 18 minutes, it performed significantly better than several other Health Boards.

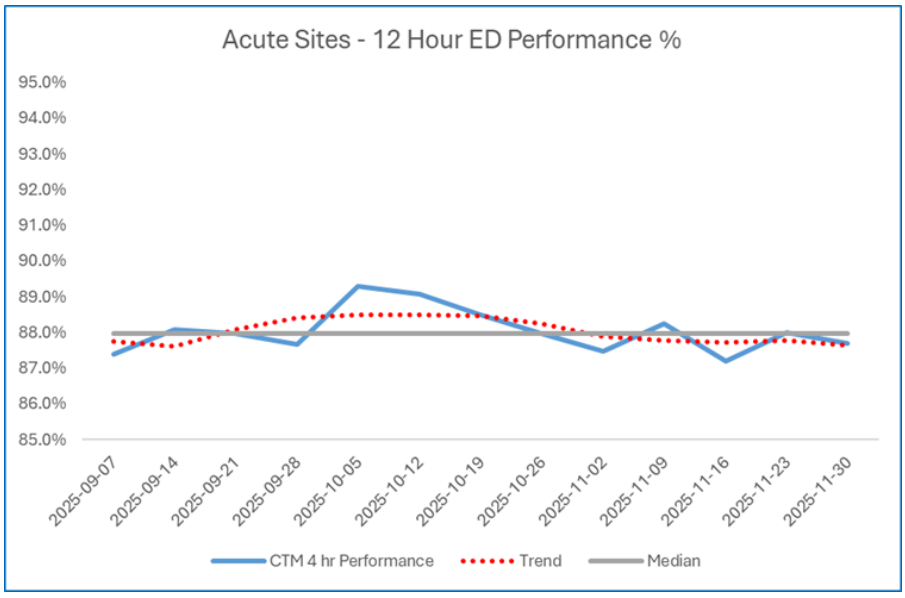


The chart above demonstrates that CTMUHB lost significantly fewer hours when compared to other Health Boards in Wales. (PCH 68 hours, POW 124 hours, RGH 126 hours).



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





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

This pattern suggests that bottlenecks have shifted downstream, within the hospital system itself. While ambulance handovers are now more efficient, patient flow beyond ED (into wards, diagnostics, discharge pathways) has at times become limited, leading to crowding and extended stays in departments. The increase in 12-hour waits highlights internal capacity pressures, suggesting the need for improved

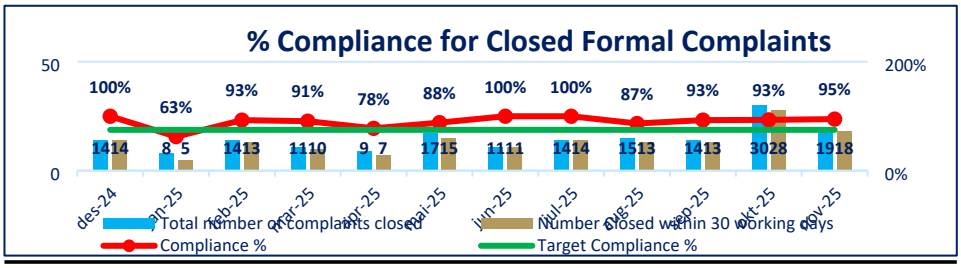
inpatient flow and discharge processes to sustain overall system efficiency.

ED Huddle

The electronic ED Huddle has now been launched Friday 19th December 2025. This is a proactive development and provides a technology enabled approach to the traditional safety huddle, using digital huddle boards to facilitate communication, improve situational awareness, and enhance patient safety and operational awareness.

- The purpose of the ED Huddle is to provide a structured, digital process to support real-time visibility of patient flow, improve operational decision-making, and enhance data quality across our Emergency Departments.
- Benefits:
  - Reduces reliance on paper-based processes.
  - Provides accurate, codified data for trend analysis and performance improvement.
  - Supports timely escalation and prioritisation of actions.
- Key Features:
  - Ability to record concerns, priorities, and actions in a standardised format.
  - Immediate release and ambulance handover indicators.
  - Pen picture functionality for quick situational awareness.

Concerns ED & Medicine



Concerns compliance

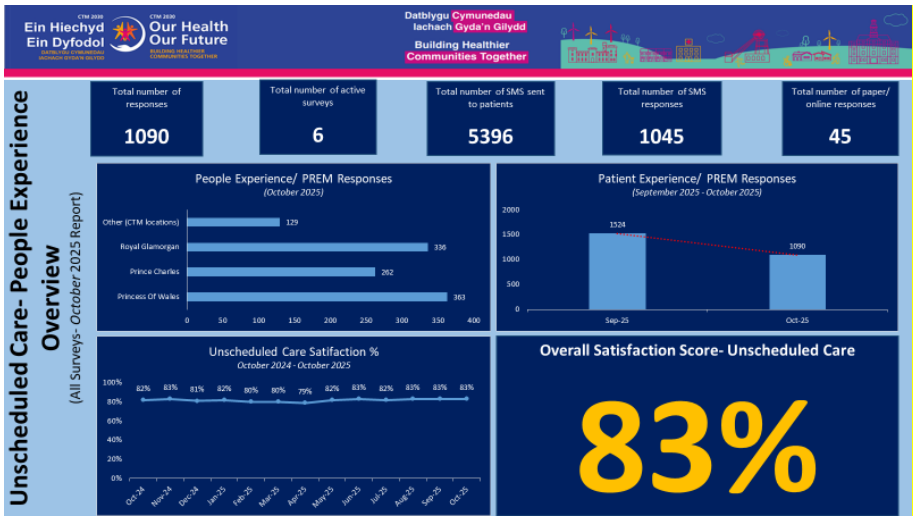
Compliance with the 30-day targets has improved, increasing from 93% to 95% in October and November 2025. Currently, there are 17 open complaints, with none exceeding the 30-day compliance threshold. This reflects a positive reduction from 21

to 17 open complaints since the previous report, while maintaining full compliance.

The USC Leadership Team has reaffirmed its commitment to supporting and improving performance trajectories. A formal escalation mechanism has been implemented to address situations where clinicians or nurses encounter challenges in meeting the 30-day compliance requirement. Progress is being closely monitored by the USC Senior Leadership Team.

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

People Experience



Nutrition and Hydration: Catering Model Pan CTMHB

The digital catering model that has been embedded successfully in PCH is formally being implemented at RGH and POW from 16th December 2025, and will support our populations nutrition and hydration needs safely. Standardising this model across all sites will strengthen governance, improve the consistency and quality of patient care, and reduce variation in practice. Implementation will focus on facilitating patients' dietary requirements safety, thus supporting recovery and improved patient outcomes. The Heads of Nursing on each site will lead the implementation.

	Risk Register No new risks greater than 15 have been added to the Risk Register
Inform	**Nursing Leadership Model** In line with the model implemented in Planned Care, the Nurse Director for USC has had formal agreement to progress a "proof of concept" proposal for 12 months to move to a Pan CTMUHB model commencing 5th January 2026. A single Lead Nurse for each Directorate across CTMUHB will ensure standardisation of care, improved communication, and enhanced collaboration. This approach strengthens operational efficiency, facilitates shared learning, and promotes equitable service delivery. **Recruitment & Workforce Stability** Targeted recruitment efforts continue across unscheduled care and medical wards, with several key posts successfully filled. Ongoing campaigns aim to reduce reliance on temporary staffing and improve workforce stability, supporting safer staffing levels and service continuity. The new approach to requesting Agency Staff implemented on the 1st December 2025, hence there has been an emphasis on resetting in terms of adherence to Roster Principles, encouraging our internal staff to join the nurse bank and reducing the reliance on agency nurses. This will facilitate continuity and consistency of nursing across our unscheduled care clinical areas. **PCH Paediatric ED-Implementation of the Immersive Room** Launched on 4th December 2025 by our chairman, including Rob and Gemma Cummings who have been integral in raising the funds externally which was matched by CTM UHB Charitable Funds, 26k in total. This is significant in terms of positive patient experience and has given us the opportunity to have a safe and calm clinical environment for our children. We would like to replicate this across not only the other 2 ED's but also across the estate of CTM UHB. This will enhance the care we deliver to our patients with a cognitive impairment.
Appendices	

3. Assessment

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

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

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

4. Recommendation

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

(Agenda Item 5.5)	20.01.26	Quality, Safety and Experience Committee	Stroke Service update

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows, Service Director, USC Gary Howell, Clinical Director of AHPs Claire Thompson, Exec Director Strategy and Transformation
Presented By:	Unscheduled Care Leadership Team Gary Howell, Clinical Director of AHPs Claire Thompson, Exec Director Strategy and Transformation
Approving Executive Sponsor:	Lauren Edwards, Exec Director AHP and HS
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Overview of the stroke service improvements to date
Related Health and Care Standard	e.g. Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes (prior to service changes)
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Paper for noting only
Link to Strategic Goals	Please Select: Improving Care

CTM Stroke Service

CTM Stroke inpatient services temporarily centralised at Royal Glamorgan Hospital.

Phase 1

- Overarching immediate improvement plan commenced in April 2025 to support stabilisation.

Key Actions

- Quality and assurance; workforce – Nursing and Medical; Leadership; Environment; MDT communication; AMaT.

Outcomes

- Significant de-escalation of risks and stabilisation of service.
- Action plan improvements are ongoing. Collaborative approach to education and training for new staff for stroke-specific skills (e.g. oral care).
- RN and HCA recruitment in progress. All HCA posts now appointed to. 3x RN posts awaiting recruitment.
- Partial stabilisation of medical workforce. Newly appointed consultant now in post. One consultant returned from Mat Leave. One locum consultant remains in place. Recruitment of Consultant Neurologist being progressed and this post will support stroke on call rota.
- Discussions with CAVUHB continue to progress regional rota and shared job descriptions.

CTM Stroke Service Transformation Programme - RGH

Key Priorities
Daily breach huddles
Clinical Pathway from ED to Ward
Pathway out of ward – non-stroke/end of acute stroke phase

Key Activities
- Daily breach huddles in place
- Stroke Clinical Nurse Specialist based in ED
- Operational team attendance at Safe to Start meetings
- Ops member holds Stroke bleep
- Post-huddle action log complete
- Escalation card and SOP to support pathways
- Weekly report each Friday
- Incremental improvement trajectories

Internal Improvement Trajectory (w/c 21.11.25)
The consolidated service is focussing on enhancing performance against these 2 internal indicators.
- CT: 80% Pts within 45 mins
- Admit to stroke ward < 4hrs – 60%

Both these important quality indicators are showing an improving trend, with significantly improved performance since consolidation of the service.

CTM Stroke Service Transformation Programme

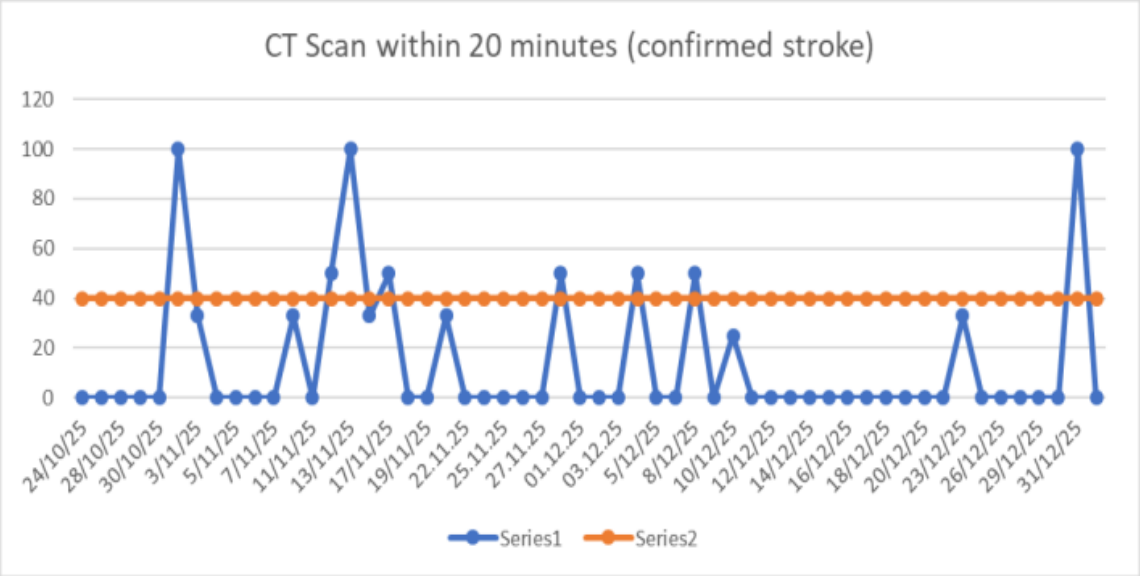
Stroke Quality Improvement Measures		
Current Month stats September 25		
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Total patients receiving scan	patients scanned within 20 minutes	% compliance
96	12	12.50%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 30mins		
Eligible patients for thrombolysis	Thrombolysed <= 30 mins	% compliance
9	0	0.00%
% of applicable patients who have direct admission to an acute stroke unit within 4 hours		
Patients admitted with stroke	Stroke patients admitted to Stroke Unit within 4 hours	% compliance
95	18	18.90%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Total consultant assessments	Assessed <= 14 hours	% compliance
96	20	20.80%
% of patients who are assessed by at least one therapy within 24 hours		
Total therapy assessments	Assessed <= 24 hrs	% compliance
95	61	64.20%
% of patients discharged with ESD / Community Therapy MDT (rolling three months)		
Total Discharges	Patients discharged with MDT	% compliance
144	64	44.40%

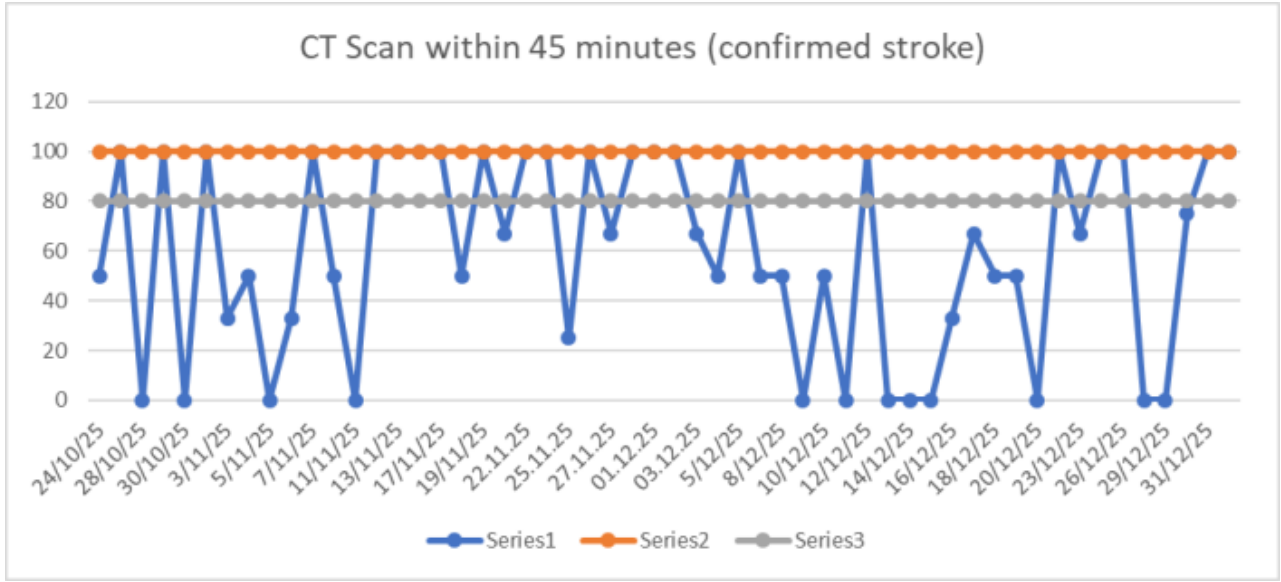
Stroke Quality Improvement Measures		
Current Month stats October 2025		
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Total patients receiving scan	patients scanned within 20 minutes	% compliance
74	8	10.80%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 30mins		
Eligible patients for thrombolysis	Thrombolysed <= 30 mins	% compliance
5	0	0.00%
% of applicable patients who have direct admission to an acute stroke unit within 4 hours		
Patients admitted with stroke	Stroke patients admitted to Stroke Unit within 4 hours	% compliance
71	6	8.50%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Total consultant assessments	Assessed <= 14 hours	% compliance
74	21	28.40%
% of patients who are assessed by at least one therapy within 24 hours		
Total therapy assessments	Assessed <= 24 hrs	% compliance
74	48	64.90%
% of patients discharged with ESD / Community Therapy MDT (rolling three months)		
Total Discharges	Patients discharged with MDT	% compliance
143	71	49.70%

- Quality Improvement Measures reporting across all acute sites.
- Position for October poor, focused Stroke Service Transformation Programme commenced on the 24th October 2025, anticipate significant improvement will be reported in November 2025 SSNAP reports, in line with internal reporting of improvement

CTM Stroke Service Transformation Programme

Time to CT Scan Performance (RGH)



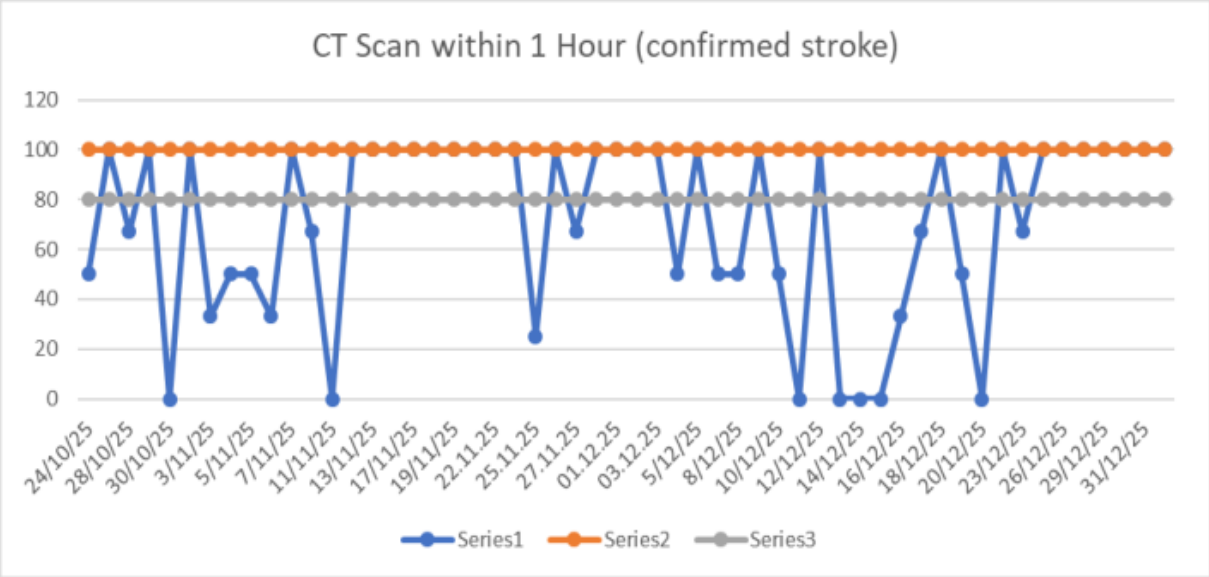


- 11% of confirmed stroke patients had CT scan within 20 minutes 26/12/2025 – 01/01/2026.
- 67% had a CT scan within 45 minutes 26/12/25 – 01/01/26.
- Significant improvement reported in CT for RGH patients.

NB: No confirmed strokes in RGH on 27th December.

CTM Stroke Service Transformation Programme

Time to CT Scan Performance (RGH)



CT Scan Within 1 Hour	Internal Performance Target	National Performance Target	Weekly Actual Performance
wc 24/10/25	80%	100%	62.50%
wc 31/10/25	80%	100%	47%
wc 07/11/25	80%	100%	77%
wc 14/11/25	80%	100%	100%
Wc 21/11/25	80%	100%	69%
Wc 28/11/25	80%	100%	83%
Wc 05/12/25	80%	100%	58%
Wc 12/12/25	80%	100%	54%
Wc 19/12/25	80%	100%	78%
Wc 26/12/25	80%	100%	100%

CT Scan Within 45 minutes	Internal Performance Target	National Performance Target	Weekly Actual Performance
wc 24/10/25	80%	100%	37.5%
wc 31/10/25	80%	100%	31%
wc 07/11/25	80%	100%	67%
wc 14/11/25	80%	100%	89%
Wc 21/11/25	80%	100%	61%
wc 28/11/25	80%	100%	75%
Wc 05/12/25	80%	100%	50%
Wc 12/12/25	80%	100%	46%
Wc 19/12/25	80%	100%	78%
Wc 26/12/25	80%	100%	67%

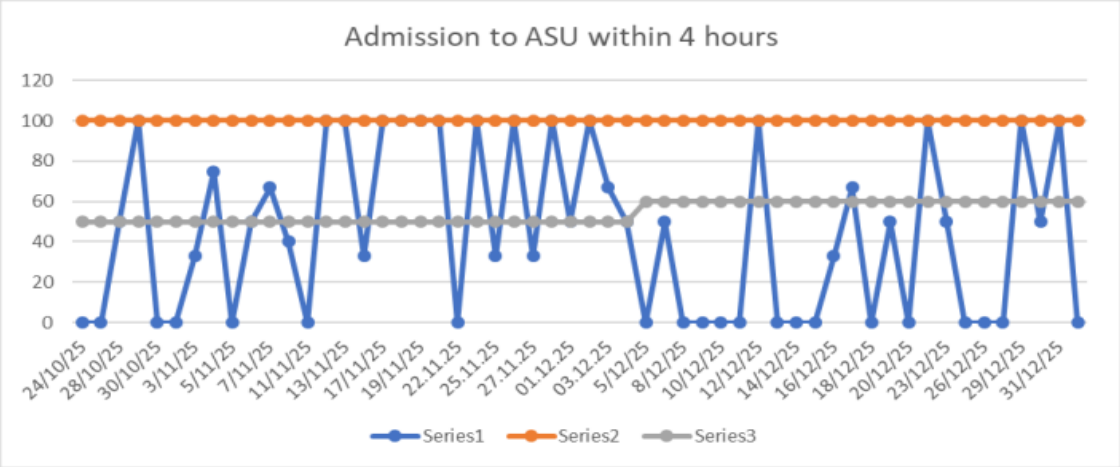
100% of confirmed stroke patients had CT scans within an hour 26/12/2025 – 01/01/2026

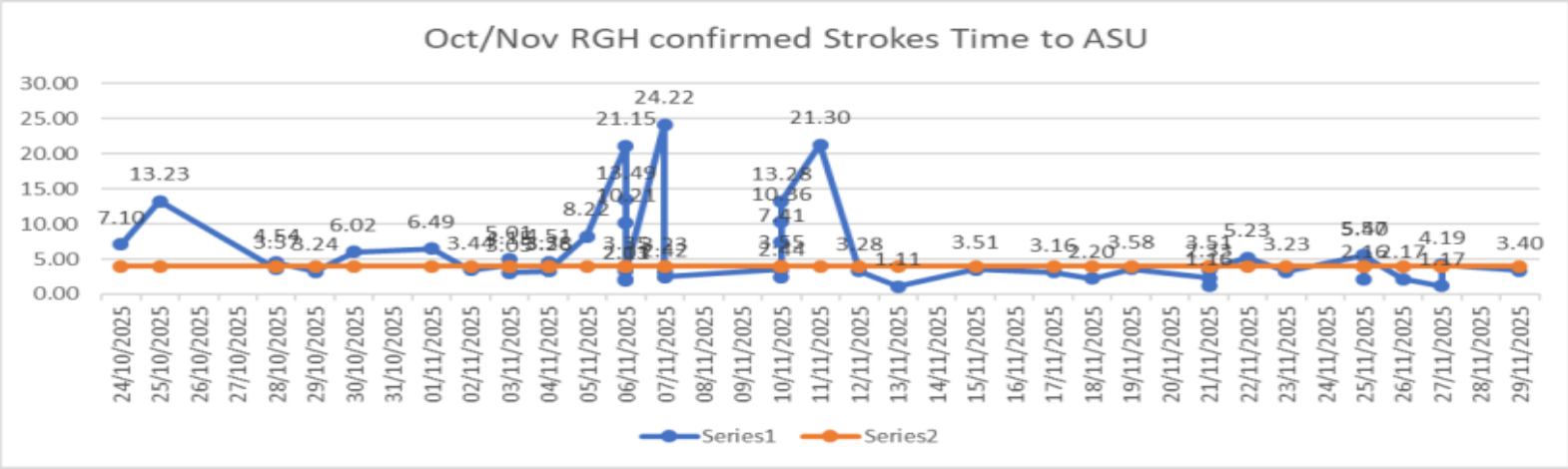
Daily huddles are enabling review of patient specific reasons for delays.

Delays were encountered in radiology reports being reported - this impacted stroke diagnosis and arrival onto ASU. This was due to staffing shortages within the CT department.

CTM Stroke Service Transformation Programme

Admission to ASU Within 4 Hours – RGH (not PCH or POW transfers)





44% of confirmed stroke patients were admitted to ASU within 4 hours 26/12/2025 – 01/01/2026.

Significant improvement in admission to ASU, and focus on maintaining flow across the whole stroke pathway

Time to ASU	Internal Performance Target	National Performance Target	Weekly Actual Performance
wc 24/10/25	50%	100%	33.30%
wc 31/10/25	50%	100%	46%
wc 07/11/25	50%	100%	50%
wc 14/11/25	50%	100%	67%
Wc 21/11/25	60%	100%	54%
Wc 28/11/25	60%	100%	70%
Wc 05/12/25	60%	100%	9%
Wc 12/12/25	60%	100%	33%
Wc 19/12/25	60%	100%	50%
Wc 26/12/25	60%	100%	44%

CTM Stroke Service Transformation Programme

PCH & POW Performance

Presenting site	Date	CT wait time (hh:mm)	Time to RGH ASU (hh:mm)
PCH	25/10/2025	0.30	5.05
PCH	27/10/2025	0.30	22.07
PCH	30/10/2025	0.60	6.30
PCH	06/11/2025	5.19	13.49
PCH	07/11/2025	4.35	47.33
PCH	07/11/2025	1.35	36.04
PCH	07/11/2025	0.29	25.37
PCH	17/11/2025	4.09	11.53
PCH	22/11/2025	1.22	8.33
PCH	24/11/2025	1.10	19.22
PCH	28/11/2025	1.18	25.55
PCH	28/11/2025	0.47	9.45
PCH	05/12/2025	0.45	6.27
PCH	06/12/2025	7.27	25.04
PCH	10/12/2025	1.26	10.35
PCH	19/12/2025	2.36	20.43
PCH	20/12/2025	0.38	12.18
PCH	23/12/2025	0	2.38

Presenting site	Date	CT wait time (hh:mm)	Time to RGH ASU (hh:mm)
POW	01/11/2025	0.13	15.08
POW	14/11/2025	5.21	25.13
POW	15/11/2025	0.27	7.10
POW	16/11/2025	0.16	23.38
POW	21/11/2025	11.24	22.12
POW	28/11/2025	1.03	23.30
POW	30/11/2025	0.36	11.10
POW	30/11/2025	0.23	15.08
POW	01/12/2025	0.14	13.35
POW	03/12/2025	1.02	25.50
POW	15/12/2025	0.24	10.33
POW	15/12/2025	3.53	22.24
POW	16/12/2025	2.39	30.49
POW	16/12/2025	7.55	29.13
POW	18/12/2025	0.29	12.12
POW	20/12/2025	2.35	25.38
POW	20/12/2025	0.48	21.14
POW	22/12/2025	0.43	9.26
POW	24/12/2025	0.24	20.33
POW	30/12/2025	0.37	10.25

From 25/10/2025, 30 confirmed stroke transfers have occurred from POW and PCH to RGH ASU.

These have been captured and discussed in the stroke huddles.

Further focus is required to support metrics for patients self-presenting to POW and PCH, although this is constrained by clinical transfer vehicle.

Allied Health Professions Provision

Key actions taken

- Following urgent temporary service changes, all AHP stroke staff in POW & PCH have been relocated to RGH
- Stabilisation of the AHP workforce and integration of PCH and POW teams as part of overarching stroke improvement plan
- Collaboration on stroke education and training for ward staff, including lunch and learn & shadowing opportunities
- Programme of Quality Improvement
  - Reduction in chest physiotherapy demand through education and training regarding related patient care activities
  - Improved capacity with the development of specialist stroke rehab groups across the pathway
  - Collaborated on swallow screening QI project with associated training and policy development
  - Commenced ESD in-reach to YCR, improving access to rehab at home. Plan to implement in RGH Jan 26.

- Appointed to 6-month secondment AHP Clinical Improvement Lead, with a focus on stroke. Key objectives:
  - Improve AHP SSNAP performance targets through a co-ordinated programme of quality improvements
  - Improve AHP handover to release time, streamline AHP 1st assessments, and focus on flow
  - Collaborate with MDT to further develop education and training offer in stroke specific skills, resulting in improved patient outcomes and experience and an improved culture of rehabilitation across the pathway
  - Review model of care for ESD.

Allied Health Professions (AHP) Provision

AHP Service Provision overview

- Ward 19 / 20 RGH: acute stroke unit and specialist stroke rehabilitation
- Inpatient Stroke Ward D4 YCR: Specialist stroke rehabilitation
- Early Supported Discharge Service provides specialist community stroke rehabilitation
- 5-day, 09:00-17:00 service across stroke pathway; RGH and YCR and Early Supported Discharge (ESD) service.
- Current workforce numbers are insufficient to provide 7-day service. A proposal is being developed to outline options to extend clinical model

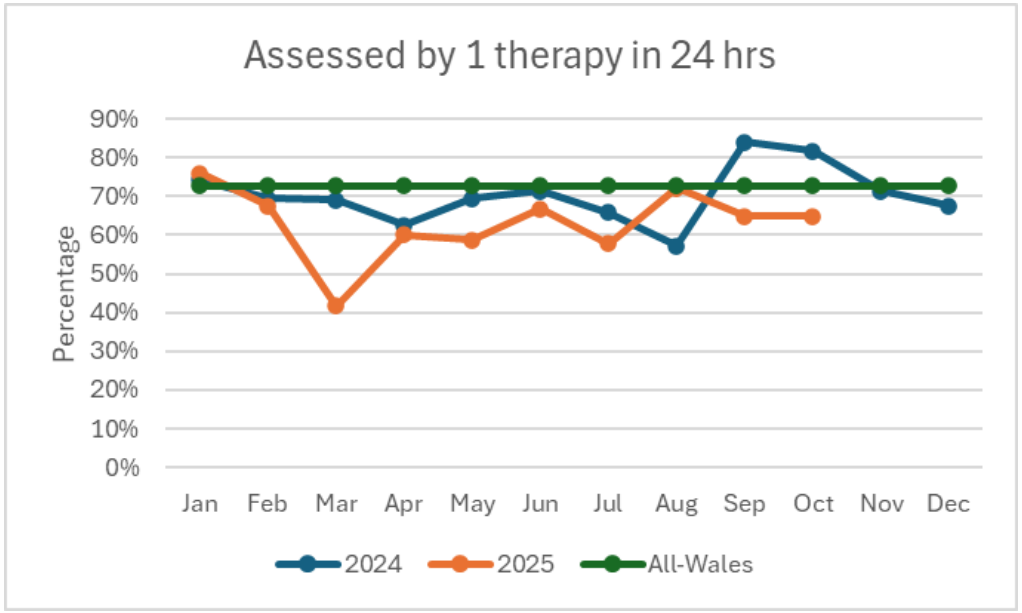
AHP inpatient registered workforce provision

Profession	RGH Acute and Rehab (wte)	YCR Rehab (wte)	Total workforce (wte)	Percentage of Stroke guidelines
Speech and Language Therapy	3.2	1.2	4.4	51.0%
Dietetics	1.0	0.1	1.1	34.0%
Occupational Therapy	6.0	3.0	9.0	51.7%
Physiotherapy	5.6	3.2	8.8	48.4%
Psychology	0.0	0.0	0.0	0.0%
Total Workforce	15.8	7.5	23.3	49.1%

Early Supported Discharge AHP registered workforce

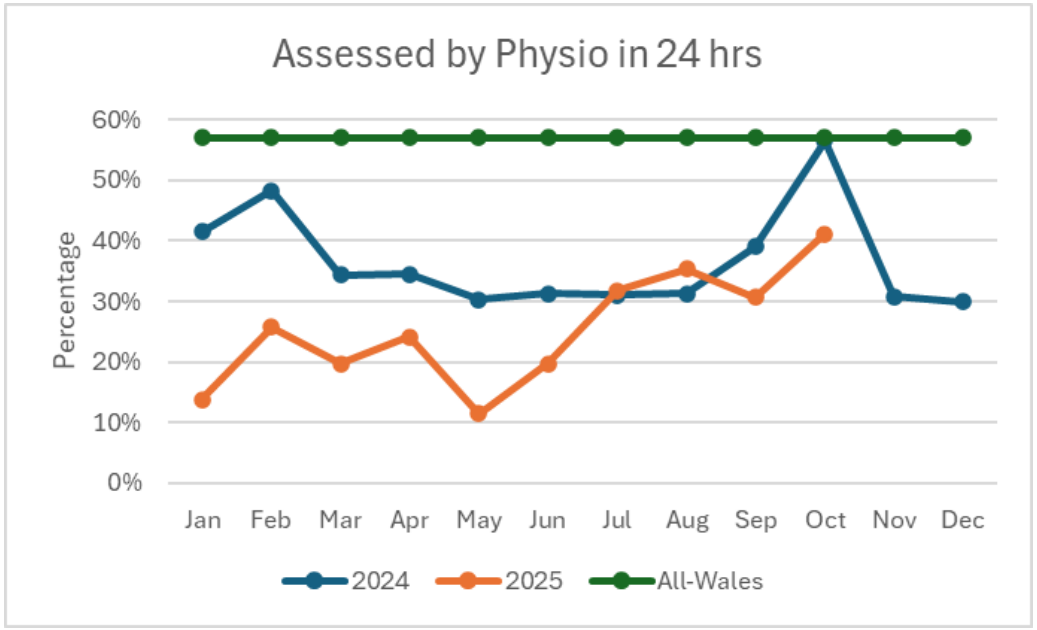
Profession	Early Supported Discharge Service (wte)	Percentage of Stroke guidelines
Speech and Language Therapy	1.1	83.3%
Occupational Therapy	2.8	84.8%
Physiotherapy	3.0	93.9%
Psychology	0.0	0%

AHP Stroke Rehabilitation Quality Metrics



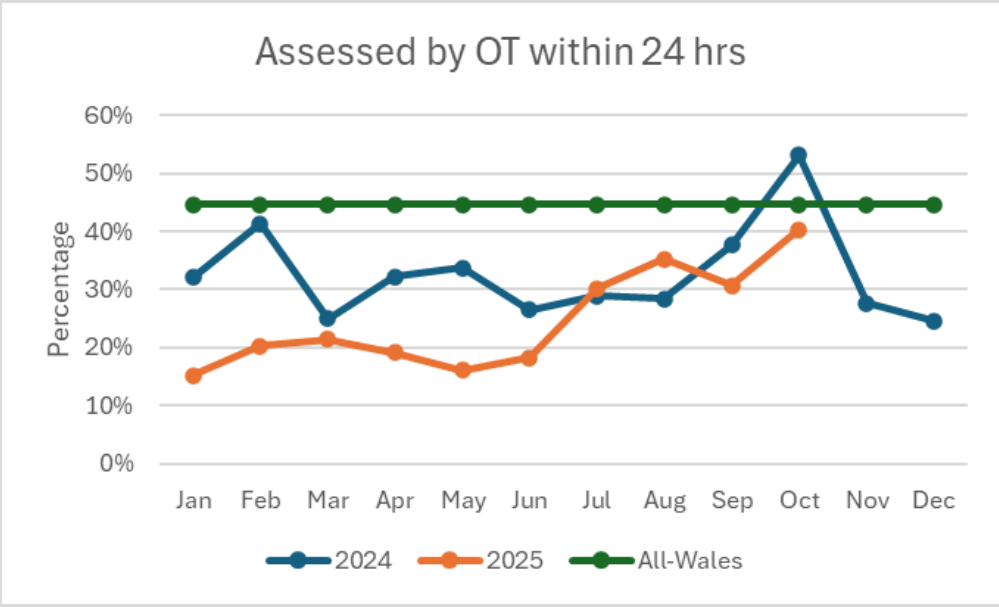
64.9% of patients were assessed by 1 therapy service within 24hours of admission (Oct 2025).

Following initial reduction in performance against 24hour target, performance is recovering to 2024 levels.

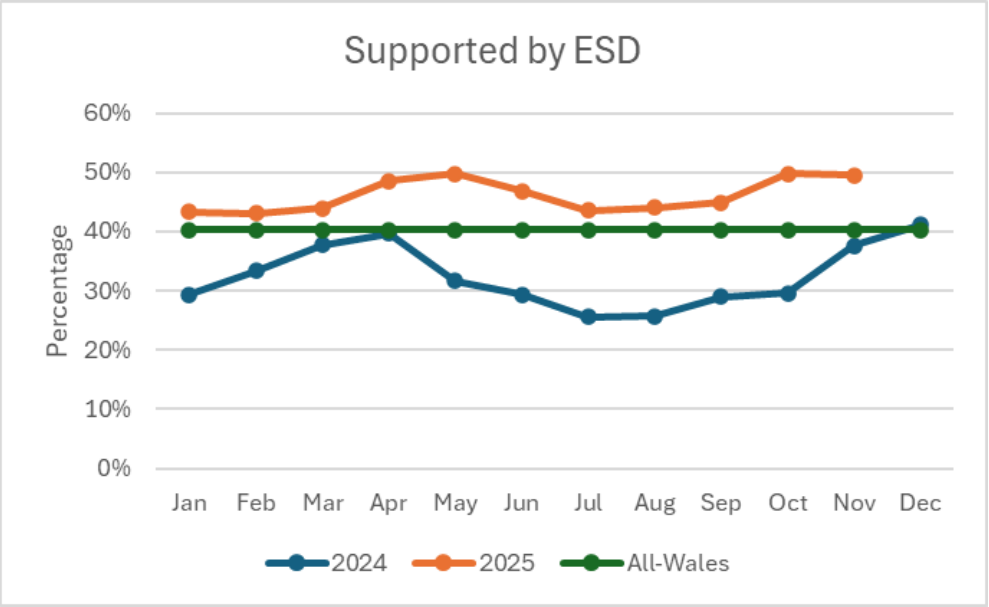


41.1% of patients were assessed by physiotherapy within 24hours of admission (Oct 2025).

AHP Stroke Rehabilitation Quality Metrics

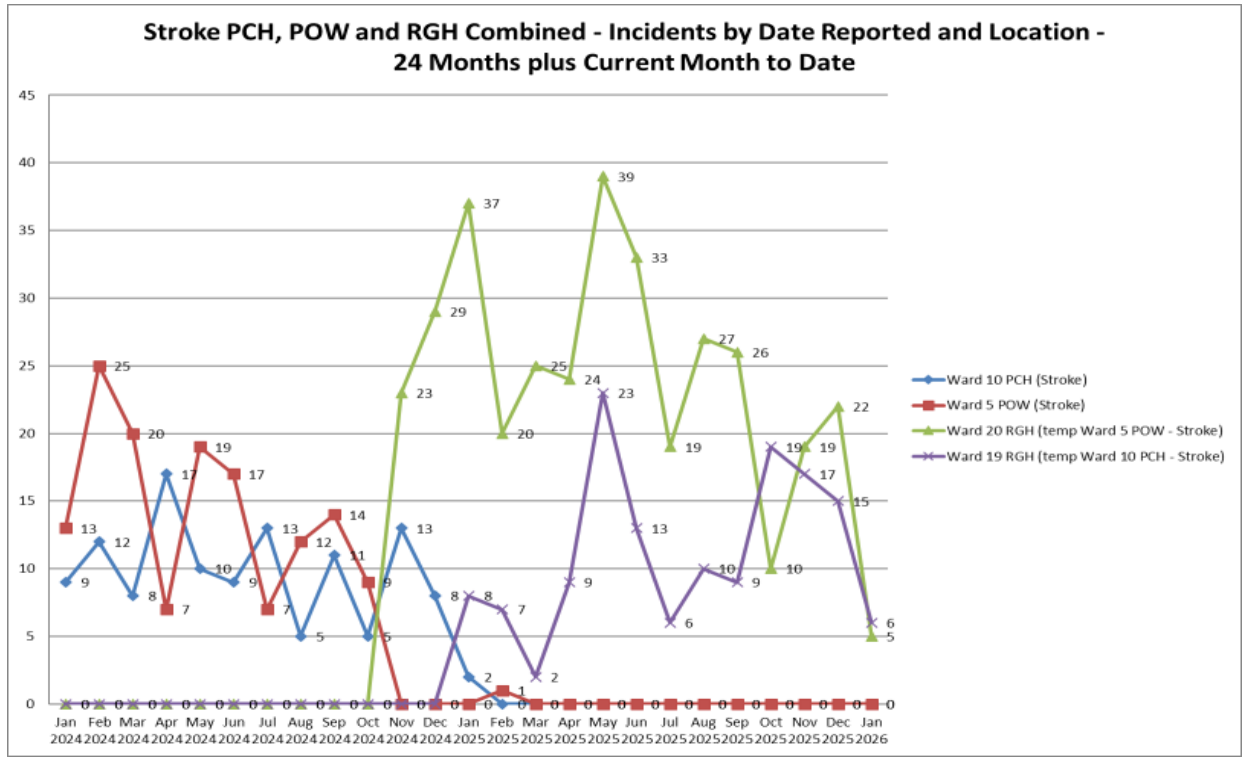


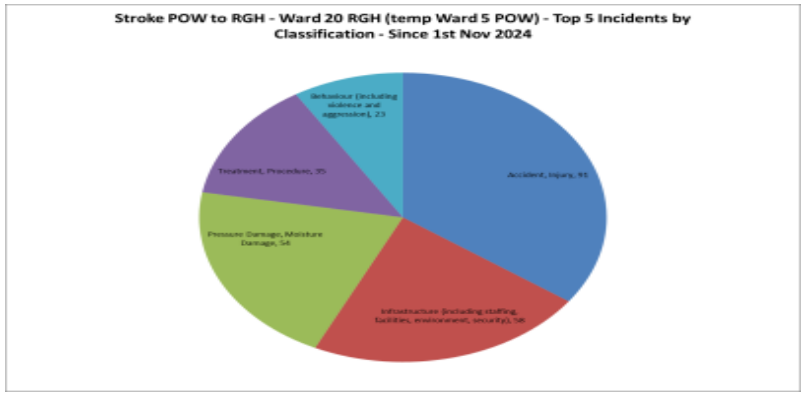
40.3% of patients were assessed by OT within 24 hours of admission (Oct 2025).

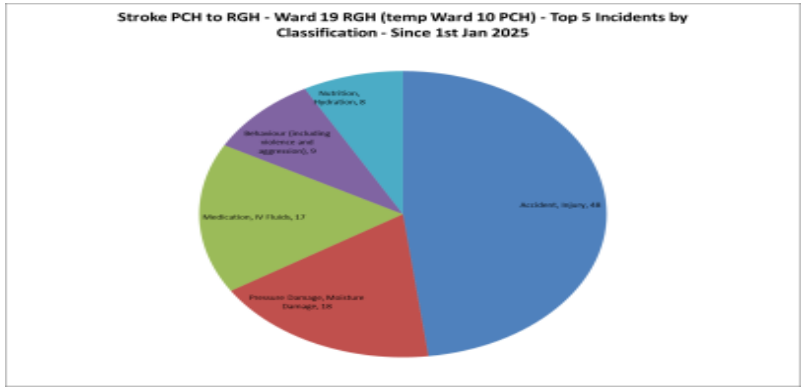


49.5% of patients were supported by ESD on discharge (Nov 2025), which is above the All-Wales average of 40.3%.

