Quality, Safety & Experience Committee

Tuesday 21 July 2026, 09:00 - 12:00

Virtually via Microsoft Teams

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Committee Chair*

09:05 - 09:05
0 min

2. CONSENT AGENDA BUSINESS

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

09:05 - 09:25
20 min

3. GOVERNANCE/COMMITTEE BUSINESS ACTIVITY

3.1. Action Log

Discussion *Carolyn Donoghue, Committee Chair*

3.1 Action Log QSEC 21st July 2026 (v1).pdf (3 pages)

3.2. Matters Arising not Contained within the Action Log

Discussion *Carolyn Donoghue, Committee Chair*

3.3. Committee Annual Self Effectiveness Survey Outcome 2025-6 & Improvement Plan

Discussion *Carolyn Donoghue, Committee Chair*

3.3 QSEC_Cmt Self-Effectiveness QSEC 21 July 2026.pdf (6 pages)

3.4. Annual Review of the Committee Terms of Reference

Discussion *Carolyn Donoghue, Committee Chair*

3.4a QSEC TOR Cover Report Template QSEC 21 July 2026.pdf (4 pages)
3.4b GC01 Standing Orders - Schedule 3.5a - QSEC ToR 21 July 2026.pdf (13 pages)

09:25 - 11:15
110 min

4. IMPROVING CARE

4.1. Shared Listening & Learning Story - Falls Prevention in the Community

Discussion *Nia Giles, Physiotherapist*

4.2. Thematic Spotlight Presentation - Hospital at Home

Discussion *Lucie Owen, Nurse Director, Primary Care and Communities*

4.2. Hospital at Home QSEC 21 July 2026.pdf (16 pages)

4.3. Thematic Spotlight Presentation - Nutrition & Catering

Discussion *Stephen Gardiner, Facilities Service Director*

4.3. QSEC Presentation - Patient Centred Care - Food Hydration - July 2026 rev1.pdf (6 pages)

4.4. The path to safer beginnings in Wales A national assurance assessment of Maternity and Neonatal Care Services (Holland 2026)

Discussion *Debbie Jones, Head of Midwifery*

4.4 A Path to Safer Beginnings in Wales QSEC 21 July 2026.pdf (7 pages)

4.5. Sexual Health Safeguarding Issues - Closure Report

Discussion *Claire O'Keefe, Head of Safeguarding*

4.5. Sexual Health Safeguarding Issues - Closure Report-Approved.pdf (8 pages)

4.6. Patient Boarding within CTM UHB, Quality, Safety and Strategic Position

Discussion *Richard Hughes, Executive Director of Nursing*

4.6 Patient Boarding within CTM UHB QSEC 21 July 2026.pdf (8 pages)

11:15 - 11:25
10 min

Comfort Break

11:25 - 11:55
30 min

5. CREATING HEALTH

5.1. Infection, Prevention & Control Annual Report 2025-2026

Discussion *Richard Hughes, Executive Director of Nursing*

5.1a IPC_Annual_Report_2025_26_QSEC_Cover QSEC 21 July 2026.pdf (8 pages)
5.1b IPC Annual report 2025 - 2026-BG QSEC 21 July 2026.pdf (80 pages)

11:55 - 12:00
5 min

6. CONSENT AGENDA

6.1. FOR APPROVAL

6.1.1. Unconfirmed Minutes from the meeting held on 3 June 2026

Decision *Carolyn Donoghue, Committee Chair*

6.1.1 Unconfirmed Minutes Public QSEC 3rd June 2026 Final QSEC 21 July 2026.pdf (13 pages)

6.1.2. Unconfirmed Minutes from the In Committee held on 3 June 2026

Decision *Carolyn Donoghue, Committee Chair*

6.1.2 Unconfirmed Minutes 3rd June In Committee QSEC final QSEC 21 July 2026.pdf (2 pages)

6.2. FOR NOTING

6.2.1. Non Routine Committee Business (Forward Plan)

Information *Carolyn Donoghue, Committee Chair*

6.2.1 CTMUHB QSEC Non Routine Bus QSEC 21 July 2026.pdf (3 pages)

6.2.2. Annual Cycle of Business

Information *Carolyn Donoghue, Committee Chair*

6.2.2 QSEC Cycle of Business 21 July 2026.pdf (9 pages)

6.2.3. Controlled Drug Accountable Officer (CDAO) Report: April 2025 – March 2026

Information *Dom Hurford, Executive Medical Director*

6.2.3 CDAO Annual Report 2025-26 QSEC 21 July 2026.pdf (12 pages)

6.2.4. National Prescribing Indicators

Information *Dom Hurford, Executive Medical Director*

6.2.4 National Prescribing Indicators report June 2026 QSEC 21 July 2026.pdf (9 pages)

6.2.5. Human Tissue Act Compliance Report

Information *Dom Hurford, Executive Medical Director*

6.2.5 HTA compliance Progress Report QSEC 21 July 2026.pdf (9 pages)

6.2.6. Organ Donation Sub Committee Highlight Report

Information *Dom Hurford, Executive Medical Director*

6.2.6 Organ Donation Sub Committee Highlight Report QSEC 21 July 2026.pdf (5 pages)

6.2.7. Clinical Audit Update – for Awareness on Clinical Outcomes from Audits Report (January – June 2026)

Information *Dom Hurford, Executive Medical Director*

6.2.7 Clinical Audit Update QSEC 21 July 2026.pdf (8 pages)

⚠ The following items exceed the meeting time which ends at 12:00.

12:00 - 12:05
5 min

7. CLOSE OUT BUSINESS

7.1. Committee Highlight Report to the Board

Discussion *Corporate Governance Lead*

7.2. 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?

7.3. Any Other Business

Discussion *Carolyn Donoghue, Committee Chair*

12:05 - **12:05**
0 min

8. Private/Closed Session Business

Information *Carolyn Donoghue, Committee Chair*

There are no matters requiring discussion in closed session on this occasion

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12:05 - **12:10**
5 min

9. Date & Time of Next Meeting

Information *Carolyn Donoghue, Committee Chair*

Tuesday 22 September 2026 at 9:00am

Committee Action Log

Name of Meeting: Quality, Safety & Experience Committee
Committee Chair: Carolyn Donoghue, Independent Member