CTM Stroke Service Transformation Programme- Incident Management

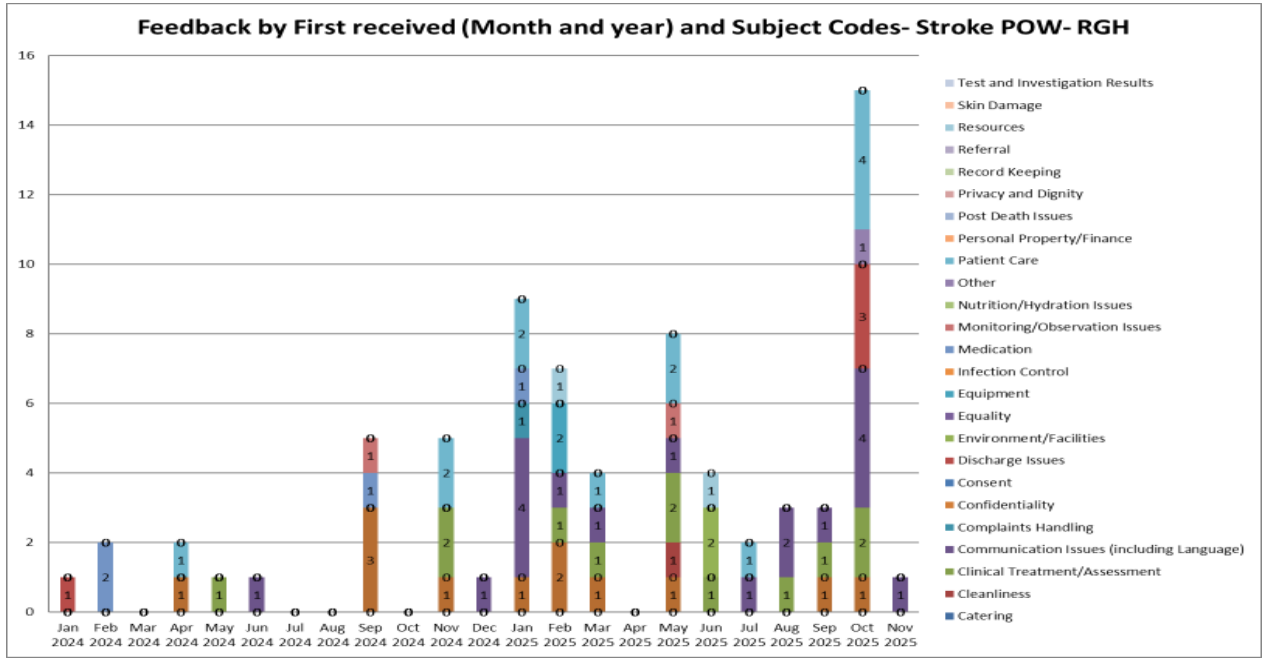


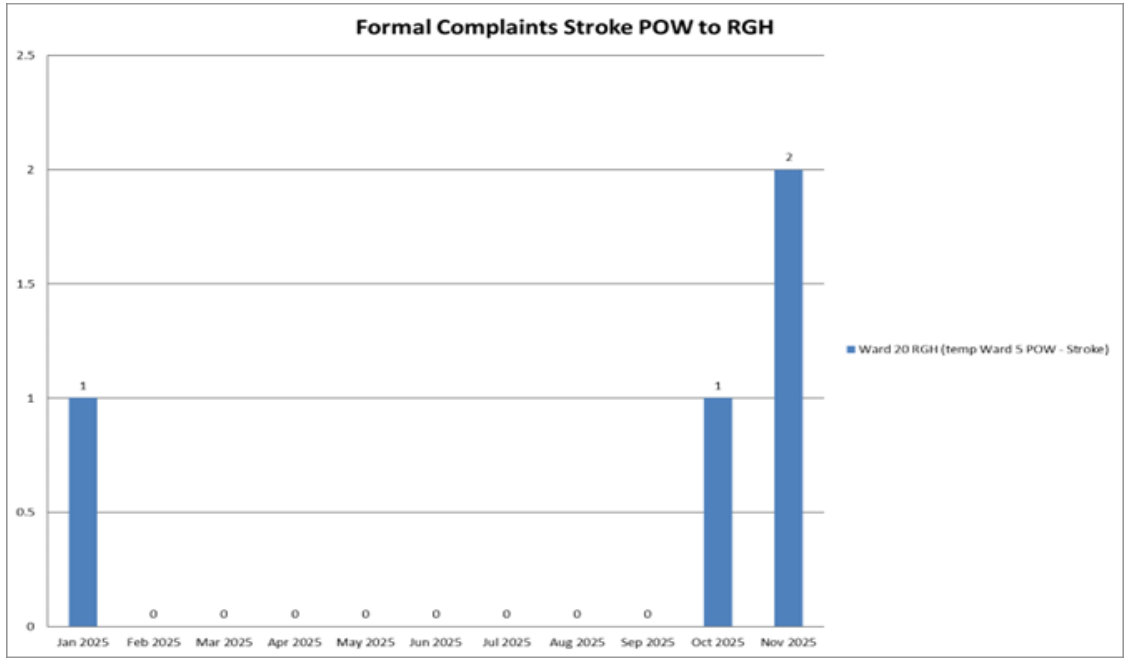




- Immediate spike in reporting post urgent temporary service change.
- Identified trends included, avoidable pressure damage, medication errors, nutrition and hydration and environmental issues and resources.

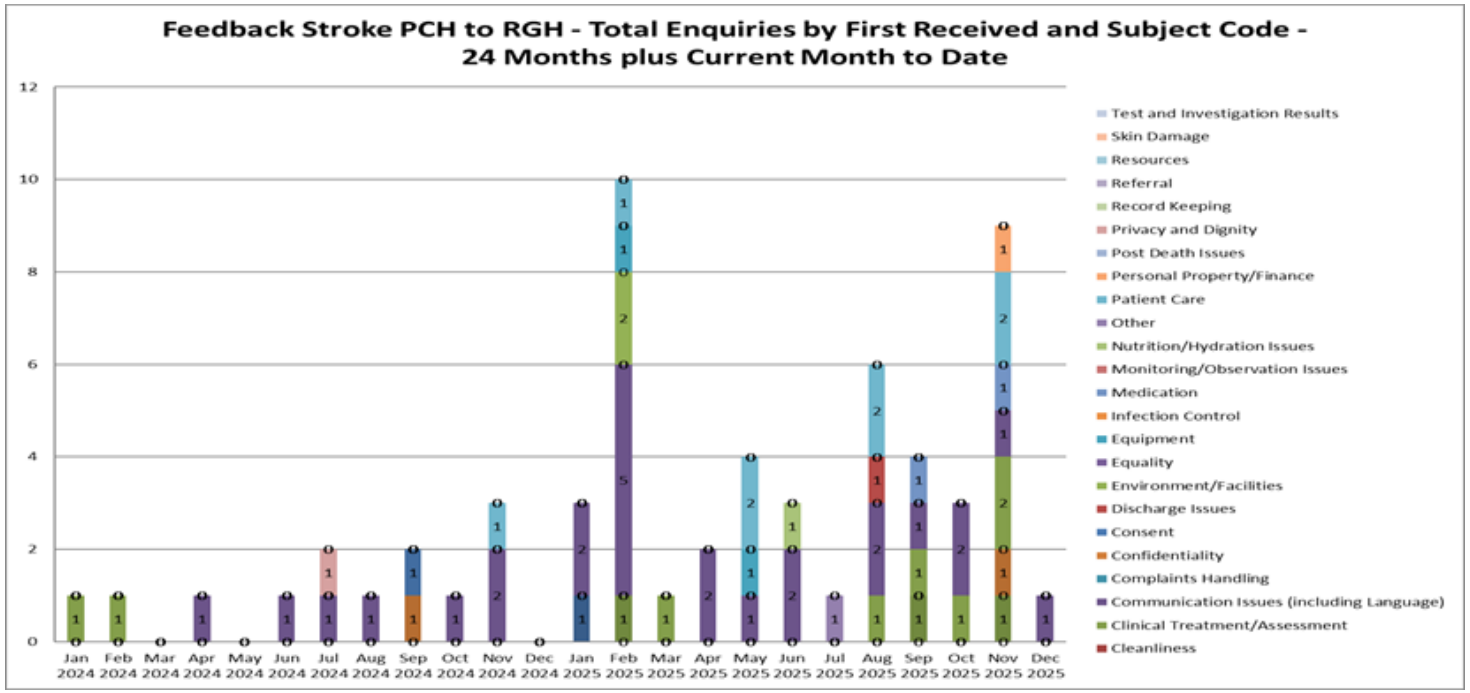
CTM Stroke Service Transformation Programme- Patient experience POW to RGH

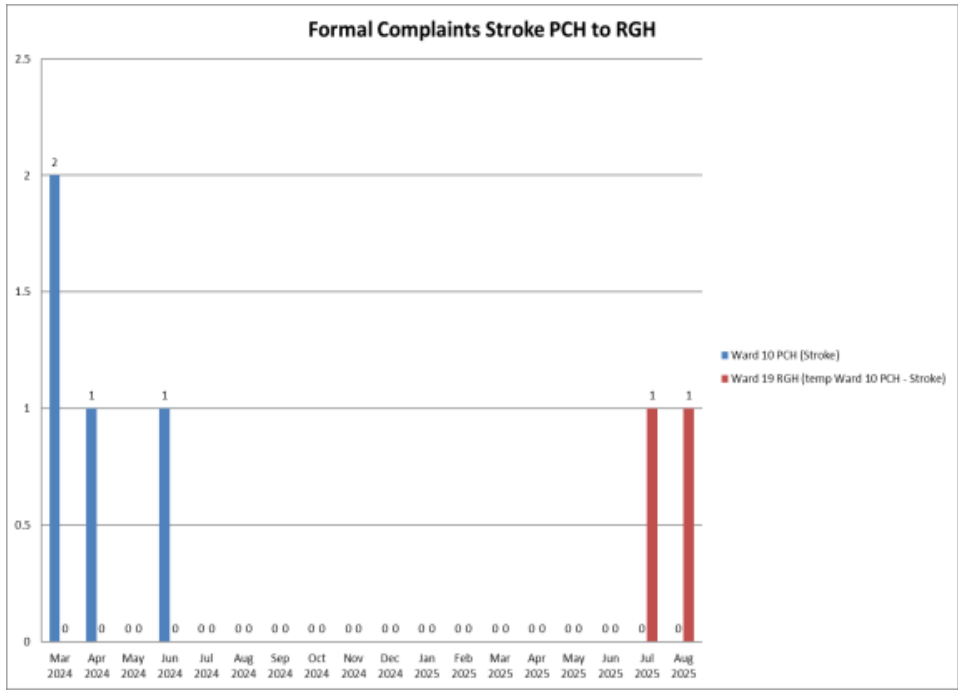




- Top 3 issues, patient care, equity and discharge planning.
- Stroke transformation programme has resulted in sustained improvement evident across the Acute Stroke Unit.

CTM Stroke Service Transformation Programme- Patient experience PCH to RGH





- Top 3 reasons, patient care, equity and environmental issues.
- Stroke transformation programme has resulted in sustained improvement evident across the Acute Stroke Unit.

Examples of ESD patient feedback

Having ESD has helped me a lot, Helped me get stronger and get back to normal. Thank you

My experience with ESD Team has been exceptional. They have got my independence back

I cannot thank you as a service enough, the girls in the service are a credit and I would not be where I am today without them

I had a highly positive and productive experience. The therapists were attentive, tailoring the treatment plan to my needs and progress. I felt supported throughout the process, improvement in my mobility, strength and overall well being. I'm thankful for the care and positive impact on my health.

Overall, I am progressing well. I have become more confident and particularly in the context of my verbal communication. This is in part to my partner's support but also from the care and understanding I have received from all the staff that I have had contact in past 5-6 weeks. I can only be in awe of the professionalism and thoughtfulness.

As a retired NHS employee I know only too well the challenges facing staff and I can say in all honesty that my experience of the ESD team has been outstanding. Thank you very much for getting me back on track and looking forward to my life ahead again.

Stroke Service Redesign Programme

- Service Redesign Programme is in place, with an agreed patient pathway from emergency admission to rehabilitation and subsequent discharge.
- Bed modelling is supporting the planning for acute and rehabilitation stroke care.
- The ambition is to provide a full South-Central stroke service to support timely access to assessment, emergency treatment, specialist care, rehabilitation and aid flow, supporting improved admission to the Stroke Unit within 4 hours.
- A draft CTM UHB paper detailing service redesign has been produced following engagement from all pathway stakeholders – USC, Therapies, Primary & Community.

Regional Update

- South-Central Wales Stroke Operational Delivery Group meeting 13/08/25. Regional model discussed and agreed: CTM to maintain Acute Stroke Unit. C&V to provide regional thrombectomy service
- National Stroke Service Standards consultation now complete.
- First meeting of Regional Stroke Workforce Planning Group held 01/10/25. Initial scoping meeting with Ops and Workforce Leads for CTM and C&V to understand shared workforce challenges within stroke services. Regional Clinical Advisory Group to be established.
- C&V and CTM Leads met to discuss regional rotas. Advice sought from Bristol colleagues to further inform discussions. Follow up meeting tbc.

Review of emergency stroke service consolidation - summary

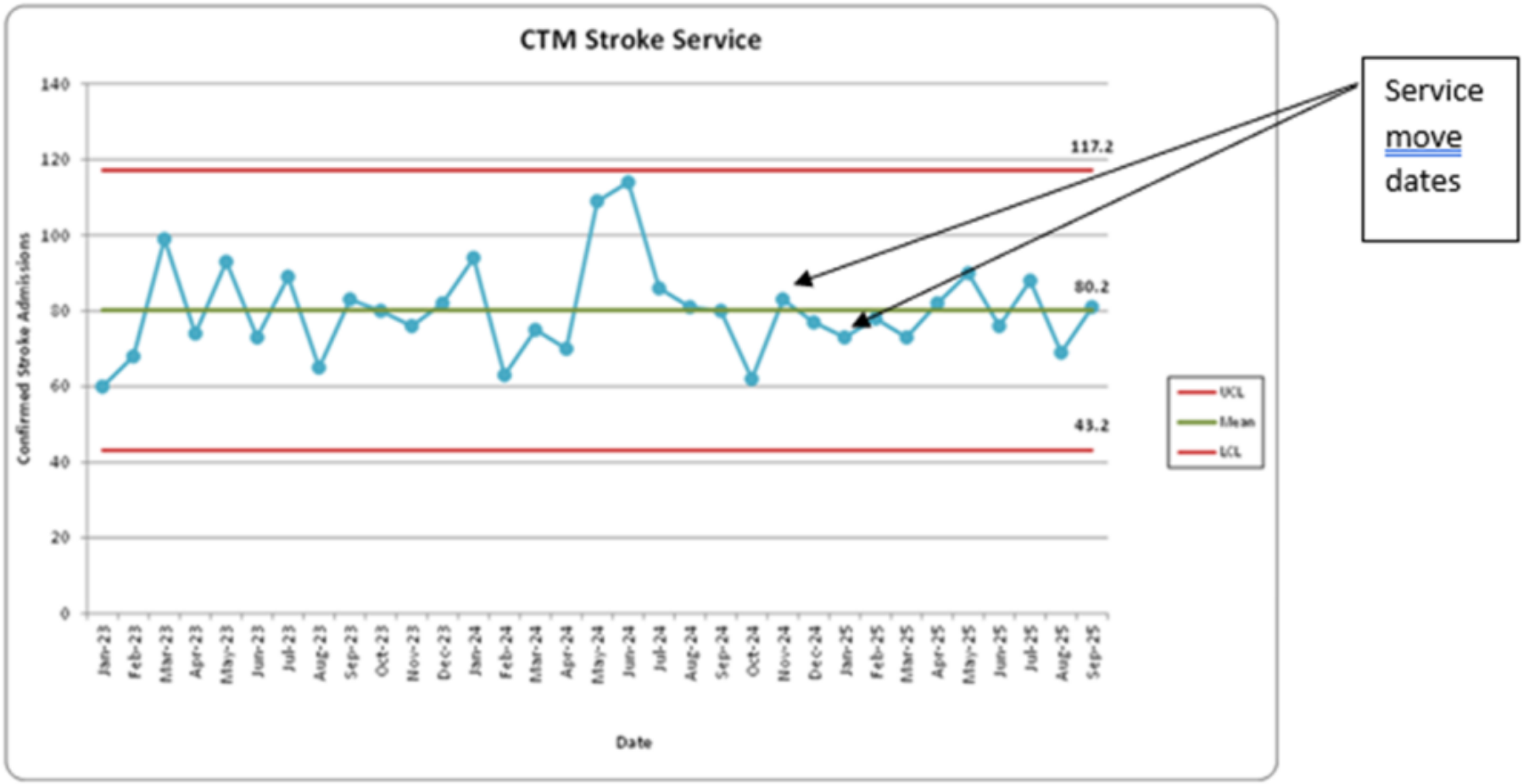
A detailed paper (available on request) was submitted to Executive Management Board in November 2025, providing assurance of the safety of current services and the greater sustainability and foundation for improvement that the consolidated service provides.

The extracts in the two slides below focus on assurance for neighbouring Health Boards and system partners, and the broader paper demonstrates that the relocation has not had a negative impact on patient care, safety, experience, or overall performance.

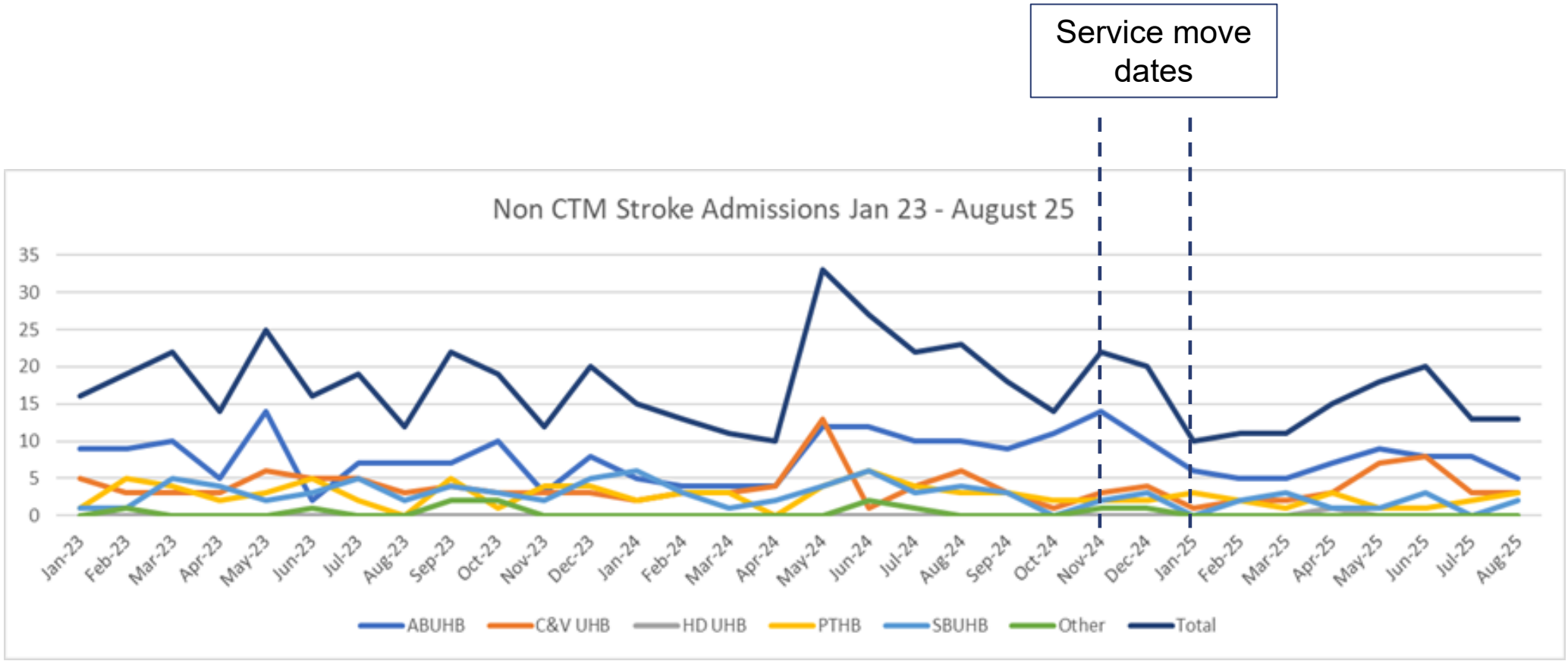
Metrics such as thrombolysis rates, length of stay, admission volumes, and safety indicators remain stable and within expected variation. Furthermore, the consolidation of acute stroke services at RGH has contributed to a more equitable and consistent provision of care across the region, addressing previous disparities in clinical pathways, reporting systems, and staffing levels that existed between the two-site model.

No significant trends or concerns have been identified in out-of-area patient data.

Total admissions



Admissions by Health Board



Specific Matters for Consideration:

- This report provides an overview of the CTM Stroke Service performance and internal transformation programme.
- The transformation programme has resulted in improved performance, but further work and improvements are required to achieve national targets.
- Information is included regarding the AHP provision and staffing numbers against Stroke Guidelines recommendations.
- Information is included regarding the review of the emergency stroke service consolidation. No negative impact on patient care, safety, experience, or overall performance has been identified.

Key Risks / Matters for Escalation:

- Whilst progress has been made to stabilise the Medical workforce the position is still fragile, mitigated by retention of Locum consultant.
- Existing Temporary centralisation expires April 2026
- Efforts to enhance the efficiencies across the AHP stroke pathway are ongoing however, delivering a 7-day AHP service for stroke patients is not feasible within the current establishment. AHP staffing numbers for stroke are small and consistently below Stroke Guideline recommendations.

Recommendation

The committee are asked to note the information provided within this slide deck.

Next Steps

Ongoing Stroke Transformation Programme and continual monitoring and evaluation of the temporary service centralisation

Agenda Item
6.1

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Services

Pwrpas yr Adroddiad / Report Purpose	For Review

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

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

PALS	Patient Advisory Liaison Service

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.11.25 and 31.12.25 taken from systems on 05.01.26, unless otherwise specified.

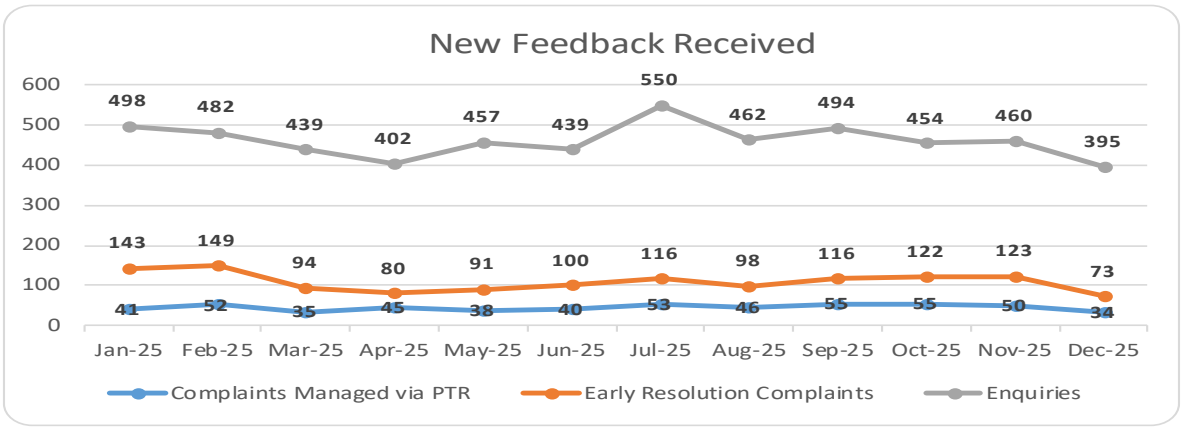
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

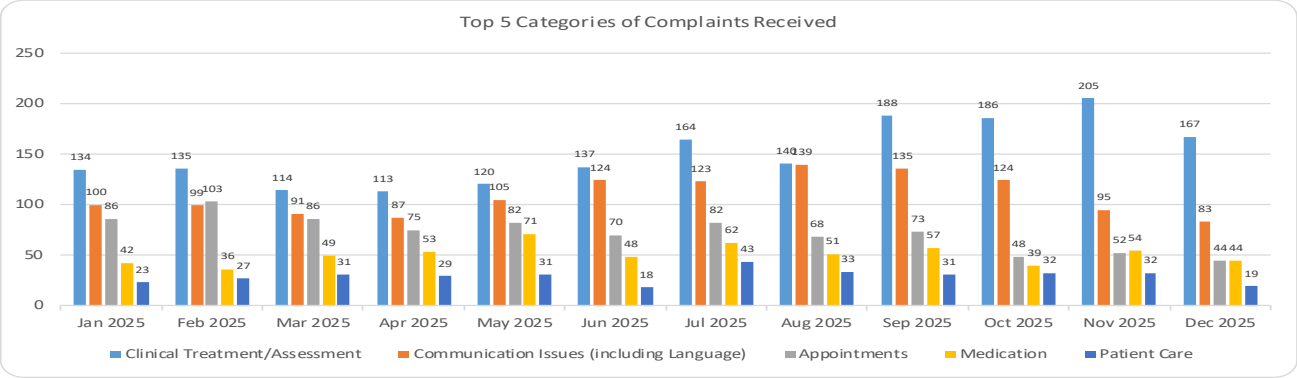
Complaints & Enquiries

New Complaints Received

Between the 01.11.25 and 31.12.25 the Health Board received a total of 280 complaints and 855 enquiries. Of 280 complaints received, 84 were categorised as formal and managed under the Putting Things Right Regulations (PTR). The number of Early Resolution complaints has increased slightly over the last two months since September 2025 figure, PTR complaints and enquiries decreased during October and November 2025 compared to September 2025, and continued to drop down for December 2025.

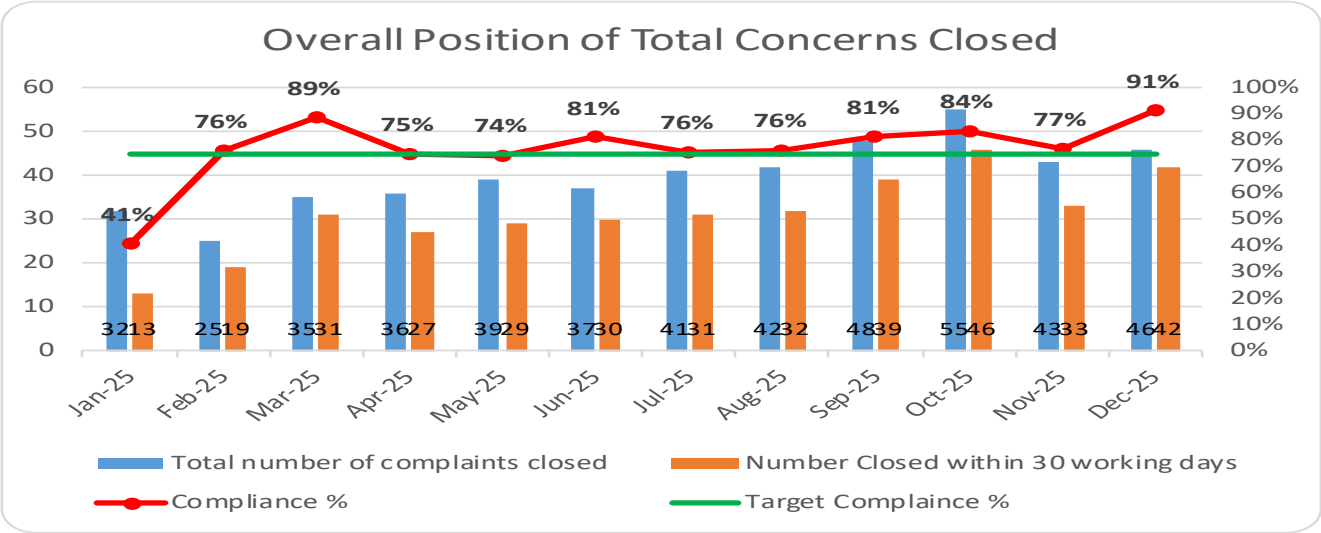


For all feedback (Complaints and Enquiries) received in November 2025 and December 2025, accounting for 61% of the feedback received, the top 3 types remain consistent with previous months. These relate to Clinical Treatment / Assessment (372), Communication Issues (including Language) (178) and Appointments (96).



Closed Complaints

Within the period of 01.11.25 and 31.12.25, the Health Board closed a total of 89 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 (84%). As at 05.01.26, the Health Board had 71 open formal complaints. Of these, 30 complaints were open over 30 working days which is 16 more open complaints compared to the position at the beginning of November. Targeted work aligned with the preparation for implementation of Listening to People to improve the efficiency and effectiveness of complaints management continues to be undertaken.



Public Services Ombudsman for Wales

Open cases

As at the 08.01.26 the Health Board has 48 open Public Services Ombudsman for Wales (PSOW) Cases. Of these, 33 are awaiting a response from the PSOW.

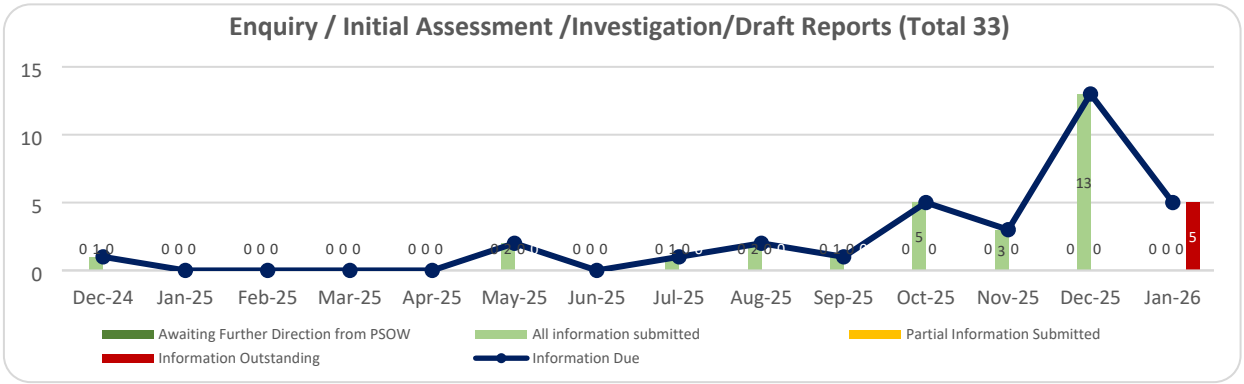
Current Status	Enquiry / Initial Assessment/ Investigation	Early Settlement	Draft Report Comments	Final Report Compliance	Information Only	Total

All evidence submitted and awaiting closure by PSOW	0	1	0	0	0	1
Awaiting further direction from PSOW	0	0	0	0	2	2
Information Received	0	0	0	0	0	0
Information Submitted	24	2	4	0	0	30
Information Outstanding	5	4	0	4	0	13
Information Partially Submitted	0	1	0	1	0	2
Total	**29**	**8**	**4**	**5**	**2**	**48**

New PSOW Cases Received

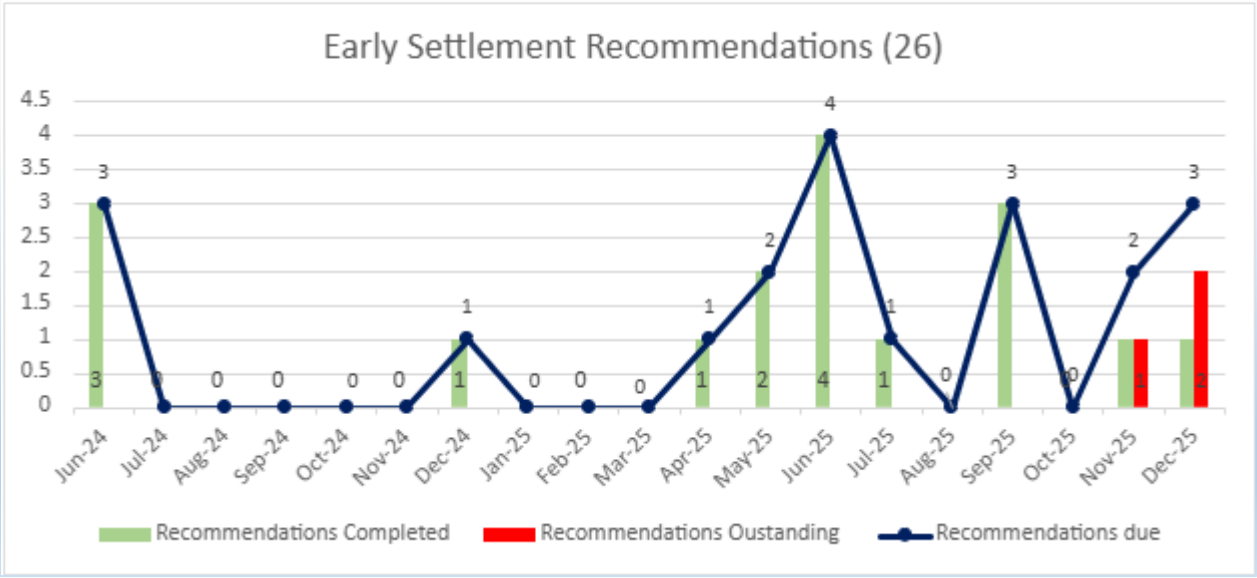
The Health Board received notification of 21 new referrals to the Public Services Ombudsman for Wales (PSOW) between the 01.11.25 and 31.12.25. Of the 21, 18 were received as enquiries, 1 as decision not to investigate, 1 as full investigation and 1 as an early settlement proposal.

Of the 33 cases the Health Board currently has at 08.01.26 in the enquiry / initial assessment/investigation stage, 5 cases have outstanding actions. No actions are currently overdue. This is reflected in the chart below:



Early Settlement Proposal

During the same period the Health Board agreed 7 early settlement proposals. It should be noted that more than one action can be attributed to a case. As at the 09.01.26, the Health Board has 8 open early settlement cases, with 26 associated case actions. Of the 25 actions, 3 are currently overdue the deadline agreed with the PSOW.



New Final Reports Received

During November and December 2025, the PSOW issued 4 final reports to the Health Board. Of these, 3 were upheld and 1 was not upheld. Of the 3 upheld reports, one was issued as a public interest report.

1. Waiting times, Trauma & Orthopaedics Upheld Public Interest Report

Background

The Health Board initially received an enquiry in June 2023 with regards to the patient's status on the waiting list for Orthopaedic Surgery. At this stage the patient was advised that he was no longer on the waiting list within Cwm Taf Morgannwg University Health Board due to initially being not medically fit for surgery and subsequently a belief that the patient had been repatriated to another Health Board.

The patient's family contacted the Health Board on a number of occasions including via the MP/MS however this did not trigger a review of the patients current status in relation to his medical fitness or confirmation that the second Health Board had accepted the repatriation.

Whilst it is recognised that the patient had a number of health conditions, the PSOW investigation focused on whether delays in the patient receiving his hip replacement were due to administrative processes rather than clinical reasons. Consideration was also given to the management of the complaints received from the patient's family and MP/MS regarding the ongoing delays. In undertaking its review, the PSOW has referenced the Welsh Government Rules for Managing Referral to Treatment Waiting Times ("RTT guidance") Version 7, October 2017.

Findings of Investigation of Clinical Care Provided

On conclusion of their investigation, the PSOW determined that there is sufficient evidence to determine that administrative failings led to the continued delay of the patient's surgery. The report further identifies that there were a number of missed opportunities to have corrected the position for the patient.

An important matter for noting within the report is that the PSOW from their "*investigation of this complaint raises significant concerns about the way in which waiting lists are managed and how waiting times are represented and recorded by the Health Board. The patient was removed from the urgent surgery list (after already waiting 19 months) without either him or his GP being informed. The reason he was removed is unclear. This is unacceptable and contrary to the RTT guidance".*

The report further highlights that the Health Board provided incomplete and misleading information within the complaint responses by repeatedly advising that the patient had been referred to a second Health Board when this referral had not been accepted. This created additional distress over a prolonged period of time.

Learning/Actions to be addressed
To address the learning, the following recommendations are included in the report:

Within **1 month** of this report the Health Board should:

a. Arrange for the Chief Executive to make a written apology to the patient and his daughter for the administrative error which delayed the patient's surgery, and for the poor and delayed response to their complaint.
b. Provide a redress payment of £750 to reflect the poor response to the complaint, and the additional stress for the patient in having to chase up the issue with the Health Board.
c. Provide a redress payment of £1,500 to reflect the additional 18 month wait when the patient was not on the waiting list due to administrative error.

Within **4 months** of the date of the final report the Health Board should:

d. Provide evidence to the PSOW that the Health Board has audited the surgery waiting lists and the transferred patient lists to satisfy itself that there are no other surgery patients who have been similarly overlooked or wrongly removed from its lists.
e. Share the report with the Board which should nominate a Committee to maintain oversight and monitoring of the Health Board's compliance with recommendation d).

2. Diagnosis and Treatment, Emergency Care

Background
In August 2023, a patient, aged 40, collapsed at home and was taken to the Emergency Department at Prince Charles Hospital. The patient presented with symptoms including

loss of consciousness, facial droop, speech loss, and limb weakness. Initial tests (CT, ECG, BP monitoring) were normal, and the patient was discharged the next day.

Two months later, in October 2023, the patient suffered a major stroke, requiring a thrombectomy and prolonged hospitalisation.

A complaint was made to the Health Board in March 2024, raising concerns that:

- A TIA (Transient Ischaemic Attack) was not properly investigated.
- Not all relevant tests were carried out.
- There were inaccuracies and contradictions in the Health Board's complaint response.

The PSOW investigation focused on whether appropriate investigations were carried out to determine if Mr A had suffered a TIA and whether appropriate treatment was provided during admission and on discharge.

Findings of Investigation of Clinical Care Provided

The PSOW investigation concluded that the care provided to the patient fell below expected standards because key symptoms suggestive of a possible TIA (such as speech loss and facial weakness) were not fully explored, and timely investigations like MRI and carotid doppler were not undertaken, meaning the patient was not referred to rapid-access TIA services as recommended. Record keeping by the Second Consultant was poor, with missing or contradictory documentation, including incorrect information about tests that had not been performed, and this amounted to maladministration. Inaccuracies in the Health Board's complaint response, along with limited involvement from key clinicians, undermined the integrity of the complaints process. Overall, these failures created significant uncertainty for the patient and their family regarding whether appropriate investigation or earlier treatment could have reduced the risk of his subsequent stroke.

Learning/Actions to be addressed

To address the learning, the following recommendations are included in the report:

Within **1 month** of this report the Health Board should:

a. Provide a written apology for the failings identified in this report.

Within **3 months** of the date of this report the Health Board should:

b. Review this case in relation to the investigations and diagnosis given to the patient to identify any points of learning which can be applied in future care.
c. Remind staff about the protocol for assessment of patients presenting with symptoms as in this patient's case.

d. As part of a reflective process, ensure that the Second Consultant shares details of this case as well as the Ombudsman's report at their annual appraisal.
e. As part of quality assurance, share this report with its Quality Patient Safety Committee.

3. Management of diabetes, General Medicine and Community Care

Background

A patient with type 2 diabetes and complex health needs, was admitted to Princess of Wales Hospital on 10 July 2023 following an episode of haematemesis. During the patient's admission, their blood glucose remained consistently high (12.4–23.9 mmol/L), indicating poor diabetes control. The patient was discharged on 14 July to their residential home with a plan for monitoring their blood sugars and community diabetes nurse follow-up. Communication issues (including discharge information sent to the wrong GP) and lack of formal referral processes led to gaps in monitoring and treatment. The patient was not started on insulin prior to discharge, despite later being prescribed insulin based on their hospital readings. The patient was re-admitted on 3 September and died the following day from urosepsis and complications of uncontrolled diabetes. The patient's family submitted a complaint to the Health Board regarding missed treatment opportunities and inadequate discharge and aftercare.

The PSOW investigation focused on whether there were missed opportunities to prescribe insulin prior to discharge and whether the discharge, aftercare, and diabetes follow up were clinically appropriate and properly communicated.

Findings of Investigation of Clinical Care Provided

The PSOW investigation concluded that the care provided to the patient fell below expected standards due to poor management of their diabetes during admission, where their persistently high blood sugar levels should have triggered a formal referral to the Inpatient Diabetes Team, but instead only informal discussions took place, resulting in a missed opportunity to initiate insulin before discharge. After discharge, the patient's follow-up care was not clinically appropriate, with unclear communication, no formal handover to community services, discharge information sent to the wrong GP, and inadequate monitoring arrangements at the residential home. Treatment decisions were poorly documented, informal advice was relied upon, and delays occurred in arranging insulin despite clear clinical need. These failures in coordination, documentation, and escalation led to inappropriate aftercare, causing lasting uncertainty for the patient's family about whether earlier intervention could have changed the outcome.

Learning/Actions to be addressed

To address the learning, the following recommendations are included in the report:

Within **1 month** of this report the Health Board should:

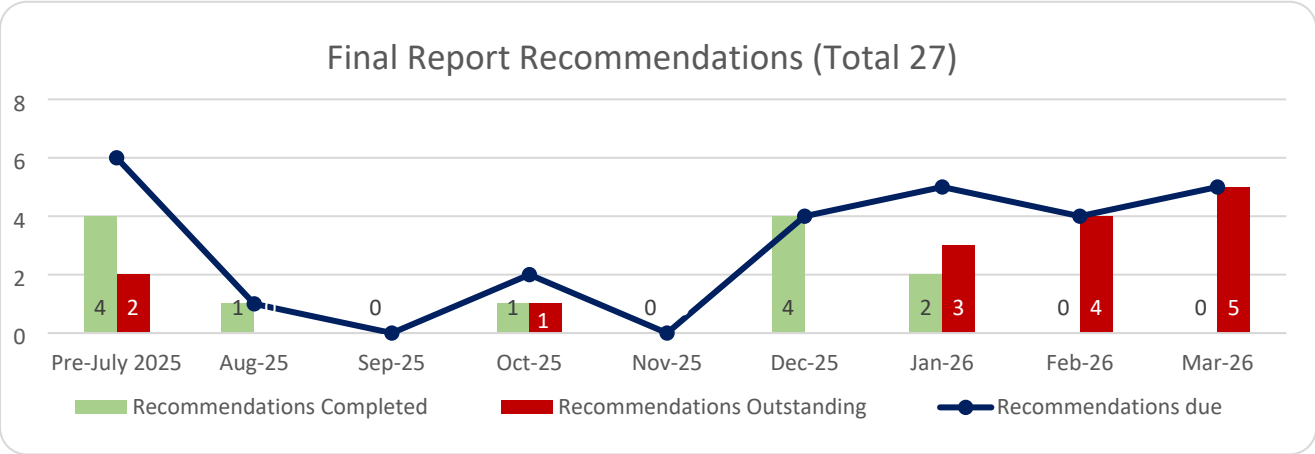
a. Apologise to the patient's family for the failings identified in this report.
b. Ensure that the Doctor and the Secondary Care DSN are familiar with the Diabetes Referral Process.
c. Remind the Doctor, Secondary Care DSN and First Consultant of the importance of keeping accurate and sufficiently detailed records that include any decisions made regarding treatment.
d. Share this report through established clinical governance structures for wider reflection and learning.

Within **3 months** of this report the Health Board should:

e. Review the role of the Diabetes Team in supporting rapid hospital discharge and review.
f. Provide refresher training to staff involved in investigating the complaint on their responsibilities under the NHS organisations' Duty of Candour.
g. As the Duty of Candour was potentially engaged reflect on why this consideration was not recorded at the time.

Open Final Report Recommendations

As at 08.01.26, the Health Board has 5 cases which are currently in the final report stage of the PSOW process. These cases have 27 associated recommendations. Of these recommendations, 15 are currently outstanding, with 3 currently overdue the timescale for completion.

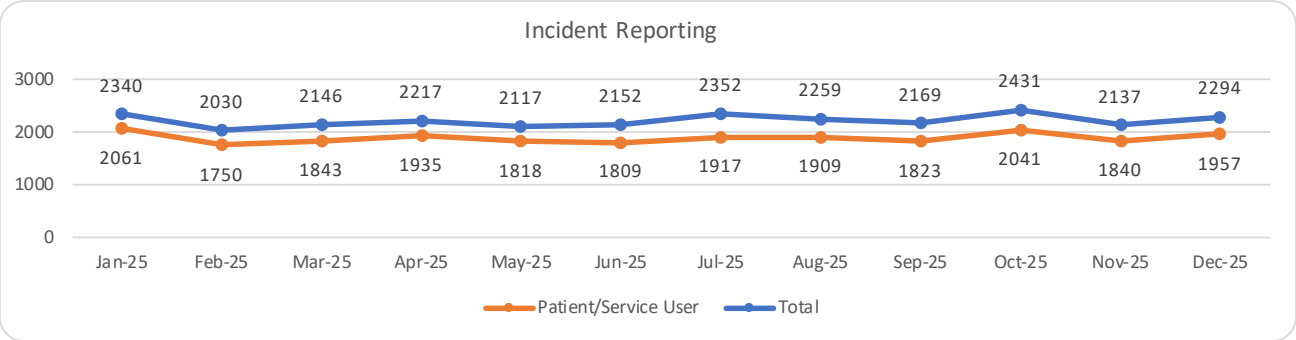


2.2 Patient Safety Incidents

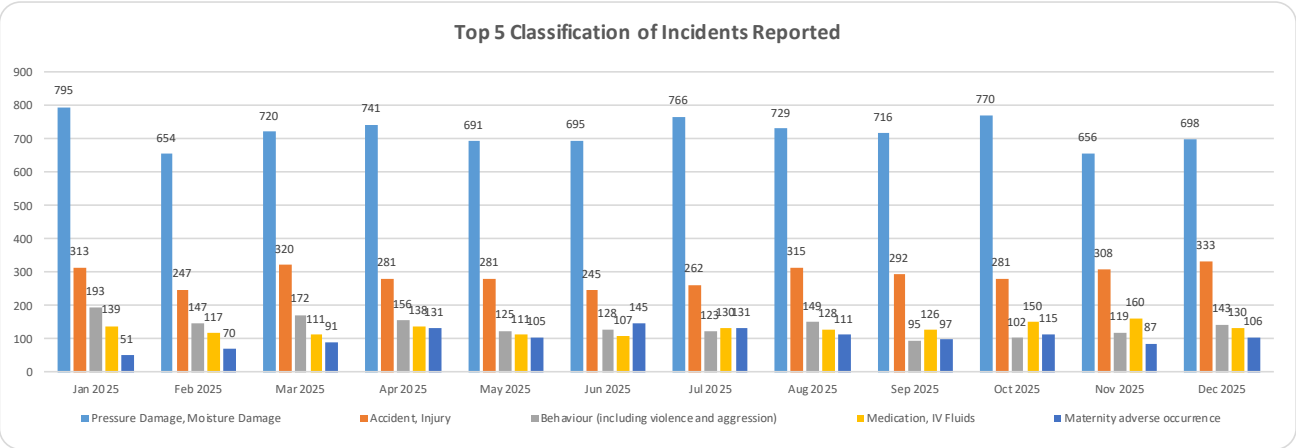
Total Patient Safety Incidents

A total of 4,431 incidents were reported as occurring between 01.11.25 and 31.12.25, this represents a decrease of 169 when compared with the previous 2 months (4,600). 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 4,431 incidents

reported, 86% (3,797) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

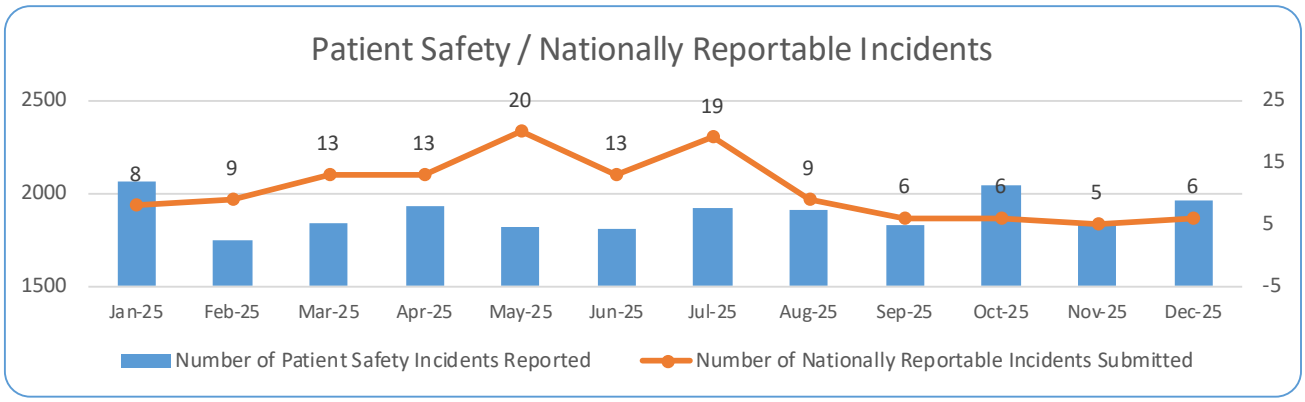


The top 5 classification of incidents reported as occurring in November and December 2025, linked to a patient affected incident are: Pressure Damage /Moisture Damage (1,354), Accident, Injury (641), Medication, IV fluids (290), Behaviour (including violence and aggression) (262) and Maternity adverse occurrence (193). This is consistent with the previous two-month period, apart from Behaviour (including violence and aggression) which has moved to fourth place with an increase in incidents from 197 to 262. The trend for the top 5 classification of incidents is highlighted in the chart below:



<u>Nationally Reportable Incidents</u>

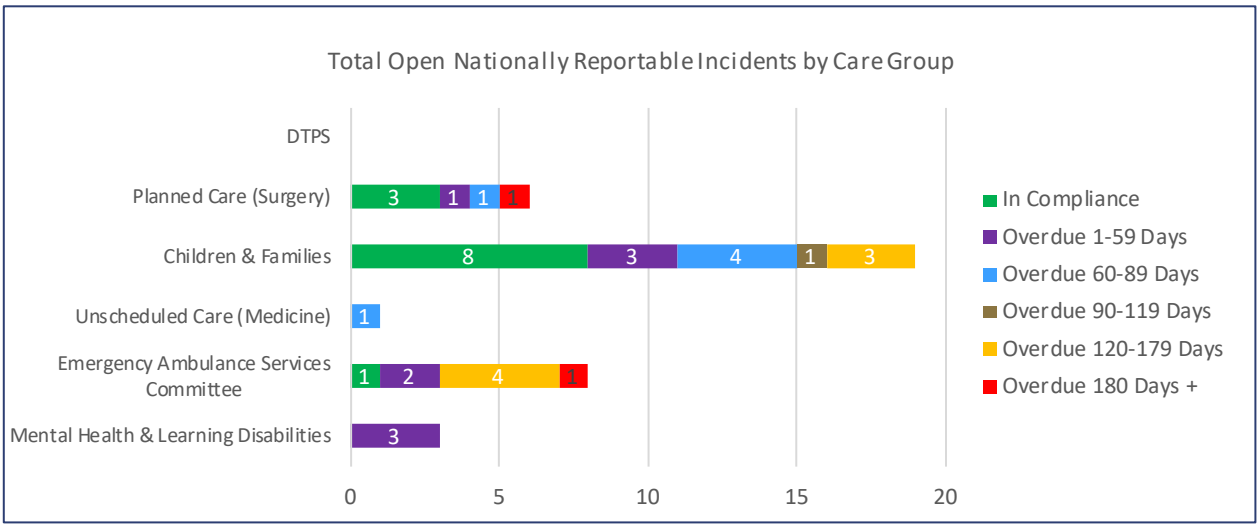
Between 01.11.25 and 31.12.25, 28 Nationally Reportable Incidents were submitted to the NHS Performance & Improvement Team. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



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:

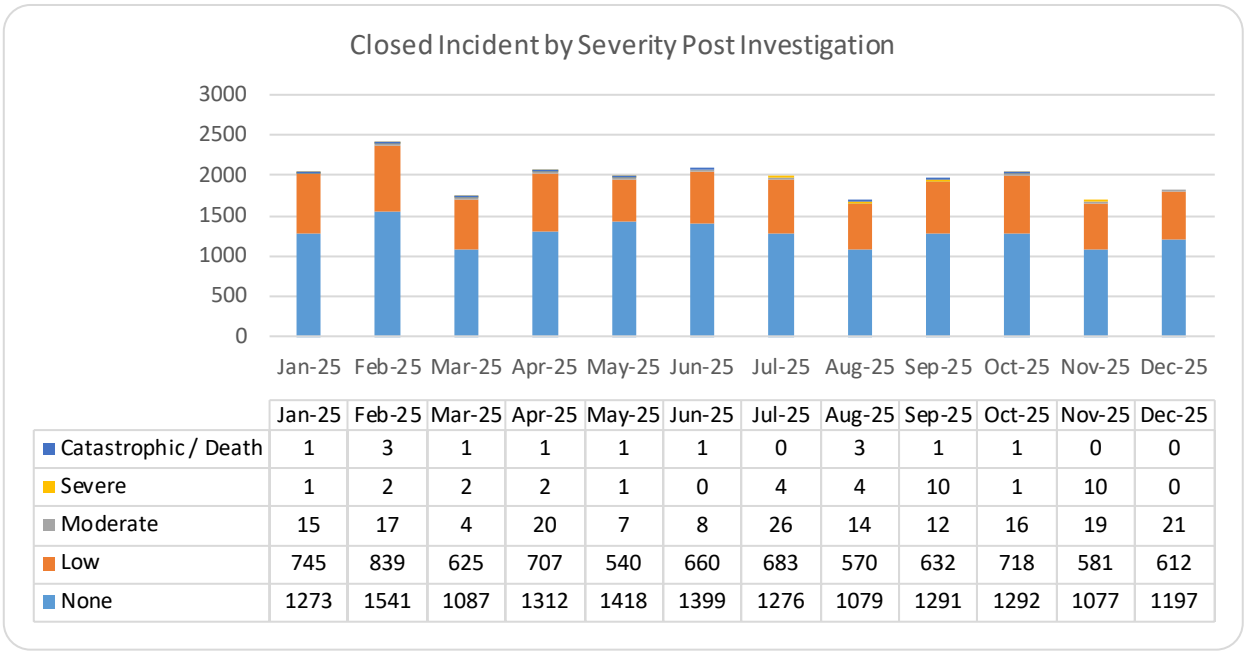
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Total
Access, Admission	0	0	1	1	3	1	0	0	0	0	0	0	6
Assessment, Investigation, Diagnosis	0	0	1	0	2	0	2	0	0	0	1	1	7
Equipment, Devices	0	0	0	1	0	0	0	0	0	0	0	0	1
Infection Prevention and Control	0	0	4	3	2	0	0	0	1	0	0	0	10
Maternity adverse occurrence	4	1	3	0	5	2	0	5	1	5	0	1	27
Nutrition, Hydration	0	1	0	0	0	0	0	0	0	0	0	0	1
Patient/service user death	1	1	0	1	1	1	1	1	1	0	0	0	8
Pressure Damage, Moisture Damage	2	4	4	3	7	6	15	3	3	1	2	4	54
Transfer, Discharge	1	1	0	4	0	2	0	0	0	0	1	0	9
Treatment, Procedure	0	1	0	0	0	1	1	0	0	0	1	0	4
Total	8	9	13	13	20	13	19	9	6	6	5	6	127

As at the 05.01.26, the Health Board currently has 37 open Nationally Reportable Incidents, of which 25 are overdue the timescale for completion. Focused work continues to be undertaken to ensure investigations are concluded and ensure a timely outcome is provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

Between the 01.11.25 and 31.12.25 a total of 3,517 patient safety incidents were closed. The 12 month trend is reflected in the table below.



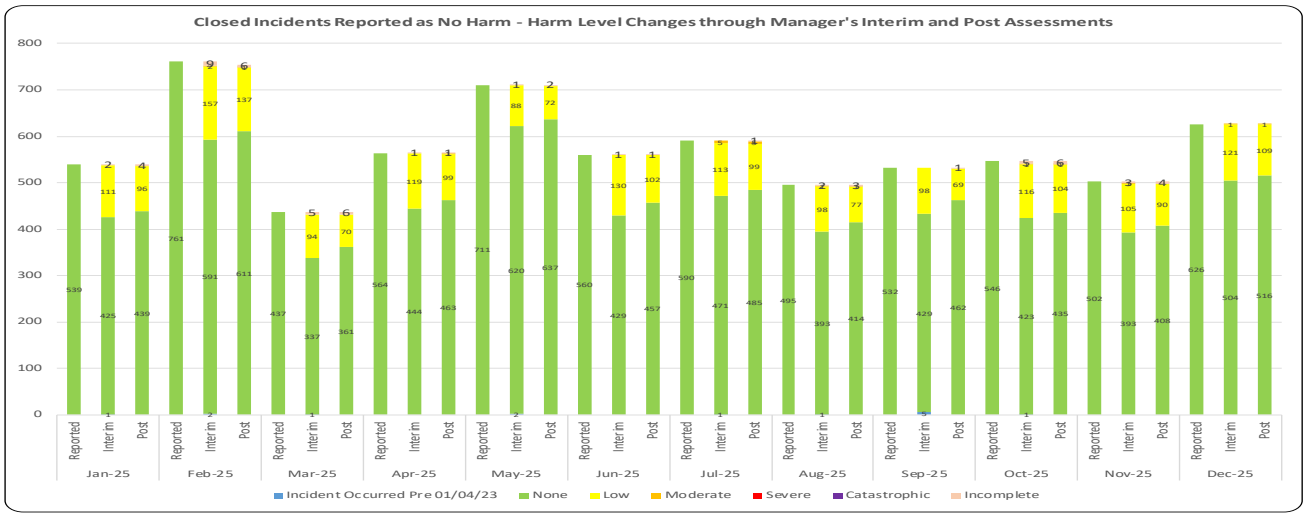
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Catastrophic / Death	1	3	1	1	1	1	0	3	1	1	0	0
Severe	1	2	2	2	1	0	4	4	10	1	10	0
Moderate	15	17	4	20	7	8	26	14	12	16	19	21
Low	745	839	625	707	540	660	683	570	632	718	581	612
None	1273	1541	1087	1312	1418	1399	1276	1079	1291	1292	1077	1197

Of the 3,517 patient safety incidents closed, 10 were closed with severity post investigation of severe harm but zero incidents of catastrophic/ death. A breakdown of incidents is provided in the table below:

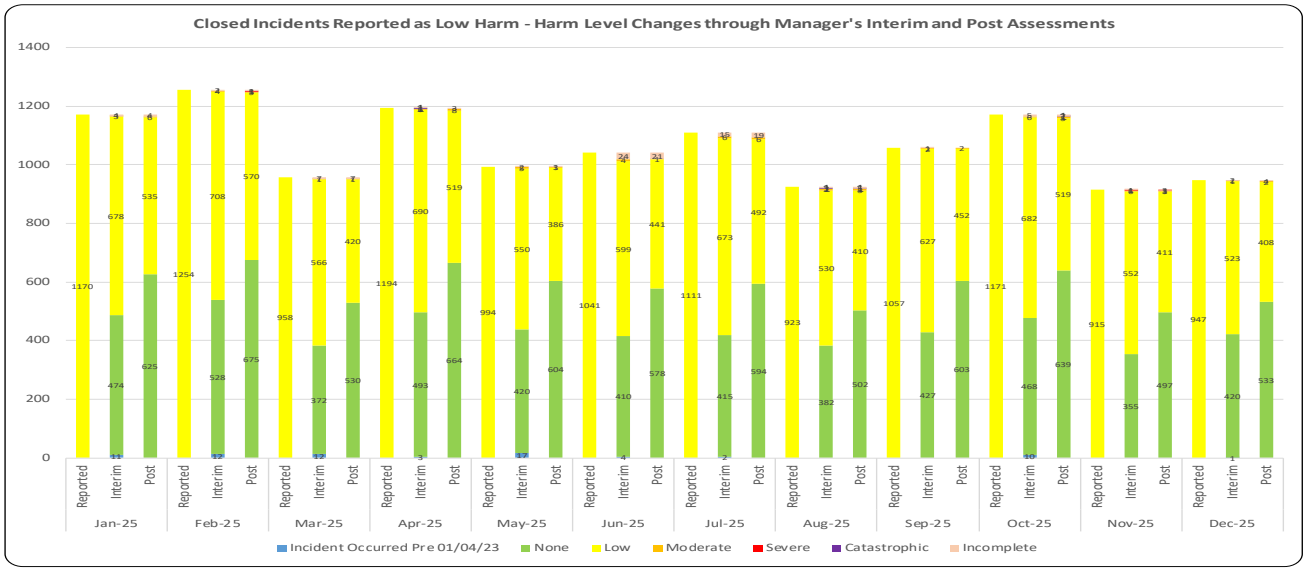
	Children and Families	DTPS	Planned Care (Surgery)	Total
Access, Admission	0	0	3	3

Assessment, Investigation, Diagnosis	0	1	1	2
Maternity adverse occurrence	2	0	0	2
Medication, IV Fluids	0	1	0	1
Patient/service user death	1	0	0	1
Treatment, Procedure	0	0	1	1
Total	3	2	5	10

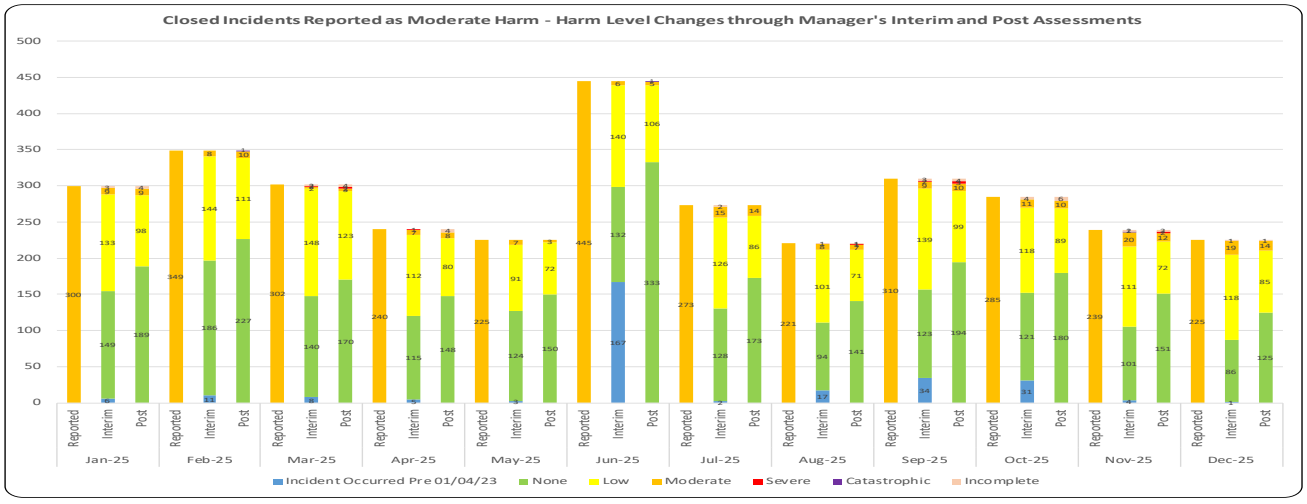
Work continues to be undertaken to ensure that a severity of moderate, severe or catastrophic / death recorded on conclusion of an investigation accurately reflects where it can be determined that an incident has been directly caused or attributable to an intervention (action/inaction) by the Health 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, level of harm following management review and severity of incident post investigation is provided below:



Between 01.11.25 and 31.12.25, a total of 1,128 incidents were initially reported as No harm, representing an increase of 50 compared with the previous two-month period (1,078). Following review, the majority remained classified as No harm. Across the period, approximately 20% of incidents were upgraded to a higher harm level at the interim stage (weighted 20.2%), reducing to around 18% at post investigation (weighted 17.7%), with most upgrades reclassified to Low harm and very few to Moderate. No incidents were classified as severe or catastrophic, and incomplete reviews reduced to zero by December. The trend in harm level changes is reflected in the chart above.

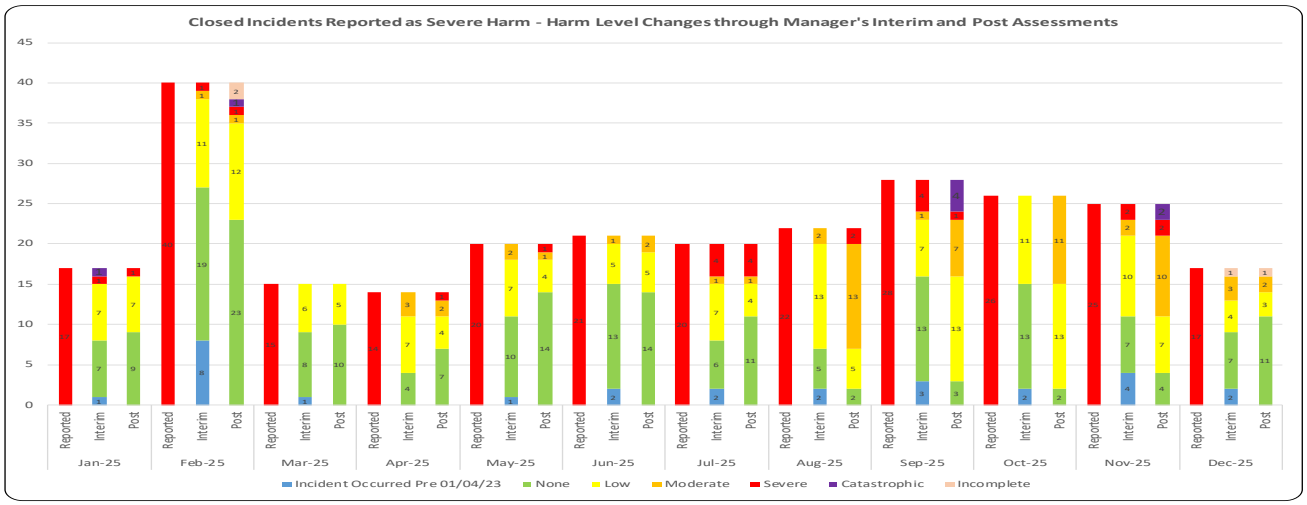


Between 01.11.25 and 31.12.25, a total of 1,862 incidents were initially reported as Low harm, representing a decrease of 366 compared with the previous two-month period (2,228). Following review, a significant amount were reclassified to No harm, approximately 42% at the interim stage, increasing to around 55% at post investigation. Upgrades to a higher harm level were rare, at 0.4% during interim and 0.3% at post, with very few progressing beyond Moderate and only one incident reaching Severe or Catastrophic. The trend in harm level changes is reflected in the chart above.

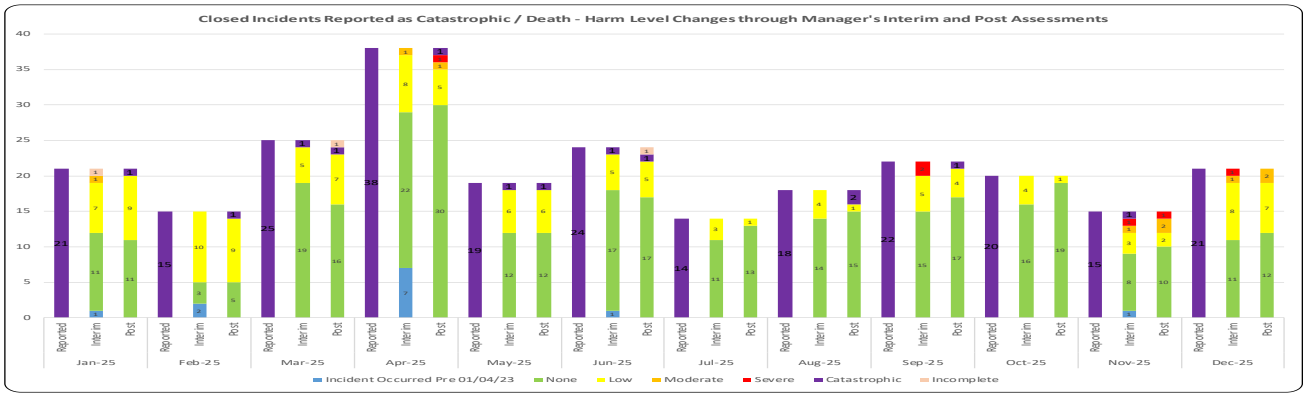


Between 01.11.25 and 31.12.25, a total of 464 incidents were initially reported as Moderate harm, representing a decrease of 131 compared with the previous two-month period (595). Following review, most incidents were downgraded at the interim stage (weighted 90.7%), predominantly to Low (49%) and None (40%), with a small proportion to Incident Occurred Pre 01/04/23 (1%). By post investigation, downgrades increased further (weighted 93.3%), with the majority recorded as 'Incident Occurred

Pre 01/04/23 (60%), alongside None (34%) and Low (6%). Upgrades to higher harm levels remained rare throughout.



Between 01.11.25 and 31.12.25, a total of 42 incidents were initially reported as Severe harm, representing a decrease of 12 compared with the previous two-month period (54). Following review, most incidents were downgraded at the interim stage (weighted 92.9%), distributed across None (33%), Low (33%), Moderate (12%), and 'Incident Occurred Pre 01/04/23' (14%), 5% remained Severe, and 2% were recorded as incomplete, with no interim upgrades. By post investigation, downgrades remained high (weighted 88.1%), with the majority recorded as None (36%), Low (24%), or Moderate (29%), 5% remained Severe and 5% were upgraded to Catastrophic, with one case incomplete.



Between 01.11.25 and 31.12.25, a total of 36 incidents were initially reported as Catastrophic harm, representing a decrease of 6 compared with the previous two-month period (42). Following review, the majority were downgraded at the interim stage (95%), primarily to None and Low, with small proportions to Moderate and Severe. By

post-review, downgrades remained high (weighted 100%), with most incidents recorded as None or Low, and a few as Moderate.

Duty of Candour

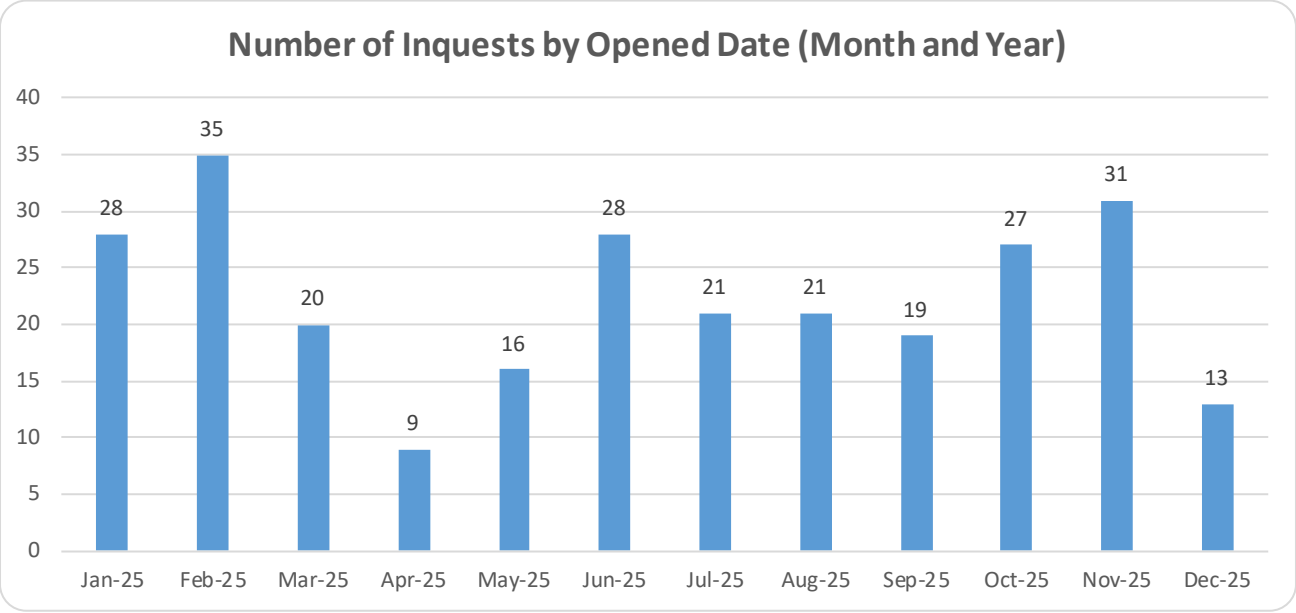
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

Number of Incidents	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Where Duty of Candour Triggered	10	8	13	15	22	17	8	12	12	27	9	16
Where In-person notification completed	8	6	12	15	21	17	8	9	11	23	9	8
Where letter of notification sent	7	6	12	14	19	17	7	8	9	20	8	7

2.3 Inquests Case Activity

New Inquests Received

In the time period 01.11.25 and 31.12.25, the Health Board received notification of 44 inquests. This is a slight decrease when compared with the previous 2 month period (46). A trend graph of the inquests opened during period is provided below.

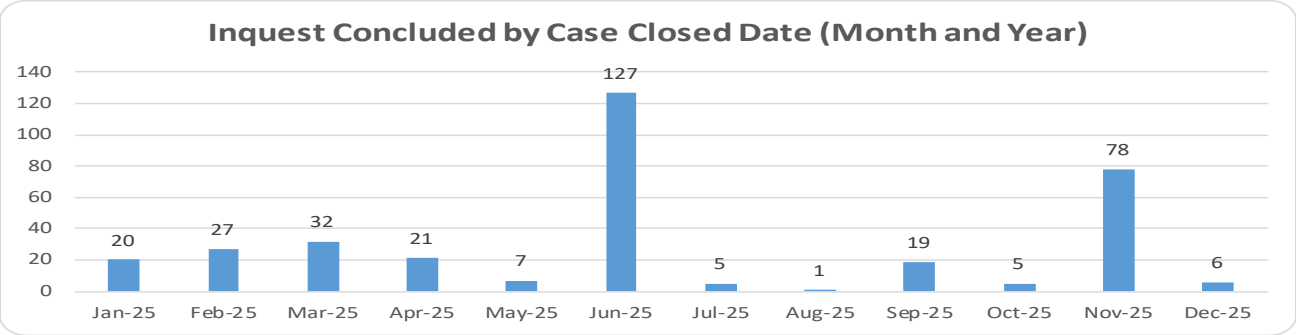


Of the 44, the highest number of inquests were received for the Mental Health and Learning Disabilities Care Group (16). A breakdown of inquests received by Care Group is provided below.

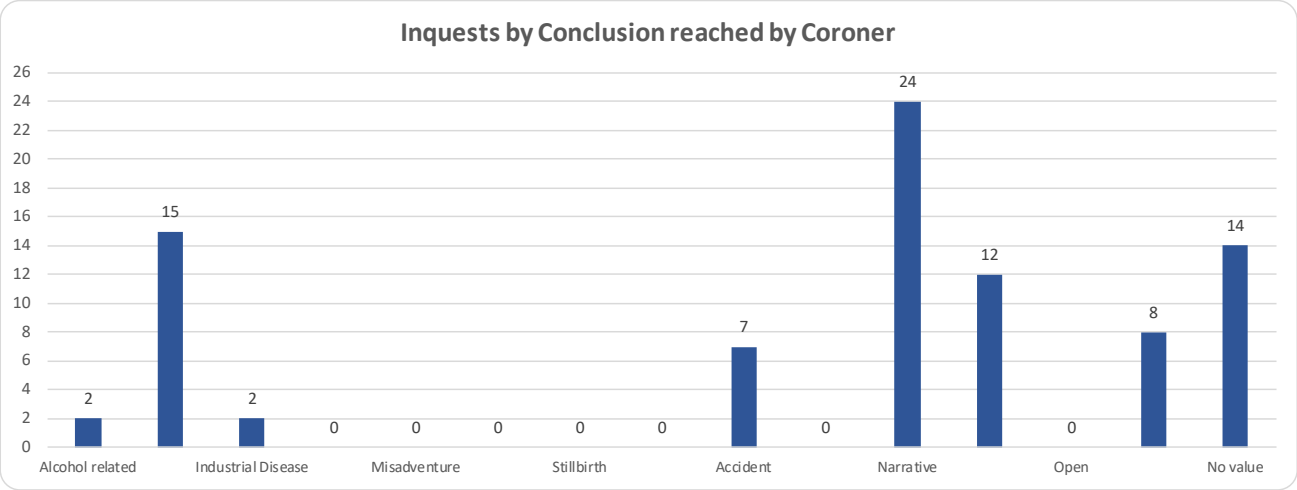
Care Group	Number Received
Children and Families	1
Primary Care and Community	6
Mental Health and Learning Disabilities	6
Planned Care	11
Unscheduled Care	19
DTPS	1
Not Specified	0
Total	44

Inquests Concluded

During the same 2 month period, 84 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 84 inquests cases closed on Datix, 14 were discontinued by the Coroner prior to hearing. Of the remaining cases (21) a breakdown of the outcome of inquests closed between the 01.11.25 and 31.12.25 is provided in the chart below.



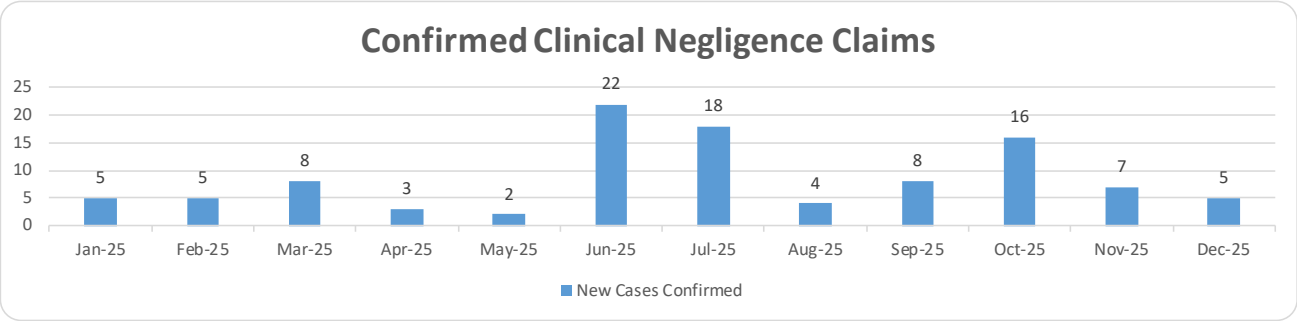
Regulation 28 Reports / HMC Letter Received

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 01.11.25 and 31.12.25 the Coroner did not issue any regulation 28 reports to the Health Board.

2.4 Clinical Negligence Claims

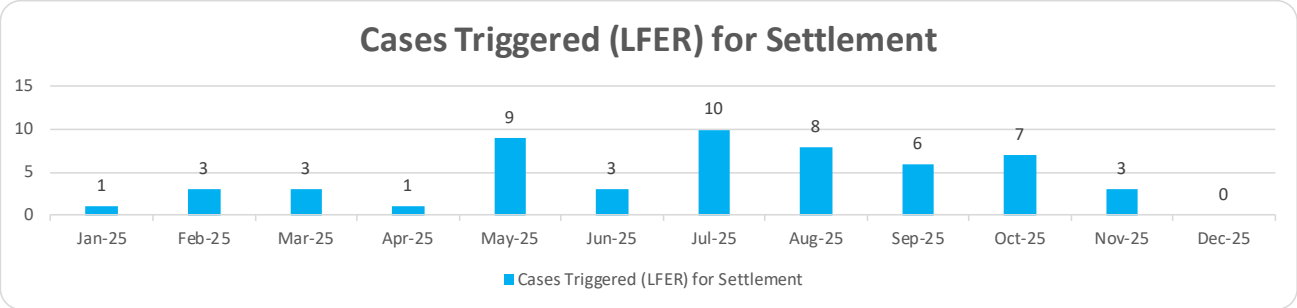
New Confirmed Clinical Negligence Claims

Between the 01.11.25 and 31.12.25 the Health Board received confirmation of a total of 12 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



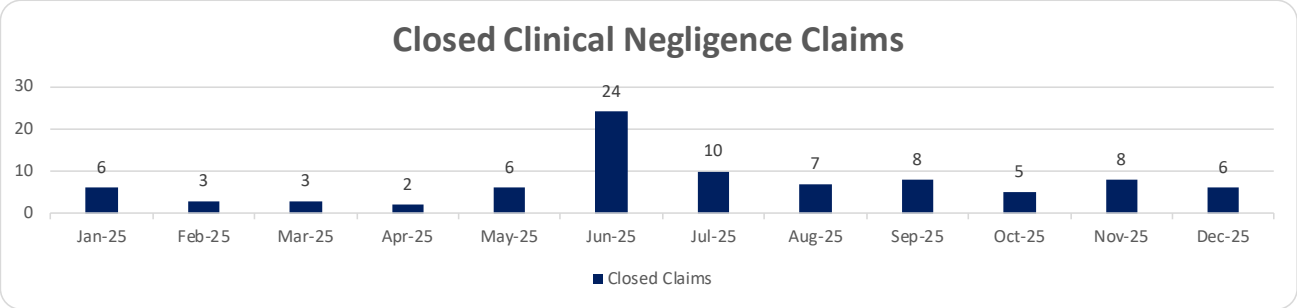
Clinical Negligence Claims triggered for settlement

Between the 01.11.25 and 31.12.25 in the Health Board, 3 Clinical Negligence Claims triggered for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



Closed Clinical Negligence Claims

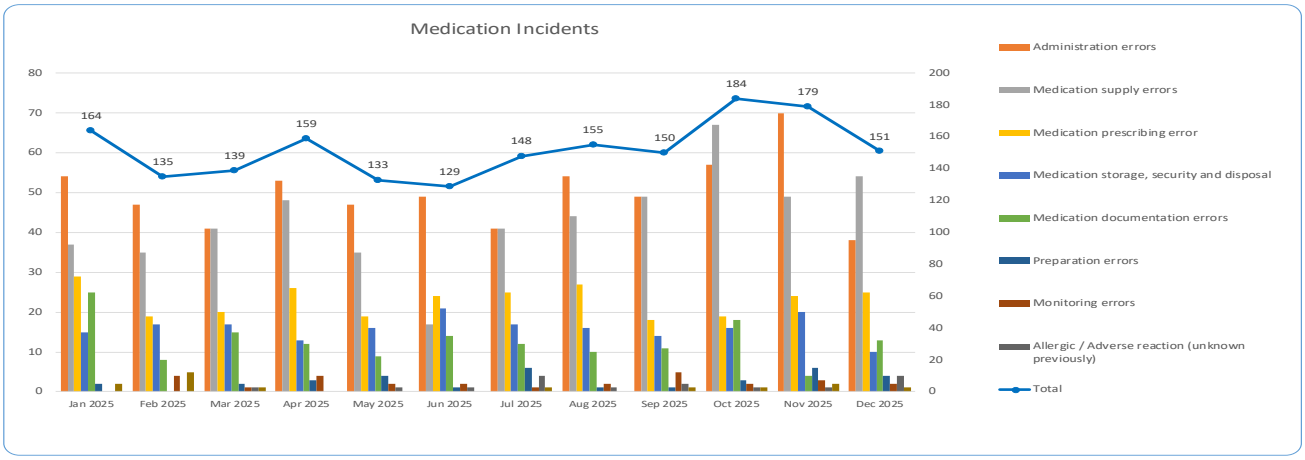
Between the 01.11.25 and 31.12.25 in the Health Board, 14 Clinical Negligence Claims were closed. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



2.5 Specific Quality & Safety Metrics

2.5.1 Medication Safety

A total of 330 medication incidents were reported as occurring between 01.11.25 and 31.12.25. This is a decrease of 4 when compared with the previous 2 month period (334). Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (108), medication supply errors (103) and medication prescribing errors (49).

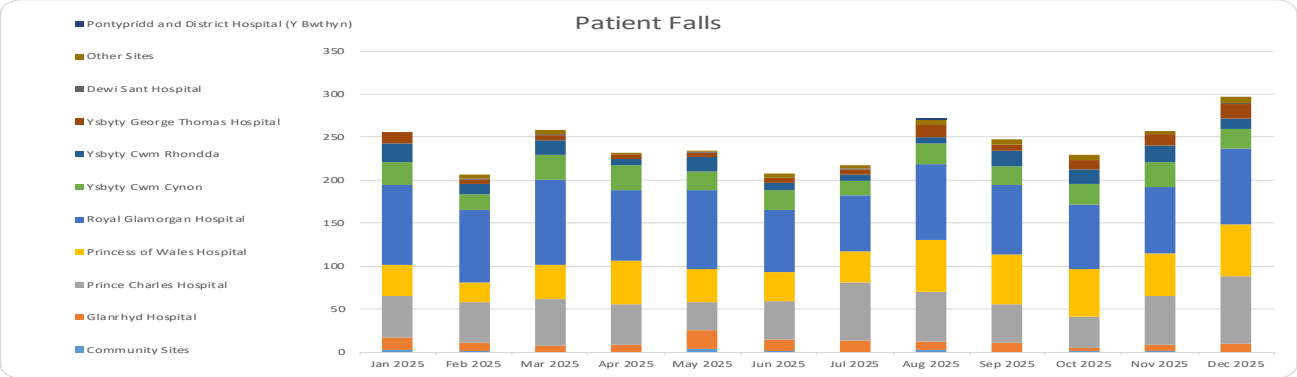


94% of the medication incidents were reported as resulting in no (142) or low (168) harm, with the remaining reported as resulting in moderate harm (19), Catastrophic / Death harm (1). While no medication incidents were reported as resulting in severe harm. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.5.2 Patient Falls Incidents

A total number of 554 falls, where the person affected was a patient, were reported during November and December 2025. This represents an increase compared with the previous two months (478).

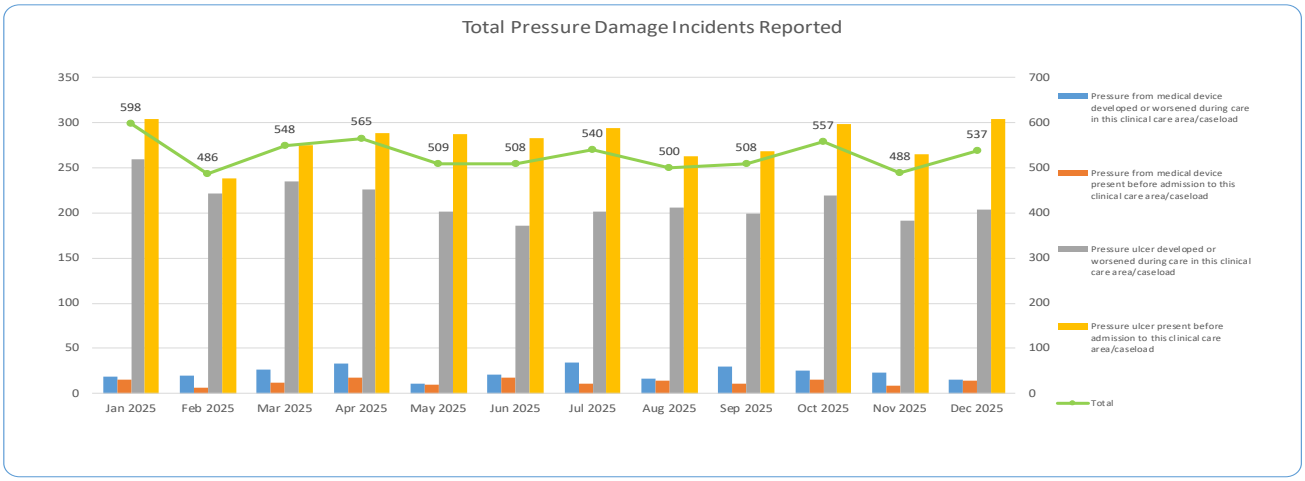
Of the falls incidents within the time period, 94% were reported as no (208) or low (311) harm. The remaining incidents were reported as resulting in moderate (32) and severe (3) harm. No incidents relating to patient falls were reported as resulting in catastrophic harm / death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



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

2.5.3 Pressure Damage

Between the 01.11.25 and 31.12.25, a total of 1025 pressure damage incidents were reported, of which 433 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (592) were reported as being present before admission to this clinical care area/caseload.



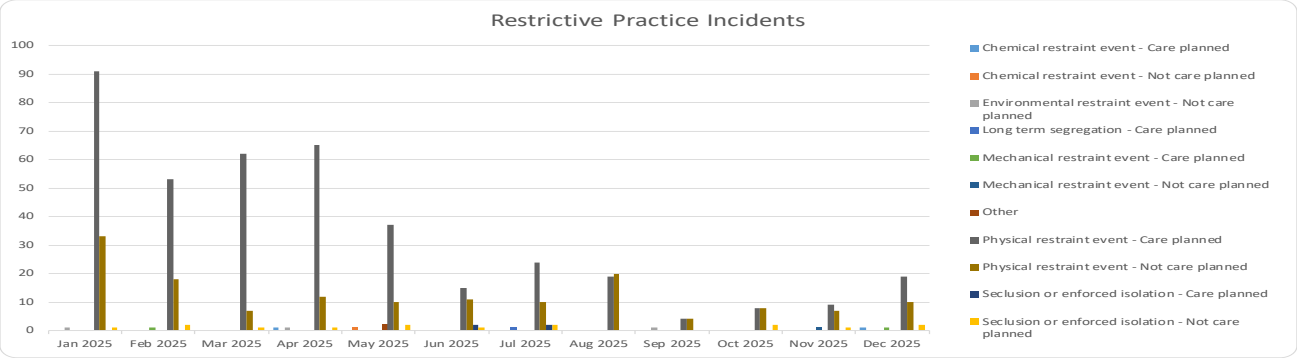
Of the 433, identified as developing or worsening during current caseload, 217 were identified as occurring within the community, which represents an increase of 6 compared with the previous two-month period (211).

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

<u>Restrictive Practices</u>

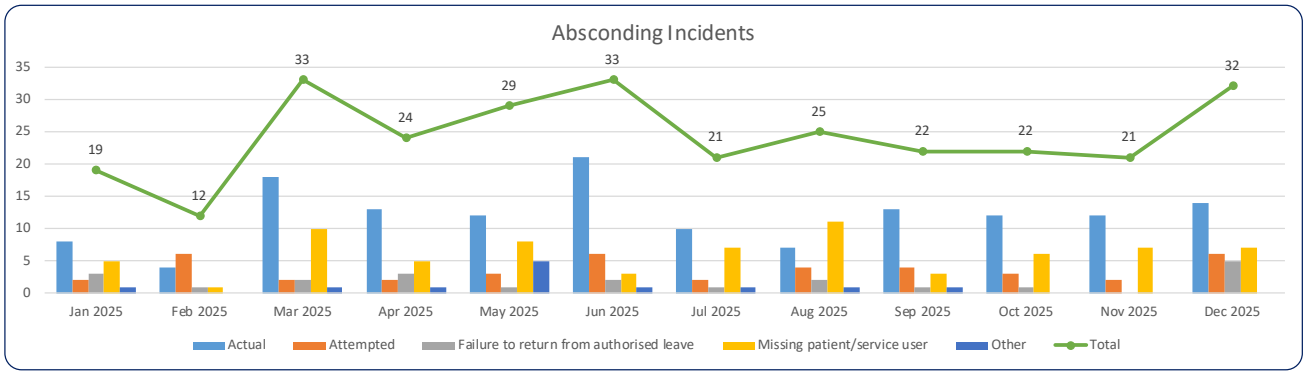
Between 01.11.25 and 31.12.25, a total of 51 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 24 incidents when compared to the previous two months (27).



Of the 51 incidents, 21 were reported as not care planned (not included in the care and treatment plan for the patient) and 30 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 Seren Unit RGH (MH Unit), Royal Glamorgan Hospital (15).

Absconding incidents

During November and December 2025, a total of 53 incidents were reported under the category of absconding, which represents an increase of 9 when compared with the previous two-month period (44). 26 were recorded as actual absconding, with the remaining recorded as missing patient/service user (14), attempted absconding (8), failure to return from authorised leave (5), and no incidents under other. The highest number of incidents were reported as occurring in the Emergency Care Centre PCH at the Prince Charles Hospital (15).



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:
	A Healthier Wales

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

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

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

5. Recommendation

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
6.2

Quality, Safety & Experience Committee	
People's Experience Activity Report October – November 2025	
Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Becky Gammon, Interim Deputy Director of Nursing & People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Interim Executive Nurse Director
Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMU HB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advisory Liaison Service
QSRE	Quality Safety Risk Experience

1. Situation /Background

The purpose of this report is to provide the Quality, Safety and Experience Committee with a high-level overview of People's Experience activity during October and November 2025, and to highlight the impact on quality, safety and people's experience.

The report draws together insights from engagement, feedback, PALS, chaplaincy, bereavement, volunteering, unpaid carers, and the armed forces/veterans to support Board assurance on person-centred care.