Date of meeting the action originated from	Minute Item reference	Minute Reference Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
3rd June 2026									
03.06.2026	4,1	4	Executive Director and Independent Member Quality & Safety Walkabouts	The Executive Director and Independent Member Quality & Safety Walkabouts report to be amended to highlight the IT issues identified during the walkabout.	Executive Director of Nursing	Executive Director of Nursing	21st July 2026	Proposed to close	Proposed for Closure IT issues that were identified during the walkabout have been noted and included in the report submitted to QSEC in June 2026
03.06.2026	4,2	5	Highlight Report for People's Experience Activity Report – February – April 2026	Consider how patient experience themes and feedback can be more captured and aligned to Committee agendas and strategic risks, including the potential development of a repository of patient stories.	Executive Director of Nursing	Executive Director of Nursing	21st July 2026	Open	**In Progress** The Head of Peoples Experience together with the Interim Assistant Director of Nursing are exploring ways which would be most beneficial for the use of patient stories and how these are more aligned to patient experience themes and feedback, including revisiting the development of a repository of patient stories across the helath board. An update will be provided in the Peoples Experience report for Septembers QSEC meeting
03.06.2026	4,3	5	Report from the Clinical Executives	A paper on multi-professional workforce challenges, including training, commissioning and retention, to be added to the forward work programme.	Executive Director of Nursing	Executive Director of Nursing	21-jul-26	Proposed for Closure	**Proposed for Closure** This has been added to the Forward Work Programme for the September 2026 meeting
03.06.2026	4,3	5	Report from the Clinical Executives	An update on the ongoing Bare Below the Elbows (BBE) / PPE behavioural change programme to be provided, including details of training, auditing and monitoring arrangements.	Executive Director of Nursing	Executive Director of Nursing	21st July 2026	Open	**In Progress** A full update on training, auditing and continuous monitoring which will include behaviours to PPE will be provided in Septembers Clinical Exec update report
03.06.2026	4.4.3	10	Primary Care & Community	To escalate the risks associated with Welsh Government GP contract negotiations through the QSEC highlight report to Board.	Care Group Primary Care & Community	Executive Director of Nursing	21st July 2026	Proposed for Closure	**Completed** This has been included in the alert/escalate section of the Highlight Report that is being presented to the Public Board meeting on 30 July 2026
03.06.2026	4.4.3	10	Primary Care & Community	To include a breakdown of patient numbers in future reports, distinguishing between standard and complex cases within paediatric dental GA waiting times to provide clarity on waiting time pressures.	Care Group Primary Care & Community	Executive Director of Nursing	22-sep-26	Open	**In progress** The team will be asked to ensure this is included in their Care Group Highlight report for the September 2026 meeting
03.06.2026	4.4.4	10	Mental health & leanring Diabilities	Feedback and lessons learned to be circulated from the Police and Crime Commissioner.	Executive Director of Public Health	Executive Director of Nursing	21st July 2026	Open	**In Progress** The Police and Crime Commissioner (PCC) commissioned provider, Dr PA, is still awaiting approval from the Health Inspectorate Wales (HIW). HIW are undertaking site visits on the 6,7,8 of July. After this process is completed, the PCC will be undertaking a lessons learned process, which will be shared.
03.06.2026	4,5	15	Quality Dashboard	Listening to People Framework be considered as a Board Development session	Head of Corporate Governance & Board Business	Executive Director of Nursing	Was 25/06/2026	Open	**In progress** This was scheduled for discussion at the Board Development session planned for the 25 June. The session was stood down and a revised date for presentation is in the process of being explored
24th March 2026									
24.03.2026	4,3	6	Thematic Spotlight Presentation - Winter Wrap Up	Summarise the emerging themes from the winter wrap up and bring back a high level follow up	Executive Director of Nursing	Executive Director of Nursing	22/07/2026 **Now 22 September 2026**	Open	**In progress** June 2026 update A summary of the emerging themes from the Winter Wrap up are being progressed by the Head of Infection Prevention & Control and presented to the IPC Committee and then to QSEC for assurance, this was scheduled for presenting at the July QSEC meeting but has now been deferred to the meeting taking place on 22 September 2026
24.03.2026	4,3	6	Thematic Spotlight Presentation - Winter Wrap Up	Consideration to be given as to whether the Winter Pressures Wrap up should be presented on an annual basis.	Executive Director of Nursing	Executive Director of Nursing	22/07/2026 **Now 22 September 2026**	Open	**In progress** June 2026 update. There will be an opportunity for this to be discussed and agreed at the September QSEC meeting linked to action above
24.03.2026	4.5.2	8	Planned Care	A further ophthalmology update to be brought to a future meeting given the interest and importance of the Audit Wales Eye Care review.	Executive Director of Nursing	Sharon O'Brien	22-sep-26	Open	**In progress** A discussion will be held at the next agenda planning a session as to whether the Committee Chair and Exec Lead would welcome an update on this at the September 2026 meeting
24.03.2026	4,9	12	CTMUHB's NHS Research & Development Framework Assessment 2026	Formal feedback to be provided at future meeting from the Welsh Government Annual review	Executive Director of Allied Health Professionals and Health Science	Research & Development Manager	03/06/2026 **Now 29 July 2026**	Open	**In Progress** The annual review meeting with Welsh Government is scheduled for 29th July2026. Feedback from WG is expected to be provided at this meeting.
20th January 2026									
20.01.2026	4,1	4	Listening & Learning Story Alcohol Services	Lessons Learnt report to be shared with Committee Members for information and awareness once completed.	Assistant Director of Value & Efficiency	Executive Director of Nursing	30-apr-26	Proposed for Closure	**Completed** Lessons learnt shared with members via email on 22nd May 2026.
20.01.2026	7,2	10	Clinical Effectiveness Update 2025-2026	Review the current reporting structure in relation to clinical audit to provide stronger audit outcomes along with a revised terms of reference.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	21-jul-26	Proposed for Closure	**Completed** A review was undertaken and the report on the agenda for the July meeting now includes stronger audit outcomes and findings

Committee Action Log

Name of Meeting: Quality, Safety & Experience Committee
Committee Chair: Carolyn Donoghue, Independent Member