2. Key messages for the Committee

Overall, patient and carer experience remains predominantly positive, but recurring themes around communication and waiting times present clear opportunities for targeted improvement in quality and safety

PALS, chaplaincy and bereavement work are providing early resolution, psychological safety and holistic support at key points in the care pathway, reducing escalation and improving people's experience

Capacity constraints in PALS, volunteering and chaplaincy, alongside the transition to a new feedback platform, present short- to medium-term risks to responsiveness, visibility and insight which require continued oversight and mitigation

3. Engagement and External Partners

The People's Experience Team has strengthened engagement with communities, voluntary sector partners and Llais to ensure that "what matters" to patients, families and carers informs service design and improvement.
Regular meetings with Llais and targeted outreach activities are enhancing transparency and supporting a more responsive, person-centred culture across the Health Board.

The table below is an example of training and engagement events where people's experience representatives have been actively involved.

Date	Event	Attendance
7th October 2025	Student Training Session - PALS	Princess of Wales PALS Team
15th October 2025	Student Training Session - PALS	Royal Glamorgan PALS Team
23rd October 2025	Student Training Session - PALS	Prince Charles PALS Team
24th October 2025	CTM 2030 – Church Village	Head of People's Experience and Clinical Bereavement Lead

28th October 2025	Llais – patient story training	Head of People's Experience
30th October 2025	Valley Veterans, Ton Pentre	Head of People's Experience, Clinical Bereavement Lead and Lead Chaplain
5th November 2025	Armed Forces Employer Event, Cardiff	Becky Gammon, Deputy Director of Nursing and People's Experience, Head of People's Experience and Senior Team

3.2 Patient feedback and surveys

3.2.1 NHS Wales People's Experience Framework and Toolkit was launched by Welsh Government via WHC (WHC/2024/015) in April 2025 and is being led for implementation by the Head of Peoples Experience.

3.2.2 The Value Based Healthcare team is leading a planned, phased transition to a new feedback platform, with an emphasis on maintaining survey coverage while ensuring data quality and continuity for trend analysis. Feedback data for October–November 2025 (detailed in the appended tables) indicate strong overall satisfaction, with negative comments concentrated in a small number of themes that are being used to inform quality improvement work.

Table 1: Feedback satisfaction score for CTMU HB (Nov 2024- Nov 2025)

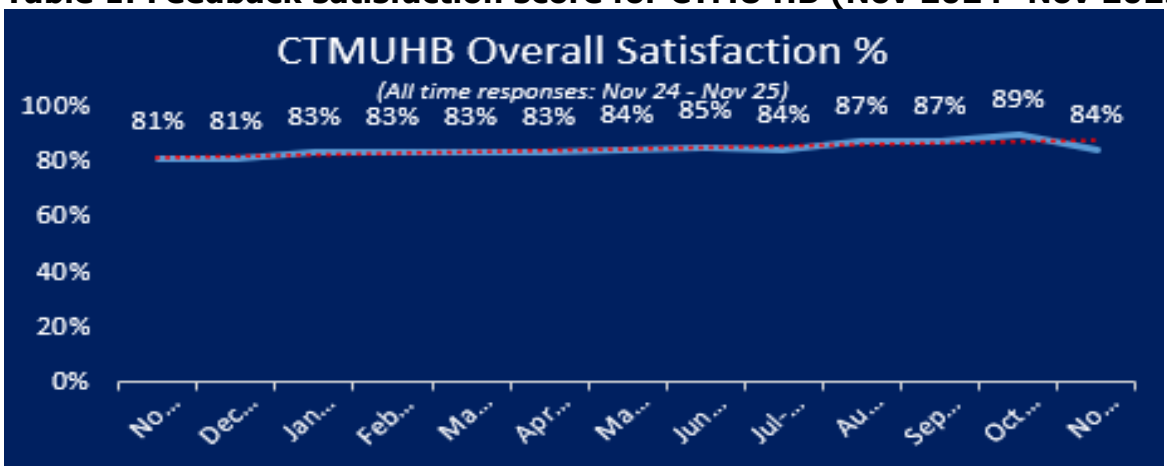


Table 2: Number of responses from the public (October – November 2025)

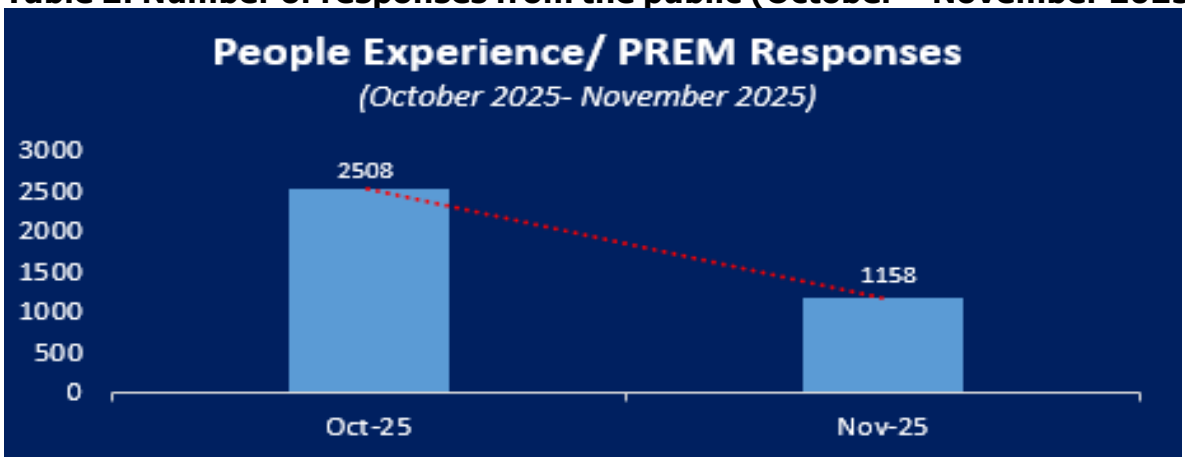


Table 3: Reflection of positive/negative comments (October – November 2025)

3.3 Chaplaincy and Bereavement

The chaplaincy team has supported a significant number of patients, relatives and staff, and delivered key events such as Baby Loss Awareness and Remembrance Day services, contributing to compassionate, holistic care including 13 training events attended by 183 student nurses.

Table 4: People supported covering October - November 2025

Number of people supported with significant spiritual and pastoral care.	
Patients	735
Relative's/Carers	212
Staff	248

One of the chaplain's is conversant in BSL (British Sign Language) and received a call to support a patient who was struggling with not only their health but with

isolation. The chaplain attended the ward and was able to converse directly with them:

"When I entered the room and began signing, something remarkable happened. The patient lit up. their eyes sparkled with recognition and relief. They told a joke and laughed with the staff."

This case example demonstrates the impact of accessible spiritual and emotional support on reducing isolation and promoting dignity, and is proposed as a future "patient experience insight" for Board reflection

The Chaplaincy team also led services across the Health Board to commemorate Remembrance Day on 11th November, with 370 people attending across the hospital sites.

Bereavement

The Clinical Bereavement Lead continues to implement the national bereavement framework, deliver staff training and support pathway development, thereby strengthening consistent, high-quality bereavement care

Two Wave of Light services were held on 15th October to support Baby Loss Awareness Week. Together with representatives from the maternity department and the Clinical Bereavement Lead, over 70 families attended the Butterfly Garden, Prince Charles Hospital, and 86 people attended a service at Trealaw Cemetery.

3.4 PALS and early resolution of concerns

PALS managed high levels of activity during the period (with detailed figures in the appended tables), with most contacts relating to communication, clinical treatment and patient care. While the team is successfully resolving many issues early and contributing to staff training, the 0.5 WTE vacancy is limiting proactive ward presence, with potential impact on early identification of quality and safety issues.

Telephone and email enquiries are the two main methods used to contact the PALS team; however, the team also regularly performs proactive ward visits to support patients and relatives at sites.

PALS Cases	October	November
Number Opened	337	280
Number Closed	238	196

Top Three Themes
Communication Issues
Clinical treatment/Assessment
Patient Care

To provide assurance that themes and learning from cases are being shared, the team attends a range of forums and Care Groups. They attend the Care Group QSRE meetings submitting a focused highlight report on PALS activities and issues raised, themes and actions are presented.

The PALS data is presented to the Peoples experience forum giving an overview of issues, concerns and wider experience to drive service improvement and shared learning. They are core members of the harm free care Nutrition and Hydration, Pressure ulcer and Falls and deconditioning oversight boards as well as the Mental Health Lived Experience and Learning Disability working groups. The team also support the learning by training community and student nurses on the PALS role and common themes, and by supporting the development of practical resources such as inpatient information leaflets and Falls and Pressure Ulcer leaflets for CTM, demonstrating that learning is translated into tangible improvements.

Example of support provided:

The family of a new-born baby with tongue-tie, who were medically fit for discharge, waited 36 hours for information about the procedure and became increasingly distressed as the baby struggled to feed. PALS intervened, contacted the relevant department to expedite the referral, and the procedure was carried out the same day.

3.5 Volunteers, armed forces and unpaid carers

- Volunteers - Over 120 volunteers are supporting patients and families across acute and community sites in roles including emergency department volunteers, activity coordinators, meet-and-greet and feedback collection. There are number of key areas the volunteer services are present such as Emergency Department, Activity co-ordinators, Meet and greet and Maternity. However, in light of evolving service provision across multiple locations, a comprehensive review is scheduled for 2026.

- Armed Forces/Veterans- Work to identify and support unpaid carers and armed forces/veterans (for example, the use of electronic whiteboard identifiers and updated information materials) is helping to promote equitable, personalised care. In partnership with community and primary care new posters and patient information leaflets have been produced and distributed.

- Unpaid carers - CTMUHB has taken several steps to raise awareness of unpaid carers and improve signposting, including supporting the Merthyr Tydfil unpaid carers partnership, providing training for new staff, supporting Carers Rights Day with stands at Prince Charles and Royal Glamorgan hospitals, and attending Pressure Ulcer and Falls meetings to highlight the role of unpaid carers in this area.

4. Key Risks / Matters for Escalation

Summary of Risk	Action taken to mitigate	RAG rating
People's experience capacity: Vacancies within PALS and the volunteer service are being managed with interim arrangements, but sustained gaps would reduce proactive engagement, early concern resolution and visible support for patients and families.	Volunteer Manager and one administrator (0.8) FTE are ensuring recruitment and support for volunteers continues, but this has reduced the capacity to explore different opportunities and recruitment events.	
Insight and data continuity: The feedback platform transition carries short-term risks to consistency of data capture and reporting, which are being mitigated through a phased approach and close monitoring of survey coverage.	Manual pulling of data while the 2 systems integrate and review if a people's experience dashboard is underway by the values-based healthcare team	
Environment for inclusive care: The size and configuration of the multifaith room at Royal Glamorgan Hospital do not fully meet demand, particularly for Friday prayers, and a risk has been logged while options are being explored.	This has been added to the Risk register – December 2025. Meeting held with the site manager, health and safety, and chaplaincy to explore capacity on RGH in December 2025. Further meeting to be held in January 2025.	

5. Assessment

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

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-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*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:

Language Impact Assessment Screening?	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Development of services aligned to communities is crucial to ensure their contribution to ensure their needs are met.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Vacancy gaps in Volunteer Service and planned sickness will impact here. PALS vacancy in Princess of Wales – 0.5 FTE from October will also impact the support that can be provided here.	

6. Recommendation

The Committee is asked to note this report and comment on whether the level of information and analysis gives assurance on quality, safety and people's experience.

7. Next Steps

The Committee is also asked to support continued focus on

- Completing the People's Experience Framework self-assessment and establishing a working group to oversee delivery of resulting actions
- Safely completing the feedback platform transition while protecting trend data and insight for Board reporting
- Reviewing chaplaincy and volunteer services to ensure they are resourced and configured to meet future service needs

Agenda Item
7.1

Quality, Safety & Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	20 January 2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	December / January 2026	RISKS REVIEWED
Executive Leadership Group	12 January 2026	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 6 January 2026. Please note that as a result of site pressures with capacity and flow there are some risks within Appendix 1 which do not have a progress update captured. The Chief Operating Officers Business Team are seeking an update, and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the Business Team as required.

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 **861** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2. A dedicated risk session was also

delivered to the Local Public Health Team Away Day on the 4 November 2025. A risk update was also provided to the Unscheduled Care Teams Away Day on the 21 November 2025.

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

2.10 124 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 124 attendees providing formal feedback found that:
- The session provided the right amount of information.
- They gained more confidence and knowledge in risk management having attended.
- They would recommend this training to a colleague.

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

2.13 Some of the recent comments from the session in January 2026, received through evaluation, have been included below:
- *Understanding the score system and Datix was really helpful*
- *Trainer ran through the relevant documents and processes for logging risks which gave me a better understanding of the escalation processes and how it's logged in the organisation.*
- *New to Datix so really helpful with risk assessing process*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Primary Care & Community Care Group
- Datix Risk ID 6397 - Shortage of GPs to deliver urgent primary care services for escalation. New risk escalated to the Organisational Risk Register in January 2026. Risk score of 16.

3.2 CHANGES TO RISKS

Risk Score Increased

None identified this period.

Risk Score Decreased

Primary Care & Community – Care Group
- Datix Risk ID 5417 - Paediatric Dentistry - General Anaesthetic (GA) theatre list. As a result of the progress being noted to lists , the care group have reviewed and reduced the score to a 12 (Likelihood reduced to a 3) but will keep under review to ensure there is no notable impact to the lists to change

position. (Action plan submitted to Board September 2025 to outline the plans to mitigate risk, as a result of the progress against the plan the Health Board were able to reduce this risk).

Patient, Care & Safety – Care Group

- Datix Risk ID 6228 - Effective and efficient management of requests from the HM Coroner. The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for Executive Leadership Group oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk score now 12.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Nil as assigned to this Committee.

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

Consequence							
	5			3337 6217	5276		
	4			5820	4417 4885 5576 6229 4632 2713 6318 6397 6280 5877	5579 5761 5793 5045 4973 6231 1793 6294 6379	4491 3826 6179 5753 6239 5821 6052
	3						4691 6232
	2						
	1						
CxL		1	2	3	4		5
		Likelihood					

Emerging Risks Identified for possible future escalation

Identified as part of the risks considered and reviewed for escalation in the January 2026 iteration of the Organisational Risk Register:

- **Pharmacy & Medicines Management** – Datix Risk ID 5890 – risk identified for escalation in relation to the temperature monitoring system which is used within CTMUHB to monitor the temperature for various areas within the Pharmacy departments and has a mechanism to alert to temperature deviations. This autodialler alert system requires action and the risk around

this is being considered with a view to escalate to the Organisational Risk Register if necessary.

- **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.
- **The Planned Care - Care Group** are continuing to review the risk regarding Laser Safety at Princess of Wales Hospital as there is no designated laser safety advisor on site. As part of the risk review the Operational Management Board has directed the Care Group to engage with the Diagnostics, Therapies, Pharmacy and Sciences Care Group to consider workforce cover across CTM. Once the review is complete further consideration will be given to escalation to the Organisational Risk Register. (Datix Risk ID 6124).
- **The Planned Care and Unscheduled Care - Care Group** are continuing to jointly consider a risk in relation to 'Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology'. Once the co-ordinated review between both Care Groups has been undertaken the risk will be considered for escalation to the Organisational Risk Register as one risk with shared actions across both Care Groups as appropriate. (Current Datix Risk IDs are 5797 and 3596).
- **Primary Care & Community Care Group** are considering the escalation of the following risks:
    - a risk relating to pathway of care delays following a notable increase. This has been highlighted with Welsh Government and Local Authorities and this will be further explored at the Discharge Board, which has representation from Local Authorities.
    - Social Care Capacity within Care Homes / Community is also being reviewed due to increasing concerns.

  The Service Director for Primary Care is currently reviewing these risks to reflect current position with a plan to formally escalate to the Operational Management Board in January 26 and then onto the Organisational Risk Register if required.

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 IMPROVING CARE SUSTAINING OUR FUTURE Click Here for Risk 1a Click Here for Risk 1b	**a) Enough capacity to meet elective demand** **b) Enough capacity to meet emergency demand**	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4) 20 (C4xL5)

2.	Improving Care, Sustaining our Future  Click Here for Risk 2	**Ability to deliver improvements which transform care and enhance outcomes**	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4)
3.	Sustaining our Future, Improving Care and Inspiring People  Click Here for Risk 3	**Enough workforce to deliver the activity and quality ambitions of the organisation** *(Including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4)

4. Assessment

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

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5	6179	Executive Director of Public Health	Public Health - Health Protection	Executive Director of Public Health	Creating Health & Improving Care	Quality / Complaints / Assurance / Patient Outcomes Impact on the safety – Physical and/or Psychological harm	High and increasing prevalence of overweight and obesity in children and adults.	**If** there is insufficient preventative activity to reduce rates of overweight and obesity **Then** rates of obesity will remain high in CTM . **Resulting in** increased activity/acuity/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents.	A range of work is currently under way in response to high levels of obesity in CTM including: 1)Grant funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment 2)Adult Weight Management Service – the scale of this is vastly insufficient to make a difference to population level rates of obesity 3)Children and Young People's weight management service – current time-limited funding for Pipyn, preventative family based intervention, ongoing development work to maximise population impact, scale remains small. Proposed future development of a service in line with level 3 of the All-Wales Weight Management Pathway. 4)Healthy pre- and health schools programmes – working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: -healthy environments -healthy settings, -healthy people, -leadership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	Update December 2025 This risk was reviewed by the Local Public Health Team Strategic group on 9th December 2025. Although a positive update was received that the business case to continue the PIPYN service has been approved via the Integrated Medium Term Plan, as there still remains a significant gap in funding to fully support level 1 and 3 services for children, the risk remains the same. The Healthy Weight roadmap is awaited and will be submitted to Board for approval in early 2026.	Quality, Safety & Experience Committee. Strategic Development Committee.	20	C4xL5	9 C3xL3	↔	06.05.2025	15.12.2025	31.1.2026
9	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. - All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The emergency departments across CTM remain overcrowded. There are many internal actions being undertaken within Care Group to reduce attendances, improve flow and reduce overcrowding: • CTM UHB Development of Urgent & Emergency Care Rapid Improvement Plan (45 minute ambulance handover and 90-day ED performance) • TRUE Rapid Improvement Plan through 6 Goals Programme – SRO - Deputy Exec Med Director and Deputy COO • USC CG Formalise and sign off 30/60/90-day improvement plan • Acute Medicine Transformation Programme (STAMP) – POW – 2 workshops complete – 3 further planned June/early July • New investment agreed for x3 Consultant Acute Physician posts. Targeted recruitment drive currently underway. • Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established. • Targeted recruitment of Acute Medicine Consultants following new investment to provide 7/7 Update December 2025 The Emergency Department (ED) huddle is now live, which provides a live snapshot of each of the ED departments including crowding score is captured. Introductions of RATS at PCH for a number of sessions a week, this will assist in alleviating ED overcrowding due to timely assessments and redirection.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	7.1.2026	7.2.2026
14	6229	Executive Nurse Director	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Timely development of, management and response to Learning From Event Reports (LFERs)	**If:** the Health Board fails to achieve timely completion of LFERs, respond promptly to the questions from the Welsh Risk Pool Learning Advisory Panel and provide assurance that learning has been implemented and shared. **Then:** there is a risk that improvement to quality and safety in healthcare aligned to learning which flows from case investigations, and the LFER (Learning From Event Report)s is not acted upon. **Resulting in:** reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned. Missed opportunities to improve patient care and safety following identification of areas for improvement. Financial penalties if the Welsh Risk Pool consider withholding reimbursements due to being dissatisfied with the learning and actions taken in a case.	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Incident Management Framework and Toolkit. Incident Investigation Training Visibility of data using the Datix System. Listening and Learning Framework	Update January 2026 The LFER panels are now fully operational, and we are seeing positive success rates in approvals through the Welsh Risk Pool. While there is scope to reduce the number of panels, the decision is to maintain the current approach until an additional cycle of WRP panels is completed to confirm sustained performance. The Legal Services Recovery Plan remains active, focusing on ensuring sufficient capacity to manage cases effectively, reviewing internal processes and systems for potential improvements, and identifying areas for further enhancement.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	08.1.2026	8.3.2026
15	6231	Executive Nurse Director	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future	Standard Duty, regulation, mandatory requirements.	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	**If:** the Health Board fails to comply and proactively manage cases that qualify for consideration under NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. **Then:** there will be a missed opportunity to deal with concerns under a single and consistent method for grading, investigating and to actively involve the person raising the concern in an open and engaged manner to put things right. **Resulting in:** Delays in improving patient safety and experience as a result of identifying how services may have improved as a result of concerns notified and dealt with under these arrangements. Early resolution of cases which provide an opportunity for closure for families and staff as well as effective and efficient learning to be implemented. Avoidable costs should a case proceed to litigation due to failure to comply proactively with the arrangements. Reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned	Review initiated to understand CTMUHB's position in terms of the number of cases underway and the response to requests. Current controls: Putting Things Right - Handling Concerns Procedures Engagement with Legal & Risk Services. Experienced Concerns Handlers in post.	Update January 2026 Sustained improvement has been observed, although complexity remains within the process. Work is underway to develop a clear structure for the team, which will require recruitment of specialist portfolio holders to strengthen capability. The Operational Control Plan (OCP) is on track for full implementation by the end of the financial year, with mitigations and monitoring in place alongside continued engagement with Welsh Risk Pool and Legal & Risk teams. The LFER panels are now fully operational, delivering positive success rates in approvals through WRP. While there is scope to reduce the number of panels, the current approach will be maintained until an additional cycle of WRP panels confirms sustained performance. The Legal Services Recovery Plan remains active, focusing on ensuring sufficient capacity to manage cases effectively, reviewing internal processes and systems for improvement, and identifying further opportunities for enhancement.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	↔	3.7.2025	08.1.2026	8.3.2026
16	6235	Executive Director of Finance (Executive Lead for Estates)	Central Directorate - Estates	Assistant Director - Capital Estates	Sustaining Our Future	Environmental / Estate / Infrastructure	Insufficient funding to address backlog maintenance across the estate.	If: There is insufficient funding to address backlog maintenance across the estate. Then: there is a risk that it may not be able to maintain an estates infrastructure that keeps services functioning, meets statutory compliance regulations and provide enhancements/ improvements for patient care and staff well being RESULTING IN: An inability to deliver its services efficiently and effectively. Poor environment and experience for patients, visitors and staff. Estate infrastructure problems. Unable to replace failing/ ageing plant and equipment. Poor estate regulatory compliance. High carbon footprint. Loss of service and productivity. Increased backlog maintenance	Prioritisation of Estate Activity based on risk-based decision making. Applications to the Targeted Estates Fund (TEF) to access funding under the infrastructure monies. Applications to the AllWalesCapital Programme on an annual basis. Discretionary Capital Maximise current revenue allocations, optimised for statutory compliance and risk priorities. Maintenance Programme established managed via the Planet Facilities Management System (planned and reactive maintenance jobs) In 2024-2025 the estates operational function was digitised, the estates operatives were provided with mobile devices so that they are now ae to work in real time, this has helped to maintain performance despite the staff shortages. **Internal -** Regular Monitoring through CTMUHB's Executive Capital Management Group. Capital Scheme Delivery Programme. Annual Estates and Energy Performance Report received at the Operational Delivery Committee (and planning, Performance and Estates Committee prior to that Committee being disbanded) Routine performance reports submitted quarterly to the Estates and Capital Governance Board and monthly at the Estates Operational Management Team meetings. Escalation of Risk through the Capital and Estates Risk Escalation Group. Comprehensive internal audit programme. **External -** NHS Shared Services Partnership-Specialist Estate Services (NWSSP-SES) have collected Estates and Performance Monitoring System data (EPPMS) on behalf of Welsh Government. ISO14001 Certification - Environmental Management Achieved. Regular Reporting and Monitoring with Welsh Government. Comprehensive external audit programme.	Lifecycle replacement programme in place to highlight risk and replacement of assets. This is utilised to secure funding form discretionary or Targeted estates funding to replaces the highest priority replacement assets. Update January 2026 Risk reviewed and no change to current risk score at this stage. Capital and Estates continue to seek all opportunities for Welsh Government funding. CTM had the highest capital allocation in 2025-26 than any other heath board in NHS Wales. However, this still does not mitigate all of the gaps and controls and the resulting impact of this risk. In November 2025 CTMUHB Board approved the Prince Charles Hospital (PCH) Refurbishment Project Finalised Phase 3 Full Business Case for submission to Welsh Government which subject to approval will support some further reduction in backlog on the PCH site.	Operational Delivery Committee & Health, Safety & Fire Sub Committee	16	(C4xL4)	9 (C3xL3)	↔	4.7.2025 - Opened on Datix	6.1.2026	6.3.2026
21	4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care Sustaining our Future	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process	If: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library.	Update December 2025 The revised "Policy on Policies" is going forward for approval at the Quality, Safety & Experience Committee on the 21 January 2026. Once approved this will be circulated and published on the internal policy page. This will be accompanied by a simplified process flow chart for approval. The new policy library web page is planned to 'go live' by the end of January 2026, however, this is dependent on the capacity within the Corporate Governance, Web Development Team and the Digital & Data Team. The archiving of previous policy versions has been delayed, however, all available documents have been downloaded and are in a searchable format should any requests be received. All Directorates have received the latest update as to the status of their current policy lists. Whilst it is hoped that the new policy and current master library will be live by the end of January it is anticipated that other aspects will be delayed until circa the end of March 2026. The policy programme continues to be monitored via the Executive Management Board.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	⇔	26.10.2021	05.01.2026	05.03.2026
22	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. Update May 2025 - No change to risk score or mitigation this period. Executive Medical Director to raise risk again at next All Wales Medical Director meeting. Update 23 June 2025 – Still no movement here. Its within the discussion of Digital HealthCare Wales provider status and open sharing of data between Health Boards. The current proposal has not been agreed between ABUHB and DHCW. CTMUHB are asking and raising the concern, however, cannot directly resolve. Update September 2025 - remains as August 2025. It is raised at the relevant forums (All Wales Medical Director Meetings) regularly. No changes to risk score. Update October 2025 - remains as reported previously. The risk continues to be raised at the relevant forums (All Wales Medical Director Meetings) regularly. Update Jan 2026 - remains as reported previously. The risk continues to be raised at the relevant forums (All Wales Medical Director Meetings) regularly.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	23.12.2025	23.02.2026

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
23	5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PIPYN continues to be delivered in Merthyr (PHW funding until 26) and Taff Ely and Rhondda (Cluster funding until 26) 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3)Business case developed submitted and submitted for IMTP consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Finance-dependant controls: 1)Set up service if funding identified via IMTP process.	Update December 2025 31/12/25 - Risk reviewed. No change in score. Budget confirmed for Health Board role out of L1 PIPYN 3-10 from March 26 onwards. L3 still significant gap and put forward again as part of Integrated Medium Term Plan planning process. (PIPYN aims to support children (aged 3-7 years) and their families make healthy choices in Merthyr Tydfil and Rhondda and Taff Ely)	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	31.12.2025	23.02.2026
27	6294	Chief Operating Officer	Planned Care - Care Group	Service Director Planned Care	Sustaining our Future	Workforce / Organisational Development / Staffing / Competence	Insufficient Consultant Workforce - Endoscopy / Gastroenterology	**If** the Consultant posts cannot be filled, **then** it will impact on Service Delivery and affect our ability to deliver both diagnostics and clinical services to patients. **If** the Consultants that are currently in post were no longer in post, **then** this would significantly affect our ability to deliver both diagnostics and clinical services to patients. Furthermore it would impact on ability to support inpatient services at POW. Fragility of the Consultant workforce is contributing to potential gaps within the on call bleed rota, with little redundancy. This could **result in** a situation in which the on call bleed rota could not be covered. Unsustainable service provision to safety care for inpatients.	In terms of recruitment posts remain out to advert. Locum in post for one of the vacancies however they are due to leave in the near future due to other obligations. There has been no interest from agencies in supporting the vacancies.	Mitigating actions currently limited. Continuing to advertise for posts. Update December 2025 No further mitigation. Posts remain out to advert. Locum has now left post as of early December (this was earlier than expected, with significant disruption to Endoscopy). Extremely fragile staffing position in POWH. There has been no interest from agencies.	Quality, Safety & Experience Committee. Operational Delivery Committee	16	C4 x L4	9 (C3xL3)	↔	07.08.2025	7.1.2026	7.2.2026
28	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTPS	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Backlog of Reporting Radiology Examinations	**IF** there is consistent backlog of Radiology reports **THEN** there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes **Resulting in** impact on patient outcomes, delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place.	There is a significant backlog of reporting radiology examinations, with just over 10,000 X-rays pending. Current mitigation measures include rostering SPRs for extra reporting, outsourcing MSK cases, utilising training posts and the returning from parental leave. We are aiming to address the backlog in the more likely clinical urgent cases (chest x rays) by December as a priority. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee. Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	6 (C2xL3)	↔	08.02.2017	6.11.2025	15.12.2025
29	6379	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTPS	Improving Care	Safety & Wellbeing Patients / Staff and Public	CT Scanners at RGH damaged by power outage and manual generator/UPS switch over	**IF** the manual switch over following a power outage is not rectified. **THEN** the CT scanners/tubes may become damaged **RESULTING IN** no CT service on site, causing significant delay in patient outcomes, and significant cost to repair (circa £350k per tube)	Discussion with manufacturer and All Wales procurement Discussion with estates team Estates will ensure CT is switched on first, for generator to kick in Regular weekly meeting with GE and estates to monitor	Action plan required urgently to show regular monitoring. If a separate or modified UPS is required then a statement of need for Capital consideration will be required. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	4 C4xL1	↔	20.10.2025	06.11.2025	31.12.2025
30	6318	Chief Operating Officer	Mental Health Care Group	Service Director - MHLD	Improving Care	Safety & Wellbeing Patients / Staff and Public	Tier 3 SHED Team Service Delivery	**If:** The level of vacancies continues in the CAVUHB service for high risk eating disorder patients (SHED) **Then:** The service will be unable to fully deliver assessment and treatment interventions for CTM UHB residents. **Resulting in:** Patient safety concerns for a number of high risk patients	Controls update December 2025: •The recent appointment of a band 7 practitioner within CTMUHB to help with coordination . Individual would be starting in this role on 15th December for a fixed term until 31st March 2026. The costs for this post would be recharged to CAVUHB. •The establishment of fortnightly SHED drop in clinics for adult CMHT staff in CTMUHB. MH Team colleague had helpfully been involved in establishing these regular meetings and initial feedback was positive. •CTMUHB adult CMHT services will continue to provide physical health monitoring arrangements for their patients who have been referred to SHED. •The Consultant lead for SHED, had agreed to schedule some training sessions for CTMUHB CMHT staff which was welcomed Further Measures are under way •Finalise the SHED service specification (when staffed at typical levels) and agree a supplementary document describing what is currently available. CTMUHB have provided comments to facilitate further discussion. •CAVUHB have commissioned 36 Degrees to review the SHED service and provide recommendations for its strategic future. The review requires CTMUHB input and lead identified to facilitate this. •In advance of the review CAVUHB are recruiting to key posts. Details of the recruitment will be shared with MH Team so that CTMUHB can help to promote and to give real time updates on the restoration of assessment and intervention work •A key risk is the reduction in medical cover (x2sessions CVUHB and x2sessions CTMUHB) from end Feb 2026. CAVUHB agreed that there were opportunities to use these sessions to create an attractive new consultant role. Colleagues will meet to consider the provision of future cover and any transition plan required.	Escalated at OMB 29.10.25 risk rating increased following dialogue with CMHTS. escalated to service director and director of nursing. The care group will progress with an action plan to mitigate the risk and the Care Group Service Director has requested a meeting with CAVUHB senior Mental Health leadership team to consider a route forward. Update December 2025 Risk reviewed and updated, current control measures have been updated. Update from a meeting held with CAVUHB colleagues 02/12/25 also captured in Datix. No change to the current risk score at present	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	C3xL2 = 6	↔	29.08.2025	19.12.2025	30.01.2026
31	6280	~~Chief Operating Officer~~ Executive Director of Strategy & Transformation Executive Medical Director	Planned Care - Care Group	Service Director - Planned Care	Improving Care	Safety & Wellbeing Patients / Staff and Public	Suspension of the Regional Hepato-Pancreato-Biliary service model	**If…** The commissioning of this service is not prioritised as part of the regional commissioning arrangements **Then…** there will be no Regional service for Severe Acute Pancreatitis **Resulting in….** sub optimal care for this group of acutely unwell patients	Each case currently being discussed on a case by case basis between neighbouring Health Board Medical Directors, however, this will add delays to an already complex and time sensitive treatment pathway.	As this is a service that is regionally commissioned the Health Board will need to have ongoing discussion with the Joint Commissioning Committee as to a way forward. Update December 2025 Risk was noted as a risk at Executive Management Board on the 29.12.26 , as a result a decision was shared by the Chief Operating Officer that the risk will sit with the Executive Director of Strategy & Transformation and Executive Medical Director. As this is a service that is regionally commissioned the Health Board will need to have ongoing discussion with the Joint Commissioning Committee as to a way forward.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	9 C3xL3	↔	06.08.2025	05.01.2026	31.03.2026
32	5877	Chief Operating Officer	Primary Care and Community Care Group	Service Director - Primary Care	Improving Care	Service / Business interruption	New Worker Contract for Out of Hour GPs	**IF** the new worker contract for out of hours GPs is implemented (ambition is for Dec 2025) it will require the application of Working Time Regulations. **THEN** there will be a significant impact on shift fill rates. **RESULTING in** the Health Boards ability to fill shifts across the whole roster having a negative impact on both WAST and ED departments.	Recruitment of more GPs who do not also work day time in other roles. Whilst the weekend service will be affected to some degree, weekday evening service will be most adversely affected as any GP working until midnight will not be able to work in practice the next morning.	Additional recruitment of GPs is critical to establish the service. Update December 2025 To mitigate the risk alternative methods for recruitment of GPs has been explored. However this process is not agile and flexible and suitable to the way in which GPs book shifts. Sometimes at very short notice as they work elsewhere. Options still being explored.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	C3xL2 = 6	↔	07.08.2024	7.1.2026	7.2.2026
33	6397	Chief Operating Officer	Primary Care and Community Care Group	Service Director - Primary Care	Improving Care	Service / Business interruption	Shortage of GPs to deliver urgent primary care services for escalation.	IF the decision to have a 'hold' on the recruitment of GPs into GP OOH and Navigation Hub continues of engagement and contractual status of Out of Hours GPs. THEN there will be a continued reduction in shift fill rates. RESULTING in shifts remaining unfilled (specifically home visiting shifts) and this will lead to more patients (palliative and end of life) being conveyed into the Emergency departments.	Explore alternative engagement routes such as bank and salaried contracting although there are challenges as these due not offer flexible engagement for GPs who have permanent day time and other employment.	Update December 2025 The following has been applied to mitigate the risks. All GPs on a 'holding list' have been contacted. Adverts have been placed via bank and GPs encouraged to apply through this, but the process is not compatible with rota and does not offer flexibility for shift fill and short notice changes. Shift fill was challenging over the Christmas Period but was covered by senior GPs form the leadership team.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	C4xL3 =12	New Risk Escalated to the Organisational Risk Register in January 2026	31.10.2025	02.01.2026	31.01.2026
34	6232	Executive Nurse Director	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future	Safety & Wellbeing Patients / Staff and Public	Stability of the Legal Services Function	**If:** the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. **Then:** there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. **Resulting in:** an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations.	Update January 2026 The position is now much more stable, with strong engagement from key stakeholders contributing to improved oversight and progress. However, risks remain associated with the pending closure of the Organisational Change Process (OCP). The Legal Services Recovery Plan continues to be implemented, focusing on ensuring sufficient capacity to manage cases effectively, reviewing internal processes and systems for potential changes, and identifying areas for further improvement.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C3xL5	C3xL2 = 6	↔	3.7.2025	08.1.2026	8.3.2026

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
35	6217	Executive Medical Director	Children & Family Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity	If: the safeguards and quality systems and processes are not robust Then: - mothers and babies may not receive the best evidence based care Resulting in - Potential for patients to have poor outcomes and experience within the service.	Rapid reviews have been undertaken on all cases with findings and learning from each. Meetings held with Care Group and executive team to decide on way forward. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan).	Update September 2025 External review commissioned on Nationally Reported Incidents. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) - the action plan and risk will be further reviewed once external report received. Response received from obstetrician reviewer with further information requested. Update October 2025 The Health Board is still awaiting obstetric review from the external clinician in order to be able to review the risk and continuation of actions. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee.	15	C5xL3	10 (C5xL2)	↔	14.05.2025	6.11.2025	31.12.2025
38	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Corporate - Digital & Data	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of a Single Electronic Patient Record in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update December 2025: CTMUHB still await the Outcome report that recommends the Supplier and allows us to plan next steps. The team continue to escalate at all relevant meetings. Therefore, our next steps are unchanged:- 1. Awaiting recommendation/outcome report 2. Report will be taken to Programme Board and Executive Board for approval 3. Supplier to be known 4. Procurement process to conclude 5. Start of implementation The first Workshops have been arranged to review the forms used and current processes. These will take place:- 20th January CAMHs and Specialised Services (Ty Lloddard) 22nd January Adults and Older Persons (Glanrhyd)	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	2.1.2026	30.01.2026
39	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update December 2025 Risk Reviewed, no change in scoring The inpatient review and remodelling programme continues to progress, with Safe Wards interventions and enhanced therapeutic input positively received by staff, patients, and external reviewers. The inpatient renaming of the wards to align with the new model remains paused pending resolution of governance and safety compliance requirements. The programme reports to the MHLD Improving Care Board. November update included in datix risk assessment record.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	22.12.2025	30.01.2026
40	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	**IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. **THEN** there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. **RESULTING in** avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	Update December 2025 This risk was reviewed in the Local Public Health Team strategic group meeting on 11.12.25.The uplift in Health Protection funding for 25/26 still does not bring parity to the funding across Wales and is insufficient to deliver the Health Protection strategic plan, there remains a funding gap. A submission to Welsh Government was made in December 2025 highlighting the remaining funding gap and areas this is impacting. Therefore the risk is to remain unchanged and for review upon confirmation of the funding allocation for 26/27	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	11.12.2025	11.03.2026

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)
5417	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	**If...** Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. **Then...** the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. **Resulting in...** 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped form 48% to 80%. Children can only wait 8 wks form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update December 2025 Prince Charles Hospital additional theatre lists have commenced and now beginning to see the positive impact on the waiting list. October figures show 443 children waiting for assessment for GA. There are also 516 children waiting for a PMBA assessment which may increase the number of children requiring GA once assessed. Following a delayed start to the RGH lists they are now due to commence the 1st week of January, with all lists in place, this should start addressing the backlog issue, however winter pressures does lead to dental GA lists being cancelled so the decrease in numbers may take time be seen. As a result of the progress being noted to lists , the care group have reviewed and reduced the score to a 12 but will keep under review to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).	Quality, Safety & Experience Committee Operational Delivery Committee	12 Decreased from a 20	9 (C3xL3)
6228	Executive Director of Nursing	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Effective and efficient management of requests from the HM Coroner	**If:** the Health Board fails to effectively respond and manage requests from the HM Coroners Office in a timely manner. **Then:** there is a risk that the Health Board will breach 'The Coroners (Investigations) Regulations 2013" in failing to provide documentation on time and take required action in a timely manner to ensure lessons have been learned. **Resulting in:** poor experience and the wellbeing impact for the families and staff members involved in inquests, reputational impact of the Health Board in terms of trust and confidence in the service, an increase in the number of Regulation 28 / 29 reports on actions to prevent future deaths, an increase in potential enactment of the Coroners powers, including under Schedule 5 - "Power to require evidence to be given or produced".	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Review and remap internal processes in the management of inquest cases within the organisation. Weekly coronial meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Update January 2026 The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	12 Decreased from a 16	8 (C4xL2)

De-escalation Rationale
As a result of the progress being noted to lists , the care group have reviewed and reduced the score to a 12 (Likelihood reduced to a 3) but will keep under review in the Care Group to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).
The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12

Agenda Item
7.2

Quality, Safety & Experience Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) CLINICAL EFFECTIVENESS UPDATE 2025-2026

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	David Morgan – Deputy AMD for Clinical Audit and Effectiveness, Mark Townsend – Head of Clinical Audit & Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
CA&QI	Clinical Audit & Quality Informatics Department
AMD	Assistant Medical Director
AMaT	Audit Management and Tracking
NCEPOD	National Confidential Enquiry into Patient Outcome and Death

NICE	National Institute for Health and Care Excellence
HQIP	Healthcare Quality Improvement Partnership
WG	Welsh Government
NCA&ORP	National Clinical Audit and Outcome Review Plan
CEC	Clinical Effectiveness Committee

1. Situation /Background

1.1 This report provides the Quality, Safety & Experience Committee with an update on Clinical Effectiveness activities. It highlights the organisation's participation in national (Tier 1) and organisational (Tier 2) priority audits, as well as compliance with Health Technology Wales (HTW) and NICE guidance for 2025/26.

1.2 **The CTMUHB Forward Plan:** Released annually in March, the plan is aligned with the HQIP directory and the National Clinical Audit and Outcome Review Plan (NCA&ORP) for Wales (published June 17, 2025).

1.3 **Governance:** Compliance is monitored via bi-monthly specialty meetings and monthly themed Clinical Effectiveness Committee (CEC) meetings.

1.4 **CEC Evolution:** The CEC system was co-produced with multi-disciplinary teams to improve accountability, review NICE/HTW compliance, and share learning across senior clinical leadership.

1.5 **Recent Activity:** Seven themed CEC meetings were held between July 2024 and October 2025 covering Cancer, Respiratory, Falls/Frailty, Paediatrics, and Cardiology.

2. Specific Matters for Consideration

2.1 Operational Efficacy

The CEC themed meeting structure allows service leads to identify risks and implement action plans based on local and national data.

2.2 Clinical Audit Forward Plan

2.2.1 While 95% of national Tier 1 audits are fully compliant, the NEIAA and NELA audits remain Amber. Targeted work is ongoing to clear existing backlogs and meet national reporting deadlines.

2.3 HTW Compliance

2.3.1 Adoptions: AI-derived software (e-stroke), UrgoStart (ulcers), and Kardia Mobile (atrial fibrillation) are currently in use or applicable.

2.3.2 Partial/Non-Adoption: Solution-focused assessment tools for mental health are used in only one team; Myopia-control lenses are not currently NHS-funded.

2.3.3 Inapplicability: Several technologies (Prosthetics, Wearable Defibrillators) are managed by tertiary centres or were recommended against by HTW.

2.4 NICE Guidance

2.4.1 The responsibility for the scrutiny and governance of NICE guidance rests with the respective care groups. To enhance this process, the Health Board is evaluating the AMaT system's guideline module, specifically focusing on its application for medicines management.

2.5 Oversight

2.5.1 While the CEC provides a central forum, individual Care Groups maintain primary responsibility for the scrutiny and governance of National Clinical Audits, HTW and NICE guidance.

2.6 Impact on Patient Quality of Care

2.6.1 Access to Proven Innovations (HTW & NICE)

Evidence-Based Treatment: Compliance with HTW and NICE guidance ensures patients have access to the latest medical technologies and evidence-based treatments that have been proven to be clinically effective and provide value.

Best Practice: Standardising care against national benchmarks ensures that a patient receives the same high-quality treatment regardless of which hospital they visit within the Health Board.

2.6.2 Continuous Quality Improvement (Audits)

Identifying Gaps: Clinical audits allow the Health Board to monitor their own services, identifying exactly where care might be improved based on national standards and implementing action plans to address any identified areas for improvement.

Proven Outcomes: Systematic auditing has been shown to significantly increase adherence to clinical guidelines, which leads to faster recovery times and fewer complications for patients.

2.6.3 Enhanced Patient Safety

Risk Mitigation: The Quality, Safety & Experience Committee can utilise the evidence to spot emerging risks before they lead to incidents, lowering the likelihood of preventable errors or harm.

Reduced Adverse Events: Research confirms that organisations who strictly follow NICE guidelines experience lower rates of complications and mortality.

2.6.4 Accountability and Transparency

Public Assurance: The outlined clinical effectiveness reporting process provides a formal mechanism for senior leadership to hold clinical teams accountable, ensuring that the health board is meeting its statutory Duty of Quality to the people of Wales.

3. Key Risks / Matters for Escalation

No key risks or concerns to note for 2025/26.

4. Assessment

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

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

5. Recommendation

5.1 **Continuous Monitoring:** The Quality, Safety & Experience Committee should **note** the progress of the 2025-26 Forward Plan, HTW Adoption Audits and the outcomes of the 2025 CEC themed meetings.

5.2 **Action Plan Follow-up:** Care Groups must continue to priorities the implementation of action plans derived from the CEC meetings and HTW adoption audits.

5.3 **Future Reporting:** Maintain the six monthly reporting cycle from the CEC to the Quality, Safety & Experience Committee to ensure ongoing assurance of healthcare quality and effectiveness.

6. Next Steps

6.1 To ensure completion of the full CTMUHB Clinical Audit Forward, to plan for the 2026 HTW adoption audits and to develop the monitoring / implementation of NICE guidance across CTMUHB.