Date of meeting the action originated from	Minute Item reference	Minute Reference Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	WAST produced Quality Report to be shared with Members at future meetings of the Committee to help Independent Members to triangulate data between WAST and the Health Board	Executive Director of Nursing	Executive Director of Nursing	20/05/2025 Now 22/07/2025 Now November 2025	Closed	Completed June 2026 update - further to the update from March QSEC, this action has been further responded to by the EDN in the Clinical Executives Update report. It is therefore proposed to close this action
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	Executive Director of Nursing	TBC	Closed	Completed June 2026 update-work is ongoing reaching the wider population by use of digital platforms. With the launch of badgernet, which came into effect for all new pregnancies in CTM from the 17th March 2026. Gestation relevant information will be shared via the badgernet app. In addition, information will continued to be shared via social media pages.
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.	Closed	**Completed** June 2026 update- The reporting routs for Nutrition and Hydration activity is through the Harm Free Care Group , reporting to the newly developing Quality & Safety Group which then reports to the Harm Free Strategic Oversight Group which will provide a highlight report on all workstreams to the QSEC meetings commencing from September 2026 due to the first Quality & Safety meeting anticipated to take place in July 2026. QSEC members have previously received a highlight report to date on the Harm Free Care Group and a further update is included for the June meeting together with the new meeting and assurance groups i.e. Quality & Safety group and the Harm Free Care Strategic Oversight Group.
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	Executive Director of Nursing	20/01/2026 **Now May 2026**	Closed	**Completed** June 2026 update - The June QSEC People's Activity Report includes an update on the PALS service, providing assurance on current activity and oversight arrangements. Further development of assurance mechanisms and the actions taken in response to PALS queries will be strengthened through the establishment of the new Quality & Safety Group, which is currently in development and scheduled to be operational by July 2026. This group, will be chaired by the Assistant Director of Quality & Safety and will provide enhanced oversight of key quality and safety metrics. This includes a strengthened focus on the prevention of harm, systematic learning from people's experience and feedback, and improved organisational sharing of learning arising from PALS activity. A progress update on the implementation of the Quality & Safety Group, alongside the development of the Harm Free Care Strategic Oversight Group, is included within the June QSEC papers for assurance. Propose to close this action
20.01.2026	6,1	10	Patient Safety, Quality & Experience Dashboard	In relation to Ombudsman cases, further consideration would need to be given to the recommendation contained within the report that stated that actions would need to be monitored via this Committee with further consideration to be given to the format this would be presented in.	Executive Director of Nursing	Executive Director of Nursing	24-mar-26	Closed	**Completed** June 2026 update - further to the action noted above where it has been previously reported that a monthly report is delivered to EMB as a standing agenda item, there is an additional group in place which is The Deputy Executives Meeting' which is led by the Deputy COO. The Ombudsman action plan will be monitored via this group (Deputy Execs) and then reported up to EMB for assurance and any required Executive escalation and awareness.
20.01.2026	6,1	10	Patient Safety, Quality & Experience Dashboard	More analysis to be provided on the Ombudsman report of how learning and improvement are presented	Executive Director of Nursing	Executive Director of Nursing	24-mar-26	Closed	**Completed** June 2026 Update - OCP has now concluded and the process of implementation has commenced with effect of 5th May 2026 with an expectation for all posts that require recruiting into to be complete by July 2026. Within the OCP structure is a NEW and specific post for a Clinical Governance and Learning Advisor who will ensure that all the learning is shared across the organisation and improvements made where appropriate. The Public Services Ombudsman for Wales has commenced an 'Own Initiative investigation' and evidence has been submitted to start the investigation and is managed by the Executive Director of Nursing, Midwifery & Patient Care with regular updates and feedback to the CEO. This investigation is being managed through EMB directly and will again form regular reporting and monitoring via the Deputy Executive meeting)
20.01.2026	8.1.6	11	IM and Exec Walkabouts Operating Model	Timelines to be reviewed in relation to a proposed go live date of the new IM and Exec Walkabouts Operating Model.	Executive Director of Nursing	Executive Director of Nursing	24-mar-26	Closed	**Completed** June 2026 update. The New IM Walkabouts Operating Model went live from January 2026. A briefing report has been submitted for June QSEC on the activity taken place from January - end May 2026.
24.03.2026	3,1	2	Action log	Action log item 5.1 to be reviewed further outside the meeting	Executive Director of Nursing	Executive Director of Nursing	3rd June -26	Closed	**Completed** June 2026 update. Action 5.1 and this action (3.1) are proposed to close. WAST no longer produce the data set that was previously received per organisation and regular updates will be reported through the Care group highlight reports. *Please see update in action 3.1 - Propose to close both action 5.1 and 3.1
24.03.2026	4,6	10	Quality Dashboard report	Regulation 28 report to be circulated	Executive Director of Nursing	Assistant Director of Quality & Safety	3rd June -26	Closed	**Completed** Regulation 28 Report circulated by email to Members on 29 May 2026
24.03.2026	4,6	10	Quality Dashboard report	To receive further clarification on NRI levels in the Children & Families Care Group Highlight report at the next meeting	Executive Director of Nursing	Assistant Director of Quality & Safety	3rd June -26	Closed	**Completed** Additional information on NRI levels circulated to Members by email on 29 May 2026

24.03.2026	4,6	10	Quality Dashboard report	To review restrictive practices, including their planning and appropriateness, with the MHLD Care Group, and provide feedback through future reporting.	Executive Director of Nursing	Assistant Director of Quality & Safety	3rd June -26	Closed	**Completed** An update has been included in the Mental Health & Learning Disabilities Csre Group Highlight report for the June 2026 meeting
24.03.2026	4,6	10	Quality Dashboard report	To provide an update to the Committee and Independent Members on the outcomes of discussions with the Public Services Ombudsman for Wales regarding concerns over delayed redress cases.	Executive Director of Nursing	Assistant Director of Quality & Safety	3rd June -26	Closed	**Completed** A report on Redress Case Management is included on the agenda for the June 2026 meeting
24.03.2026	4,7	10	Quality Dashboard report	Consideration be given by members to specific questions relating to the tracker so they can be addressed at the next committee	Executive Director of Nursing	Executive Director of Nursing	3rd June -26	Closed	**Completed** June 2026 update-specific questions received in relation to the tracker will be considered and a response will be provided either outside of the meeting or addressed at the time of the QSEC meeting
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	Closed	**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	Closed	**Completed** An update on this has been included in the report being presented to the January Committee
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	Closed	**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
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	Closed	**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	Closed	**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	Closed	**Completed** Addressed in the Patient Safety and Quality Dashboard for January's Committee.
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	Consideration to be given outside the meeting on the frequency of reporting on this matter to future Committee meetings. Deputy Director of Nursing to discuss further with Committee Chair to determine the level of information required moving forwards	Committee Chair	Executive Director of Nursing	25/03/2025 Now 22/07/2025 Now November 2025 **Now January 2026**	Closed	**Completed** Being proposed for closure once again due to further improvements in performance and compliance.
22.07.2025	6,1	13	Patient Safety, Quality & Experience Dashboard	Response to be provided outside the meeting regarding inconsistencies reported in figure contained in paragraph 2.2 regarding number of incidents reported compared to bar chart graph contained later in the report	Head of Concerns & Business Intelligence	Executive Director of Nursing	23.09.2025	Closed	**Completed** Executive Director of Nursing has confirmed that he has discussed the context of this action with the Committee Chair and is proposing this action for closure
20.01.2026	5,3	6	Clinical Executives Report	Winter Wrap up Report to be presented to the March meeting	Executive Director of Nursing & Chief Operating Officer	Executive Director of Nursing & Chief Operating Officer	24-mar-26	Closed	**Proposed for Closure** Report is on the agenda for discussion at the March 2026 meeting
20.01.2026	5,3	6	Clinical Executives Report	Breakdown of the roles and responsibilities of the Health Board and other agencies in relation to Substance Misuse services to be submitted to the Executive Board.	Executive Director of Public Health	Executive Director of Public Health	23-mar-26	Closed	**Proposed for Closure** Mapped breakdown being presented to the Executive Leadership Group taking place on 23 March 2026.
20.01.2026	5,3	6	Clinical Executives Report	Breakdown of the roles and responsibilities of the Health Board and other agencies in relation to Substance Misuse services to be submitted to the Executive Board.	Executive Director of Public Health	Executive Director of Public Health	23-mar-26	Closed	**Proposed for Closure** Mapped breakdown being presented to the Executive Leadership Group taking place on 23 March 2026.
20.01.2026	5,3	6	Clinical Executives Report	Report to be presented to a future meeting of the Committee in relation to Physicians Associates outlining training, governance and patient communication.	Executive Medical Director	Executive Medical Director	24-mar-26	Closed	**Completed as now on Forward Plan for Update in September** Given the ongoing nature of this action and given that there is currently no progress being made on this nationally for at least the next 6 months, it is proposed that this is closed as an action and included on the forward work programme for the Committee.
20.01.2026	5.4.1	6	Primary Care & Communities Care Group Highlight Report	Next report to include further updates on the dental contract and the demand and the capacity activities of the Cellulitis service workload	Nurse Director, Primary Care & Community	Executive Director of Nursing	24-mar-26	Closed	**Completed** Updates on both matters have been included in the March 2026 Care Group Highlight report.
20.01.2026	7,1	10	Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Responses to be shared outside the meeting to the questions raised prior to the meeting regarding the Organisational Risk Register.	Head of Corporate Governance & Board Business	Director of Corporate Governance/ Board Secretary	24-mar-26	Closed	**Completed** Questions and responses were shared with Members by email and the questions and responses have also been included within the minutes of the January 2026 meeting

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

Committee Annual Self Effectiveness Survey Outcome 2025-6 & Improvement Plan

Eitem yr Agenda / Agenda Item	3.3
Dyddiad y Cyfarfod / Date of Meeting:	21 July 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Carolyn Donoghue, QSEC Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to **REVIEW** the outcome of the 2025-26 Committee Self-Effectiveness Survey and **APPROVE** the proposed self-development action plan
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care This report supports the **Improving Care** strategic pillar by strengthening the effectiveness of the Committee responsible for quality, safety and experience assurance.
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	The report supports delivery of the Integrated Medium Term Plan by ensuring that the Quality, Safety and Experience Committee remains effective in providing scrutiny, assurance and oversight of quality, safety and patient experience matters.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The 2025-26 annual self-effectiveness survey for the Quality Safety and Experience Committee (QSEC) was undertaken in June-July 2026. Twelve responses were received from Committee members and attendees. Overall, the feedback provided strong positive assurance regarding the effectiveness of the Committee. Across almost all questions, all respondents gave positive responses, including in relation to the Terms of Reference, frequency of meetings, openness of debate, professional behaviour, quality of chairing, Executive Director support, and the Committee Highlight Report to Board.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	A small amount of constructive feedback was received, as summarised below with suggested actions. ***Committee Business Planning, Assurance and Reporting*** One respondent was unsure whether the Committee had an established Cycle of Business. In addition, several free-text comments suggested opportunities for further enhancement, including: • maintaining a clearer cycle of key priorities to support focused discussion and minimise repetition; • improving access to data to support the narrative within reports; • reviewing the level of assurance presented to the Committee in light of the developing Integrated Performance Review approach; and • ensuring that the Committee's work programme provides opportunities to celebrate success and positive outcomes, as well as exercising scrutiny over areas of concern. The Quality, Safety and Experience Committee (QSEC) Cycle of Business is reviewed regularly, updated for each meeting, and presented under the Consent Agenda. **ACTION:** During 2026/27, the Cycle of Business will be refreshed to reflect the developing Integrated Performance Review approach and will explicitly consider the feedback summarised above. **DUE DATE: 31 March 2027** One respondent also suggested increasing the visibility of staff safety issues. **ACTION:** The role and remit of the Health, Safety and Fire Committee, and its relationship with QSEC, are currently under review and the outcome of this work will be reported to the Committee later in 2026. ***Welsh Language in Meetings*** Two respondents indicated that they would welcome greater use of the Welsh language in Committee meetings.

	Further detail was requested from respondents; however, no additional information was provided. **ACTION:** The Governance Team will meet with the Equality and Welsh Language Impact Team to explore practical and proportionate opportunities to increase the visibility and use of Welsh within Committee meetings and will discuss any potential actions with the Committee Chair and Lead Officer. **DUE DATE: 31 July 2026** ***Member Development and Succession*** Respondents did not identify any requirement for additional training. However, one free-text comment suggested considering whether aspiring leaders could be given greater exposure to Committee business to support future leadership development. **ACTION:** The Governance Team will discuss this suggestion with the People Team to identify whether opportunities exist within current leadership and development arrangements to increase understanding of Committee business and governance processes and support future leadership development. **DUE DATE: 31 July 2026**
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Subject to agreement by the Committee, the actions listed above will be completed and reported back to the Committee.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee is asked to **REVIEW** the outcome of the 2025-26 Committee Self-Effectiveness Survey and **APPROVE** the proposed self-development action plan

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework**	Strategic Risk 2 The report supports the governance and assurance arrangements relating to strategic quality, safety and experience risks, particularly **Risk 2: Ability to deliver**

(Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	**improvements which transform care and enhance outcomes.** The impact is indirect: the report does not change the risk score, but supports the Committee's ability to scrutinise assurance, identify areas for improvement and maintain effective oversight of quality and safety matters.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	The report supports the Well-being Goals indirectly by strengthening the governance and assurance arrangements through which the Committee oversees quality, safety and experience matters. The proposed actions also include proportionate consideration of Welsh language visibility and future leadership development, supporting inclusive and sustainable governance practice.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Leadership
	Culture & Valuing People
	Learning, Improvement & Research
	The report supports the Enablers of Quality by using feedback from Committee members and attendees to identify opportunities for improvement

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	There are no direct environmental sustainability impacts arising from this report. The report relates to committee effectiveness and governance improvement, rather than a service, estates, procurement or operational change proposal.

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome**	Outcome for Equality: NEUTRAL Summary of impact: No direct equality impact has been identified. The report relates to the outcome of the Committee's annual self-effectiveness survey and proposed governance improvement actions. One	If no, please select a reason below. Choose an item. Not required at this stage – governance effectiveness report with no

(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	action relates to exploring whether existing leadership and development arrangements could provide greater exposure to Committee business for aspiring leaders, which may support inclusive development opportunities. Outcome for Welsh Language: POSITIVE Two respondents indicated that they would welcome greater use of the Welsh language in Committee meetings. The proposed action is for the Governance Team to meet with the Equality and Welsh Language Impact Team to explore practical and proportionate opportunities to increase the visibility and use of Welsh within Committee meetings, with any potential actions to be discussed with the Committee Chair and Lead Officer.	direct service, policy or operational change. Named Executive/Board member sign off for no EWLIA completion: Gareth Watts
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	A separate Quality Impact Assessment has not been undertaken as the report does not propose a direct change to clinical services, patient pathways, staffing models or operational delivery. The report is expected to have a positive governance impact by supporting the ongoing effectiveness of the Quality, Safety and Experience Committee in scrutinising assurance and overseeing quality, safety and experience matters.	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	Choose an item. The report may have a positive reputational impact as it publicly demonstrates that the Committee routinely reviews its own effectiveness, considers feedback from members and attendees, and identifies proportionate improvement actions.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact**	There is no direct impact on resources as a result of the activity outlined in this report	

(People / Financial)	The proposed actions are expected to be progressed within existing governance, equality and Welsh language, and workforce development arrangements. Any further actions arising from discussion with relevant teams would be considered separately if they have resource implications.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Survey sent to all Quality, Safety and Experience Committee members and attendees	Click or tap to enter a date. June–July 2026	Twelve responses were received. Feedback provided strong positive assurance overall, with a small number of constructive development themes identified.

Acronyms / Glossary of Terms	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

Terms of Reference – Quality, Safety & Experience Committee

Eitem yr Agenda / Agenda Item	**3.4**
Dyddiad y Cyfarfod / Date of Meeting:	21/07/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter:	Louise Stait, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	Endorse for Board Approval
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee are being asked to ENDORSE the Terms of Reference for Board Approval

1. Situation /Background

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

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

1.3 The Quality, Safety & Experience Committee Terms of Reference form schedule 3.5a of the Standing Orders and the purpose of the paper is to seek endorsement of the current Terms of Reference as part of its annual review.