Agenda Item	8.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 18th November 2025 at 09:00
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Committee Chair/Independent Member - University
	Kath Palmer	Vice Chair
	Patsy Roseblade	Independent Member - Finance
	Hayley Proctor	Independent Member – Trade Union
In Attendance	Dom Hurford	Executive Medical Director (In part)
	Gethin Hughes	Chief Operating Officer
	Richard Hughes	Interim Executive Director of Nursing, Midwifery and Patient Care
	Lauren Edwards	Executive Director of AHPs and Health Science (In part)
	Philip Daniels	Executive Director, Public Health
	Cally Hamblyn	Assistant Director of Risk and Governance
	Emma Walters	Head of Corporate Governance and Board Business
	Gaynor Jones	RCN Convenor
	Sarah Bradley	Service Director, Primary Care & Community
	Becky Gammon	Interim Deputy Director of Nursing
	Alex Brown	Medical Director, Unscheduled Care
	Sophie O'Donovan	Lead Nurse, Anaesthetics, Critical Care & Theatres
	Sallie Davies	Deputy Medical Director
	Carl Verrecchia	Care Group Service Director, Children & Families
	Kellie Jenkins-Forrester	Head of Concerns and Business Intelligence
	Deborah Matthews	Nurse Director, Unscheduled Care

	Hannah Wilton	Director of Pharmacy & Medicines Management (In part)
	Mohammed Elnasharty	Consultant, Obstetrics and Gynaecology
	Chris Beadle	Assistant Director of Health Safety and Fire
	Lloyd Griffiths	Interim Nurse Director, Mental Health & Learning Disabilities
Meeting Observers	Farhan Naqib	Aspiring Board Member (in part)

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	C. Donoghue welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Hywel Daniel, Executive Director for People • Sharon O Brien, Care Group Nurse Director, Planned Care • Suzanne Hardacre, Director of Midwifery
1.3	**Declarations of Interest**
	There were no interests declared.
2.	**CONSENT AGENDA BUSINESS**
2.1	C. Donoghue reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 8) that the Committee Members wished to bring forward to the main agenda for discussion. There were none.
3.	**MATTERS ARISING**
3.1	**Action Log**
	The Action Log was received, and Members supported the actions proposed for closure.
3.2	**Matters Arising Not Captured on the Action Log**
	There were none.

4.	STAFF AND SERVICE USER EXPERIENCE
4.1	**Shared Listening & Learning Story – Mental Health and Patient Experience**
	L Griffiths introduced the story and played an audio recording of a patient sharing experiences of treatment received after being diagnosed with Complex Post Traumatic Stress Disorder. Following the audio recording, L Griffiths highlighted that the feedback had been shared via the PALS team as opposed to the Care Group and emphasised the importance of listening to and hearing people, particularly as the individual found it cathartic and helpful to provide feedback. Members noted that steps would now be taken to incorporate this learning into improvement work and to ensure lessons are learned where appropriate. R Hughes advised that he felt the story was impactful and highlighted its relevance to the current organisational environment, particularly regarding sickness absence attributed to anxiety, mental health, or depression, which were now the leading causes for staff absence. R Hughes advised that this topic had recently been discussed at a workshop he had led with Health Education Improvement Wales and added that this story reinforced the importance of focusing on staff well-being, with efforts required over the coming months to support staff to ensure they can remain in work with the appropriate support. D Hurford agreed with the points made by R Hughes and emphasised concern that the individual in the story waited four years to access services, highlighting the significant need for mental health support in the community. D Hurford expressed concern as to whether other cases might be missed, noting the challenges GPs face in managing mental health within short appointment times, and added it prompted reflection on how to improve service delivery which he would discuss further with GP colleagues. K Palmer emphasised the importance of using data, information, and learning from patient experience to inform transformation programmes, particularly in relation to mental health services and integration into community and primary care, noting the variation in GP experiences described in the story, and highlighted that cluster funding was being directed to psychological therapies and mental health. K Palmer reiterated the need for immediate service access rather than long waiting lists, expressed interest in how patient experience would be used in transformation programmes, and concluded that the story reinforces known issues and the improvement needed in this area. G Hughes advised that significant work had already been undertaken to improve access to mental health services, such as the introduction of '111 press 2' and efforts to improve access times, and stressed the importance of providing the right level of care for each patient, recognising the range of referrals from those needing significant input to those requiring less intensive support. G Hughes highlighted the need to ensure patients who can be managed locally have appropriate support, while those needing specialist care can access it promptly, and emphasised the importance of patients feeling confident they can be quickly re-admitted if needed

	after discharge. G Hughes stated that shared patient experiences should underpin the approach to service delivery, ensuring primary care manages what it can, with secondary care handling more complex cases and how this would help inform ongoing work. S Bradley clarified that the common perception of 10-minute GP appointments is not mandated by Welsh Government or the organisation and advised it was a scheduling choice made by practices, with some practices offering more flexible appointment systems, including longer slots for complex or mental health cases. S Bradley added that she would be happy to work with her team to encourage more practices to adopt flexible timing to better meet patient needs. D Matthews highlighted the importance of not simply accepting a resignation from staff experiencing difficulties, adding that it would be remiss for the organisation to allow this without further exploration of the underlying reasons and the opportunity to offer support. She further emphasised the need for senior nursing leadership to fully understand and explore the rationale behind such resignations. G Jones advised that she had found the story to be upsetting, particularly as the individual was both a patient and a staff member, adding that she felt the organisation had let the staff member down and agreed with the comments made that resignations from staff experiencing difficulties should not be accepted without further exploration and offer of support where possible. C Donoghue agreed with the views shared by G Jones that the organisation had failed the staff member in several stages and emphasised the need to learn from the shared experience, particularly regarding the occupational health service, and sought assurance as to whether the organisation could be confident that similar situations would not happen again, stressing the importance of putting measures in place to prevent recurrence. L Griffiths explained that the initial part of the staff member's experience occurred about four years ago and that significant changes have since been made, especially regarding capacity and access to psychological therapies. L Griffiths advised that the care group model now allowed for a more unified approach, which had improved access to highly specialist therapists and reduced waiting times. Members noted that the individual in the story was now well on their recovery journey, back in full-time employment, and was willing to contribute their lived experience to help with complex trauma pathway developments and outpatient redesign. G Hughes advised that while some improvements were required in relation to the occupational health service, the issue also involved the leadership exercised by managers in relation to the quality of referrals being made into the service, with all leaders and managers having a duty of care to employees, which had not been fulfilled in this instance.

	C Donoghue acknowledged this was a system wide issue and not solely attributable to the occupational health service and advised she was encouraged to hear the assurance provided that issues like this would now be addressed given improved processes and systems had been put into place.
Resolution:	The Listening and Learning Story was **NOTED.**
4.2	**Outcome Reports – Executive and Independent Member Patient Safety Walkabouts**
	R Hughes presented the report and highlighted the key matters for Members attention. Members noted that a final proposal would be shared at the Board Development Session taking place on 18 December 2025. C Donoghue welcomed the report which she found to be helpful and added she welcomed sight of the outcomes from some of the visits held. K Palmer also welcomed the report and was pleased that the report had identified key themes, such as physical infrastructure, staffing pressures, and delays in patient discharge, which appeared to highlight consistent issues across different visits and locations. K Palmer advised that it would be helpful if the reporting process could be kept as simple as possible while making it impactful and clear on outcomes and emphasised the importance of evidencing themes to enable the Committee to have strategic oversight and address urgent actions when needed. R Hughes provided assurance that he was looking to strengthen the existing process for walkabouts and was not seeking to add additional layers to the reporting process. H Proctor supported the proposed approach and suggested that she would welcome training in this area given that she had limited experience in this process. She also welcomed further discussion at the December Board Development session in relation to best practice in terms of reporting outcomes. R Hughes provided assurance that training and coaching would be provided, which would be discussed further at the Development Session, alongside clarifying the roles and responsibilities of Executive Leads and Independent Members during walkabouts.
Resolution:	The Committee **Noted** the findings and **Approved** the development of a standardised reporting framework for walkabouts, to be rolled out from January 2026
5.	**SETTING THE SCENE - SERVICE DELIVERY**
5.1	**Thematic Spotlight Presentation - Quality Impact of the Health Board's new Escalation Framework**
	Following D Matthews presentation of the report which highlighted the key matters for members attention, C Donoghue extended her thanks for providing a concise update on the significant activity being undertaken in this area. In relation to the specific matter of slide sheets, B Gammon confirmed that work had been undertaken with Procurement and Manual Handling teams in relation

	to securing a single supplier, which had improved the speed and consistency of supply. B Gammon also advised that documentation was a key area requiring improvement, given that poor documentation affected the ability to distinguish avoidable from unavoidable pressure damage and added that work was ongoing across the health board to address this. G Jones expressed concern that a lead nurse would now be covering three Emergency Department (ED) sites which was likely to result in excessive time being spent traveling between hospital sites and queried why the model changed. D Matthews advised that this was a 'proof of concept' activity implemented recently to provide continuity across the three sites, especially given identified anomalies and assured the Committee that the lead nurse would not be constantly traveling between sites as they as they would have a clear plan of activity based on priorities, with a Senior Nurse remaining present within each ED. Members noted the model was being trialled due to a secondment opportunity and would be discussed further at upcoming meetings. C Donoghue noted the importance of evaluating the sustainability and impact of the approach, acknowledging the demonstrated reduction in pressure damage and positive impact, and suggested ongoing evaluation to assess future changes. C Donoghue concluded by commending the systematic nature of the work and reiterated its value.
Resolution:	The Committee **NOTED** the presentation.
5.2	**Clinical Executives Report**
	R Hughes introduced the report and alongside his Executive Director colleagues, highlighted the key matters for members attention. G Jones extended her congratulations to colleagues who had secured promotions within the Patient Care & Safety Team and sought confirmation that the Executive Director of Nursing and the Deputy Director of Nursing roles had been appointed to on an interim basis at present. R Hughes confirmed the appointments made were interim as opposed to permanent. In relation to the update included in the report in relation to Mental Health Team cultural issues, P Roseblade sought clarification on what the involvement of Health Education Improvement Wales in supporting trainees and ensuring a safe, productive environment, related to. D Hurford advised that the two issues are directly related and originated from trainee feedback and added he would provide more detail in the closed session. In response to a query raised by C Donoghue in relation to CTM being an outlier in BBV (blood-borne virus) testing and whether this was as a result of funding allocations, P Daniels confirmed that the low treatment uptake and delays between diagnosis and treatment were related to funding issues, adding that CTM had the lowest allocation for health protection in Wales and that a request

	for increased funding had been submitted to support improved throughput and service architecture.
Resolution:	The report was **NOTED.**
5.3	**Care Group Highlight Reports**
5.3.5	**Diagnostics, Therapies, Pharmacy & Specialties Care Group**
	H Wilton presented the report and highlighted the key matters for Members attention. Members noted that the ERCP (endoscopic retrograde cholangiopancreatography) scopes had been approved by Welsh Government, and a procurement exercise was underway to move the service back to Prince Charles Hospital, as it was currently centralised at Royal Glamorgan Hospital. In response to a query raised by H Proctor, confirmation was provided that there was a date error contained within page 4 of the report, with the following sentence to read *"we are expecting to hear by the end of November 2025"* as opposed to November 2026. H Proctor expressed concern in relation to the substantial increase in new audiology patients, noting that this could lead to more follow-ups and potentially unsustainable demand on staff, and sought assurance as to the support offered to staff in terms of their wellbeing and how this would be monitored. C Verrecchia acknowledged the increased referrals into audiology and confirmed that staff were volunteering for weekend work to help manage the backlog. Members were provided with assurance that staff wellbeing was being monitored and that steps were being taken to balance the workload. G Hughes highlighted that there was significant waste capacity in audiology as a result of audiologists being routinely allocated to Ear Nose Throat (ENT) clinics, resulting in lost capacity on a weekly basis, and added that a reduction in the number of audiology-staffed ENT clinics had been agreed, which will require changes in how ENT patients are booked and would significantly increase audiology capacity. In response to a query raised by C Donoghue as to whether there was a long term plan in place to address the issues with Sonographers experiencing repetitive strain injuries, which was leading to sickness absence, L Edwards explained that issues mainly related to non-obstetric ultrasound lists, which require repetitive firm pressure and contribute to repetitive strain injury. Members noted that the long-term solution involved changing how lists were being managed and noted that although current staffing shortages made this challenging, work was underway both locally and nationally to make the service more sustainable for the workforce. K Palmer praised the mortuaries for their outstanding work, highlighting the positive Human Tissue Authority (HTA) inspection results for all three mortuaries and expressed her appreciation for the team's efforts to standardise practice and maintain high standards. D Hurford welcomed the comments made by K Palmer and advised that the Team had recently received a Seren award, with

	their practices now being used as examples by the HTA authority across England and Wales.
Resolution:	The report was **NOTED.**
5.3.1	**Unscheduled Care - Care Group**
	D Matthews presented the report and highlighted the key matters for Members attention. Members noted that since the report was written, there had been recent improvements in stroke performance, noting that for the week of the 7th November, 77% of patients achieved CT scan within 20 minutes and 50% reached the acute stroke unit. Members also noted there was a strong focus and motivation to improve stroke service performance, with daily Multi-Disciplinary Team (MDT) huddles and weekly live reports implemented to monitor barriers and progress. P Roseblade advised that whilst she had found the verbal update on stroke performance to be encouraging, she questioned the timing and format of reporting, noting that the current report detailed improvement rather than actual performance. P Roseblade added that the report showed a green rating for admissions to the stroke unit, despite only 5 out of 67 admissions occurring within 4 hours and suggested the need for outcome-based performance reporting rather than improvement-based reporting. D Matthews agreed with the comments made and stated that the next report would include more detailed performance data, showing the trajectory of improvement. L Edwards advised that although the Committee had not yet received the latest data, there had been a recent spike in the number of stroke cases presenting to acute sites, and added that, despite this increase, the team had maintained the improvement trajectory in the target areas for stroke performance. In relation to the update provided within the highlight report regarding care and deconditioning at Ysbyty George Thomas, L Edwards extended her thanks to D Matthews for her robust response to the concerns raised and advised that a comprehensive action plan had been developed which would be handed over to the Primary Care & Community Care Group to manage moving forwards as a result of the transfer of service. C Donoghue referred to the statement in the report regarding training provision and ESR compliance, specifically referencing the need for a review of training capacity and a recovery plan and questioned where and how this recovery would happen. In response, D Matthews advised that a reset was being undertaken, with the first Unscheduled Care Group workforce and business meeting held in November, where focus was placed on resetting rosters, sickness management, and training compliance. Members noted follow-up actions would be reviewed in December, with an expectation of seeing improvement in the next meeting.
Resolution:	The Committee **NOTED** the report.

Action:	Next report to include more detailed performance data in relation to stroke performance, showing the trajectory of improvement.
5.3.2	**Children & Families Care Group**
	C Verrecchia presented the report and highlighted the key matters for Members attention. Members noted risks remained in relation to the special school nursing service, with ongoing challenges being faced in relation to recruitment and that ongoing discussions are needed at pace with Welsh Government and Education Partners to help mitigate the risk. C Donoghue advised that this matter would continue to be escalated to the Board within the Committee Highlight report as a result of the persistent challenges. C Verrecchia highlighted a factual inaccuracy within the report regarding Unite currently balloting their members and clarified that Unite was not currently balloting but had sent a letter of intention to discuss the Band 7 job description with staff, pending a response from management. In response to a query raised by P Roseblade as to whether the Band 7 issue was an all-Wales matter or specific to CTM, C Verrecchia explained that last year there was industrial action short of strike by Unite members for health visiting, leading to an improvement plan being developed and engagement with staff undertaken. Members noted that the Band 7 job description was reviewed nationally and resulted in an enhanced knowledge score as opposed to a change to the whole job description and noted that the current conversation with Unite was specific to CTM and related to a disparity in understanding regarding the job description, which may lead to further national discussions depending on the outcome within CTM.
Resolution:	The Committee **NOTED** the report.
5.3.3	**Planned Care - Care Group**
	S O'Donovan presented the report and highlighted the key matters for Members attention. Members welcomed the reduction in the average length of stay to 1.9 days as a result of the elective arthroplasty work moving to Princess of Wales Hospital and noted that there are now three dedicated laminar flow theatres, a dedicated 28-bed orthopaedic ward with seven-day therapy and Allied Health Professional support. C Donoghue sought clarity in relation to the statement regarding endoscopy equipment and queried if her understanding was correct in thinking that although the risk was not low, the risk of cancelling patients was greater than the risk of proceeding with the current equipment. S O'Donovan confirmed this to be the case which is why the decision was made to continue using the unit with an action plan in place. G Hughes added that the decision was made in conjunction with Infection, Prevention & Control professionals, who were confident that continuing to use the equipment was appropriate. Members noted

	that a new endoscopy decontamination facility was being built at the Princess of Wales Hospital. In response to a query raised by P Roseblade regarding the current status of JAG accreditation, G Hughes advised that the JAG accreditation process is ongoing at Prince Charles Hospital given the unit was compliant and added that once the endoscopy decontamination works at Princess of Wales Hospital were completed, JAG accreditation would be reapplied for.
Resolution:	The Committee **NOTED** the report.
5.3.4	**Mental Health & Learning Disabilities Care Group**
	L Griffiths presented the report and highlighted the key matters for Members attention. In response to a query raised by C Donoghue as to whether the meeting with senior representatives at Cardiff and Vale University Health Board (CAVUHB) regarding the commissioned Tier 3 eating disorder service had taken place, L Griffiths advised that whilst a face-to-face meeting had not yet been held, email conversations had occurred, with proposals made to move forward and mitigate issues. Members noted that confirmation is awaited from CAVUHB's senior team in relation to recharging to provide services internally.
Resolution:	The Committee **NOTED** the report.
5.3.6	**Primary and Community Care - Care Group**
	S Bradley presented the report and highlighted the key matters for Members attention. C Donoghue welcomed the positive developments highlighted within the report in relation to the Paediatric General Anaesthetic lists. K Palmer commented on the renaming of the Navigation Hub and questioned the implications of the name change given that many people were now familiar with the facility. S Bradley advised that the term 'single point of access' was being used for Welsh Government reporting and provided assurance that the facility would continue to be referred to as the Navigation Hub internally. K Palmer welcomed the head injury pathway, particularly in relation to falls and hospital admissions, and commented on the importance of additional space requirements for healthcare services at Parc Prison. In relation to Parc Prison, S Bradley advised that the need for additional space had been acknowledged by G4S Security Services and HM Prison and Probation Service and added that plans were in place to address this, particularly for medicines management and dispensing. Members noted that a report was being prepared in relation to the need for additional dental capacity.
Resolution:	The Committee **NOTED** the report.
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 referred to the maternity adverse occurrence data in the table of reportable events by clinical area on page 7, highlighting its monthly variability and questioned whether there was an in-depth review of what causes the difference between months with high and low numbers. K Jenkins-Forrester explained that the Nationally Reportable Incidents in maternity are reported based on the month the report is submitted to the NHS performance and improvement team, not the month the incident occurred and advised that incidents are often received via a panel or scrutiny process before being reported, which can result in delays and clustering of incidents in certain months. K Jenkins-Forrester agreed to include the actual date of occurrence in future reports to provide further clarity. P Roseblade drew attention to the disparity between the incidents as initially reported on Datix and the outcome following investigation, specifically regarding how harm is measured and reported and questioned how this affected the triggering of duty of candour and any potential redress incurred due to the high initial assessment of harm. K Jenkins-Forrester clarified that duty of candour was triggered after a management review, which occurred prior to the formal investigation. Members noted that the management review assesses whether healthcare was a factor and the potential level of harm, and if criteria are met, duty of candour is triggered, and the patient/family notified. The investigation then follows, and its outcome may lead to redress or further advice to the individual. K Jenkins-Forrester acknowledged the variation between initial harm assessment and final outcome and committed to providing more clarity in future reports. R Hughes suggested that a focused discussion on duty of candour, its process, and triggers would be useful for the Committee and agreed there was a significant difference between initial harm assessments and what ultimately triggers duty of candour and proposed bringing more clarity and reassurance to a future meeting. C Donoghue suggested this be considered at the next agenda setting meeting. C Donoghue reflected on the assurance the Committee receives that care groups will investigate where there are clusters of incidents and undertake corrective action where appropriate, as has been seen over the past year.
Resolution:	The Committee **NOTED** the report.
Action:	Actual date of occurrence to be included in future reports in relation to the maternity adverse occurrence data in the table of reportable events by clinical area Clarity to be provided in future reports in relation to the variation between initial harm assessment and final outcome in relation to reported incidents
6.2	**People's Experience Activity Report August – September 2025**

	B Gammon presented the report and highlighted the key matters for Members attention. K Palmer recognised the importance of the Patient Advice and Liaison Service (PALS) for patients, families, and carers, and welcomed the update that the service was now present in Emergency Departments. K Palmer noted the reported number of 332 PALS contacts seemed low without context and asked how assurance was provided regarding actions taken from PALS queries and enquired about staff awareness and referral to PALS. B Gammon advised that she would ensure more detail was included in the next report on the points raised by K Palmer and described efforts to raise awareness of PALS, such as posters, QR codes, and a new patient information leaflet for inpatients which had recently been approved that signposts to PALS and other support services. P Roseblade referred to catering and sought clarity as to what was in place to ensure patients were eating and questioned what steps could be taken to address the large amount of food waste. B Gammon explained that the new catering model allows patients to choose their meals, which should help reduce waste and added that snacks were available for patients arriving at hospital late, with catering staff monitoring food left on plates which was then reported to nursing staff. Members noted the ongoing work by the hydration and nutrition steering group, including the use of red trays and lids to identify patients requiring additional help. G Jones shared some positive experiences of being a recent patient at Prince Charles and Royal Glamorgan hospitals, stating the choice of food was excellent. G Hughes highlighted the importance of linking catering and nutrition to visiting, noting that family support can encourage patients to eat and aid recovery, and suggesting it would be useful to see how changes in visiting hours correlate with nutrition. B Gammon advised that the team were rolling out the carer's passport alongside extended visiting hours which would allow carers to indicate when they want to visit to support individuals (e.g., lunchtime, evenings) which would alleviate placing too much onus on relatives.
Resolution:	The Committee **NOTED** the report.
Action:	Further detail to be included in future reports in relation to how assurance was provided regarding actions taken from PALS queries.
6.3	**Status Report on Commissioned Services (Quality Focused)**
	R Hughes presented the report and highlighted the key matters for Members attention. K Palmer welcomed the report stating it was positive to receive the report for oversight and scrutiny purposes of quality focussed commissioned services. She also expressed her agreement with the next steps, emphasising the importance of escalating any issues with commissioned services to the Committee. R Hughes extended his thanks to K Palmer for her comments and explained that his first

	step was to check if the services were compliant from a duty of quality and duty of candour perspective and added that through the Planning & Partnerships Team, he had immediate access to all commissioned services and could make that assessment at baseline. R Hughes advised he would continue to work with the Planning & Partnerships Team to enhance the process further. In response to a query raised by C Donoghue as to whether the Planning & Partnerships team had capacity to undertake this work, R Hughes confirmed that the team had capacity to address the enhancements, stating that the current approach is satisfactory and compliant, and that the proposed improvements would further streamline the process without introducing any additional resource requirements.
Resolution:	Members **NOTED** the report and **APPROVED** a revised approach to quality assurance for commissioned services
7.	**GOVERNANCE, RISK AND ASSURANCE**
7.1	**Organisational Risk Register – Risks Assigned to Quality & Safety Committee**
	C Hamblyn presented the report and highlighted the key matters for members attention. C Donoghue queried the wording around the Right Care Right Person risk, specifically questioning the phrase "it was unlikely the policy is not going to adversely affect the frequency of RCRP related incident," and suggested this may require reframing. In response, L Griffiths agreed and clarified that the intention was to say it is unlikely the policy will affect the frequency, which is why the risk score was reduced. In response to a query raised by C Donoghue regarding the CT scanner risk, C Verrecchia advised that one of the switches had been replaced and the second was underway, and confirmed that once completed, the risk would be significantly reduced resulting in a likely removal from the Organisational Risk Register.
Resolution:	The Committee **REVIEWED** the risks escalated to the Organisation Risk Register and **CONSIDERED** if all that can be done is being done to mitigate the risks.
7.2	**Mortality Indicators and Mortality Reviews**
	S Davies presented the report and highlighted the key matters for Members attention. C Donoghue commented that whilst the mortality report seemed to be developing good governance framework, she noted it appeared to have created additional work for staff in regard to managing the backlog whilst an improved structure was being put into place. S Davies advised that a significant amount of work was being undertaken in relation to strengthening the consultant job planning process, with an expectation that there would be a mortality champion in each service with recognised time for the role, which should further strengthen the system.

	In response to a query raised by K Palmer as to whether the Mortality Board would report into the Quality, Safety & Experience Committee and how findings would translate into future services and transformation, S Davies confirmed that whilst not finalised, it was being proposed that the Mortality Board reports into this Committee on a six monthly basis and agreed that learning needed to be strengthened and made more global whilst balancing resources and time.
Resolution:	The report was **NOTED**
7.3	**Highlight Report from the Harm Free Care Agenda**
	R Hughes presented the report and highlighted the key matters for Members attention. C Donoghue commented that she found the report to be comprehensive and assuring that common themes were present across all reports, indicating that focus was being directed to areas needing impact. C Donoghue added that she felt encouraged by the overall focus and detailed action plans, noting that while these efforts take time to deliver results, the direction was positive.
Resolution:	The report was **NOTED.**
7.5	**Annual Presentation of Nurse Staffing Levels**
	B Gammon presented the report and highlighted the key matters for Members attention. C Donoghue welcomed the report and extended her thanks to B Gammon and the Team for the detailed update.
Resolution:	The report was **NOTED** and **ENDORSED** for Board Approval
8.	**CONSENT AGENDA**
8.1	**FOR APPROVAL**
8.1.1	**Unconfirmed Minutes of the Meeting held on 23 September 2025**
	The Unconfirmed Minutes of the Committee Meeting held on 23rd September 2025 were **APPROVED.**
8.1.2	**Unconfirmed Minutes of the In-Committee Meeting held on 23 September 2025**
	The Unconfirmed Minutes of the In-Committee Meeting held on 23rd September 2025 were **APPROVED.**
8.1.3	**Organ Donation Sub Committee Terms of Reference**
	The Organ Donation Sub Committee Terms of Reference were **APPROVED.**
8.1.4	**Safeguarding Annual Report 2024-2025** The Annual Report was **APPROVED**.
8.2	**FOR NOTING**
8.2.1	**Non-Routine Committee Business (Forward Plan)**
	The Committee **NOTED** the Forward Plan.
8.2.2	**Annual Cycle of Business**
	The Committee NOTED the Annual Cycle of Business.
8.2.3	**Clinical Policies Highlight Report**
	The Committee **NOTED** the report.

8.2.4	**CTMUHB National Clinical Audit Programme Quarter 2 Update 2025-2026**
	The Committee **NOTED** the report.
8.2.5	**CTM Clinical Learning Academy Annual Report 24/25**
	The Committee **NOTED** the report.
8.2.6	**Bi-Annual Report CTM Radiation Safety Committee**
	The Committee **NOTED** the report.
8.2.7	**Antimicrobial Stewardship Report – October 2025**
	The Committee **NOTED** the report.
8.2.8	**Health Inspectorate Wales (HIW) Audit Tracker Report**
	The Committee **NOTED** the report.
8.2.9	**Terms of Reference Annual Review**
	The Terms of Reference are being reviewed as part of the Committee Business Reviews for 2026 and will be presented to a future meeting
9.	**CLOSE OUT BUSINESS**
9.1	**Committee Highlight Report to the Board**
	C Hamblyn suggested that for the alert section, specific mention would be made to the special school nursing service risk and suggested reporting back the positive escalation and assurance received regarding the Paediatrics General Anaesthetic list, in order to close the loop on previous concerns. C Donoghue advised that it would also be helpful to highlight the update provided in relation to the Mortality Reviews and Indicators report.
9.2	**Meeting Feedback**
	H Proctor commented that she felt the meeting had been positive and appreciated the expanded number of presenters which had made the agenda easier to follow and helped the meeting flow better and added the she would welcome this approach for future agenda planning.
9.3	**Any Other Business**
	There was no other business to report.
10.	**PRIVATE / CLOSED SESSION BUSINESS**
	The following items will be received In Committee: • Organisational Risk Register - Closed Risks • Adult Mental Health Cultural Challenges
11.	**DATE & TIME OF THE NEXT MEETING**
	20th January 2026 at 9:00am

Agenda Item	8.1.2

Unapproved Minutes of the Quality, Safety & Experience In Committee

Date and Time of Meeting	Tuesday 18 November 2025 12:00
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member University (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Hayley Proctor	Independent Member Trade Union
	Patsy Roseblade	Independent Member – Finance
In Attendance	Dom Hurford	Executive Medical Director
	Gethin Hughes	Chief Operating Officer
	Richard Hughes	Interim Executive Director of Nursing, Midwifery and Patient Care
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Science
	Lloyd Griffiths	Interim Nurse Director, Mental Health & Learning Disabilities
	Cally Hamblyn	Assistant Director of Risk and Governance
	Emma Walters	Head of Corporate Governance and Board Business
	Becky Gammon	Interim Deputy Executive Director of Nursing
	Sallie Davies	Deputy Medical Director
Meeting Observers	Not applicable	

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	C Donoghue welcomed everyone to the meeting.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Hywel Daniel, Executive Director for People • Philip Daniels, Executive Director of Public Health
1.3	**Declarations of Interest**
2.	**MAIN AGENDA**
2.1	**Mental Health & Learning Disabilities Workforce Cultural Challenges**
	D Hurford presented the report and highlighted the key matters for Members attention which related to cultural challenges experienced at Royal Glamorgan Hospital, within the Mental Health Service. Members were assured that steps had been taken to maintain patient safety in the immediate and longer term and that the concerns raised were being acted upon by the Executive Team.
Resolution:	The report was **NOTED**
2.2	**Organisational Risk Register – Closed Risks**
	C Hamblyn presented the report and highlighted the key matters for members attention. Members noted that one risk was being proposed for de-escalation. In response to a query raised by K Palmer as to whether the issues discussed in the previous agenda item (2.2 – Mental Health Learning Disabilities Workforce Cultural Challenges), would result in new risks being escalated to the Organisational Risk Register around operational resilience in the service , G Hughes advised that the challenges are currently being discussed and investigated with the Care Group Leadership Team in terms of any impact on operational resilience and should risks be identified these would be escalated as appropriate.
Resolution:	The report was **NOTED.**
3.	**ANY OTHER BUSINESS**
	There was no other business to report.
4.	**DATE AND TIME OF NEXT IN COMMITTEE SESSION**
	Tuesday 20 January 2026 – if required

Agenda Item
8.1.4

Quality, Safety & Experience Committee

Organ Donation Committee
January – December 2025

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Corinna McNeil, Specialist Nurse Organ Donation
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
ODC	Organ Donation Committee
SNOD	Specialist Nurse Organ Donation
CLOD	Clinical Lead Organ Donation
ME	Medical Examiner

ORGAN DONATION COMMITTEE
ANNUAL REPORT – JANUARY TO DECEMBER 2025

FOREWORD

I am pleased to present the Annual Report of the Cwm Taf Morgannwg University Health Board, Organ Donation Committee for 2025. The purpose of this report is to formally report on the work of the Organ Donation Committee for January to December 2025 in accordance with the Committee's Terms of Reference.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines.

The Annual Committee Cycle of Business was approved by the Committee at the meeting held in January 2025, which outlined the forward planning for the work of the Committee for 2025.

I continue to advocate the promotion of a culture of continual improvement, and as usual look forward to the learning that will come from the self-assessment which is undertaken each year to reflect on the Committee's effectiveness.

Helen Lentle
Committee Chair

1.0 Situation /Background

1.1 Cwm Taf Morgannwg UHB is recognised by NHS Blood and Transplant (NHSBT) a Level 2 Health Board. Between 1 January 2025 and 31st October 2025, Cwm Taf Morgannwg University Health Board had 7 deceased solid organ donors, resulting in 22 patients receiving a life saving transplant. Furthermore, 23 corneas were donated from patients within CTMUHB.

1.2 CTM UHB has two embedded Specialist Nurses for Organ Donation (SNODs), two Clinical Leads for Organ Donation (CLODs), and the current Regional CLOD for South Wales is a CTM Consultant. These are NHSBT funded activities and are subject to annual performance management. A business case was put forward to NHSBT to apply for a further 0.2 WTE specialist nurse hours. This was also supported in writing from the CTMUHB chief operating officer for the Specialist nurses. We can confirm that these hours have now been awarded to us enabling adequate cover and service delivery for all 3 sites.

1.3 CTM UHB has a well-attended Organ Donation Committee (ODC), which has representation from all relevant internal and external stakeholders, including patient and family representatives. The ODC is the forum in which Health Board performance is reported, missed opportunities discussed, a communication strategy developed, and education sessions are planned.

1.4 Financial support for Organ Donation activities is funded by NHSBT. These monies are held in a regional fund, which can be easily accessed by the local Organ Donation Committee. These funds can support educational events, memorial activities, facilities for visitors to Intensive Care, and artwork installations on hospital sites. Our incredible artwork recently installed to Prince Charles Hospital Outpatients Department was funded via the South Wales Organ Donation team and CTMUHB charitable funds.

1.5 Clinical performance and engagement within CTM are excellent. In the previous 10 months, there was only 1 occasion when a patient was not referred who could have been an organ donor as part of their end of life care. There was also 1 occasion when a SNOD was not present during family discussions. The consultant was aware that a specialist nurse was onsite but declined them joining the conversation with family. Further education and training has been giving to avoid this from happening in the future. A performance dashboard is available to the public.

1.6 We have excellent support from HM Coroner for South Central Wales – should a potential donor require coronial investigation – we are able to discuss the matter with the Coroner out-of-hours, and there was 1 case when the Coroner placed restrictions on donation of specific organs. With the role out of the mandatory ME scrutiny we have established a robust process to hold preliminary conversations with the ME service to discuss a

cause of death. This service is 24/7 to ensure there will be no delays or prohibit donation proceeding in a timely manner.

1.7 In March 2022, the Welsh Organ Donation and Transplantation Plan 2030 was launched. This was developed by the Welsh Transplant Advisory Group (WTAG) which identified the key targets below:

i. Increasing deceased donation opportunities
ii. Increasing tissue and eye donation
iii. Increasing living donation and transplantation
iv. Increasing access to transplantation
v. Improving transplant outcomes
vi. Supporting a sustainable and diverse workforce

1.8 The theatre team are now comfortable and familiar with the process of the Withdrawal of Life Sustaining Therapies in the anaesthetic room, and our practices and experiences have been shared at national level as examples of good practice.

1.9 The National Organ Retrieval Service (NORS) receive excellent support from our theatre teams when retrieving organs from our donors. There are no obstacles in accessing theatre space, and it is widely accepted that an Organ Retrieval is a "lifesaving" procedure – in a much wider sense than usual.

1.10 There is excellent follow-up support for the families of deceased donors. The Critical Care psychology service is sector leading in the bereavement service that they provide, and this is supplemented by the SNOD feeding back to families the outcomes of their gift of life.

1.11 All donor families are invited to an annual memorial event where the Gift of Life is recognised, and they are presented with an Order of St. John Award. The Chair was also privileged to attend representing the Cwm Taf Morgannwg Organ Donation Committee and also in her role as Regional Chair for Organ Donation.

1.12 SIGNET research programme has now been rolled out to all 3 sites. This will aid in advancing the future of organ donation and transplantation.

2.0 Specific Matters for Consideration

2.1 How the Health Board, with the ODC, will continue the excellent practice.

2.2 How the Health Board will support the SNOD and CLOD in meeting the key priorities of the 2030 plan.

2.3 Supporting NHSBT to ensure the CLOD and SNOD workforce matches the reconfiguration of Critical Care Services in CTM.

3.0 Key Risks / Matters for Escalation

3.1 How the Health Board works with NHSBT to increase the number of CTM residents on the Organ Donation Register and support community engagement to raise awareness. Attached for the Committee's information is the latest letter from the NHSBT acknowledging CTMUHB's activity and performance in supporting and facilitating organ and tissue donation and translation between April and September 2025.

4.0 Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome:	If no, please include rationale below: Not applicable.

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

5.0 Recommendation

5.1 The Committee is asked to **NOTE** the content of this report along with the letter from the NHSBT.

NHS
Blood and Transplant
www.nhsbt.nhs.uk

November 2025

Dear P Mears and Mr Hurford,

I would like to acknowledge the efforts of all our colleagues involved in supporting and facilitating organ and tissue donation and transplantation over the last 6 months. Thank you to your teams. However, the number of donors and transplants in the UK has still not returned to pre-pandemic levels and we must redouble our efforts to maximise the opportunities for donation.

This letter explains how your Health Board contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - Apr-Sep 2025

From 5 consented donors, Cwm Taf Morgannwg University Health Board facilitated 5 actual solid organ donors resulting in 15 patients receiving a transplant during the time period. Additionally, 22 corneas were received by NHSBT Eye Banks from your Health Board.

Quality of care in organ donation - Apr-Sep 2025

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation.

- Your Health Board referred 41 patients to NHSBT's Organ Donation Services Team; 15 met the referral criteria and were included in the UK Potential Donor Audit. There was a further 1 audited patient that was not referred.
- A Specialist Nurse was present for 7 organ donation discussions with families of eligible donors. There was 1 occasion when a Specialist Nurse was absent for the donation discussion.
- There were 2 (8%) missed opportunities to follow best practice out of 24 during the time period, compared with 0 (0%) out of 27 in the first six months of 2024/25.
- In Wales, 45% of the population have registered an NHS Organ Donor Register (ODR) opt in decision. This compares to 43% of the population nationally.

Up to date Health Board metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Our ask

- Ensure your Health Board supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Health Board has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Why it matters

In the first six months of 2025/26, 91 people benefited from a solid organ transplant in Wales. However sadly, 11 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Agenda Item
8.1.5

Quality, Safety & Experience Committee

Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
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 Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Consultation -widespread email distribution	30.09.2025	All comments received addressed as appropriate.
Consultation page on CTMUHB Internal SharePoint Page	30.09.2025	All comments received addressed as appropriate.
Consultation awareness included in Staff Update	30.09.2025	All comments received addressed as appropriate.
Executive Management Board	24.11.2025	Endorsed for Committee Approval

Acronyms / Glossary of Terms	
Nil	

1. Situation /Background

1.1 The *'Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents'* provides a robust and clear governance framework for the management of written control documents. The policy outlines the process to support the development or review, approval, dissemination and management of written control documents within CTMUHB.

1.2 Recognising the commitment in the People Plan to remove unnecessary barriers and simplify processes a complete re-write of this policy has been undertaken along with a review of the approval process map for Clinical and Non-Clinical Written Control Documents.

1.3 The policy, enclosed as Appendix 1, has been reviewed and is consistent with the approach across NHS Wales / legislation.

2. Specific Matters for Consideration

Consultation Engagement

2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality & Welsh Language Impact Assessment (EWLIA)	30.09.2025
Informal Consultation with interested parties	30.09.2025
Formal Consultation	30.09.2025
EMB Endorsement	24.11.2025

Consultation Outcome

2.2 As a result of widespread engagement at the consultation stage, responses were received from the following service areas:

- Speech and Language Therapy
- Pathology
- Children & Family Care Group including Maternity.
- Community Health Visiting
- People Directorate
- Hosted Organisations (Joint Commissioning Committee and National Imaging Academy Wales)

- CTM Improvement Team
- Mental Health Team
- Medical Directorate Business Team

2.3 Whilst not an exhaustive list of all changes made during the consultation stage, the key changes made were:

- Including a definition regarding 'local' documents which apply to a *single department or profession* where there is *no wider impact* beyond that departmental/local level to the wider Health board.
- Reframing the definition of 'legally binding' in terms of policies to reflect the position as set out in employment contracts.
- To include the requirement of authors to comply with the All Wales NHS Accessible Communication and Information Standards.
- The requirement for authors to record which protected characteristic / priority groups were consulted and how feedback influenced the final document.
- The process staff should follow if they identify a document that is beyond its three-year lifespan.
- Compliance with Welsh Language and Equality, Diversity & Inclusion legislation.
- Other feedback included typographical and grammatical amendments.
- Freedom of Information Act Status captured on the front cover of the policy template and narrative captured within the policy as to this requirement.
- Change to the Equality and Welsh Language Assessment reference on the front page of policy template and at section 8 of the template to change reference to Equality and Welsh Language Assessment from "Statement" to "outcome".

Equality, Welsh Language Impact (EWLIA) Outcome

2.2 The EWLIA concluded that this policy is assessed as having a neutral to positive impact on all protected characteristics, as well as on additional Equality and Inclusion priorities.

Organisational Values and Behaviours

2.3 Organisational values and behaviours have been reflected within the policy.

3. Key Risks / Matters for Escalation

3.1 The following risk is escalated to the Organisational Risk Register. It is hoped that the review of this policy will help support the effective and timely review of written control documents and that the 'Non-Clinical Policy Review Programme' also aims to strengthen the system and process to supporting reviews. These mitigations will in time lead to a reduction in the current risk score.

- Datix Risk ID 4885 - Failure to deliver and sustain effective Policy Management System and Process. Currently scored with a risk rating of 16.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
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))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable
	If more than one applies please list below:

Environmental /Sustainability Impact (5Rs)	

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: A QIA is not required, however, the policy includes reference 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): Assessed as having a neutral to positive impact on all protected characteristics, as well as on additional Equality and Inclusion priorities.	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	Adherence to policies is mandated.	
Enw da / Reputational	Yes (Include further detail below)	
	Noncompliance can result in a loss of trust and confidence in the Health Board.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	As outlined in the risk section of this report there is a significant amount of activity required to review and update written control documents that are beyond their 3-year life span and this will require dedicated resource. The Quality & Compliance Team are also implementing a new system to support authors with prompts and reminders when documents are nearing their review period.	

5. Recommendation

5.1 The Quality, Safety & Experience Committee are asked **APPROVE** this policy and **NOTE** the revised approval process (Appendix 2) and policy template (Appendix 3) that will be implemented if the Policy is approved.

6. Next Steps

6.1 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

Appendices:

- Appendix 1 - Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents.
- Appendix 2 – Approval Process for Clinical and Non-Clinical Policies and other WCDs
- Appendix 3 – Revised Policy Template

Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents

Document Type:	Policy
Indicate Clinical or Non-Clinical:	Non-Clinical
Document Reference:	CG06
Document Author (Title Only):	Assistant Director of Governance & Risk
Document Executive Sponsor (Title Only)	Director of Corporate Governance
Date Equality & Welsh Language Impact Assessment Completed:	30 September 2025
Freedom of Information Act Status	Open
Approving Forum:	CTMUHB Public Board Meeting
Approval / Effective from Date:	TBC
Review date due by:	TBC
Document Version:	3.0
Target Audience	All Staff

Disclaimers

CTMUHB Policies, Procedures and other Written Control Documents can only be considered valid and up to date if viewed on the SharePoint Pages, which is considered as the master library: LINK

If the review date of a document is passed, please contact the author or CTM.QualityassuranceCompliance@wales.nhs.uk

Contents

Introduction

The Cwm Taf Morgannwg University Health Board, subsequently referred to in this policy as the CTMUHB, has a statutory duty to ensure that appropriate policies, procedures etc are in place. Policies ensure Health board compliance to legislative and mandatory requirements. Policies outline the overarching principles for staff to perform their roles safely and competently.

A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Health Board has developed a system to support the development or review, approval, dissemination and management of polices.

1 Policy Statement

1.1 The development of any CTMUHB Policies, Procedures and other Written Control Documents should be developed in accordance with this policy.

1.2 For the purposes of this policy the term "Written Control Document" will encompass Policies, Procedures, Strategies, Equality and all other Written Control Documents as appropriate.

1.3 All CTMUHB Written Control Documents must be drafted in line with and incorporating CTMUHB's organisational values and behaviours available via the following link: Value & Behaviours Home Page

2 Purpose

2.1 Standardisation in production, approval, registration and implementation of CTMUHB Written Control Documents is an important part of corporate and clinical governance.

2.2 CTMUHB will have a systematic and planned approach to the development of Written Control Documents

2.3 Written Control Documents should provide a clear understanding of what is expected of employees.

2.4 Written Control Documents will only be developed when there is a clear identified need for them to enable achievement of objectives and standards which would not be possible without written policy and guidance. This will enable CTMUHB to manage and control the development of Written Control Documents and support other external standards. This document sets out:

- CTMUHB's definitions of policy, procedure, protocol and guidelines.
- The required style and format of policy and guidance documents.
- Accountabilities and responsibilities for policy.
- The process for the development, approval and ratification of documents.

2.5 Establishing a clear system for the management of Written Control Documents is a critical component of a transparent risk management programme and integrated governance.

3 Scope

3.1 This policy applies to CTMUHB and all its employees and must be followed by all those who work for the organisation, including those on temporary or honorary contracts, secondments, contractors, Independent Members and students.

3.2 In respect of CTMUHB-hosted organisations, all staff members are considered employees of CTMUHB and are therefore subject to its policies, procedures, and guidance. Hosted organisation staff are entitled to the same employment rights, responsibilities, and protections as any other CTMUHB employee, including access to applicable services.

3.3 It is recognised, however, that hosted organisations may operate services with a national remit or specialised scope that extend beyond the provisions of CTMUHB's standard policies. In such cases, hosted bodies may need to develop supplementary policies or procedures to ensure equitable access to safe, sustainable, and high-quality healthcare services across Wales. These bespoke arrangements should be clearly defined, aligned with CTMUHB governance expectations, and agreed upon as part of the hosting agreement.

3.3 This policy applies to Health Board wide documents however, it should be used to inform local processes for the development, review and approval of local Written Control Documents.

3.4 **Health Board Wide** documents are applicable to staff across the Health Board and are subject to approval via the arrangements set out in this policy. All Health Board wide documents require an Executive sponsor.

3.5 **Local** documents apply to a *single department or profession* where there is *no wider impact* beyond that departmental/local level to the wider Health board.

For example, within the Pathology Directorate there are specific requirements to develop specific pathology related policy documents in order to comply with regulation and accreditation bodies, such as UKAS, Medicines Healthcare Regulatory Agency (MHRA) etc, that have no impact or applicability beyond the Pathology Department and their activity, systems and processes. When developing a Local Document please check with the Care Group Director / Service Director Sponsor to ensure that the document falls within the "local" definition.

Local documents such as this example are subject to approval via local approval mechanisms. Such documents should follow the principles

contained in the Policy Framework and must not conflict with relevant Health Board policies or Health Board wide procedures. All local WCDs require a Care Group Director / Service Director Sponsor.

4 Definitions

4.1 CTMUHB aims to have a clear understanding of the terms policy, procedure, protocol and guidelines and a common approach to the development of policy and management of the associated procedural documents.

4.2 This policy is particularly relevant for those staff responsible for writing or reviewing Written Control Documents, however it is equally important that all CTMUHB employees understand the relevance of having these in place.

4.3 Occasionally Written Control Documents will be developed through partnership working and may have a different format than that described here e.g. All Wales Policies. In these instances, the Written Control Documents themselves will be adopted but will still be quality-assured by the relevant manager in consultation with the Quality & Compliance Team who hold the responsibility for Non-Clinical policy development and Medical Directorate Team for Clinical Policy, against the criteria of this document to ensure that when presented for final approval it meets CTMUHB's requirements.

4.4 **Strategy** - is a long-term plan designed to achieve particular goals or objectives which is supported by policies and or procedures. A Strategy must have an Equality, Welsh Language Impact Assessment and Quality Impact Assessment (only limited exceptions will apply). A Strategy should be endorsed by the Strategic Development Committee and approved by the Board. CTMUHB has one overarching Strategy, 'Building Healthier Communities (CTM2030) any portfolio specific strategy documents should be referred to as Strategic Delivery Plans.

4.5 **Policy –** "A policy says what you must know or do". A policy is a statement of intent, describing an approach or course of action to be adopted or pursued in respect of a particular issue. Each policy should have a purpose and specific requirement as to how the policy is to be accomplished. A policy is a formal document which enables managers and staff to make correct decisions, comply with relevant legislation and follow specific rules. The formal policy applies to all staff and/or those defined as within the scope of the policy i.e. a particular profession. The contract of employment between an employee and employer is a legally binding document and as per the contract of employment employees are required to adhere fully and faithfully to all relevant policies which the Health Board has put in pl*ace.*

Non-compliance with a policy may therefore result in disciplinary action. Policies must have an Equality, Welsh Language Impact Assessment and

Quality Impact Assessment (only limited exceptions will apply). A Policy requires formal approval by the Board or Board Committee as appropriate.

4.5 **Procedure -** "A procedure tells you how it must be done." A procedure is a standardised series of actions / instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and to ensure efficiency, consistency and safety. A procedure is a formal document. Procedures do not require approval by the Board or Board Committee; they can be approved by the Executive Management Board. Procedures must have an Equality, Welsh Language Impact Assessment.

4.6 **Protocol -** A protocol is a formal set of procedures which are to be followed in order to achieve specific outcomes. Protocols do not require approval by the Board, Board Committee or Executive Management Board; they can be approved by an Executive Director of the responsible function. Protocols must have an Equality, Welsh Language Impact Assessment

4.7 **Guidelines** - A guideline is a document that outlines best practice. Guidelines are not mandatory, though staff are expected to follow guidelines except when exceptional circumstances determine otherwise. Guidelines do not require approval by the Board, Board Committee or Executive Management Board; they can be approved by an Executive Director of the responsible function. Guidelines must have an Equality, Welsh Language Impact Assessment

5. Document Development

5.1 The diverse nature of health care means there will be many Written Control Documents in place. Some will apply across the organisation and be relevant to all staff, and others will be specific to certain areas or activities. It is important that documents are assigned the correct definition as set out in section four.

5.2 Documents that apply across the organisation must be sponsored by a lead Executive Director and therefore the author proposing the development of a Written Control Documents will need to discuss any proposal to create a new Written Control Documents with the relevant sponsor before proceeding. The author of the Written Control Documents should identify themselves by job title as the contact point on the front of the document. The authors cannot be named as more than one person and therefore if there is a group acting as the author a decision will need to made as to who the contact will be.

5.3 All Written Control Documents must align and complement the CTMUHB organisational values and behaviours which must be referenced and feature throughout the Written Control Documents as appropriate.

5.4 When the need for a Written Control Documents arises, the Quality & Compliance Team (Non-Clinical) or Medical Directorate Team (Clinical) should be informed before preparation commences to ensure there is not a document already in existence on the same or a similar subject and to note its development, support you in its approval and publication and provide reference numbers. At this stage an Equality, Welsh Language Impact Assessment must be completed. Guidance for this is available here: CTM At Our Best - Documents - Equality Impact Assessments - All Documents

5.5 The language used within Written Control Document development should avoid technical terms wherever possible. If technical terms are necessary, or abbreviations desirable, they must be explained using a glossary / footnotes.

5.6 All Written Control Documents must fully comply with the renewed All-Wales NHS ACIS. This includes ensuring documentation uses clear, accessible language to support low literacy levels and addresses the needs of staff whose main language is not English or Welsh (in addition to WCAG compliance). All-Wales NHS Accessible Communication and Information Standards (September 2025):

6 Governance & Legal

Duties, Accountabilities and Responsibilities

6.1 The following provides an overview of the duties of individuals, departments, Board and Board Committees etc, including levels of responsibility for the development of Written Control Documents.

6.2 ***Chief Executive -*** Written Control Documents are vital to the organisation for effective management, service delivery and the management of associated risks. It is therefore essential that responsibility is placed at the highest level. The Chief Executive is responsible for ensuring there is a structured approach in place for Written Control Document development and management.

6.3 ***Executive Directors -*** Responsibility for Written Control Document development is delegated to the Executive Directors; however, accountability remains with the Chief Executive.

The Executive Director / Sponsors are responsible for ensuring that all Health Board Written Control Documents (WCDs) within their remit are maintained and updated by liaising with the appropriate policy author/lead.

They are also responsible for signing off on the creation of a new Written Control Document and agree any changes proposed to such documents within their portfolio area.

They are responsible for ensuring that the appropriate advice and assistance is provided to the author/lead and that consideration is given to any training/resource implications that are identified.

6.4 ***Quality Assurance & Compliance Team*** – who sit under the portfolio and accountability of the Director of Corporate Governance/ Board Secretary will act as a central point of contact for all CTMUHB non-clinical Written Control Documents queries and will manage CTMUHB's non-clinical policy publication and archive system.

6.5 ***Medical Directorate Team –*** who sit under the portfolio and accountability of the Executive Medical Director will act as a central point of contact for all CTMUHB clinical Written Control Documents queries and will manage CTMUHB's clinical policy publication and archive system.

6.6 ***Directors, Deputy Directors / Heads of Service -*** Directors / Deputy Directors / Heads of Service must ensure that, through management lines, all staff have an awareness of all Written Control Documents etc, with emphasis given to those that are specifically relevant to their area of work. Directors / Deputy Directors / Heads of Service must ensure employees are aware that wilful or negligent disregard of any Written Control Document will be investigated and potentially treated as a disciplinary offence.

6.7 ***Managers (Policy Authors) -*** Day to day responsibility for the development and review of Written Control Documents is with Managers. Each document must have a named responsible officer which will usually be a Head of Service or a Manager. The responsible officer must ensure that an appropriate author is nominated to develop the Written Control Documents within the requirements of this document. Managers in consultation with the Quality & Compliance Team and/or Medical Directorate Team with responsibility for policy are responsible for ensuring that documents are reviewed in line with the review date. Managers should identify arrangements for any training support for the Written Control Document.

6.8 **All Employees –** Employees have a responsibility to work in line with CTMUHB approved Written Control Documents and should:

- Be aware of how to access them.
- Be aware of those which are relevant to their area of work.
- Act in accordance with them.
- Attend any relevant training which is offered in relation to them.
- Report any issues affecting compliance with them to their line manager, in order that these can be taken account of.

6.9 All staff need to ensure they are aware of the system for Written Control Document dissemination. This includes a requirement on receipt of new policies to review their contents and assess the relevance to their role.

6.10 All staff must be aware that wilful or negligent disregard of any Written Control Document will be investigated and potentially treated as a disciplinary offence.

Consultation

6.11 Once the Written Control Document author is confident that the draft is in a reasonable condition, they will then proceed to wider consultation to ensure all appropriate views are considered prior to seeking approval. At this stage an Equality and Welsh Language Impact Assessment must be completed then this should accompany the consultation and/or be referred to as completed and outline the outcome in the consultation document. This equally applies to other impact assessment requirements. The questions asked must then reflect the outcome of that impact assessment so that stakeholders can make informed comments on the proposed policy or change. Liaise with the Welsh Language Lead at this stage to ensure our legal duties are met.

6.12 CTMUHB expects all stakeholders, including patients and staff where relevant, to be involved in the development of Written Control Documents.

6.13 Consultation should be to secure the support and experience from all relevant individuals and groups. Expertise and experience of all relevant parties should be considered, particularly those who will be expected to implement the requirements of the Written Control Documents.

6.14 Consultation should involve appropriate expert groups and other stakeholders where appropriate and it is the responsibility of the author to ensure relevant people have been consulted.

6.15 Authors are required to record which Protected Characteristic/Priority groups were consulted and how their feedback specifically influenced the final document. This evidence must be recorded with the policy development for audit purposes.

6.16 Whilst not an exhaustive list, groups to consult are captured below:

As a Minimum

First Stage Consultation:

- Subject matter experts /forums on the topic area i.e. IPC Policy would go to the IPC Committee for review.
- Key staff including staff representatives from the professional associations and trade unions (as appropriate).
- Local Partnership Forum and/or Joint Local Negotiation Committee as appropriate. These forums via consultation will support / endorse subsequent approval of applicable policies - advice available from People Directorate on applicability.
- Patient/user representatives (as appropriate).
- Carer representatives (as appropriate).
- and other organisations (as appropriate).

- Third sector (voluntary and community) organisations relevant to the subject.
- Liaise with the Welsh Language Lead to consider the statutory consultation requirements that are required under the Welsh Language Standards.
- Staff Equality Networks

Second Stage Consultation prior to approval:

- Operational Management Board who will endorse Written Control Documents for approval. The relevant Care Group / Directorate Lead The relevant care group lead will attend Operational Management Board to present the document.
- For clinical policies please consult with the Assistant Medical Director for Quality & Safety.
- Minimum 2 weeks on the Staff Intranet and highlighted in the "News Banner".

6.17 The consultation process is an opportunity to influence the content and a draft document when sent out to stakeholders should be as near to the 'final' draft version as possible whilst still at a stage to make changes.

6.18 It should include all relevant references with details of associated documentation. This will help to ensure that the stakeholders are able to review and make appropriately informed comments. An appropriate length of time should be allotted to facilitate consultation. Once the consultation has been completed, the author should update the review log and version number to outline any changes made to the policy as a consequence of consultation. As part of the consultation, the author should keep a record of any discussions with supporting documentation.

6.19 The final consultation stage is to place the Written Control Document on the CTMUHB's live consultation page on SharePoint for a minimum of two weeks to allow for a final opportunity for comment. This can be facilitated by the Quality & Compliance (Non-Clinical) or Medical Directorate (Clinical) Teams.

6.20 Once the consultation stages are completed the document can proceed to approval.

Approval of Documents

6.21 Once a Written Control Document is ready for approval the author, in consultation with either the Quality & Compliance (Non-Clinical) or Medical Directorate Team (Clinical), shall determine the appropriate route for approving the document. It is the responsibility of the author to take the policy through all the approval stages which includes checking with their Executive Lead if approval was received and then updating the relevant fields with the approval information. The Quality & Compliance (Non-Clinical) or Medical Directorate Team (Clinical) will support authors through these stages as appropriate.

6.22 This should be in line with the organisation's Scheme of Reservation and Delegation.

6.23 Once the approval process is completed, the author should forward an electronic copy of the approved Written Control Document to either the Quality & Compliance (Non-Clinical) or Medical Directorate (Clinical) Team for uploading to the SharePoint Page and master document library.

6.24 Whilst this is subject to change the general rule of thumb for approval of Written Control Documents is outlined below:

6.25 **Board and Board Committees –** The Board or named Board Committees are required to approve Policies and Strategies, as detailed within CTMUHB's Scheme of Delegation and Reservation. The Board will be responsible for the formal approval of CTMUHB Strategy and Policies that Committees, Legislation or the Scheme of Delegation deem require Board approval. For example, in the main Clinical Policies will be approved by the Quality, Safety & Experience Committee.

6.26 **Executive Management Board –** The Executive Management Board will approve all CTMUHB Procedures.

6.27 **Strategic Development Committee (SDC) –** supporting Strategic Delivery Plans should be endorsed by the SDC prior to seeking Board Approval.

6.28 **Executive Directors –** Protocols and Guidelines can be approved by an Executive Director of the responsible function.

Review and Revision Arrangements

6.29 All Written Control Document should be reviewed at least every three years from the date of ratification or earlier if required or there is changes as a result of legislation/guidance. At this stage the impact assessments should be reviewed to ensure that they remain fit for purpose.

6.30 The Written Control Document owner is responsible for the review and updating of the document.

6.31 Any Written Control documents beyond their three-year lifespan will remain extant until reviewed. The author (executive lead sponsor) must therefore ensure that they take steps to ensure that they either arrange for a document to be reviewed and reapproved prior to the three-year anniversary or for it to be identified for archive.

6.32 Where staff may identify a Written Control Document that is beyond its three-year lifespan, they should contact the following departments who will be able to provide an update as to the current status of the review and/or signpost to the responsible lead(s).

- **Non-Clinical** Written Control Documents please contact:

CTM.QualityassuranceCompliance@wales.nhs.uk

Clinical Written Control Documents please contact:

CTM.MedicalDirectorsOffice@wales.nhs.uk

6.33 The Written Control Document author is responsible for the review and updating of the document.

6.34 Managers are responsible for ensuring that Written Control Documents are reviewed in line with the review date.

6.35 The Quality & Compliance (Non-Clinical) or Medical Directorate (Clinical) Team will keep a central database of all Written Control Documents to enable the monitoring of review dates.

6.36 This Written Control Documents will be reviewed at least every three years by the author noted on the cover sheet, unless an early review period is deemed necessary.

Integrated Impact Assessment

6.37 Particularly for policies and strategy related documents, the following impact assessments must be considered. If in doubt you should contact the relevant lead in this area (See section 7).

- Equality Impact Assessment
- Quality Impact Assessment
- Welsh Language Impact Assessment

Welsh Language Requirements

6.38 Any policy that is in relation to the following must be available in Welsh:

- a policy relating to behaviour in the workplace;
- a policy relating to health and well-being at work;
- a policy relating to salaries or workplace benefits;
- a policy relating to performance management;
- a policy relating to absence from work;
- a policy relating to working conditions;
- a policy relating to work patterns.

The email for translation is ctt_welsh_translation@wales.nhs.uk

Information Governance

6.39 In accordance with the requirements of the General Data Protection Regulations, names of individual staff must not be contained within Written Control Documents, however job titles can be used. This will prevent a Written Control Document being out of date should staff members leave their posts. If the key document you are developing or reviewing involves the sharing of information or data you should link in at the start of the process with the Information Governance Team in order to determine if a Data Protection Impact Assessment is required and if so ensure this is

undertaken in conjunction with the Written Control Document development or review.

Freedom of Information Act (FOIA) Compliance

6.40 Policy documents will be considered as "Open" status under the Freedom of Information Act unless an exemption under the FOIA can be applied. The exemptions are captured here:

https://ico.org.uk/for-organisations/foi/guide-to-managing-an-foi-request/exemptions/list-of-exemptions/

If an exemption is chosen this should be accompanied with the appropriate rationale as to why the Policy could not be released into the public domain and why it should be considered in Closed/Private Committee Session.

The "FOIA Status" section on the front page of Policy documents should be completed in this regard.

This would only apply to Policies.

If you are unsure as to the status of your Policy document and the exemption to apply if applicable, please seek further guidance from the Information Governance Team: CTM.IGTeam@wales.nhs.uk

Dissemination and Implementation

6.41 The Quality Assurance & Compliance (Non-Clinical) or Medical Directorate (Clinical) Team is responsible for the effective dissemination of the Written Control Document and should make arrangements for the dissemination as follows:

- ensure the policy is added to CTMUHB Website where relevant
- ensure the policy is added to the Policy SharePoint / drive where relevant
- undertake any additional methods of dissemination as appropriate. These may include email, staff bulletin, staff briefing etc.

Directorates responsible for WCD's may have specific distributions they wish to target, and this can still be undertaken to ensure widespread dissemination to key target areas.

6.42 For documents other than policies and procedures the Director / Deputy Director / Head of Service in conjunction with the document author should consider the most appropriate means of dissemination. It would not normally be appropriate for procedure and guidance documents to be placed on the external facing website, for example, however, should be available on the internal SharePoint Page.

6.43 Written Control Document should include how any training that is needed in order to ensure implementation will be delivered, how it can be accessed

and describe who should attend training, frequency of updates and who provides the training.

Legislation

6.44 All Written Control Documents must comply with current legislation, national and professional guidance. They must be based on sound evidence and be appropriately referenced.

7. Support and Guidance

Associated documentation

7.1 This policy should be read in conjunction with the following CTMHB policies, procedures and guidance:

- CTMUHB Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.
- Other policies and procedures, as required.

Templates and Toolkits

7.2 A dedicated "toolkit" to support staff in developing Written Control Documents is available on the Health Board's internal SharePoint site this includes templates and policy examples etc.

Support

7.3 Whilst not an exhaustive list the following contacts are a key source of support in Written Control Document development.

- For support with all aspects of **Non-Clinical** Written Control Documents please contact: CTM.QualityassuranceCompliance@wales.nhs.uk
- For support with all aspects of **Clinical** Written Control Documents please contact:CTM.MedicalDirectorsOffice@wales.nhs.uk
- For support with Equality Impact Assessments and Welsh Language Impact Assessments please visit this page:

  CTM At Our Best - Equality Impact Assessments - All Documents
- For support with Quality Impact Assessments please contact the Patient, Care & Safety Directorate.

Approval Process for Polices, Procedures and other Written Control Documents

Please ensure you have read the "Policy on Policies" to ensure the Written Control Document has been defined appropriately, drafted in the correct template and appropriate consultation completed. The policy is available here: XX

Engagement and Consultation

Whilst not an exhaustive list, groups to consult are captured below and should be considered as a minimum:

First Stage Consultation:

- Subject matter experts /forums on the topic area i.e. IPC Policy would go to the IPC Committee for review.
- Key staff including staff representatives from the professional associations and trade unions (as appropriate).
- Local Staff Partnership Forum as appropriate – advice available from People Directorate on applicability.
- Patient/user representatives (as appropriate).
- Carer representatives (as appropriate).
- and other organisations (as appropriate).
- Third sector (voluntary and community) organisations relevant to the subject.
- Liaise with the Welsh Language Lead to consider the statutory consultation requirements that are required under the Welsh Language Standards.

For clinical policies:

- Care Group Triumvirate (Service Director, Clinical Director, Medical Director and Nurse Director) endorses the Clinical Policy for onward consultation /approval.

Second Stage Consultation prior to approval:

- For non-clinical policies, minimum 2 weeks on the Staff Intranet and highlighted in the "News Banner". Clinical policies do not need to undertake this step.
- Operational Management Board who will **endorse (not approve)** Written Control Documents for approval (Link in with (CTM.COO@wales.nhs.uk to add to the agenda). The relevant Care Group / Directorate Lead will attend Operational Management Board to present the document and then notify the following leads to confirm whether the document was endorsed or not.
- For clinical policies please consult with the Assistant Medical Director for Quality & Safety.
    - **Non-Clinical** Written Control Documents please contact: CTM.QualityassuranceCompliance@wales.nhs.uk
    - **Clinical** Written Control Documents please contact CTM.MedicalDirectorsOffice@wales.nhs.uk
      The Medical Directors office will notify the Assistant Medical Director for Quality & Safety of the outcome from the Operational Management Board.

Preparing for Validation and Approval

Once the consultation stage is complete the following approval routes can be followed for both Clinical and Non-Clinical Written Control Documents.

Whilst this is subject to change the general rule of thumb for approval of Written Control Documents, following consultation, is outlined below:

Board and Board Committees – The Board or named Board Committees are required to approve Policies and Strategies, as detailed within CTMUHB's Scheme of Delegation and Reservation. The Board will be responsible for the formal approval of CTMUHB Strategy and Policies that Committees, Legislation or the Scheme of Delegation deem require Board approval. For example, in the main Clinical Policies will be approved by the Quality, Safety & Experience Committee.

Executive Management Board – The Executive Management Board will approve all CTMUHB Procedures.

Strategic Development Committee (SDC) – supporting Strategic Delivery Plans should be endorsed by the SDC prior to seeking Board Approval.

Executive Directors – Protocols and Guidelines can be approved by an Executive Director of the responsible function.

An Equality and Welsh Language Impact Assessment must be completed before you submit for approval and that assessment needs to be embedded in the covering paper and uploaded here via the link on the page.

To initiate approval via the above routes please liaise with the following support contacts. Please note that it is the responsibility of the author to take the policy through all the approval stages which includes checking with their Executive Lead if approval was received and then updating the relevant fields with the approval information. The Quality & Compliance (Non-Clinical) or Medical Directorate Team (Clinical) will support authors through these stages as appropriate.

Non-Clinical Written Control Documents please contact:
CTM.QualityassuranceCompliance@wales.nhs.uk

Clinical Written Control Documents please contact:

CTM.MedicalDirectorsOffice@wales.nhs.uk

Post Approval

The author of the Written Control Document is responsible for seeking confirmation that their document has been approved and then notifying this and sharing the finalised document in **word format** to the relevant team below:

Non-Clinical Written Control Documents please contact:
CTM.QualityassuranceCompliance@wales.nhs.uk

Clinical Written Control Documents please contact:

CTM.MedicalDirectorsOffice@wales.nhs.uk

The relevant team above will then assign a reference number and ensure it is uploaded to the relevant SharePoint page and the master library for policies updated.

(Add Document Title Here)

Document Type:	Choose an item.
Indicate Clinical or Non-Clinical:	Choose an item.
Document Reference:	(If you are not sure this is available from: ctm.qualityassurancecompliance@wales.nhs.uk)
Document Author (Title Only):	
Document Executive Director Sponsor	
Date Equality and Welsh Language Impact Assessment Completed:	
Freedom of Information Act Status (For Policies Only)	Choose an item.
	If indicated as closed please indicate exemption that has been applied: ( )
Approving Forum:	(If you are not sure this is available from: ctm.qualityassurancecompliance@wales.nhs.uk)
Approval / Effective from Date:	
Review date due by:	
Document Version:	
Target Audience	All Staff

Disclaimers
CTMUHB Policies, Procedures and other Written Control Documents can only be considered valid and up to date if viewed on the SharePoint Pages, which is considered as the master library: LINK If the review date of a document is passed, please contact the author or CTM.QualityassuranceCompliance@wales.nhs.uk

Components

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non-Clinical Policy Development please contact:

ctm.qualityassurancecompliance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint.

Table of Contents

Introduction

1. Policy Statement

1.1 Text

•

2. Scope of Policy

2.1 Text

2.2

3. Aims and Objectives

3.1 Text

3.2

4. Responsibilities

4.1 Text

4.2

5. Definitions

5.1 Text

5.2

6. Implementation / Policy Compliance

6.1 Text

6.2

7. Information, Instruction and Training

7.1 Text

7.2

8. Equality and Welsh Language Impact Assessment Outcome

8.1 Text

8.2

9. Main Relevant Legislation

9.1 Test

9.2

10. References

10.1 Text

10.2

11. Getting Help

11.1 Text

11.2

12. Related Policies

12.1 Text

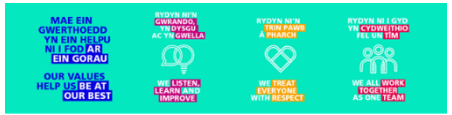
12.2

(Please note: The above is not an exhaustive list and you may wish to add more sections to your document)

Agenda Item 8.1.6	20th January 2026	Quality Safety and Experience Committee	

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Richard Hughes– Interim Executive Director of Nursing & Midwifery
Presented By:	Richard Hughes– Interim Executive Director of Nursing & Midwifery
Approving Executive Sponsor:	Richard Hughes – Interim Executive Director of Nursing and Midwifery
Report Purpose	For Endorsement
Engagement undertaken to date:	Executive Directors Team Independent Members Patient Care & Safety Team

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Shared learning and visible leadership. Assurance of Quality and Safety standards.
Related Health and Care Standard	Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No, refining the current model. Information will be made available in Welsh for Welsh speakers.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Improving Care, sustaining our future, Creating Health



Purpose and outcomes

- Provide visible leadership across our services and communities.
- Triangulate assurance: data + lived experience + direct observation.
- Understand pressures and what helps teams to deliver safe, kind, effective care.
- Listen to patients, families and visitors and act on what we hear.
- Strengthen a consistent ‘Ward/Service to Board’ quality management approach.

Case for change (why now)

1.The current approach has shown some variability, which may have impacted overall effectiveness.

a) Inconsistent facilitation and preparation for visits.
b) Use of insights is not always systematic; actions are not consistently tracked.
c) Role clarity needed between Independent Members (assurance) and Executives (delivery).
d) Opportunity to align with committee/Board assurance cycles and our Quality Management System.

Roles and responsibilities – Independent Members

01	02	03	04	05	06
Provide independent observation, challenge and assurance at the point of care.	Actively engage with staff, patients, and visitors.	Concentrate on enhancing experiences, culture, and learning, allowing for open dialogue.	Use the standard MS Form to effectively document observations, highlight strong practices, and identify areas for improvement.	Promptly address any immediate safety concerns through the designated channels on the same day, ensuring a proactive approach.	Embrace opportunities for growth by participating in visit-specific briefings, training sessions, and reflective learning.

Roles – Executives and governance

1. Convert insights into delivery and maintain oversight.
2. Executive Director of Nursing, Midwifery & Patient Care (EDoN) as Executive Lead for the process and monitoring of associated actions.
3. Facilitation through the EDoN's office; monitoring through the Patient Care & Safety Directorate.
4. Translate findings into clear actions (operational, quality, safety and service).
5. Track actions via a shared tracker overseen by the Directorate Business Manager; visible to IMs and Executives.
6. Progress monitored at the Executive Management Board; annual reporting to the Board.

Operating model

1. Six-month rolling programme linked to priorities and key events.
2. Areas selected six months in advance, aligned to Board/committee insights and national/international events (e.g. policy changes, professional recognition days).
3. Standard visit pack: aims, prompts, local data lens and site logistics.
4. Visit-specific training/coaching offer for IMs (Jan/Feb 2026).
5. MS Form remains the standard capture tool – 'we heard, we did' feedback loop to services and Board.

Process flow and action tracking

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

Measuring success

We will track impact at both activity and outcome levels.

% of planned visits delivered; % of visits with completed MS Forms.

Time to action; action closure rates.

Themes and learning (staff & patient experience); examples of improvement.

Feedback from IMs/Executives/teams; external assurance/inspection feedback.

Measuring success, suggested measurable questions

Question ID	Domain	English	Welsh	Scale	Order
H1	Headline	Overall, how likely are you to recommend IM walkabouts as a way to strengthen Board assurance and visible leadership at CTMUHB?	Yn gyffredinol, pa mor debygol ydych chi o argymell ymweliadau 'walkabout' Aelodau Annibynnol fel dull o gryfhau sicrwydd y Bwrdd ac arweinyddiaeth weladwy yn CTMUHB?	FFT	1
Q1	Preparation	I received a clear pre-visit brief (purpose, route, safety, roles) and knew what to look for.	Derbyniais friff cyn-ymweliad clir (pwrpas, llwybr, diogelwch, rolau) a gwyddwn beth i edrych amdano.	Likert	2
Q2	Preparation	On-site facilitation ensured staff and patient conversations were respectful, timely and proportionate.	Sicrhaodd hwyluso ar y safle fod sgyrsiau gyda staff a chleifion yn barchus, yn brydlon ac yn gymesur.	Likert	3
Q3	Preparation	The prompts and local data lens helped me triangulate what I saw/heard with committee/Board information.	Helpodd y cwestiynau cymorth a'r data lleol imi dryianglo'r hyn a welais/glywais gyda gwybodaeth y pwyllgor/y Bwrdd.	Likert	4
Q4	Role	I was clear about my role as an IM (assurance, insight, constructive challenge) versus operational roles.	Roedd yn glir imi beth oedd fy rôl fel AA (sicrwydd, mewnwelediad, her adeiladol) o gymharu â rolau gweithredol.	Likert	5
Q5	Role	I felt psychologically safe to ask questions and surface concerns without directing operations.	Teimlais yn ddiogel yn seicolegol i ofyn cwestiynau a chodi pryderon heb arwain gweithrediadau.	Likert	6
Q6	Role	I had sufficient opportunity to speak with staff, patients and/or visitors.	Cefais ddigon o gyfle i siarad â staff, cleifion a/neu ymwelwyr.	Likert	7
Q7	Value	Today's visit improved my understanding of risks, culture and service pressures in this area.	Gwnaeth yr ymweliad heddiw wella fy nealltwriaeth o'r risgiau, diwylliant a'r pwysau gwasanaeth yn yr ardal hon.	Likert	8
Q8	Value	What I observed corroborated or constructively challenged the assurance I've seen in committees/Board.	Cefnogodd yr hyn a welais neu heriodd yn adeiladol y sicrwydd a welais mewn pwyllgorau/y Bwrdd.	Likert	9
Q9	Value	I can identify at least one example of good practice to share ('we heard / we will amplify').	Gallaf nodi o leiaf un enghraifft o arfer da i'w rhannu ('clywsom / byddwn yn ei gryfhau').	Likert	10
Q10	Follow-through	Issues or improvements I noted have been captured with owners and dates.	Mae'r materion neu'r gwelliannau a nodais wedi'u cofnodi gyda pherchnogion a dyddiadau.	Likert	11
Q11	Follow-through	I am confident there is a clear route for tracking actions via EMB and reporting to QSEC/Board ('we heard, we did').	Rwy'n hyderus bod llwybr clir ar gyfer tracio camau drwy EMB ac adrodd i QSEC/y Bwrdd ('clywsom, gwnaethom').	Likert	12
Q12	Overall	Overall, this walkabout was time well spent for Board assurance.	Yn gyffredinol, roedd yr ymweliad hwn yn ddefnydd effeithiol o amser ar gyfer sicrwydd y Bwrdd.	Likert	13
Q13	Overall	I would take part in future IM walkabouts.	Byddwn yn cymryd rhan mewn ymweliadau 'walkabout' AA yn y dyfodol.	Likert	14

Specific Matters for Consideration:

- The effectiveness of this approach depends on the quality and completeness of data captured, as well as the willingness of staff and patients to provide honest feedback. Consider mechanisms to encourage robust participation and to validate the data collected.
- If uptake is low, some IMs may not be fully prepared, potentially undermining the consistency and quality of visits. Consider whether training should be mandatory or if additional incentives/support are needed.

Key Risks / Matters for Escalation:

- **Risk:** If the new model does not fully resolve issues of inconsistent facilitation, action tracking, or role clarity, previous weaknesses may persist, impacting quality and assurance.
  Escalation: Early warning signs of recurring issues should be escalated promptly to the Executive Management Board.
- **Risk**: The model relies on MS Forms and self-reporting. There is a risk of under-reporting or bias.
  Escalation: Any evidence of data gaps, incomplete forms, or reluctance to report issues should be escalated for review.
- **Risk**: The process depends on a shared tracker and timely closure of actions. If actions are not tracked or closed effectively, assurance and improvement will be undermined.
  Escalation: Persistent delays or failures in action closure should be escalated to the Board or relevant committee.

Recommendation

The Committee are asked to:
Endorse the operating model, governance and reporting.
Endorse the governance process with the Quality Safety and Experience Committee being the reporting committee.
Support the visit-specific training/coaching offer for IMs (opt-in).

Next Steps

Publish initial six-month schedule (for February 2026 onwards).
Issue the visit pack and confirm the MS Form fields/assurance prompts.
Launch training/coaching (Jan/Feb 2026); first EMB progress review in April 2026.

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

(1st January 2026 to the 31st December 2026)

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
14 August 2024	Request received by email for this to be presented as a spotlight presentation to a future meeting of the Committee	Senior Nurse Acute Deterioration and Outreach Services	Spotlight Presentation Decision Making around ACP/DNACPR/TEP	Case presentation to highlight the need for more resource in end-of-life education and training	Senior Nurse Acute Deterioration and Outreach Services	Executive Medical Director	25 March 2025	**In progress** Consideration being given to governance reporting routes for RADAR. In this respect this item may be removed from to forward plan for Quality, Safety & Experience Committee
11 March 2025	Request made by an Independent Member at the January 2025 QSEC for this report to added to future meeting agenda's	Executive Director of Nursing	WAST Produced Quality Report	USC Care Group to provide a report on the joint working with WAST looking at the People's Experience and Quality of care as this is work that is undertaken jointly with the central team and sits within USC portfolio.	USC Care Group Nurse Director	Executive Director of Nursing	20 May 2025 22 July 2025 Now November 2025 **Now January 2026**	**In progress** Interim Executive Director of Nursing for CTMUHB to meet with Director of Nursing at WAST to discuss what quality data sets were now available within WAST that could be shared with Committee members.
10 April 2025	Request made at the agenda planning session held on 10 April 2025	Committee Chair	Stroke Services Progress Report	Stroke Services report to be presented to the July meeting of the Committee	Executive Director of Allied Health Professionals & Healthcare Sciences	Allied Health Professionals & Healthcare Sciences	22 July 2025 – 23 September 2025 – **Now January 2026**	**Proposed for Closure** Detailed update on Stroke is on the agenda for the January 2026 meeting
22/07/2025	Request made at the July meeting for this item to be brought back to a meeting in 2026	Interim Executive Director of Nursing	Listening & Learning Story - Carers	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed, with further discussion required as to what could be done to address the issues	Carers Lead	Interim Executive Director of Nursing	Date to be confirmed	**In progress** Date to be confirmed with Carers Lead
7 August 2025	Suggestion made at agenda planning session held on 7 August 2025	Closure Report - Inpatient Mental Health Improvement Programme	Report to highlight progress made since the update presented to the July 2024 meeting	To be presented to Committee for assurance purposes	Mental Health & Learning Disabilities Care Group Nurse Director	Mental Health & Learning Disabilities Care Group Nurse Director	23 September 2025 18 November 2025 Deferred to 20 January 2026 **Now 24 March 2026**	**In progress** This has been deferred to 24 March 2026
23 September 2025	Request made at the meeting held on 23 September 2025	Listening & Learning Story - Domestic Violence	Head of Safeguarding to return to the Committee in one year to provide	To be presented to the Committee for assurance purposes	Head of Safeguarding	Executive Director of Nursing	22 September 2026	**In progress** Scheduled for September 2026

			more evidence in relation to learning points					
23 September 2025	Request made at the meeting held on 23 September 2025	Physicians Associates	Report on the current position regarding the proposed changes to the roles and remits for Physicians Associates	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	20 January 2026	**Proposed for Closure** Update has been included in the Clinical Executives report for the January 2026 meeting
23 September 2025	Request made at the meeting held on 23 September 2025	Planned Care - Care Group Highlight Report	Outcome and impact of the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate to be presented to the Committee after the trial period of 12 Months	To be presented to the Committee for awareness	Planned Care Group Nurse Director	Executive Director of Nursing	22 September 2026	**In progress** Will be presented to the September 2026 meeting
24 September 2025	Email request received from the Assistant Director of Governance Risk following discussion held at the September 2025 meeting	Focussed review on Ambulance Handover times improvement	Report to identify whether the improvement on handover times has not had any adverse effect on quality and safety i.e. increase in incidents, complaints, waiting time performance, patient experience feedback etc.	To be presented to Committee for assurance purposes	Unscheduled Care Group Service Director/Nurse Director	Unscheduled Care Group Service Director/Nurse Director	24 March 2026	**In progress** Will be presented to the March 2026 meeting
6 October 2025	Email request from the Executive Medical Director	Clinical Effectiveness Update	To be presented to the Committee for awareness	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	18 November 2025 **Now January 2026**	**Proposed for Closure** This item is on the agenda for the January 2026 meeting
4 November 2025	Request received from Interim Executive Director of Nursing	Spotlight Report - Quality Impact of the Health Board's new Escalation Framework	To be presented to the Committee for awareness	To be presented to the Committee for awareness	USC Care Group Nurse Director & Planned Care – Care Group Nurse Director	Executive Director of Nursing	Was 20 January 2026 **Now 24 March 2026**	**In progress** This item will be presented to the Committee in March 2026
10 November 2025	Request received from the Assistant Director of Governance & Risk	Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents	To be presented to the Committee for approval	To be presented to the Committee for approval	Assistant Director of Governance & Risk	Director of Corporate Governance	20 January 2026	**Proposed for Closure** This item is on the agenda for the January 2026 meeting
16 December 2025	Request made at agenda planning session held on 16 December	Spotlight Presentation – Hospital at Home	To be presented to Committee for discussion	To be presented to Committee for discussion	Chief Operating Officer	Chief Operating Officer	24 March 2026	**In progress**

16 December 2025	Request made at agenda planning session held on 16 December	Winter Wrap Up to include: • Ambulance Handovers and Onboarding Impact • IPC and Infection outbreaks	To be presented to Committee for discussion	To be presented to Committee for discussion	Chief Operating Officer and Interim Executive Director of Nursing	Chief Operating Officer and Interim Executive Director of Nursing	24 March 2026	**In progress**
18 December 2025	Request made at the Board Development Session held on 18 December 2025	IM & Exec Walkabouts Operating Model	To be presented to the Committee for endorsement prior to Board approval	To be presented to the Committee for endorsement prior to Board approval	Interim Executive Director of Nursing	Interim Executive Director of Nursing	20 January 2026	**Proposed for Closure** This item is on the agenda for the January 2026 meeting
13 January 2026	Reference made in the Clinical Executives Report presented to the January 2026 meeting	Maternity & Neonatal Services Performance Report for 2025/2026 plus outcome of the national assessment	To be presented to the Committee for discussion	To be presented to the Committee for discussion	Director of Midwifery	Director of Midwifery	24 March 2026	**In progress**
Completed Items								
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	**Completed** The revised Escalation Policy was presented to the October 2025 meeting of the Operational Delivery Committee and has been made available to QSEC members via the documents folder on Admincontrol
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	**Completed** This item was received and discussed at the November 2025 meeting
30 September 2025	Email request received from the Medical Directorate Business Manager	Organ Donation Sub Committee Terms of Reference	Further amendments required to membership and attendee section	To be presented to the Committee for approval	Medical Director Business Manager	Executive Medical Director	18 November 2025	**Completed** This item was received and approved at the November 2025 meeting
28 October 2025	Email request from the Executive Medical Director	Adult Mental Health Cultural Challenges	To be presented to the Committee for awareness	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	18 November 2025	**Completed** This item was received via In Committee session at the November 2025 meeting

Agenda Item
8.2.2

Quality, Safety & Experience Committee

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

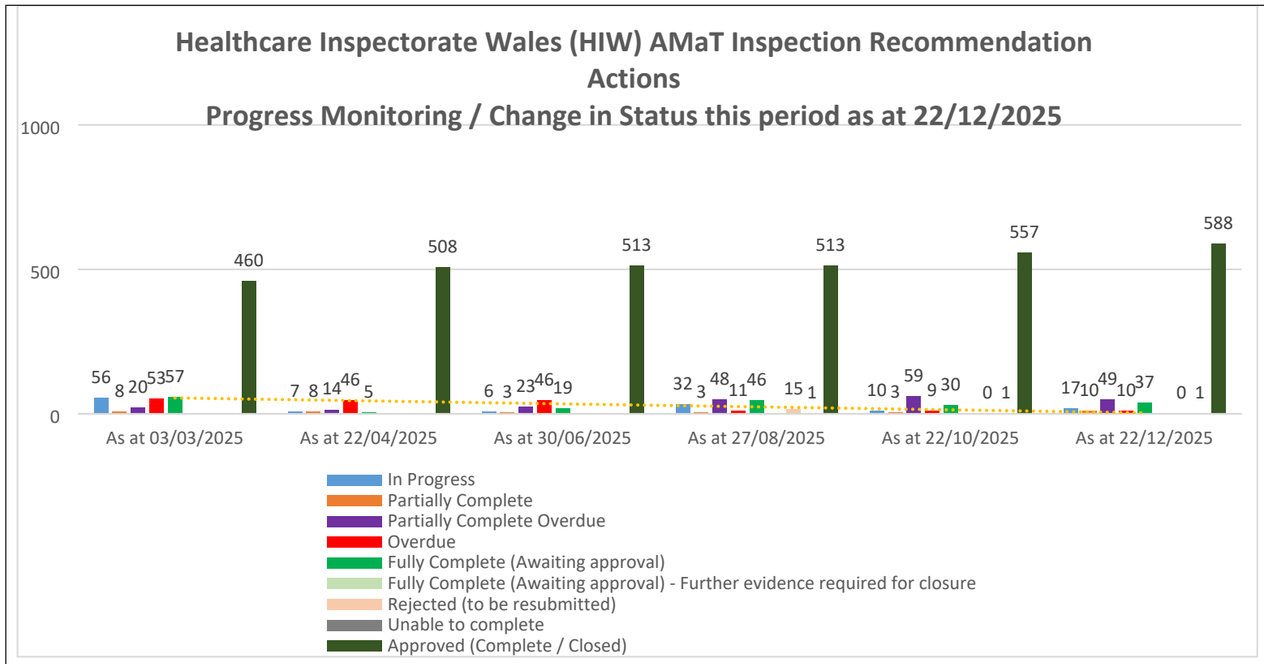
Dyddiad y Cyfarfod / Date of Meeting	20th January 2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Jones- Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes -Interim Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes - Interim Executive Nurse Director

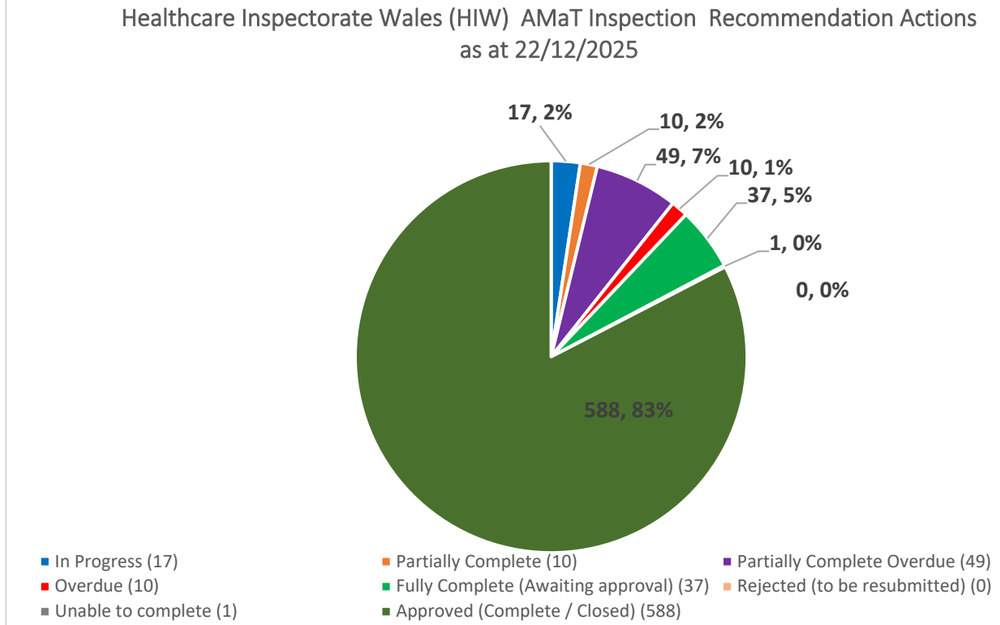
Pwrpas yr Adroddiad / Report Purpose	For Noting

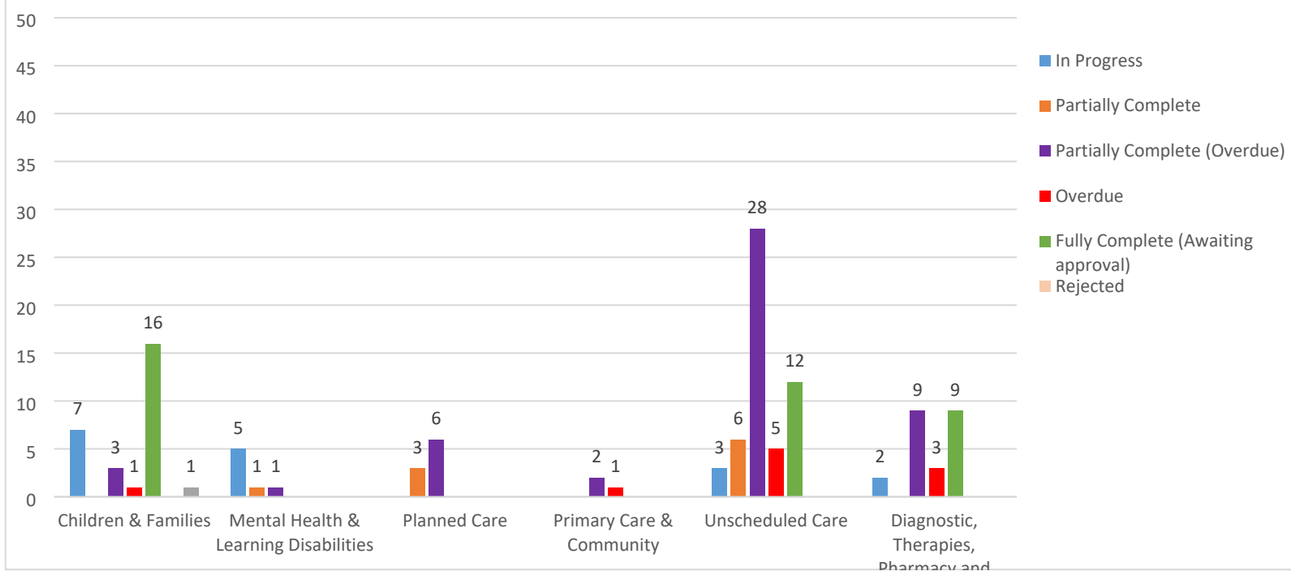
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	12th January 2026	Management Sign off Received