2. Specific Matters for Consideration

2.1 The Terms of Reference were previously amended to reflect an update to membership and quoracy, changing the number of Independent Members from 4 to 6 and the quoracy from 2 Independent Members to 3 Independent Members. These changes were approved by Board at the meeting held on 26 March 2026.

2.2 Any additional changes have been identified in red.

3. Key Risks / Matters for Escalation

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

4. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)*	Not Applicable
Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research
	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:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	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

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	

5. Recommendation

5.1 The Quality, Safety & Experience Committee are asked **ENDORSE** the Terms of Reference for Board Approval.

6. Next Steps

6.1 The Terms of Reference will be presented to the September 2026 Board for approval.

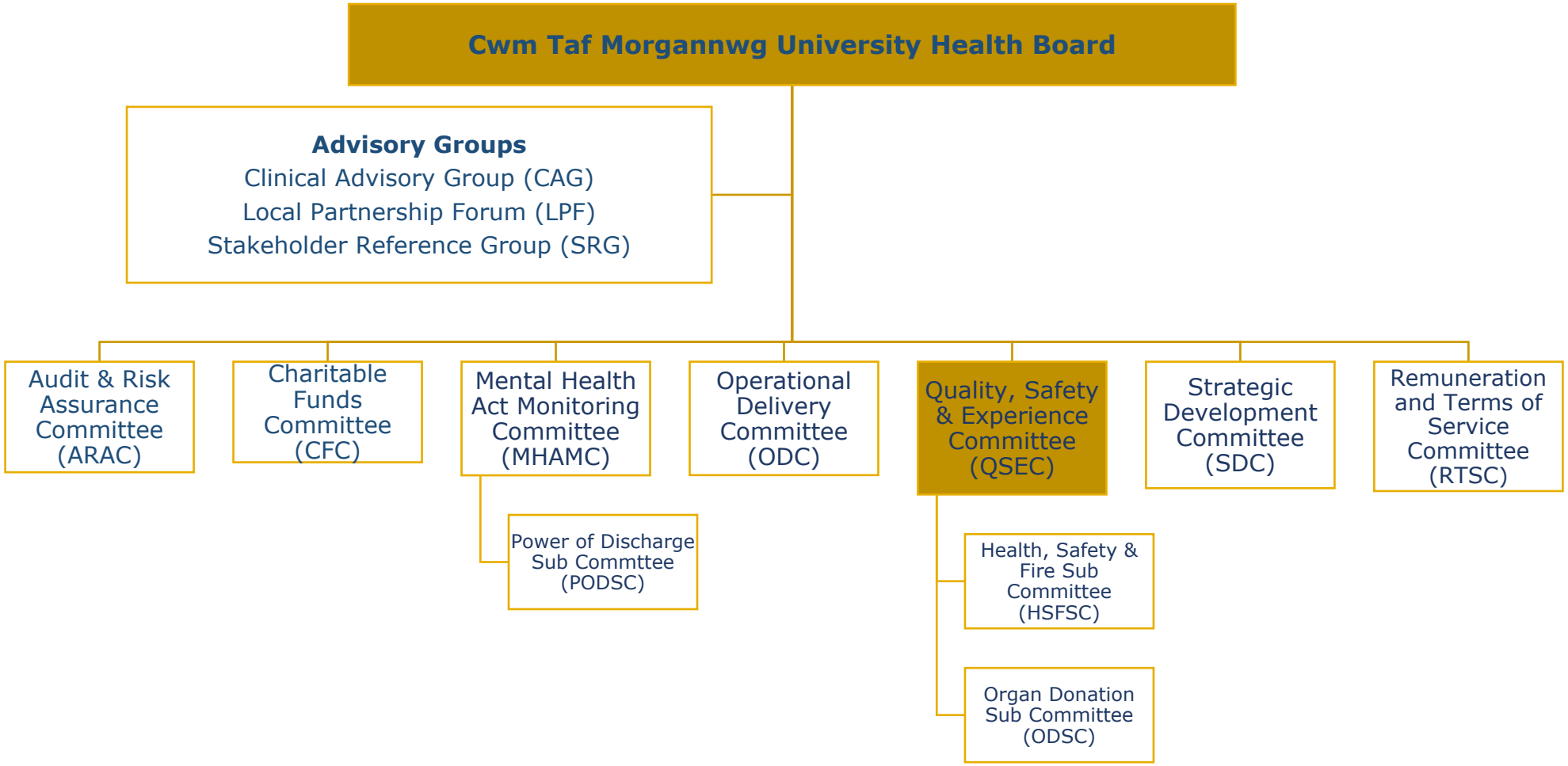
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC)

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

Last Approved: Health Board Meeting 26th March 2026

CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
Charitable Funds Committee (CFC)
Mental Health Act Monitoring Committee (MHAMC)
Power of Discharge Sub Commttee (PODSC)
Operational Delivery Committee (ODC)
Quality, Safety & Experience Committee (QSEC)
Health, Safety & Fire Sub Committee (HSFSC)
Organ Donation Sub Committee (ODSC)
Strategic Development Committee (SDC)
Remuneration and Terms of Service Committee (RTSC)

Contents

Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Board Meeting	26th September 2024	Approved	No later than the end of September 2025.
Version 2	Health Board Meeting	26 March 2026	Approved	No later than September 2026.

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

1. Introduction & Constitution

1.1 The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

1.2 In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Quality, Safety & Experience Committee (QSEC).** The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2. Purpose

2.1 The purpose of the QSEC "the Committee" is to provide assurance to the Board on the provision of safe and high quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Committee will ensure the needs of its service users, carers, people and the public are at the centre of all its business.

2.3 The Committee will provide:

- ***assurance*** to the Board on the setting of local organisational Quality, Safety & Experience standards and supporting an organisational safety culture.
- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality, safety and experience of health care provided and secured by CTMUHB, and that at all levels, it has the right governance arrangements and strategies in place to ensure that the care planned or provided across the breadth of the organisation's functions, is based on sound evidence, clinically effective and meeting agreed standards.
- ***assurance*** to the Board in relation to CTMUHB's arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales;

- ***assurance*** to the Board in relation to improving the experience of patients, carers, citizens and all those that come into contact with our services including those provided by other organisations or in a partnership arrangement.
- ***assurance*** that the Board is operating in accordance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- ***assurance*** that the Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate.

3. Scope and Duties

3.1 Provide advice to the Board on the adoption of a set of key indicators of quality, safety and experience of care against which the CTMUHB's performance will be regularly assessed and reported.

3.2 Assure the development and delivery of the enabling strategies within the scope of the Committee, aligned to organisational objectives and the Annual Plan/Integrated Medium Term Plan for sign off by the Board.

3.3 Oversee and monitor workplace health and safety, providing assurance to the Board on the development of related strategies and operating practices to ensure arrangements for staff workplace health and safety are in compliance with associated legislation.

3.4 To receive an assurance on delivery against relevant Planning Objectives aligned to the Committee, in accordance with Board approved timescales, as set out in CTMUHB's Annual Plan.

3.5 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Organisational Risk Register (ORR) as allocated to the Committee and provide assurance to the Board that risks are being managed effectively. Report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

3.6 Recommend acceptance of risks that cannot be brought within CTMUHB's risk appetite/tolerance to the Board through the Committee Update Report.

3.7 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.8 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.

3.9 Seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the processes that are developed

and implemented, supporting and endorsing these as appropriate.

3.10 Oversee the development and implementation of strengthened and more holistic approaches to triangulating intelligence to identify emerging issues and themes that require improvement or further investigation.

3.11 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular, that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.

3.12 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.

3.13 Provide assurance to the Board in relation to improving the experience of patients, including for those services provided by other organisations or in a partnership arrangement. Patient Stories, Patient Charter and Board Members walkarounds will feature as a key area for patient experience and lessons learnt.

3.14 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with CTMUHB strategies.

3.15 Ensure that CTMUHB is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.

3.16 Ensure that CTMUHB is meeting the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

3.17 Agree actions, as required, to improve performance against compliance with incident reporting.

3.18 Provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary.

3.19 Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators.

3.20 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.

3.21 Provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and operating effectively at operational level, with concerns escalated to the Board.

3.22 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.

3.23 Oversee the arrangements for the approval of clinical and non-clinical written control documents.

3.24 Oversee the arrangements for the ongoing delivery of the CTMUHB's Research & Development Strategy.

3.25 Approve policies within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.

3.26 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance

3.27 Develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year.

3.28 Review and approve work plans for Sub-Committees to scrutinise and monitor the impact on patients of the Health Board's services and their quality.

3.29 Refer quality, safety and experience matters, which impact on people, planning, finance and performance to the relevant Board Committees and vice versa.

3.30 Agree issues to be escalated to the Board with recommendations for action

3.31 Hosted Bodies - The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by CTMUHB as appropriate. The Committee will consider any quality, safety and experience issues associated with services commissioned for Cwm Taf Morgannwg residents and those services provided by CTMUHB.

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

4. Membership

Members

4.1 The Membership of QSEC is as follows:

Chair	Independent Member
Vice Chair	Independent Member
Members	4 further Independent Members (including the Chair of the Audit, Risk & Assurance Committee and the Chair and/or Member of the Health, Safety & Fire Sub Committee).

4.2 The Chair of CTMUHB reserves the right to attend any of the Committee's meetings as an ex officio member.

Support to Committee Members

4.3 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director for People.

4.4 The membership of QSEC will be reviewed annually.

In Attendance

Executive Director of Nursing ~~/ Deputy CEO~~
Executive Medical Director
Executive Director of Allied Health Professions and Health Science
Executive Director of Public Health
Chief Operating Officer
Director of Corporate Governance / Board Secretary
Care Group Director representation: • Unscheduled Care • Planned Care • Diagnostics, Therapies, Pharmacy and Specialties • Mental Health and Learning Disabilities • Primary Care and Community • Children and Family
Deputy Executive Director of Nursing
Deputy Executive Medical Director or Assistant Medical Director (Quality & Safety)
Assistant Director of Quality & Safety
Assistant Director of Nursing and Peoples Experience
Llais Cymru/ Citizens Voice Body Representative (not counted for quoracy purposes)
Staff Side Representative

4.5 It is expected that the representative for the Sub Committee will attend the QSEC for presenting their update reports.

By Invitation:

4.6 Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

4.7 The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

5 Quorum & Attendance

5.1 A quorum shall consist of no less than three of the membership and must include as a minimum the Chair or Vice Chair of the Committee and two other Independent Members, together with a third of the In Attendance Members.

5.2 For effective governance, at least two Executive Directors, one of which must be a Clinical Executive Director should be in attendance at the meeting.

5.3 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

5.4 Any senior officer of CTMUHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.5 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.6 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.7 The Chair of CTMUHB reserves the right to attend any of the Committee's meetings as an ex officio member.

5.8 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the QSEC.

5.9 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.

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

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet **at least six times per annum** and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8 Withdrawal of Individuals in Attendance

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

9 Circulation of Papers

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

10 Access

10.1 The Chair of the QSEC shall have reasonable access to Executive Directors and other relevant senior staff.

11 Accountability, Responsibility & Authority

11.1 The QSEC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and

safety of healthcare for its citizens, through the effective governance of the organisation.

11.3 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

11.4 The Committee shall embed the CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.5 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

11.6 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It may seek relevant information from any:
    - Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
    - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.
- Approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

11.7 The Committee may, subject to the approval of the Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

11.8 At this stage, the Committee has established the following Sub Committee:

- ***Health, Safety & Fire Sub Committee***
- ***Organ Donation Sub Committee***

11.9 The Health, Safety & Fire Sub Committee supports the Health Boards statutory obligation by virtue of the Health and Safety at Work etc. Act 1974 (Section two sub-section seven) to establish and maintain a Health and Safety Committee*: "it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of*

keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed".

12 The Organ Donation Sub Committee supports the Health Boards obligation to influence policy and practice in order to ensure that organ and tissue donation is considered in all appropriate situations, and to identify and resolve any obstacles to this. It will also ensure that a discussion about organ and tissue donation features in all end of life care, wherever located and whenever appropriate, recognising and respecting the wishes of the individuals. It will also maximise the overall number of organs donated, through better support to potential donors and their families.

13 Reporting

13.1 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub committees and groups, to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of information.

13.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

13.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

13.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

13.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.

- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

13.6 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook

14 Applicability of Standing Orders to Committee Business

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

- Quorum

15 Chairs Action on Urgent Matters

15.1 There may, occasionally, be circumstances where decisions which would have been made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with at least two other members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

15.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

16 In Committee (Private Meeting)

16.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information

17 Review

17.1 These Terms of Reference shall be approved at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

Cwm Taf Morgannwg Quality Thematic Review Hospital@Home

Eitem yr Agenda / Agenda Item	4.2
Dyddiad y Cyfarfod / Date of Meeting:	Tuesday 21 July 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Choose an item..
Adroddiad wedi'i baratoi gan / Report Prepared by:	Lucie Owen, Nurse Director, Primary Care and Communities
Cyflwynydd yr Adroddiad / Report Presenter:	Richard Hughes, Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	This internal thematic review provides assurance to the Quality, Safety and Experience Committee regarding the quality, safety and effectiveness of the Hospital@Home (H@H) model across Cwm Taf Morgannwg University Health Board. The review assesses the service's contribution to the Health Board's strategic ambition of supporting people to remain at home wherever possible, avoiding unnecessary admissions and facilitating timely discharge from hospital.
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Quality, Safety and Experience Committee is asked to: • Review the findings of the Hospital@Home Quality Thematic Review. • Note the overall assurance opinion and areas of good practice identified. • Consider the strategic risks and improvement opportunities highlighted within the report. • Take assurance regarding the contribution of Hospital@Home services to patient outcomes,

	patient flow and discharge arrangements.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care Hospital@Home supports the Health Board's strategic ambition to provide care closer to home wherever clinically appropriate, reduce unnecessary hospital admissions, improve patient flow and support timely discharge. The service contributes to delivery of Home First and Discharge to Recover then Assess (D2RA) principles and supports wider transformation of community-based care models.
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	This review supports delivery of priorities relating to urgent and emergency care, patient flow, reduced delayed transfers of care, care closer to home and development of integrated community-based services. Hospital@Home is a key enabler of Home First and Discharge to Recover then Assess (D2RA) approaches across the Health Board.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: **Executive Summary of what the report is describing:** Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	An internal quality thematic review of the Hospital@Home service was undertaken to assess its contribution to quality, safety, effectiveness and patient outcomes across CTMUHB. The review concluded **Reasonable Assurance**, reflecting evidence of positive impact alongside a number of areas requiring further development. This opinion represents **first-line operational assurance** from those closest to service delivery and is intended to support Committee scrutiny and service improvement. It is not an independent Internal Audit or regulatory assurance opinion. Over time, this assessment can be supplemented by additional sources of assurance, including audit, benchmarking, peer review and routine governance reporting.

Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The review identifies evidence that Hospital@Home is supporting the Health Board's strategic ambitions of improving patient flow, reducing delays in discharge and delivering care closer to home. Reported benefits include: • A 72% reduction in delays for patients awaiting home care. • Reduction in median length of stay for pathway 1 patients from approximately 30 days to 24 days. • Approximately 320 delayed bed days saved per month following implementation of Bridging Care. • Improved patient experience and support for independence. • Growth in integrated multidisciplinary working. • Reduced waiting times within community frailty pharmacy services from 26 weeks to 8 weeks. The review also identifies a number of strategic and operational risks that may affect sustainability and future service development, including workforce shortages, recruitment constraints, inconsistent discharge arrangements, digital system limitations and variation in implementation of Discharge to Recover then Assess (D2RA) processes**.**
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The report identifies a number of opportunities and recommendations to support further service development, including: • Development of a fully funded Hospital@Home workforce model. • Acceleration of Early Supported Discharge and Admission Avoidance pathways. • Development of an integrated Health Board-wide discharge model based on D2RA principles. • Establishment of a single digital solution to support multidisciplinary working and reporting. • Routine collection of patient outcome and experience measures, including PREMs and PROMs.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).*	The Committee is asked to:

Recommendation (Linked to the "What Next" section above).	• Note the findings of the Hospital@Home Quality Thematic Review. • Take assurance from the reported benefits achieved to date. • Note the key risks and improvement opportunities identified. • Support ongoing service development in line with the recommendations outlined within the report.

1. Background / Context

1.1 Hospital@Home is a multidisciplinary frailty service providing community-based alternatives to hospital admission and supporting earlier discharge for patients with complex health and care needs. The service is a key enabler of the Home First and Discharge to Recover then Assess (D2RA) models. Nationally, Hospital@Home services have been associated with reduced hospital admissions, improved patient outcomes, reduced deconditioning and better patient experience.

1.2 Within CTMUHB, Hospital@Home was established in July 2025 through integration of existing community frailty services alongside additional workforce investment. Implementation has occurred against a backdrop of organisational change, recruitment challenges and increasing system demand.

1.3 The review considered the following Hospital@Home components:

- Bridging Care
- Community Frailty Teams
- Frailty Clinics
- Frailty Hot Clinics
- Supporting Front Door Turnaround
- Early Supported Discharge
- Admission Avoidance Pathways

1.4 The review focused on quality outcomes achieved during winter pressures between December 2025 and March 2026.

2. Strategic Insights

Findings by Quality Domain

Safe

Key Findings

2.1 Hospital@Home is reducing exposure to risks associated with prolonged hospital stays, including deconditioning, hospital-acquired infection and functional decline. National and local evidence supports care delivery closer to home where clinically appropriate.

2.2 The Bridging Care element has enabled earlier discharge for patients awaiting domiciliary care packages and contributed to significant reductions in delayed pathways of care. A 72% reduction in delays for patients waiting for home care was observed between December 2025 and March 2026[1].

2.3 Patient feedback highlights positive experiences regarding safe discharge, continuity of care and restoration of independence. This patient story demonstrates the quality-of-life benefits associated with timely discharge supported by Hospital@Home services.

I was taken into hospital found that I had broken two ribs and pierced a lung.

I wasn't aware of the Hospital@Home service, but was told by the ward staff I was going home with care. I was informed that there was a new initiative out there to stop delays and it was a new service. I felt excited to go home with this new service.

I was visited by a fabulous Nurse and a smiley healthcare assistant within hours of me being home. They asked me questions, explained what the Hospital@Home service was and how they could help.

As the pain eased the carers worked with me and encourage me to be as independent as possible, they also encouraged me to think for myself.
The carers taught me to gain my independence and rather than say I'll do this for you, they would say come on now have a go yourself.

I dread to think what the alternative outcome would have been if Hospital@Home were not there to take care of me. I probably would have been in hospital for three weeks or even more longer. I would have lost heart and I was so fed up and just wanted to go home.

I would not have recovered as well and as quickly as I did. What a brilliant initiative it is to have this team to take over care to support me to come out of hospital early. I thank the Lord for this team I'm truly so grateful.

[1] Appendix 1

2.4 Areas of Good Practice

- Reduced risk of harm associated with delayed discharge.
- Rapid support following discharge home.
- Multidisciplinary community intervention.
- Improved medication support through integrated pharmacy services.
- Increased collaboration and integrated pathways of care with LA partners.

2.5 Risks

- Poor quality of proportionate assessment for discharge
- Patients occasionally referred before discharge readiness.
- Reliance on fragmented digital systems presents clinical governance risks.
- Higher LoS in some areas.

Timely

2.6 Key Findings

The review found strong evidence that Hospital@Home is improving patient flow across acute hospitals.

Key improvements[2] include:

- 72% reduction in delays for home care.
- Reduction in median length of stay for pathway 1 patients from approximately 30 days to 24 days.
- Average saving of approximately 320 delayed bed days per month since implementation of Bridging Care.

2.7 Risks

Timeliness is affected by:

- Delays in transition to local authority care packages.
- Variation in local authority handover arrangements.
- Workforce shortages limiting expansion of admission avoidance and early supported discharge pathways.

Effective

2.8 Key Findings

Hospital@Home is delivering measurable impact against its intended objectives.

[2] Appendix 2

Evidence demonstrates:

- Significant reductions in delayed discharge.
- Improved patient flow.
- Reduced waiting times within community frailty pharmacy services from 26 weeks to 8 weeks.
- Growth of integrated multidisciplinary working. Current service components operating effectively include:

Service Element	**Status**
Bridging Care	Fully Operational
Community Frailty	Fully Operational
Frailty Clinics (Merthyr/RCT)	Operational
Front Door Frailty Support	Development Phase
Early Supported Discharge	Development Phase
Admission Avoidance Expansion	Capacity Limited

2.9 **Risks**

The full Hospital@Home model has not yet been realised due to workforce and financial constraints. Several interventions remain partially implemented.

Person-Centred

2.10 **Key Findings**

The service strongly reflects person-centred principles and the Health Board's commitment to care closer to home.

Patients benefit from:

- Remaining in familiar surroundings.
- Improved dignity and independence.
- Reduced reliance on long-term care.
- Improved experience of care.

Patient experience narratives demonstrates how Hospital@Home supports recovery, independence and emotional wellbeing following discharge.

2.11 **Areas of Strength**

- Home First approach.
- Independence-focused support.

2.12 **Opportunities**

The service would benefit from formal collection of Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs). This has been tested and is being rolled out through PROMPTLY with a target date of November 2026.