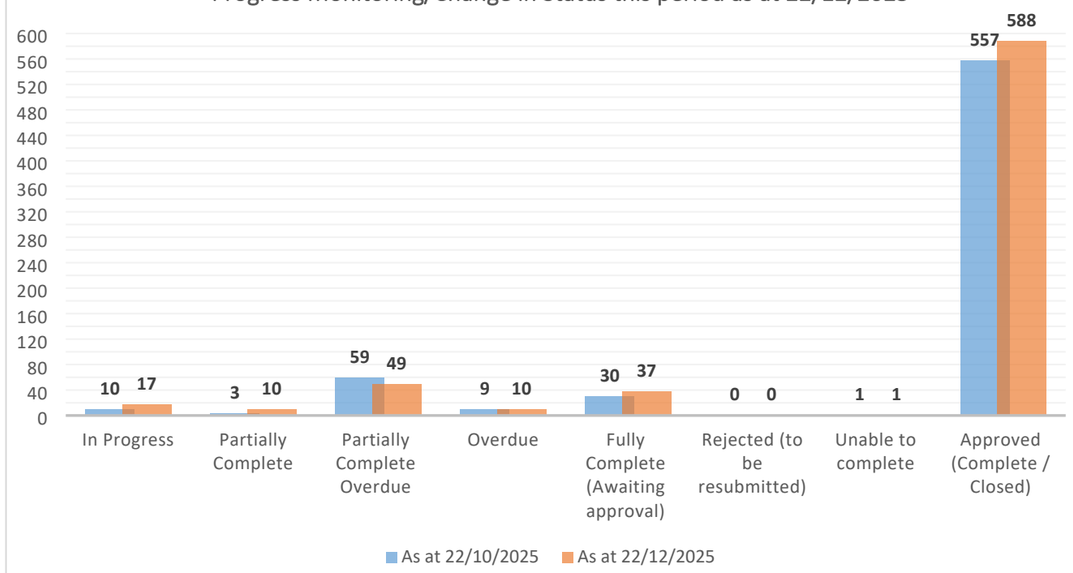
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking

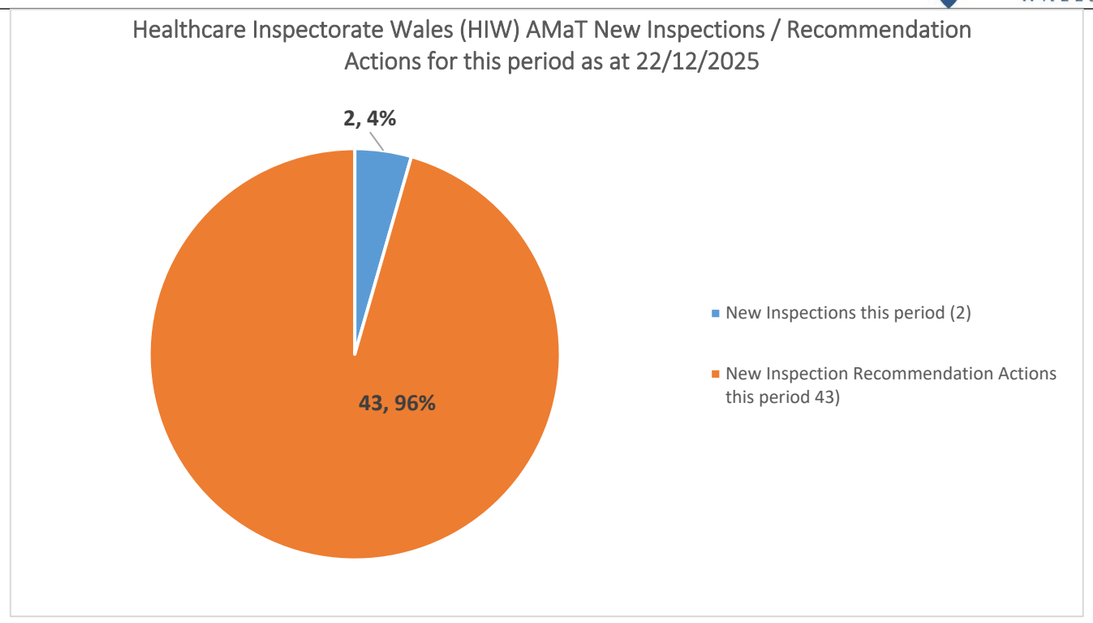
Compliance Dashboard

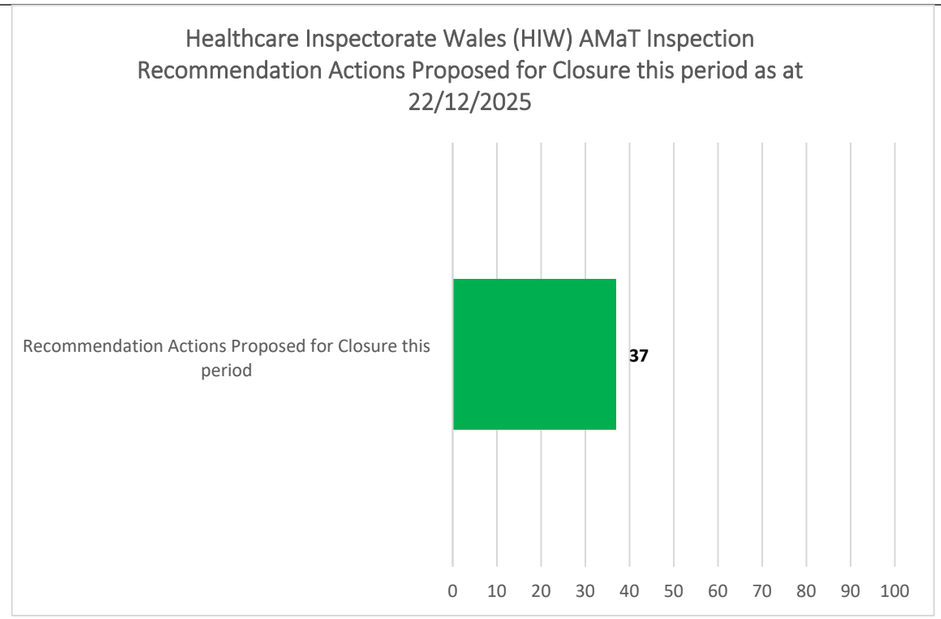









Healthcare Inspectorate Wales (HIW) AMaT New Inspections / Recommendation Actions for this period as at 22/12/2025
2, 4%
43, 96%
New Inspections this period (2)
New Inspection Recommendation Actions this period 43)


Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions Proposed for Closure this period as at 22/12/2025
Recommendation Actions Proposed for Closure this period
37
0
10
20
30
40
50
60
70
80
90
100

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 22nd October 2025 to 22nd December 2025.

2. Specific Matters for Consideration

2.1 There are no new development updates from AMaT noted by the team for this period. New developments are expected to be released in January 2026.

2.2 The Assistant Director of Corporate Governance and Head of Quality Assurance and Compliance have been meeting with care group managers focussing on the succinct and accurate reporting process in response to recommendations arising from Inspections and Audits.

2.3 Following on from the last report the Quality and Assurance team were able to increase engagement across some Care Groups which is hoped will improve in engagement and ownership of actions in the coming months. The team will continue to engage with the Care groups to reflect on the original recommendation/action to close these down succinctly.

2.4 A breakdown of the status position with regards to all actions up to the 22nd December 2025 is detailed below.

- A total of **712 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.

- **31** Inspections actions were 'fully complete, approved and closed' with a further **37** actions 'fully complete and awaiting approval'.

3. New Inspections / Actions

There were **2** new Improvement Plans and **43** new actions added for this period.

4. Key Risks / Matters for Escalation

4.1 The HIW actions tracker continues to use the live AMaT system with a continued targeted focus on actions where the action agreed due by date has passed or no update has been received.

4.2 Regular and consistent updates are encouraged throughout each period to ensure updates are captured for each report. Reminders are being shared that when updating an action progress, it is always helpful to refer back to the original management action that was agreed as often it can be that the original ask has been completed and the action can close. It is evident that on some occasions there is a tendency to update based on the previous update which can lead to the original action being left open for longer than necessary.

4.3 The Quality Assurance and Compliance team continue to encourage Care group leads to engage in the AMaT process for Audits and Inspections whereby the approval process differs slightly to the AMaT programme used in the clinical setting allowing for more robust governance and assurance.

5. Assessment

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

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

6. Recommendation

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

7. Next Steps

7.1 The Head of Quality Assurance and Compliance and Assistant Director of Governance and Risk continue to encourage engagement and offer support to Care Groups to focus on improving upon the regularity and quality of updates by bringing the focus of updates back to the original management action agreed in the Improvement Plan.

HIW Inspection Recommendations Tracker
Leads as at 22/12/2025

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	22	22	**Planned Care** Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	2	2	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	17	18	**Mental Health & Learning Disabilities** Ana Llewellyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	2	2	**Unscheduled Care** Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	7	7	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	50	50	**Unscheduled Care** Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	31	36	**Unscheduled Care** Deborah Matthews, Nurse Director
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
Healthcare Inspectorate Wales (HIW)/2025/276	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	18.08.2025	16	24	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2025/277	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	05.08.2025	19	19	**Unscheduled Care** Deborah Matthews, Nurse 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 satify closure of the action and to provide assurance it has been completed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.
Unable to Complete	This action is unable to be completed.

HIW Inspections Recommendation Actions Tracker as at 22/12/2025
(for Quality, Safety and Experience Committee 20/01/2026)

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	31.12.2025	Partially complete	December 2025 Update (19/12/2025) - Working group established. On target to roll out by end of March 2026. Glaucoma already implemented. Next phase cataracts. October 2025 Update (14/10/2025) - Roll out of open eyes is planned for March 2026 for all ophthalmic services across Wales.
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	December 2025 Update (19/12/2025) - Working group established. Implemented for Glaucoma. Next phase cataracts. On target for end of March 2026. October 2025 Update (14.10.2025) - Awaiting confirmation from digital team regarding roll out of open eyes planned for March 2026 .
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Healthcare Inspectorate Wales (HIW)/2017/141/MD10/1	Documents and resource related to FUNB patients are shared between the business Informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PIFU Patients with appointments cancelled	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2025 Update (19/12/25) - FUNB list known. CIN recommendation agreed for those on PIFU / SOS. Retrospective application of CIN PIFU / SOS agreed for FUNB list. Awaiting start date from medical records. October 2025 Update (14/10/2025) - Awaiting confirmation of health board strategy to manage the backlog of patients - PIFU and SOS pathways being agreed and implemented in accordance with CIN recommendations. these pathways will be applied retrospectively to FUNB list MM & CR.
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)	December 2025 Update (19/12/2025) - All outcome forms from OP clinics have PIFU / SOS option included. No option for patients to be put on FUNB list. Agreed PIFU / SOS pathways which will be applied retrospectively to FUNB list. October 2025 Update (14/10/2025) - Health Board strategy being developed to address and manage backlog. PIFU and SOS being implemented via CIN recommendations. These pathways will be applied retrospectively to FUNB list CR & MM 14.10.25.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	Healthcare Inspectorate Wales (HIW)/2017/141/MD13/1	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2025 Update (19/12/2025) - FUNB strategy agreed through PIT programme. Retrospective application of PIFU and SOS CIN pathways to be implemented. Awaiting start date. October 2025 Update (14/10/2025) - Health Board strategy being developed to address backlog of FUNB patients. Meetings in diary to complete all outstanding NRI's. PIFU and SOS pathways to be implemented in accordance with CIN recommendations. These will be applied retrospectively to FUNB list cr & mm 14.10.25.
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	December 2025 Update (19/12/2025) - Ongoing discussions. October 2025 Update (14/10/2025) - New optometry lead appointed who is reviewing this and in discussions with HEIW. Re placements this year qualifies for 0.5 WTE band 4. Working through with HEIW finance - waiting for confirmation of admin support for post - CR & MM 14.10.25.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/141/MD17/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions, 27/8/25 - as of today we are still waiting WG decision re further advice / shared learning (KJ)
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update (14/10/2025) - No further updates to provide CR & MM 14.10.25.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HIW)/2017/141/MD21/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	December 2025 Update (19/12/2025) - Extended 3 part time optometrists whilst workforce review and BC approval. October 2025 Update (14/10/2025) - Business case submitted to make the current 3 parttime temporary optometrists substantive. CR & MM 14.10.25.
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HIW)/2020/139/MD2/1	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care and Community	01.10.2020	01.10.2020	Overdue	November 2025 Update (27/11/2025) - Head of Quality Assurance and Compliance email to Head of Nursing Primary Care & Community.
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)	December 2025 Update - Plan to review and discuss with aim to complete end of Jan 2026. October 2025 Update - Unfortunate delay in this being signed off will be brought back to November QSE for sign off.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Healthcare Inspectorate Wales (HIW)/2022/131/MD1/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Unable to complete	August 2025 Update - this action is unable to be completed - this matter has been escalated to the Exec colleagues and was raised on the recent HIW inspection August 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 Ba Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. •A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCSWs Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ILS and PILS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	December 2025 Update - Emergency Department PCH: Basic Life Support (BLS) 78.57% Intermediate Life Support (ILS) 62.92% Advanced Life Support (ALS) 47.83 % (Band 7 and Band 6) Emergency Paediatric Life Support (EPLS) -60% Advanced Paediatric Life Support (APLS) -29% (Band 7) awaiting further course dates to be released Updated trajectory action plan to be uploaded by Jan 2026 October 2025 Update - Clinical decisions Unit (CDU) is now called Acute Medical Unit (AMU) - Basic Life Support (BLS) - 82% Intermediate Life Support (ILS) Registered Nurses 46% awaiting further course dates to be released Emergency Department - Basic Life Support (BLS) 81% Intermediate Life Support (ILS) 69% Advanced Life Support (ALS) 45% (Band 7 and Band 6) Emergency Paediatric Life Support (EPLS) -60% Advanced Paediatric Life Support (APLS) -29% (Band 7) awaiting further course dates to be released
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken . To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October, December 2025 - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MD7/1	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include- flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October, December 2025 - No update against this recommendation action has been received 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 6goals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Unscheduled Care	01.11.2023	01.11.2023	Fully complete (Awaiting approval)	October 2025 Update (14/10/2025) - Actions described in the overview are complete and embedded across the HB. August 2025 Update - The overarching Action Plan has supported this work whereby the below is embedded and the Senior Stroke Team undertake a formal patient review daily identifying who does not require ongoing care within the Stroke Unit and that includes discharge and transfer out internally across the HB and neighbouring HB's (formally discussed on the national call at 11.00 daily. The detail is communicated robustly to the Flow Team daily and updated accordingly to ensure Stroke capacity available.
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)	November 2025 Update - no further update on dedicated pharmacist. However stroke specific pharmacy training and support to be provided internally via Dep Head of Pharmacy. August 2025 Update - CTM wide review of stroke pathway ongoing including all workforce requirements. The need for dedicated pharmacy support will be included in this service review

Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD8/1	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cymru. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS Exec colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our speciality demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	Fully complete (Awaiting approval)	November 2025 Update - Fully complete, awaiting approval. August 2025 Update - The Stroke Unit for CTM has been relocated to the RGH since January 2025 and this work is ongoing due to the change of service. The review to date has identified that the demand for CTM is supported more efficiently from the RGH. There is ongoing regional stroke work where this is currently being worked through.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	Healthcare Inspectorate Wales (HIW)/2023/155/MD9/1	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	November 2025 Update - Critical Incident at POW now complete. Medical flows have returned to POW. Surgical & Trauma pathways remain at RGH with workforce and footprint mapped to support this. August 2025 Update - the introduction of SDEC, STAMP, Surgical and Trauma Assessment Units that has supported the concerns identified. These are now established at RGH but review of surgical, medical and trauma pathways will be reviewed post critical incident to confirm whether these units are fully formalised.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD10/1	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within work stream 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams having direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon Safe2Start site based meeting. This piece of work is Optimise and focuses of value added care. This work is ongoing and is large scale transformation with a detailed project plan and times lines for implementation that are monitored via 6goals Board.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	November 2025 Update - Fully complete, awaiting approval. August 2025 Update - SAFER, Red2Green and right patient, right time now embedded in daily practice and implemented across wards. Lead Nurse for Optimise in post to support patient flows across the Health Board.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Healthcare Inspectorate Wales (HIW)/2023/155/MD11/1	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	November 2025 Update - Fully complete, awaiting approval. August 2025 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD12/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	November 2025 Update - FAST training for ED Reception teams to be coordinated and delivered by newly appointed Senior Nurse for Professional Development. August 2025 Update - E-triage not currently in place in CTM. OCP now complete. Awaiting update from Service Manager, Emergency & Acute Medicine to confirm FAST training programme for clerical staff.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Healthcare Inspectorate Wales (HIW)/2023/155/MD13/1	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Stroke Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and query arriving at our emergency departments. In addition, we are currently reviewing our nurse specialist provision in order to create capacity to better support the early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	31.01.2025	Fully complete (Awaiting approval)	November 2025 Update - Fully complete, awaiting approval. August 2025 Update - collaborative work with WAST continues, specifically following temporary consolidation of inpatient stroke services at Royal Glamorgan Hospital. WAST colleagues included in Stroke Programme Board / Stroke Operational Group. CNS workforce included within the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD14/1	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 update - This action remains ongoing. Stroke inpatient services currently centralised at Royal Glamorgan Hospital. Stroke Service Redesign programme reviewing the full stroke pathway, including community / rehabilitation provision with bed modelling and workforce review to ensure that flow through the pathway is not blocked.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Awaiting update from Clinical Director, Emergency Medicine re internal ED mitigations. Triage times and numbers of patients awaiting triage are noted on 3x daily HB conference calls. E-triage not currently implemented in any Health Board Emergency Departments.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time-frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Review of stroke clinical workforce is included in the Stroke Service Redesign programme. Stroke services currently centralised at Royal Glamorgan Hospital with clinical teams combined to support one Acute Stroke Unit. New stroke consultant recently appointed and will start January 2026. CNS workforce also centralised at Royal Glamorgan Hospital to support emergency presentations and ward patients. The 3 CTM Emergency Departments continue to provide emergency stroke care. Stroke teaching is included in induction programmes for ED resident doctors.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 - Stroke Services currently centralised at the Royal Glamorgan Hospital. CNS Stroke Workforce currently centralised too. CNS workforce being reviewed as part of the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - remains ongoing with digital team as per August 24 update.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HIW)/2023/155/MD19/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Clinical Director, Emergency Medicine
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Clinical Director, Emergency Medicine.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD22/1	The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Time to CT Scan KPI is now 20 minutes. Performance against this KPI is reported via Stroke Operational Group to Stroke Performance Board. Current improvement programme in progress to identify any delays to scan and process map patient journey to CT scan with involvement of all key stakeholders.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD25/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Thrombolysis guideline has been updated nationally to 30 minutes (following CT scan within 20 minutes). Performance against this target is monitored monthly and reported via Stroke Operational Group to Stroke Programme Board. Current improvement work reviewing this key metric with all key stakeholders engaged.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Work continues to improve 4 hour performance. Stroke inpatient services are currently centralised at Royal Glamorgan Hospital and improvement work ongoing to support improvement in 4 hour performance with process mapping and key stakeholder involvement. Dedicated ambulance transfer vehicle commissioned for clinical transfers from PCH / POW to RGH to support transfer for emergency patients to Royal Glamorgan Hospital. 4 hour performance measured and reported at Stroke Operational Board and Stroke Programme Board. 4 hour performance included within Stroke Service Redesign programme as KPI for acute patient pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Inpatient stroke services currently centralised at Royal Glamorgan Hospital. Agreement that confirmed strokes only will be admitted to the Acute Stroke Unit to prevent medical outliers occupying stroke capacity. Daily aim to ensure ringfenced stroke bed to support flow and stroke pathway. Stroke demand on all three sites discussed at Safe to Start meetings twice daily and at HB conference calls. Ring fenced beds and ASU capacity continues to form part of the out of hours and weekend planning cycle of the HB.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD31/1	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Following the temporary relocation of stroke services the therapy workforce has been reviewed and an investment proposal has been submitted
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - due to critical incident and urgent service move, Stroke Services now currently centralised at Royal Glamorgan Hospital. There is currently no psychology support for stroke patients across the Health Board. The lack of psychology support is noted on the corporate risk register (risk ID 4632). 0.6 wte Neuropsychology post currently advertised. This will support stroke services. The need for psychology support will be included in the workforce review as part of the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - CTM UHB continues to offer a 5 day clinical model. The Health Board aim is to provide a 7 day clinical model to support patient outcome and experience. Workforce requirements to support this are being identified as part of the Stroke Service Redesign programme and will require investment as the current workforce is unable to support 7 day working.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Inpatient acute stroke services currently centralised at Royal Glamorgan Hospital. Dedicated therapy bay established within the Acute Stroke Unit for use by all therapists. Community hospital provision - 8 funded stroke specific rehabilitation beds at Ysbyty Cwm Rhondda (ability within current workforce to flex up to 14 patients if required). Stroke Service Redesign programme reviewing workforce model and optimum patient pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the DZRA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Primary & Community Care Group DM
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Primary & Community DM
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD41/1	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025 Update -No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Primary & Community DM
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD42/1	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD44/1	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Patient discharge manually updated on whiteboards by ward staff. Currently no progress with 'push report' functionality.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	Overdue	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - Capital work is still ongoing and PCH major construction works are continuing. Welsh Government funding continues to be explored, which will facilitate improved patient clinical areas allowing for improved patient and staff experience.

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**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update -pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care has been implemented. This reinforces that patient flow is a team approach across the site. The plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area are ongoing. Capital environmental works remain ongoing across the site.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/7	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	**Overdue**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 no change to action -part of ongoing capital plans , We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DoLS (CDU) training.	Healthcare Inspectorate Wales (HIW)/2023/167/MD29/1	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug'23 fire training for staff is as follows:- ED-RN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024	01.04.2024	**Overdue**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - ED Fire Training Compliance Registered Nurses - Department Training - RNs 94% and HCSWs 90% Classroom Training - RNs 90% and HCSWs 88% CDU (now AMU) Fire Training Compliance - RNs 100% and HCSWs 100%
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD30/1	Monthly mandatory training study days and reports now include V & A, DoLs, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration-action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024	01.04.2024	**Overdue**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update Violence and aggression training compliance AMU - (Module A ESR) - RN - 100% HCSW - 100%, Module B Classroom - RN 16% Has -10% Awaiting training dates from Violence and Aggression Training Teams Violence and aggression training compliance ED RN - 75% HCSW - 84%% MCA training compliance AMU RN - 59% HCSW - 87% Awaiting training dates from Training Teams MCA training compliance ED - RN - 48% HCSW - 80% Safeguarding training compliance AMU (Adult) - RNs -100% HCSWs -96% (children) RN -100% HCSWs - 89% Safeguarding training compliance ED (Adult) - RNs - 80% HCSWs -92 % (children) RN - 94% HCSWs -89%
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	**Partially complete (Overdue)**	June, August, October, December 2025 Update - No update against this recommendation action has been received on these occasions. March 2025 Update - Meetings planned to revisit this work for PCH and PoW in March 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits of attracting staff to CTM UHB.	Children & Families	29.02.2024	29.02.2024	**Partially complete (Overdue)**	June, August, October, December 2025 Update - No update against this recommendation action has been received on these occasions. March 2025 Update - Mat-Neo services in PoW has now re-opened - Will revisit this work, contact made with recruitment to meet in April 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	**Partially complete (Overdue)**	June, August, October, December 2025 Update - No update against this recommendation action has been received 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)/2024/235	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	31.03.2026	**In progress**	December 2025 Update - New revised date of completion 31/03/2026. October 2025 Update - Continue to be working towards the completion date of 31st October, being presented at OMB next month.
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	31.03.2026	**In progress**	December 2025 Update - revised due date 31/03/2026. October 2025 Update - continuing to be working towards completion date 31st October.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	9. The health board must ensure that a mental health pharmacist is allocated to the ward to support staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD9/1	Pharmacy provision to form part of the wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. The mitigation includes; Ysbyty Cwm Cynon pharmacy teams screen medication charts and supply medication to the wards and the Principle Pharmacist for Mental Health supports the ward on an ad hoc basis with reviewing medication incidences.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	**Partially complete**	December 2025 Update - Ward 7 YCC, now have Pharmacy support. Pharmacist visits the ward weekly. Pharmacy technician visits the ward daily Monday to Friday. The ward is also able to contact Pharmacy and have support for any urgent issues. completed and evidence attached needs sign off at next QSE meeting in January
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	31.03.2026	**In progress**	December 2025 Update - Inpatient redesign will look at inequities across the region with regards all AHP provision. Extended completion date 31-3-26.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	12. The health board must ensure that policies are reviewed to ensure they are current.	Healthcare Inspectorate Wales (HIW)/2025/241/MD12/1	The policies identified within the inspection that were; Mental Health policies • Management of violence and behaviours that challenge, no review date (this has been completed) Corporate / Health Board policies • Health and safety policy, review date August 2024 • Consent to examination or treatment, review May 2024 • Policy for safe support and supervision of patients, review date October 2018 • PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents, however, at appropriate intervals there will be engagement with the Assistant Medical Director Quality & Clinical Effectiveness, who leads on Clinical Written Control Documents to ensure consistency and flow. Project Objectives: 1. To establish a baseline compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. 4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents. To review the "Policy on Policies" and develop a simplified document supported with clear process maps.	Mental Health & Learning Disabilities	31.12.2025	31.03.2026	**In progress**	December 2025 Update - Revised completion date 31-3- 26.
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	31.03.2026	**In progress**	December 2025 Update - Staffing establishment will be reviewed through inpatient redesign and in line with CTM establishment review. Date extended 31-3-26.
Healthcare Inspectorate Wales (HIW)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/3	CTM DRL group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRLs. The DRL group will feed into CTM image optimisation team and radiation safety committee.	Diagnostic, Therapies, Pharmacy and Specialities	05.06.2025	05.06.2025	**Partially complete (Overdue)**	October, December 2025 Update - No update against this recommendation action has been received on this occasion. August 2025 Update (20/08/2025) - Meeting scheduled for 22/7/2025 cancelled. Date of next meeting to be held in September (Date TBC)
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	1. The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Healthcare Inspectorate Wales (HIW)/2025/264/MD1/2	Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	**Fully complete (Awaiting approval)**	October 2025 Update - To be ratified in Radiation Safety Committee Friday October 24th.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	1. The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Healthcare Inspectorate Wales (HIW)/2025/264/MD1/3	All amended EPs will be shared and acknowledgement of changes required and recorded. Amended EPs will be added to CTMUHB SharePoint.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	**Fully complete (Awaiting approval)**	October 2025 Update - Will be added to SharePoint following ratification of document at Radiation Safety Committee 24th October.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	2. The employer must ensure that training and competency is evidenced prior to duty holder entitlement.	Healthcare Inspectorate Wales (HIW)/2025/264/MD2/1	Review existing practitioner and operator duty holders training and competency evidence. Ensure that practitioner and operator training and competency prior to entitlement is assessed for specific tasks e.g. Cardiologists practitioner training to justify imaging in theatre. Duty holder competency will be assessed by ongoing referral form audit i.e. accurate completion of request form; signature, adequate clinical information, date.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	**Partially complete (Overdue)**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - Documentation ready for sign off, awaiting training records as evidence.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	3. The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	Healthcare Inspectorate Wales (HIW)/2025/264/MD3/2	Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	**Fully complete (Awaiting approval)**	October 2025 Update - To be ratified in Radiation Safety Committee Friday October 24th.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	3. The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	Healthcare Inspectorate Wales (HIW)/2025/264/MD3/3	All amended EPs will be shared and acknowledgement of changes required and recorded. Amended EPs will be added to CTMUHB SharePoint.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	**Fully complete (Awaiting approval)**	October 2025 Update - To be added to SharePoint following ratification at Radiation Safety Committee 24th October.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/2	CTMHUB employer's procedures will be available via the intranet to employers/referrers outside CTMUHB.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	**Fully complete (Awaiting approval)**	October 2025 Update - PowerPoint sent to Web development for Radiology site to be added to CTMUHB internet page. Documents will then be added. Documents added November 2025
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	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	**Fully complete (Awaiting approval)**	October 2025 Update - Documentation to be ratified October 24th in radiation safety committee. Complete Novermber 2025 - added to web
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	4. The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	Healthcare Inspectorate Wales (HIW)/2025/264/MD4/6	Entitlement of external referrers will be an agenda item at the following groups: Radiography Professional Heads Group	Diagnostic, Therapies, Pharmacy and Specialities	13.08.2025	13.08.2025	**Fully complete (Awaiting approval)**	Complete September 2025
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	6. The employer must ensure that the non-medical referrers who were clinically evaluating are appropriately entitled and that the entitlement is supported by relevant training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD6/2	Scope of practice for clinical evaluation and entitlement by Radiology CD will be sent to existing NMRs on receipt of evidence of training and competency. Policy for NMRs will be updated to include entitlement for clinical evaluation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	**Partially complete (Overdue)**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - Scope of practice sent. NMR policy to be updated.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/2	Retrospective audit of CT forms justified by a Radiographer to ensure exposures have been justified appropriately.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	**Partially complete (Overdue)**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - Discussion required as to audit approach.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/3	To be discussed at CT modality user group meeting, pan-CTM to clarify justification or authorisation process for Radiographers.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	**Partially complete (Overdue)**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - CTMUHB CT user group to meet November 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/4	If authorisation as an operator is agreed, guidelines will be issued by an individually named practitioner.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	**Overdue**	October, December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	8. The employer must ensure that individuals outside radiology performing practitioner and operator tasks are appropriately entitled. The entitlement should be underpinned with the appropriate training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD8/1	Review duty holder entitlement outside of Radiology. Identify any gaps and entitle, where appropriate, following confirmation of training and competency.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	**Partially complete (Overdue)**	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - Documentation complete, awaiting evidence of training before entitlement sign off.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	12. The employer must ensure that: • All AMaT forms are completed fully to support robust audit • The clinical audit schedule includes the list of all scheduled audits, timeframes and frequency of audit and the individuals responsible for performing the audit and ensuring findings are actioned.	Healthcare Inspectorate Wales (HIW)/2025/264/MD12/1	Meet with clinical audit team, and radiology audit leads to ensure that all audits are registered on AMaT, and all documentation is complete. Ensure clinical audit schedule is updated to include timeframes, frequency of audit and responsible person for carrying out audit.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	**Fully complete (Awaiting approval)**	October 2025 Update - Discussion with audit team taken place. Clinical audit schedule updated.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/3	Observation and referral form audit will be added to AMaT system to ensure action plans in place, robust analysis and re-audit in an appropriate time frame.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	**Overdue**	October, December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	15. The employer must review the gaps in the QC records and the inconsistencies in baselines between the policy and manufacturer recommendations.	Healthcare Inspectorate Wales (HIW)/2025/264/MD15/2	Meeting with MPEs to review baselines and manufacturer recommendations. Will review policy and amend.	Diagnostic, Therapies, Pharmacy and Specialities	29.07.2025	29.07.2025	**Partially complete (Overdue)**	October, December 2025 Update - No update against this recommendation action has been received on this occasion.

Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	16. The employer must ensure that the process to ensure that training records and the review of entitlement are checked at suitable intervals and evidenced appropriately.	Healthcare Inspectorate Wales (HIW)/2025/264/MD16/1	All training records and entitlement will be reviewed at personal development reviews. All staff that perform PDR's will be reminded.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	October 2025 Update - All staff that perform PDRs have been asked to include review of training records and entitlement.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	18. The employer must ensure that staff are reminded of the intellectual task of justification and exposure and how this differs to authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD18/1	CPD session to be delivered on changes to employers procedures to include the difference between justification and authorisation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Overdue	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - To be scheduled.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&CQS – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/3	Feedback Friday to be implemented i.e., staff will actively ask patients to give feedback. Once feedback has been gathered 'you said, we did' board will be displayed.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Partially complete (Overdue)	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - Champions appointed - further engagement with front of house staff required.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20. The department must continue to highlight the business case to the employer and ensure that a decision is made in a timely manner.	Healthcare Inspectorate Wales (HIW)/2025/264/MD20/1	A case has been submitted for additional radiography staff that supports the future workforce model and demand as part of the IMTP investment priorities for 2025-26 across the sites. This will continue to remain the priority for Radiology. To date, no source of funding has been identified. Additional staff have been rostered out of hours at RGH temporarily while services from POW are temporarily relocated.	Diagnostic, Therapies, Pharmacy and Specialities	30.04.2026	30.04.2026	In progress	October, December 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/9	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Wellbeing champions to be established.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Partially complete (Overdue)	December 2025 Update - No update against this recommendation action has been received on this occasion. October 2025 Update - Scoped well being champion role - staff to be appointed.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/11	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Preceptorship programme to be developed for Band 7 team leaders.	Diagnostic, Therapies, Pharmacy and Specialities	31.12.2025	31.12.2025	In progress	October, December 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	1. Review feedback around staff communication and address any issues.	Healthcare Inspectorate Wales (HIW)/2025/276/MD1/1	To ensure all new starters, including medical colleagues are orientated to the unit. Ensure all new starts received a 'welcome pack' which supports staff to familiarise them with processes and procedures.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	2. Ensure timely pain relief is available postnatally.	Healthcare Inspectorate Wales (HIW)/2025/276/MD2/1	All Wales self-administration policy is currently distributed for comment, once ratification the organisation will support implementation.	Children & Families	30.04.2026	30.04.2026	In progress	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	2. Ensure timely pain relief is available postnatally.	Healthcare Inspectorate Wales (HIW)/2025/276/MD2/2	Communication to be shared with all staff regarding timely medication.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	3. Improve Welsh language active offer and ensure Welsh-speaking staff are easily identifiable.	Healthcare Inspectorate Wales (HIW)/2025/276/MD3/1	All Welsh speaking staff are provided with All Wales identifiable uniforms with 'Cymru' logo.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	4. Improve signage to the department.	Healthcare Inspectorate Wales (HIW)/2025/276/MD4/1	Videos to be developed to support women and their families how to find maternity departments. Ensure clear signage is displayed to help women and families locate the maternity unit. Estates to review signage across the site to ensure easy access to maternity.	Children & Families	28.02.2026	28.02.2026	In progress	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	5. Ensure equality policies and training are consistently translated into practice so that no person using the service suffers discrimination.	Healthcare Inspectorate Wales (HIW)/2025/276/MD5/1	Ensure staff complete the All Wales ESR learning module for EDI. CTMUHB annual quality report which promotes equality has been shared to all staff.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	6. Fully implement BSOTS, including dedicated telephone advice lines, comprehensive staff training, and consistent triage processes.	Healthcare Inspectorate Wales (HIW)/2025/276/MD6/1	Core staff to be appointed to work within MPU (maternity priority unit).	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'September 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	6. Fully implement BSOTS, including dedicated telephone advice lines, comprehensive staff training, and consistent triage processes.	Healthcare Inspectorate Wales (HIW)/2025/276/MD6/2	Staff to receive BSOTS training.	Children & Families	30.11.2025	30.11.2025	Overdue	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	6. Fully implement BSOTS, including dedicated telephone advice lines, comprehensive staff training, and consistent triage processes.	Healthcare Inspectorate Wales (HIW)/2025/276/MD6/3	Share patient information to ensure women and families know where and when to contact MPU.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'September 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	6. Fully implement BSOTS, including dedicated telephone advice lines, comprehensive staff training, and consistent triage processes.	Healthcare Inspectorate Wales (HIW)/2025/276/MD6/4	Undertake data collection and complete clinical audit to monitor compliance of BSOTs.	Children & Families	28.02.2026	28.02.2026	In progress	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	7. Ensure timely repair of equipment or resolution of estates issues.	Healthcare Inspectorate Wales (HIW)/2025/276/MD7/1	Areas requiring improvement to be escalated to QSRE. Escalation to be raised via operational management board. Escalation via internal assurance meetings (SWAG).	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	8. Review and address any outstanding theatre estates concerns and theatre staffing levels and skill mix.	Healthcare Inspectorate Wales (HIW)/2025/276/MD8/1	Perioperative MDT meetings to be established to ensure timely and effective communication to improve safe rota's.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	8. Review and address any outstanding theatre estates concerns and theatre staffing levels and skill mix.	Healthcare Inspectorate Wales (HIW)/2025/276/MD8/2	Undertake BirthRate Plus workforce review.	Children & Families	31.01.2026	31.01.2026	In progress	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	8. Review and address any outstanding theatre estates concerns and theatre staffing levels and skill mix.	Healthcare Inspectorate Wales (HIW)/2025/276/MD8/3	Estate issues escalated via operational management board meeting.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	9. Review and improve safe storage of patient's own medication.	Healthcare Inspectorate Wales (HIW)/2025/276/MD9/1	Order lockable lockers for every bed space, in preparation for the All Wales self administered medication policy.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'September 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	10. Review and act on staff feedback themes and implement and monitor actions to improve staff satisfaction and morale.	Healthcare Inspectorate Wales (HIW)/2025/276/MD10/1	Establish a wellbeing team within the unit to support wellbeing events. Unit meetings to be scheduled to allow staff an opportunity to receive unit updates and notification of wellbeing events. RCM local reps to undertake site visits (wellbeing walk arounds). Promote RCM recruitment to support health and safety roles locally. Update and present the Mat/Neo leadership and culture plan. CTM Wellbeing team to undertake drop in/feedback sessions to allow staff an opportunity to raise/discuss concerns/area for improvement.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'September, October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	11. Review, evaluate and improve communication and engagement between senior management and staff.	Healthcare Inspectorate Wales (HIW)/2025/276/MD11/1	Establish a maternity/neonatal newsletter to share with staff 'MatChat' newsletter. Unit meetings to be established.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	11. Review, evaluate and improve communication and engagement between senior management and staff.	Healthcare Inspectorate Wales (HIW)/2025/276/MD11/2	Create a Maternity specific Share-point page to support staff to access key information.	Children & Families	28.02.2026	28.02.2026	In progress	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	12. Ensure that established investigation processes are implemented consistently when needed.	Healthcare Inspectorate Wales (HIW)/2025/276/MD12/1	The Maternity Governance team to undertake an engagement event to celebrate the rebranded title of – quality assurance team.	Children & Families	31.01.2026	31.01.2026	In progress	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	12. Ensure that established investigation processes are implemented consistently when needed.	Healthcare Inspectorate Wales (HIW)/2025/276/MD12/2	Develop an assist me pack which is specific to maternity and neonatal staff to support staff who maybe involved in an incident and the process	Children & Families	31.01.2026	31.01.2026	In progress	December 2025 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	13. Ensure effective measures are in place to share learning from incidents.	Healthcare Inspectorate Wales (HIW)/2025/276/MD13/1	Ensure all investigations are shared with staff involved to ensure factual accuracy. Ensure '7 minute briefings' are shared to all staff Update Rapid review templates to ensure staff wellbeing and staff liaison to be allocated to each NRI. Reflection meetings are established to ensure learning is shared with staff.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	14. Review and prioritise a plan to address the gaps in CSFMs to provide support for those involved in incidents.	Healthcare Inspectorate Wales (HIW)/2025/276/MD14/1	Review the establishment of CSfM, ensure wellbeing is provided to all staff absent from work. Ensure recruitment of any vacant hours is appointed into.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	15. Improve PADR levels in line with health board targets.	Healthcare Inspectorate Wales (HIW)/2025/276/MD15/1	Ensure all line managers have had an opportunity to received guidance and training to undertake PADR's. Monitor PADR compliance and present via internal assurance meetings.	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	16. Ensure that an induction programme is available for all new staff within the unit.	Healthcare Inspectorate Wales (HIW)/2025/276/MD16/1	Ensure all new starters receive a 'welcome pack' to support their introduction to the unit. Ensure all new starters received a period of supernumerary at the start of their employment. Ensure all new starter meet with CSfM to support their introduction into the unit. Ensure clear communication is shared with all specialist midwives to ensure the team are aware of 'new starters'	Children & Families	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'October 2025: Completed action' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	1. The health board must ensure that the ED has access to food for patients as appropriate, such as to support a patient with diabetes to maintain their blood sugar control.	Healthcare Inspectorate Wales (HIW)/2025/277/MD1/1	Cwm Taff University Health Board (CTMUHB) acknowledges that patients must have access to a variety of food to meet individual needs, including patients who are diabetic to ensure that blood sugar levels are controlled. We recognise that the ability to provide regular offers of food and fluids to patients within the department has been challenging however improvement work with the facilities team has supported options available to our patients. The catering team attend the department to provide refreshments 3 times a day from the catering trolley: 08:00 – 08:30 hours – cereal, toast and hot drink 12:00 – 12.30 hours – soup, sandwich and hot drink 17:00 – 17.30 hours – hot meal and hot drink At the times of when the catering team attend the department, the Nurse-in-Charge (NIC) will advise of any patients that require food or drink who are currently in the waiting room, on the back of an ambulance waiting to be handed over or within our fit to sit areas. Out of hours, the Emergency Department (ED) nursing team will provide refreshments of hot drinks and sandwiches which are kept in the department fridge. The Nursing staff record on the nursing documentation when a patient is offered refreshments. The ED waiting room has a vending machine offering cold snacks and there is also a vending machine providing hot and cold drinks. The vending machine stocks are replenished daily. For patients who require specific dietary needs, the catering department can be contacted and food to meet the needs of the patient can be arranged. Additional information: A Band 5 registered nurse (RN) and Band 3 Emergency Department Assistant (EDA) in ED undertook a patient survey to identify if menu choice was made available to them. A PowerPoint presentation was completed to record the findings. Next steps are to meet with the facilities team to discuss the findings and discuss a plan to improve meal choice and options for our patients attending the ED.	Unscheduled Care	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'Complete 30th September 2025' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	2. The health board should ensure that staff remain mindful of the need to actively engage with certain patients / patient groups when time permits.	Healthcare Inspectorate Wales (HIW)/2025/277/MD2/1	CTMUHB acknowledges the findings and the importance of ensuring that all staff are mindful of the needs to ensure engagement with all patients. We recognise that effective communication and engagement are crucial to providing patient centred care to promote positive outcomes. Ensuring our patients are actively engaged with is a whole team approach. Patient feedback is gathered on a weekly basis where feedback is collected and reviewed. Feedback from both service users and carers is utilised to support service and environmental improvements. All staff are regularly reminded to introduce themselves to patients, informing them of their name and their role and to repeat this information regularly as needed. "You Said", "We Did" promotes an inclusive culture and engagement with all patient groups, the CTMUHB Patient Experience group are reviewing this information with a view to clearly displayed it within the department. The ED has been supported by a volunteer group over the past 18 months. Under nursing direction, the team undertake shift working to support peoples experience within in the ED. Volunteers may carry out a combination of the tasks listed below as required: • Provide support and companionship for patients. • Support patients to contact relatives and loved ones either using patient's personal device, CISCO phone or tablet where appropriate. • Provide feedback to staff, transfer messages and run errands to other departments within the hospital. • Provide refreshments for patients (with staff guidance, checking for any allergies or diet/liquid restrictions) • Help at mealtimes to hand out food and drinks, check cutlery and utensils are suitable for patients, clear away etc. and fill up water jugs. • Check in on patients and visitors in waiting areas. • Replenish stock. • Direct, and accompany where appropriate, patients/visitors to other areas of the hospital (not where patients require a clinical escort). • Encourage and assist patients and family/friends to complete feedback survey. The Department has use of the Reminiscence Interactive Therapy Activities (RITA) system for patients attending the ED. This is digital tablet-based therapy tool for patients with Dementia, cognitive impairment, and other conditions. The RITA system provides music, games, films, photos and historical news to stimulate memories, promote engagement and helps to reduce anxiety and agitation. The ED has improved training compliance in undertaking Equality and Diversity online training compliance is currently 88%. Targeted area to improve training compliance by January 2026.	Unscheduled Care	31.01.2026	31.01.2026	Partially complete	December 2025 Update - - memo completed to raise awareness of the RITA system/ Memo to be shared widely with the ED team via our communication platforms. Memo will be uploaded to share evidence - Patient experience group under development - plan to schedule first meeting in Jan 2026. - Dementia training underway. Update training compliance to be uploaded

Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	3. The health board should explore the availability of washing or showering facilities for patients who are accommodated in the ED for significant periods of time, or whose medical condition / presentation might necessitate it.	Healthcare Inspectorate Wales (HIW)/2025/277/MD3/1	Cwm Taff University Health Board recognises the current unavailability of washing and/or showering facilities within the ED. All patients attending the ED are offered wash facilities by the way of disposable wash bowls, individual soap sachets also providing a stock of toothbrushes, toothpaste and hair combs. For our patients who are accommodated in the ED for a longer period of time, we have explored departments located around the ED to identify facilities which may be considered as an available option to our patients. The Radiology Department which is adjoined to the ED has showering facilities. Since the HIW visit, we have discussed the option of the use of the showering facilities with radiology colleagues who have confirmed that showering facilities within the radiology department can be utilised. This agreement enables staff to offer suitable patients to access washing and showering facilities during their stay within the ED. - Environmental audit / risk assessment of washing facilities to ensure suitable for patients. - Review staffing allocations where patients may require supervision or support with personal care. Additional Information: • Share the above agreement with the nursing team to raise awareness of accessible facilities for our patients who can be offered to shower during their stay at ED.	Unscheduled Care	30.09.2025	30.09.2025	Partially complete (Overdue)	December 2025 Update - Agreement arranged with the radiology department regarding use of showering facilities. Memo to be uploaded.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	4. The health board must continue to be highly cognisant of the footprint of the department and its ability to remain fit for purpose in the context of current demand, capacity and usage.	Healthcare Inspectorate Wales (HIW)/2025/277/MD4/1	CTMUHB recognises the requirement to continually the ED footprint and its ability to remain fit for purpose in the context of current demand and capacity. Following service reconfiguration as a result of the Critical Incident in Princess of Wales Hospital, a comprehensive review of the current ED footprint will be required to ensure it aligns with evolving service needs. This review should consider patient flow, workforce requirements, infrastructure limitations, and future growth projections to ensure the department remains responsive, safe, and sustainable.	Unscheduled Care	31.03.2026	31.03.2026	In progress	December 2025 Update - Ongoing discussions - for IMTP.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	5. The health board must ensure that the length of time a patient in seated for is appropriate in the context of the patient criteria and clinical need.	Healthcare Inspectorate Wales (HIW)/2025/277/MD5/1	CTMUHB recognises that assurance must be provided to acknowledge the importance of ensuring that patients sitting in chairs are appropriate in the context of clinical need and are not in chairs for extended periods of time. To address this, a 12-hour action card is being developed, in its infancy stages, to identify and support prioritisation of patients who have been within the department in excess of 12 hours which can include prompts to review the length of stay experienced within a chair and prioritisation for a suitable flat space. The nursing team including a newly developed role of the 'Helicopter Nurse' will conduct regular assessments of patients in chairs to determine appropriateness and highlight patient prioritisation. The NIC ensures appropriate escalation, ensuring daily discussions as part of the formal "Safe to Start" meetings undertaken at 08:00 hours and 14:30 hours, recognising risk to patients, risk of pressure damage and patient experience. The number of patients waiting in chairs is also highlighted at the three daily HB conference calls. Recent patient experience improvement work has been undertaken to offer suitable patients ear plugs and eye masks within busy fit to sit areas to promote rest and sleep. The ED utilises Repose pressure relieving aids which are offered to patients who are identified as at risk of developing pressure damage. The ED huddles which occur 3 times daily include focus on patient safety and quality, which includes escalation for patients who are seated for prolonged length of time and who are at risk of developing pressure damage. A recent Pressure Ulcer prevalence audit has been undertaken within the ED where feedback has been presented. The audit recognises the requirement to continue to supply a sufficient stock of repose pressure relieving cushions for our patients who are seated in chairs. Next Steps: • In addition to the steps already undertaken an amendment will be made to the ED Safe to Start proforma to include details of patients who have spent a prolonged wait in a chair. The 4-hour performance metric should support the reduction in length of time waiting in chairs and this needs to be supported by effective patient flow out of the Emergency Department.	Unscheduled Care	31.10.2025	31.10.2025	Partially complete (Overdue)	December 2025 Update - - S25 proforma updated including patients who have spent a prolonged wait in chair which is discussed as a priority at S25 - prolonged waits included in ED safety huddle reporting - electronic safety huddle commences launch 15th Dec 2025. This will provide facilitation of communication, improve situational awareness, and enhance patient safety and operational awareness highlighting long wait in ED
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	6. The health board must consider the recommendations of RCEM (December 2020) regarding security and restraint and ensure that ED staff can access a consistent site security presence.	Healthcare Inspectorate Wales (HIW)/2025/277/MD6/1	CTMUHB acknowledges the findings regarding the requirement to ensure consistent access to on site security presence. The ED regularly receive Violence and Aggression (V&A) Modules B - Personal Safety & De-escalation and Module C - Breakaway & Escape Techniques. Historically CTMUHB Emergency Departments have not been trained in Module D - Physical Restraint Techniques (PMVA) and the onsite security team are trained to assist with restraint. Since the introduction of Right Care Right Person by South Wales Police, ED staff cannot guarantee support from South Wales Police to attend incidents of violence. Datix incident analysis over the past few years shows security porters have been required to manage restraint incidents without back up support from South Wales Police. There are two security porters available to manage violence at any given time and this is to support the hospital site. Next steps: The facilities team are currently undertaking a review of the security team establishment and a training needs analysis to support the increase of security availability at the hospital site. The facilities team are undergoing improvement work to review the current establishment of the security team and implement a training plan for PMVA training.	Unscheduled Care	31.03.2026	31.03.2026	In progress	December 2025 Update - - facilities team progressing the review of the security team with a view to increase establishment for cross-site security support - training analysis being supported by Violence and Aggression Case Manager including the safeguarding team and EDs to implement a training plan for PMVA training
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	7. The health board should ensure that staff are reminded of the importance of good hand hygiene principles.	Healthcare Inspectorate Wales (HIW)/2025/277/MD7/1	CTMUHB recognises the importance of reminding staff to comply with Bare Below Elbow (BBE) guidance and adhering to good hygiene principles. The ED has undertaken targeted work to improve BBE compliance by: • displaying visual posters at the entrances of the ED to remind staff to ensure BBE prior to entering the clinical area. • reiterating the necessity of being BBE on each nursing and clinician handover. • Regular memos shared with staff via our information sharing platforms – weekly newsletter, printed memos and internal social media platforms. • Departmental monthly AMaT audits are undertaken to monitor trends, improvements and progress. • Deputy Medical Director has reminded all resident medical staff of the need for BBE compliance (this is also included in Resident Doctor Induction sessions). • BBE compliance is presented via the monthly IP&C site meetings including lessons learned. • BBE audits are presented at the bi-weekly ED governance meetings for wider learning.	Unscheduled Care	04.11.2025	04.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'Complete 30th September 2025' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	8. The health board should replace torn seating to maintain effective cleaning and IPC standards.	Healthcare Inspectorate Wales (HIW)/2025/277/MD8/1	CTMUHB recognises the importance of ensuring that all equipment and seating are maintained effectively to ensure effective cleaning and adhering to IP&C standards. We recognise that torn or damaged seating can pose a risk to IP&C and compromise the cleanliness of the department. A walk-through in the department has been undertaken on the 24th September 2025 by the ED Band 7 management team to identify both condemned and torn seating. This enables us to prioritise the replacement or repair of our chairs. AMaT audits are undertaken which incorporates IP&C environmental audits to ensure regular maintenance of our chairs are implemented to enable us to efficiently address damaged or torn seating. Next Steps: • Received quote for new chairs to replace condemned furniture. This quote has been submitted for approval.	Unscheduled Care	31.10.2025	31.10.2025	Partially complete (Overdue)	December 2025 Update - - quote received - order submitted via Oracle. - awaiting update of authorisation to progress with order
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	9. The health board must ensure that staff accurately assess and document pressure and skin tissue damage in clinical notes.	Healthcare Inspectorate Wales (HIW)/2025/277/MD9/1	CTMUHB acknowledges the importance of providing assurance that staff assess and document pressure and skin tissue damage. The nursing team are able to provide assurance of awareness that a skin assessment must be undertaken within 6 hours of arrival as per Health board policy. The ED Nursing documentation includes relevant risk assessments and documents to allow contemporaneous documentation following a skin assessment. This includes initial skin assessment with body map, Purpose T assessment and repositioning charts. The role of the 'Helicopter nurse' is to undertake documentation checks which is documented within a checklist on the back of the ED nursing pack to support live auditing and timely actions to be undertaken. As addressed previously, a recent Pressure Ulcer prevalence audit has been undertaken within the ED and feedback has been presented. Should an incident occur relating to Pressure, ED attends the pressure assurance panel which runs weekly. The Pressure Ulcer Prevention Champion collates lessons learned following panels to include within the training programme as described in next steps. The ED displays a Governance Board on the main corridor of the ED which includes incident reporting data, lessons learned, learning from excellence and trends identified. Current ED training compliance for Pressure Ulcer Training is 71%. A trajectory of improvement of training compliance has been made. The Band 7 Practice Development Nurse (PDN) will work alongside the ED Pressure Ulcer Prevention Champion to target training compliance improvement by December 2025. Next Steps • The audit recognises the requirement to update the ED nursing documentation pack to include a formalised care plan which has been supported by our Tissue Viability Nursing (TVN) team. The updated ED nursing pack is currently in draft and with a view to implement across the 3 ED's in CTMUHB. The ED has recently supported the enthusiasm of Band 6 RN to become the ED Pressure Ulcer Prevention Champion who is currently working on an internal training programme collaboratively with the TVN to incorporate education, the good work	Unscheduled Care	31.12.2025	31.12.2025	Partially complete	December 2025 Update - - AMaT task and finish group to be commenced to progress audit for ED nursing documentation - Support with TVN team to provide a care management plan in to the ED nursing pack to support pressure ulcer care. Awaiting agreement on finalized version to role out. - internal training plan underway
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	10. The health board must ensure that multifactorial risk assessments and relevant care plans are completed promptly when identified as necessary.	Healthcare Inspectorate Wales (HIW)/2025/277/MD10/1	CTMUHB recognises the importance of completing multifactorial risk assessments and care plans in a timely manner to ensure that our patients receive the highest quality of care which is patient centred. We recognise the importance in completing these assessments and plans to promote patient safety. The ED nursing documentation pack includes relevant risk assessments and care plans to support our patients. To ensure that our assessment processes are efficient, effective and timely, we are planned to undertake a review of the current ED nursing pack across the 3 EDs in CTMUHB. Following a review and implementation of the updated ED nursing pack, we will ensure nursing staff are trained and competent to complete the multifactorial risk assessments. As identified previously, the role of the 'Helicopter nurse' is to undertake documentation checks which is documented within a checklist on the back of the ED nursing pack to support live auditing and timely actions to be undertaken. In the event of implementing new/updated documents, we ensure that all staff are briefed both via verbal and written memos, by utilising internal social media page, emails, weekly ED newsletter and uploaded on the ED SharePoint page on the Health Board Intranet.	Unscheduled Care	31.12.2025	31.12.2025	In progress	December 2025 Update - - awaiting agreement on finalised draft of updated nursing documentation for role our across the 3 EDs - unfortunately the role of the 'helicopter nurse' has been stepped down since critical incident step down. Nursing establishment under review
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	11. The health board should re-audit the paediatric department against the RCPCH standards, with particular focus on paediatric workforce capacity.	Healthcare Inspectorate Wales (HIW)/2025/277/MD11/1	CTUMHB recognises the importance to audit and revisit the RCPCH audit following the implementation of a designated paediatric area in the ED. The ED has developed a Paediatric Emergency Medicine (PEM) group who are currently undertaking a review of the RCPCH standards to benchmark against previous audits prior to implementing the designated paediatric area. Current workforce establishment: 1.6 WTE PEM consultants covering a 6-hour period, 5 days a week. x 1.0 WTE Band 7 Paediatric Lead x 2.0 WTE Band 6 Paediatric nurses x 4.0 WTE Band 5 Paediatric Nurses Additional Information: • Focus on workforce capacity • The RGH ED PEM group will complete benchmarking exercise within the next 3 months.	Unscheduled Care	31.12.2025	31.12.2025	Partially complete	December 2025 Update - - RCPCH benchmarking underway with paediatric team - CTM PEM group commenced
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	12. The health board must ensure that patients' nutrition and hydration intake is accurately assessed, actioned, and recorded in their clinical notes.	Healthcare Inspectorate Wales (HIW)/2025/277/MD12/1	CTMUHB acknowledges the importance of accurately assessing, acting on and recording patients nutritional and hydration intake to ensure that patients nutritional needs are met. The ED nursing pack includes the appropriate nutritional risk assessments to facilitate recording of a patient's requirements. The ED nursing pack includes appropriate risk assessments to ensure that patients' nutrition and hydration intake is accurately recorded within nursing notes and that the information documented is used to inform a plan of care. To ensure compliance with its use 'Helicopter nurse' will undertake documentation checks which is documented within a checklist on the back of the ED nursing pack to support live auditing of risk assessments and to ensure timely actions are undertaken.	Unscheduled Care	05.11.2025	05.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'Complete 30th September 2025' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.

Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	13. The health board should continue to review its catering provision for patients who remain in the department for extended periods, as well as for those with specific medical conditions, vulnerabilities, or dietary requirements.	Healthcare Inspectorate Wales (HIW)/2025/277/MD13/1	Cwm Taff University Health Board (CTMUHB) acknowledges that patients must have access to a variety of food to meet individual needs, including patients who are diabetic to ensure that blood sugar levels are controlled. We recognise that the ability to provide regular offers of food and fluids to patients within the department has been challenging however improvement work with the facilities team has supported options available to our patients. The catering team attend the department to provide refreshments 3 times a day from the catering trolley: 08:00 – 08:30 hours – cereal, toast and hot drink 12:00 – 12.30 hours – soup, sandwich and hot drink 17:00 – 17:30 hours – hot meal and hot drink At the times of when the catering team attend the department, the Nurse-in-Charge (NIC) will advise of any patients that require food or drink who are currently in the waiting room, on the back of an ambulance waiting to be handed over or within our fit to sit areas. Out of hours, the Emergency Department (ED) nursing team will provide refreshments of hot drinks and sandwiches which are kept in the department fridge. The Nursing staff record on the nursing documentation when a patient is offered refreshments. The ED waiting room has a vending machine offering cold snacks and there is also a vending machine providing hot and cold drinks. The vending machine stocks are replenished daily. For patients who require specific dietary needs, the catering department can be contacted and food to meet the needs of the patient can be arranged. Additional information: A Band 5 registered nurse (RN) and Band 3 Emergency Department Assistant (EDA) in ED undertook a patient survey to identify if menu choice was made available to them. A PowerPoint presentation was completed to record the findings. Next steps are to meet with the facilities team to discuss the findings and discuss a plan to improve meal choice and options for our patients attending the ED.	Unscheduled Care	05.11.2025	05.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'Complete 30th September 2025' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	14. The health board should ensure that hydration needs are being met in a more consistent and structured manner.	Healthcare Inspectorate Wales (HIW)/2025/277/MD14/1	CTMUHB wishes to acknowledge the vital importance of ensuring our patients' hydration status is regularly assessed. Accurate monitoring and recording of patients' fluid intake is vital to ensure that accurate hydration is received. CTMUHB recognises the importance of ensuring that drinks are offered and available for our patients. The nursing team will ensure that water jugs are regularly filled with fresh water and available to patients in the waiting area and that jugs of water are offered to our patients within clinical areas. The ED volunteer team will also support regular refreshments and refills under direction from the nursing team. During catering hours, the catering team will attend the department 3 times a day to offer both hot and cold refreshments. Outside of catering working hours, the catering team will ensure that the department has stock for the nursing team to offer both hot and cold drinks to our patients. Continuous work via patient surveys will allow monitoring and improvements of catering provisions available which allow efficient action to support continuous improvements.	Unscheduled Care	05.11.2025	05.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'Complete 30th September 2025' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	15. The health board should consider incorporating an audit of the condensed nursing bundle into existing departmental audit processes to ensure its appropriate use and effectiveness.	Healthcare Inspectorate Wales (HIW)/2025/277/MD15/1	CTMUHB acknowledges the importance of auditing the ED nursing pack to measure appropriateness of its use. To ensure that our assessment processes are efficient, effective and timely, we are planned to undertake a review of the current ED nursing pack across the 3 EDs in CTMUHB. Following a review and implementation of the updated ED nursing pack, we will ensure appropriateness and effectiveness of its use. • Following a review of the ED nursing pack and agreement of the updated documentation, we plan to meet with the AMaT team to discuss implementing an electronic audit which can record usage and effectiveness of the ED nursing pack. • An audit review will allow monitoring of the use of the ED nursing pack and highlight what is working well and which areas require improvement.	Unscheduled Care	31.12.2025	31.12.2025	Partially complete	December 2025 Update - awaiting finalised draft of ED nursing pack for role out - AMaT audit will be added following implementation of role out
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	16. The health board should also ensure that staff are reminded of the organisation-wide processes available to them for raising concerns, including the option to do so anonymously.	Healthcare Inspectorate Wales (HIW)/2025/277/MD16/1	CTMUHB recognises the importance of ensuring that all staff are aware of the organisational availability to raise concerns including the option to raise concerns anonymously which promotes an open culture. The ED has set up a process for staff to have the opportunity to post written feedback on small cards that can be placed in a sealed box or via a QR code to a Microsoft form (ideas and concerns) which is collected and reviewed on a weekly basis. Following feedback review, we will ensure that we feedback to the team on actions we can support, progress or which may require further discussion. The ED band 7 managers undertake 1:1 wellbeing session with staff. The wellbeing session is an informal meeting offering the nursing team to have dedicated time with their line managers to discuss what is going well, areas of concern and allows a confidential session to discuss the staff members wellbeing. • A memo will be circulated to the ED team via our information sharing platforms to remind staff of the process on how concerns can be raised and the opportunity to raise a concern anonymously. • The 'Dealing with Anonymous Concerns Procedure' is accessible via the intranet page. We will ensure a link is provide on the ED SharePoint page to raise awareness and allow ease of access to this information. The 'Dealing with Anonymous Concerns Procedure' details how the organisation will act upon any information received anonymously, in accordance with existing protocols, policies and procedures, and aims to ensure that: • Anonymous allegations or concerns are taken seriously; and • CTMUHB provides a consistent approach in dealing with anonymous communications. The ED senior team will ensure that the policy is accessible to all staff to raise awareness of the support offered by the organisation.	Unscheduled Care	31.10.2025	31.10.2025	Partially complete (Overdue)	December 2025 Update - - updated policy received and circulated with the wider team to raise awareness on the process to raise anonymous concerns - memo to be uploaded
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	17. The health board should consider the training suggestions provided by staff in response to our survey, such as, Advanced Life Support, Paediatric Advanced Life Support, and Advanced Trauma Life Support.	Healthcare Inspectorate Wales (HIW)/2025/277/MD17/1	CTMUHB acknowledges that compliance for mandatory resuscitation training is not where we want it to be. The ED currently has 46 staff booked on various resuscitation courses, compromising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTLS = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An 8a Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all RNs and HCSW which will align across the 3 ED's. • The PDN across the 3 EDs are currently working towards instructor potential to enable and facilitate inhouse training to support training compliance improvements. A trajectory improvement action plan has been made to improve compliance to 100%.	Unscheduled Care	31.03.2026	31.03.2026	Partially complete	December 2025 Update - instructor course complete - plan with Senior Nurse for education and PDN to commence inhouse training - trajectory action plan to be completed
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	18. The health board must review staff compliance with all Immediate and Advanced Life Support training for both adult and paediatric patients, ensuring that improvements are made promptly.	Healthcare Inspectorate Wales (HIW)/2025/277/MD18/1	CTMUHB acknowledges that compliance for mandatory resuscitation training is not where we want it to be. The ED currently has 46 staff booked on various resuscitation courses, compromising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTLS = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An 8a Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all RNs and HCSW which will align across the 3 ED's. The Practice Development Nurses (PDN) across the 3 EDs are currently working towards instructor potential to enable and facilitate inhouse training to support training compliance improvements. A trajectory improvement action plan has been made to improve compliance to 100%.	Unscheduled Care	31.03.2026	31.03.2026	Partially complete	December 2025 Update - - instructor training undertaken - plan with senior nurse for education and PDN to arrange inhouse training - trajectory action plan to be uploaded
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	19. The health board must ensure that both the department and the wider service remain fully informed of audit outcomes and areas requiring improvement. Audit findings and associated learning must be applied effectively and subject to re-audit at appropriate intervals to monitor progress.	Healthcare Inspectorate Wales (HIW)/2025/277/MD19/1	CTMUHB recognises the importance of ensuring that staff are fully informed of audit outcomes and areas requiring improvement to promote staff engagement and drive continuous quality improvement. Audit outcomes are shared with our clinical and nursing teams during departmental audit days, where each audit lead presents their findings to the wider group. These sessions provide a platform for open discussion, enabling staff to contribute to the development of improvement actions. The next planned audit day is scheduled for 5th November 2025. Audit results are also incorporated into our monthly Performance and Assurance meetings, which feeds into a ward-to-board assurance processes, ensuring a consistent and transparent flow of information across all levels of the organisation. Further dissemination occurs through our departmental Governance meetings, where audit outcomes are reviewed and discussed with teams. Quality improvement projects arising from these audits are shared during our weekly departmental senior team meetings, weekly pan-CTM ED meetings, and Quality, Safety, Risk and Experience (QSRE) meetings for Unscheduled Care, promoting shared learning across the Health Board. To ensure staff are kept up to date, new developments and improvement work driven by audits are communicated weekly via our "Message of the Week." This message is distributed through the ED internal social media platform, the weekly ED newsletter, and displayed in the ED staffroom to maximise visibility. The ED clinicians have bi-annual audit day and a dedicated paediatric audit day been introduced in July 2025. CTMUHB remains committed to fostering a culture of quality improvement, learning, and transparency. • Audit outcomes will be summarised and included in the weekly ED newsletter to enhance visibility and support wider team engagement. There is an ED Consultant lead for audit.	Unscheduled Care	05.11.2025	05.11.2025	Fully complete (Awaiting approval)	Added to tracker November 2025; this action is marked as 'Complete 30th September 2025' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 20th January 2026 as completed.

Agenda Item
8.2.3

Quality, Safety & Experience Committee

Human Tissues Act Compliance Progress Report

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Dr Paul D Davies Assistant Director (Operational Support) & Designated Individual (HTA)
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dr Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
Mr Carl Verrecchia, HTA Board Chair	18/12/2025	Approved

Acronyms / Glossary of Terms	
HTA	Human Tissue Act
DI	Designated Individual
HTAuth	Human Tissue Authority
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
HTARI	Human Tissue Act Reportable Incident
PLR	Pregnancy Loss Remains
DTPS	Diagnostics, Therapies, Pharmacy & Specialities

1. Situation /Background

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

1.2 This report presents an updated status regarding compliance since July 2025.

2. Specific Matters for Consideration

Quality Control

2.1 The Quality Control Department within Pathology conduct a cyclic audit programme around the specific standards within the HTAuth Codes, predominantly items regarding consent, tissue traceability, governance, quality control, protection, environment and facilities.

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

2.3 During 2023 and in 2024 there has been a focus upon security following the Fuller Inquiry Phase 1 and this has continued into 2025.

2.4 The quality assurance of security arrangements is supported through monthly CCTV audit of Mortuary Departments and unauthorised swipe card attempts out of hours (Table 1)

2.5 All non-conformances are followed up by the Quality Department and DI.

2.6 There are currently no significant shortfall in standards to report from the three HTA licensed Mortuary Departments.

Table 1 Security audits for 2025

Audit Objective	Frequency	Number of completed audits for 2025 to date	All Finding Actioned
Verification of Mortuary CCTV	Monthly	12	Yes, no major findings
Unauthorised Access	Monthly	11	Yes, no major findings
Time spent in Mortuary OOHs	Quarterly	4	Yes, one finding relating to the supervision of main door entrances by porters at two mortuaries OOHs
Mortuary Swipe Card Access	Quarterly	4	Yes, no major findings

HTA Inspection 2025

2.7 The Health Board is legally compliant with the HTA as assessed by the HTAuth in an unannounced inspection conducted in September 2025.
2.8 HTA inspectors visited all three licenced mortuaries over two days which included interviews with the DI, a mortuary staff member, a mortuary trained porter and a Bereavement Midwife.
2.9 In addition to the environmental inspection all relative policies, standard operating procedures, risk assessments, audits, maintenance schedules, governance meetings and staff training records were inspected within the following five working days.
2.10 The final inspection presented that there were no major or minor findings and there were eight helpful advisories (Appendix 1).
2.11 The Health Board Chair, Chief Executive, Corporate Licence Holder and Chairs of the HTA Board thanked and commended all staff for their excellent work to maintain compliance, which has also been recognised by Welsh Government officials.
2.12 The HTA Board Chair noted that having no findings from an unannounced HTA inspection was an assurance that compliance at this level is *'business as usual'* for services.
2.13 The DI has compiled an action plan for the advisories which will be monitored through the HTA Board.

Maintaining Compliance

2.14 The DI has put in place a number of continual actions within a governance framework to ensure the services maintain compliance including on-going audit, local inspections, incident analysis and *Deep Dive* exercises.
2.15 The DI reports quarterly to the HTA Board in terms of compliance and this serves to ensure robust governance. This meeting is chaired by the Care Group Service Director (DTPS and Children and Families), reporting to the Corporate Licence Holder (Executive Medical Director).
2.16 The DIs local inspection focuses upon the HTA standards for security, temperature monitoring, traceability, cleanliness, equipment, competence and patient dignity.

Incident Analysis

2.17 All HTA related incidents are collated by the DI and presented on a quarterly basis to the HTA Board and Persons Designated. Appendix 2 presents data for the last two years.
2.18 The importance of collating such data is primarily to analyse trends and seek improvements within clinical areas which may be experiencing issues with training compliance and high staff turnover.
2.19 Each reported incident is diligently followed up and learning post-incidents implemented.

2.20 Since the last progress report the DI has submitted two HTARIs reports in December 2025 which are currently being assessed by the HTAuth subject to departmental internal investigation. This process can take up to eight weeks.

2.21 One of these potential HTARIs is related to a loss of two tissue slides and the other to a consent issue.

2.22 In relation to the reporting trend of incidents the leading two categories are reports regarding the adult deceased, followed by PLRs.

2.23 The majority of incidents relate to incomplete or incorrect paperwork from clinical areas.

Welsh Government Guidelines for Community Body Stores

2.24 Welsh Government has published interim recommendations to Health Boards in Wales following the Fuller Inquiry Phase 1 in 2021.

2.25 Welsh Government recommended to Health Boards that there should be a plan to consolidate the management of the body stores into Mortuary services.

2.26 Both YCC and YCR do not require a separate HTA Licence as there is no storage of relevant material or scheduled activity as defined by the HTA (2004), however it is important that these body stores are maintained to a high standard.

2.27 To ensure high standards at these community hospital body stores a plan is in place via a Memorandum of Understanding between Pathology, Facilities, Nursing, Estates and Hospital Management.

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

2.29 It is proposed that the Pathology Directorate will have overall responsibility of standards with the support of the DI, a similar set up to the main HTA licenced sites.

2.30 Since November 2025 a three month pilot project of consolidation has commenced at both YCC and YCR with a view to permanent transfer to Mortuary services.

2.31 Nursing staff are now responsible for the transfer of the deceased to Funeral Directors to ensure there is a safe and dignified handover.

2.32 Mortuary staff will attend each site once a week to undertake cleaning, quality assurance audits and security checks.

2.33 An evaluation will be led by the DI at the end of January 2026.

Fuller Inquiry Phase 2 Report

2.34 Welsh Government has requested that Health Boards assess their status against the recent Fuller Inquiry Phase 2 report and advise their Executives accordingly. The Corporate Licence Holder requested the Designated Individual to lead this work

2.35 There are 75 recommendations within the Phase 2 Report of which 22 relate to NHS Hospitals.

2.36 Following an assessment it was concluded that the Health Board already meets most of the recommendations and others identified are generally low risk.

2.37 Where there are two recommendations assessed as *'low to medium'* risk these related to the on-going update programme at Community Hospital Body Stores, which aims to resolve a number of shortfalls.

3. Key Risks / Matters for Escalation

3.1 There are no key risks or matters for escalation.

4. Assessment

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

Impact Assessment

Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Compliance is statutory and longstanding.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): 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)	
	HTA Compliance at POW/RGH/PCH is a legal requirement and the Designated Individual has primary legal responsibility under Section 18 of the Human Tissue Act (2004)	
Enw da / Reputational	Yes (Include further detail below)	
	Non-compliance with the HTA is a reputational risk for the Health Board.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	There is Capital Planning resource impact following the DIs assessment of the Fuller Inquiry Phase 2 recommendations. These relate to additional CCTV cameras (3) and upgrading the electronic access at the POW mortuary.	

5. Recommendation

5.1 The paper is for discussion and **NOTING**.

6. Next Steps

6.1 Continue to implement the governance framework key themes to maintain compliance with the Human Tissue Act (2004).

6.2 Implement HTA standards within the YCC and YCR body stores through consolidation within mortuary services.

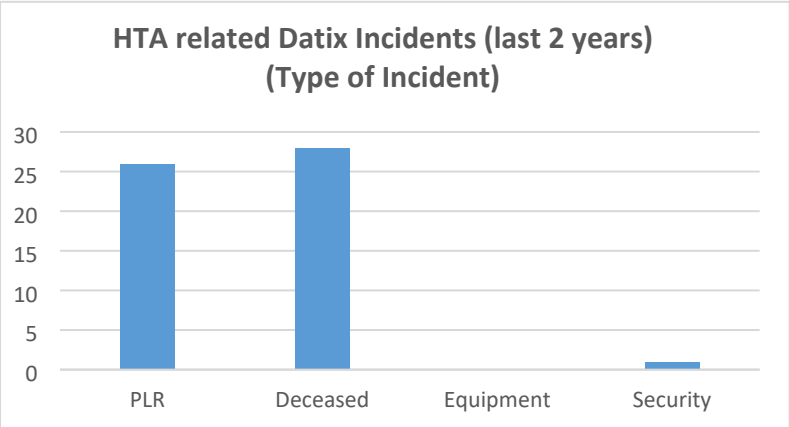
APPENDIX 1

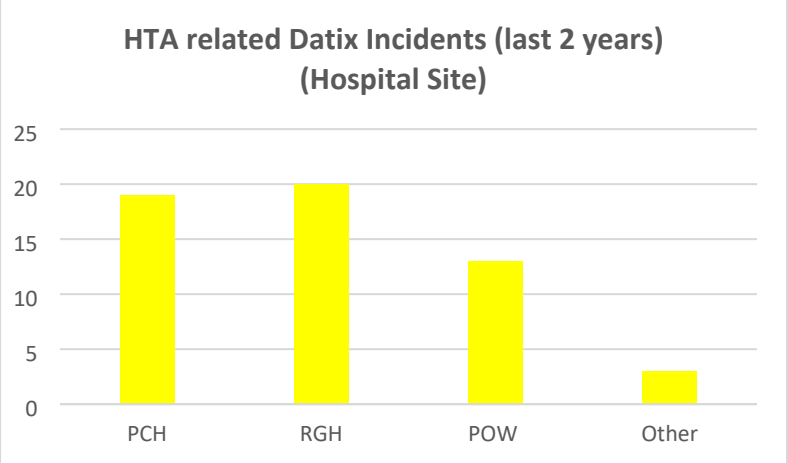
2025-09-03 12338
Royal Glamorgan Hos

APPENDIX 2

Table 1 – HTA related Datix incidents over 2 year period 23/24 to 25/26

		PLR	Deceased	Equipment	Security	PCH	RGH	POW	Other	TOTAL	HTARI	Near-Miss
2023/24	Q4	6	3	0	0	4	3	1	1	**9**	0	2
2024/25	Q1	0	5	0	0	0	1	4	0	**5**	0	1
	Q2	4	4	0	1	3	2	4	0	**9**	0	2
	Q3	5	3	0	0	5	2	0	1	**8**	0	0
	Q4	4	2	0	0	4	2	0	0	**6**	0	0
2025/26	Q1	1	2	0	0	1	2	0	0	**3**	0	0
	Q2	2	2	0	0	0	2	1	1	**4**	0	0
	Q3	4	7	0	0	2	6	3	0	**11**	0	0
		26	**28**	**0**	**1**	**19**	**20**	**13**	**3**	**55**	**0**	**5**





Inspection report on compliance with HTA licensing standards
Inspection date: **3 and 4 September 2025**

Royal Glamorgan Hospital

HTA licensing number 12338

Licensed under the Human Tissue Act 2004

Licensed activities

The table below shows the activities this establishment is licensed for and the activities currently undertaken at the establishment.

Area	Making of a post-mortem examination	Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation	Storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose
Hub site **Royal Glamorgan Hospital**	Licensed	Licensed	Licensed
Mortuary	*Carried out*	*Carried out*	*Carried out*
Pathology lab	-	-	*Carried out*
Satellite site **Prince Charles Hospital**	Licensed	Licensed	Licensed
Mortuary (satellite site)	*Carried out*	*Carried out*	*Carried out*

Satellite site **Princess of Wales Hospital**	Licensed	Licensed	Licensed
Mortuary (satellite site)	*Carried out*	*Carried out*	*Carried out*

Summary of inspection findings
The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation.

Royal Glamorgan Hospital ('the establishment') was found to have met all HTA standards.

The HTA has assessed the establishment as suitable to be licensed for the activities specified.

Compliance with HTA standards
All applicable HTA standards have been assessed as fully met.

Advice
The HTA advises the DI to consider the following to further improve practice:

Number	Standard	Advice
1.	GQ2(c)	The DI is advised to continue his review of arrangements for the ongoing storage of blocks and slides.
2.	GQ4(a)	The DI may wish to investigate the introduction of an electronic register system. This will reduce the use multiple paper documents across three sites, reduce the risk of transcription errors and aid traceability.

3.	PFE1(a)	The DI is advised to monitor the condition of bench legs, and the autopsy saw at the hub site. These items are showing early signs of deterioration but were compliant with HTA standards at the time of inspection.
4.	PFE1(d)	The DI should undertake a review of power supplies to the outside storage units and consider actions to enhance the security of plant equipment at Royal Glamorgan Hospital.
5.	PFE3(c)	The DI is advised to monitor the condition of the ventilation unit at the hub site. A recent engineers report has noted at the time of inspection it is functional but at end of its serviceable life.
6.	PFE2(e)	The DI is advised to arrange for testing of temperature alarms out of hours to ensure the documented escalation process is embedded.
7.	General	The DI may wish to review the current arrangements for primary mortuary service provision at the Royal Glamorgan. Whilst the Mortuary is in serviceable condition, the facilities are limited and will require future investment to maintain compliance with HTA standards.
8.	General	The Mortuary at Princess of Wales site has discontinued post mortem service provision. The DI may wish to review licencing arrangement for this site.

Background

Royal Glamorgan Hospital and it's two satellite sites, Prince Charles Hospital and Princess of Wales Hospital, are licensed for the making of a PM examination, removal of relevant material from the deceased and storage of bodies of the deceased and relevant material for use for scheduled purposes.

Royal Glamorgan Hospital has been licensed by the HTA since November 2007. This was the seventh inspection of the establishment; the most recent previous inspection took place in February 2023.

Since the previous inspection, post mortem services have ceased at the Princess of Wales Hospital.

Description of inspection activities undertaken
The HTA's regulatory requirements are set out in Appendix 1. The inspection team covered the following areas during the inspection:

Standards assessed against during inspection
All 72 HTA licensing standards were covered during the inspection (standards published 3 April 2017).

Review of governance documentation
The inspection team reviewed documentation on site and submitted after the inspection. Standard operating procedures, risk assessments and policies were reviewed. Audit schedules, competency records, cleaning record forms and meeting minutes were inspected as part of the review process.

Visual inspection
The inspection included a visual assessment of the body storage areas in the mortuary, PM room, viewing room, and tissue storage areas at the hub site. The inspection team observed the processes for release of bodies within the mortuary. Visual assessments of the body storage areas in the mortuary and viewing room were made at both satellite sites.

Audit of records
A traceability audit of four bodies in storage was undertaken at the hub site. The audit included bodies from both the community and hospital with same and similar names and one in long-term storage. Details were cross-checked against identity bands and the mortuary register. No discrepancies were found.

A traceability audit of three bodies in storage was undertaken at the Prince Charles Hospital satellite site. This included bodies from the hospital including those with same and similar names and one in long-term storage. Details were cross-checked against identity bands and the mortuary register. No discrepancies were found.

A traceability audit of four bodies in storage was undertaken at the Princess of Wales Hospital satellite site. This included bodies from the hospital including those with same and similar names. Details were cross-checked against identity bands and the mortuary register. No discrepancies were found.

Audits were conducted of tissue taken at post mortem examination for ten cases. Information was cross-checked between the mortuary electronic database, Coroner's paperwork, family wishes forms, the laboratory database, and tissue blocks and slides being stored. No discrepancies were found.

Meetings with establishment staff
The inspection team conducted interviews with staff carrying out processes under the licence. This included the Designated Individual, Trainee APT, Quality Manager, Bereavement Midwife and Porter.

Report sent to DI for factual accuracy: 16 September 2025

Report returned from DI: 16 September 2025

Final report issued: 16 September 2025

Appendix 1: The HTA's regulatory requirements

Prior to the grant of a licence, the HTA must assure itself that the DI is a suitable person to supervise the activity authorised by the licence and that the premises are suitable for the activity.

The statutory duties of the DI are set down in Section 18 of the Human Tissue Act 2004. They are to secure that:

- the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity;
- suitable practices are used in the course of carrying on that activity; and
- the conditions of the licence are complied with.

Its programme of inspections to assess compliance with HTA licensing standards is one of the assurance mechanisms used by the HTA.

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. They are grouped under four headings:

- consent
- governance and quality systems
- traceability
- premises facilities and equipment.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that there has been a shortfall against a standard, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is provided.

HTA inspection reports are published on the HTA's website.

Appendix 2: Classification of the level of shortfall

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as ‘Critical’, ‘Major’ or ‘Minor’. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the Human Tissue Act 2004 (HT Act) or associated Directions.

1. **Critical shortfall:**

   A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the HT Act or associated Directions

   or

   A combination of several major shortfalls, none of which is critical on its own, but which together could constitute a critical shortfall and should be explained and reported as such.

   A critical shortfall may result in one or more of the following:

   - A notice of proposal being issued to revoke the licence
   - Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
   - A notice of suspension of licensable activities
   - Additional conditions being proposed
   - Directions being issued requiring specific action to be taken straightaway

2. **Major shortfall:**

   A non-critical shortfall that:

   - poses a risk to human safety and/or dignity, or
   - indicates a failure to carry out satisfactory procedures, or

- indicates a breach of the relevant Codes of Practice, the HT Act and other relevant professional and statutory guidelines, or
- has the potential to become a critical shortfall unless addressed

or

A combination of several minor shortfalls, none of which is major on its own, but which, together, could constitute a major shortfall and should be explained and reported as such.

In response to a major shortfall, an establishment is expected to implement corrective and preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

3. **Minor shortfall:**

   A shortfall which cannot be classified as either critical or major, but which indicates a departure from expected standards.

   This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk based review or at the time of the next inspection.

   In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with both the draft and final inspection report. Establishments must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine inspection.

After an assessment of the proposed action plan establishments will be notified of the follow-up approach the HTA will take.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
8.2.4

Quality, Safety & Experience Committee

RADAR COMMITTEE REPORT

Dyddiad y Cyfarfod / Date of Meeting	20/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Dr Richard Jones, Clinical Lead for Resuscitation and Acute Deterioration Vanessa Jones, interim Lead Nurse for Resuscitation, Acute Deterioration and outreach services FOR NOTING
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Committee / Group / Individuals	Date	Outcome
Executive Leadership Group		APPROVED
RADAR committee	11/11/2024	NOTED

Acronyms / Glossary of Terms

RADAR	Recognition of Acute Deterioration and Resuscitation
NEWS	National Early Warning Score
PEWS	Paediatric Early Warning Score
MEWS	Maternity Early Warning Score
NEWTT	Newborn Early Warning Track and Trigger

1. Situation /Background

1.1 To provide the Quality, Safety & Experience Committee with a high-level overview of governance, performance, and strategic priorities for the Recognition of Acute Deterioration and Resuscitation (RADAR) Committee across CTMUHB during 2025

1.2 RADAR underpins CTMUHB's commitment to safe, timely, and effective care for patients at risk of acute deterioration and cardiac arrest. This report highlights:

- Governance and leadership progress.
- Education and quality improvement initiatives.
- Assurance data and benchmarking.
- Future priorities and risks requiring escalation

2. Specific Matters for Consideration

To note the Governance and quality response:

2.1 Key Achievements

2.1.1 Leadership Strengthened: Appointment of Clinical Lead (Medical), Interim Lead Nurse for RADAR, and Interim Senior Nurse for Acute Deterioration & Outreach. However, this structure is temporary, and funding will not continue into the next financial year unless resource agreed.

2.1.2 24/7 Outreach Service: Sustained across all acute sites, though resilience remains fragile (single practitioner per shift).

2.1.3 System-wide Implementation: New Early Warning Scores for Neonates, Children, Adults, and Obstetric patients rolled implemented as per Welsh Health Circular.

2.1.4 National Benchmarking: Enrolled in the National Cardiac Arrest Audit for comparative performance data.

2.1.5 Policy Updates: New NEWS2 & Escalation Policy drafted; Resuscitation Policy implemented.

2.2 Acute Deterioration Processes

2.2.1 RADAR is working toward the requirements of the Welsh Health Circular on Patient and Family Initiated Escalation.

2.2.2 Embedding of the All-Wales Treatment Escalation Plan (TEP) continues across the Health Board, however progress is slow due to a lack of a

dedicated workstream for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and TEP.

2.2.3 RADAR is working on the requirements of the latest Welsh Health Circular on Safety netting discharge leaflets for adults and children with confirmed or suspected infection

2.3 Outcomes and assurances

2.3.1 Regular audits on NEWS2/PEWS/MEWS/NEWTT2 compliance, Rapid Responses, and Cardiac Arrest reviews.

2.3.2 Feedback loops established with Care Groups to drive improvement in areas identified from EWS audits, rapid responses and cardiac arrest reviews which highlight the ongoing need for a workstream dedicated for DNACPR and Treatment Escalation Planning

2.3.3 Standard Operating Procedures maintained for Outreach teams

3. Key Risks / Matters for Escalation

3.1 Structural Risks

3.1.1 Training Infrastructure

Limitations in dedicated training space—particularly at RGH—are restricting delivery of essential Acute Deterioration and Resuscitation education, directly impacting staff competency and patient safety. Some mitigation measures include use of Glanrhyd hospital as a base for training however this does impact on staff travel and resuscitation team presence on RGH site.

3.1.2 Data & Informatics

Gaps in informatics support and analysis preventing timely, meaningful performance reporting, undermining assurance and the ability to drive targeted improvements. Mitigation includes RADAR leads accessing and interpreting data which is both time consuming and limits meaningful reporting.

3.1.3 Training Compliance

Resuscitation training faces a 6-16% Did Not Attend (DNA) rate across all courses this is compounded by poor staff preparation leading to course cancellations—creating a significant risk to clinical readiness and patient outcomes. Adequate pre-course information is provided to staff, and quarterly feedback is provided to care group leads through QSRE meetings to ensure attendance, but DNA rates and staff preparedness is still impacted.

3.1.4 **System Barriers**

Persistent ESR misalignment with competency frameworks compromises accurate compliance reporting, making it difficult to assure workforce capability and meet statutory requirements. Plans are in place to ensure that there is better alignment of competency requirements with resuscitation through ESR.

3.1.5 **Advance Care Planning**

Urgent need for a dedicated governance workstream to address DNACPR and Treatment Escalation Planning—identified as recurring themes in cardiac arrest reviews and escalation incidents.

3.1.6 **Administrative Support**

Lack of administrative resource/business support for RADAR is hampering effective planning, tracking of actions, and delivery of improvement programmes.

3.1.7 **Fragile Outreach Resource**

Current outreach provision is critically under resourced, operating with minimal staffing per shift. This fragility poses high-risk to patient safety, as it compromises timely identification, escalation, and response to acute deterioration. Additionally, it severely limits the delivery of essential education programs designed to prevent deterioration, creating a systemic vulnerability that could lead to increased adverse events, poorer outcomes, and reputational risk for the Health Board

3.1.8 **Clinical Safety and Service Resilience Risks**

There is a growing concern regarding the alignment of demand and capacity within emergency response teams, which is impacting patient safety and quality of care. These concerns have been fed back to the Unscheduled Care Group to review alongside RADAR.

Key areas of risk include:

Rapid Response Capacity: Current staffing and resource allocation are not always consistent for the demand for urgent clinical interventions, leading to delays in escalation and treatment. To address this emergency teams, call rates and outcomes are currently being reviewed.

Cardiac Arrest Leadership: Observed deficiencies in leadership during cardiac arrest events, resulting in variability in team coordination and adherence to best practice standards. To address this, plans are in place to

introduce simulation-based training for team leaders and resuscitation teams

Timely Sepsis Management: Delays in recognition and initiation of sepsis bundles, increasing the risk of avoidable harm and mortality. To mitigate this risk a *CTM sepsis group* has been generated with the objective of implementing a standardised approach to the recognition, escalation and management of Sepsis across the Health Board in the three areas of Adults, Paediatrics and Maternity.

Advance Care Planning: Need for a better systematic approach to advance care planning, as without it contributes to potential inappropriate escalation and interventions that may not align with patient wishes or clinical appropriateness.

3.1.9 Key areas that need recognition within CTM:

- Role of a RADAR Clinical Lead and Lead Nurse for Resuscitation Acute Deterioration and Outreach services to drive improvement in this area through RADAR approach.
- Essential role that the Outreach teams have in both the response to Acute Deterioration and in delivering education to reduce the impact of Acute Deterioration on the patient and on the Health Board.
- Importance of good quality training in Resuscitation to ensure as good an outcome as is possible following Cardiac Arrest
- Need to focus on the quality issues around DNACPR, Treatment Escalation and Advance Care Planning.

4. Assessment

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

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Inability to provide essential acute deterioration training due to fragility within the outreach services could impact on increased adverse incidences	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Under resourced emergency teams could impact on timely response and poorer outcomes	

5. Recommendation

That Quality, Safety and Experience Committee:

5.1 NOTE the content of this report.