Efficient

2.13 **Key Findings**

Hospital@Home is demonstrating improved use of system resources.

Evidence includes:

- Reduced bed occupancy.
- Reduced delayed transfers of care.
- Improved use of community workforce.
- Reduced pharmacy waiting lists.
- Integrated pathways of care.

Current activity demonstrates:

Indicator	**Performance**
Bed days saved per month	Approx. 320
Patients supported monthly	38 - 45
Median Length of Stay	Reduced from 30 to 24 days

2.14 Efficiency gains are constrained by workforce shortages.

Current staffing establishment:

- Planned workforce: 85.55 WTE
- Staff in post: 55.04 WTE
- Vacancy gap: 30.51 WTE

This significantly limits service capacity. Current service delivery supports approximately 30 patients per month compared with the planned capacity of 80 patients per month.

There is also evidence of significant inefficiency related to unreliable implementation of D2RA and discharge processes. It is estimated that up to 40% of patients declared as a delay for pathway 1 services in acute hospitals are not ready for discharge, with changes to optimised status or waits for other factors.

There is also evidence that shows that patients who are optimised are waiting proportionate assessment (EToC) or have an ongoing query regarding this assessment.

3 Risks and Opportunities

3.1 The review identified the following risks:

Risk	Impact	Assurance Assessment
Workforce gaps	Reduced service capacity	High
Recruitment freeze	Limits implementation of full model	High
Inconsistent and inaccurate proportionate assessment (EToC)	Patient safety and efficiency risk	High
Lack of integrated digital solution	Patient safety and efficiency risk	High
Variable local authority handover arrangements	Delayed discharge capacity	Medium
Unreliable implementation of D2RA and discharge processes.	Reduced effectiveness	Medium

3.2 Opportunities

The review identified opportunities to:

- Expand service capacity through workforce investment.
- Implement Early Supported Discharge and Admission Avoidance services more consistently.
- Improve digital integration.
- Strengthen collection of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs).
- Further support integrated discharge arrangements across partner organisations.

4. Compliance and Governance

4.1 Strengths

- Full leadership structure in place since February 2026.
- Established clinical, operational and pharmacy leadership.
- Clear clinical governance within the Primary and Community Care Group.
- Clear strategic alignment with Home First and D2RA principles.

4.2 Challenges

- Recruitment delays.
- Training bottlenecks.
- Recruitment freeze limiting service development.
- Absence of a coherent integrated discharge model across CTMUHB.
- Variation in discharge pathway arrangements between local authorities.
- Fragmentation of Datix reporting, due to amalgamation of services (resolved June 2026)

5. Benchmarks

5.1 National evidence cited within the review indicates that Hospital@Home services are associated with reduced hospital admissions, improved patient outcomes, reduced deconditioning and improved patient experience. The review also demonstrates local improvements in delayed transfers of care, length of stay and discharge performance following implementation of Hospital@Home services within CTMUHB.

5.2 No formal benchmarking against peer organisations is included within the review. Future iterations may wish to consider comparative benchmarking where data become available.

6 Conclusion

6.1 Hospital@Home is delivering significant benefits for patients and the wider health and care system across CTMUHB. The service has demonstrated measurable improvements in delayed transfers of care, reduced length of stay and enhanced patient experience. The Bridging Care model has been particularly effective in supporting timely discharge and improving patient flow.

6.2 However, the review identifies several strategic risks that limit sustainability and scaling of the service. These include substantial workforce gaps, ongoing recruitment restrictions, inconsistent discharge arrangements and the absence of an integrated digital platform. Addressing these barriers will be essential if CTMUHB is to realise the full benefits of the Hospital@Home model.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)*	Choose an item. This report relates to several strategic risks concerning service capacity, workforce sustainability, patient flow, quality of care and delivery of integrated care closer to

Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	home. The review identifies both mitigations and residual risks associated with workforce shortages, discharge arrangements, digital infrastructure and service sustainability.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Choose an item. The Hospital@Home model supports a: • Healthier Wales • More Equal Wales • Cohesive Communities by enabling people to receive care within their own homes where clinically appropriate, promoting independence, reducing avoidable hospital stays and supporting person-centred care.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Choose an item. This review demonstrates links to multiple enablers of quality, through its consideration of governance arrangements, workforce sustainability, patient outcomes, service improvement and quality assurance mechanisms.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Choose an item. By supporting care closer to home and reducing unnecessary hospital stays, Hospital@Home has the potential to contribute positively to environmental sustainability through more efficient use of healthcare resources and reduced reliance on acute hospital infrastructure. No formal sustainability assessment has been undertaken as part of this review.

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)*	This paper presents the findings of a review of an existing service and does not itself introduce any changes to policy, service provision or eligibility criteria. No adverse equality or Welsh language impacts have been identified from the report itself. Any	If no, please select a reason below. Policy/Plan/Proposal too broad Richard Hughes, Executive Nurse Director

Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	future service developments arising from the recommendations would be subject to appropriate impact assessment as required.	
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	**A separate Quality Impact Assessment has not been undertaken as this report presents a retrospective thematic review of an existing service. The report itself focuses on quality, safety, effectiveness, efficiency and person-centred outcomes and identifies opportunities for further quality improvement.**	
Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**	
Enw da / Reputational	Choose an item. **The review demonstrates positive outcomes and service benefits; however, the report identifies workforce, capacity, discharge and digital risks which may affect future service sustainability if not addressed.**	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Choose an item. The review identifies workforce shortages and vacancy levels as significant constraints on current service capacity and future development. Recommendations include development of a fully funded workforce model and expansion of service capacity. Financial implications associated with implementation of recommendations would require separate consideration through normal planning processes	

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	

Appendices – Key Data

Fig 1: Number of People Waiting for Home Care in CTM

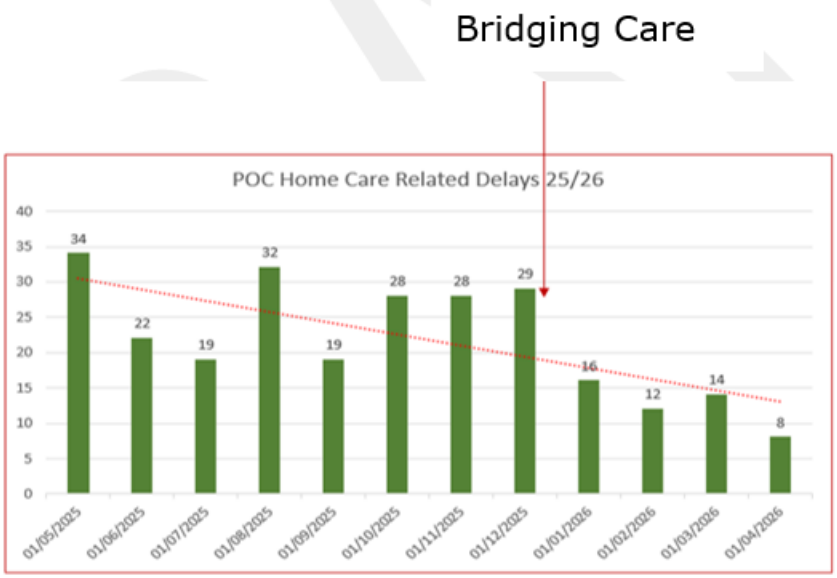
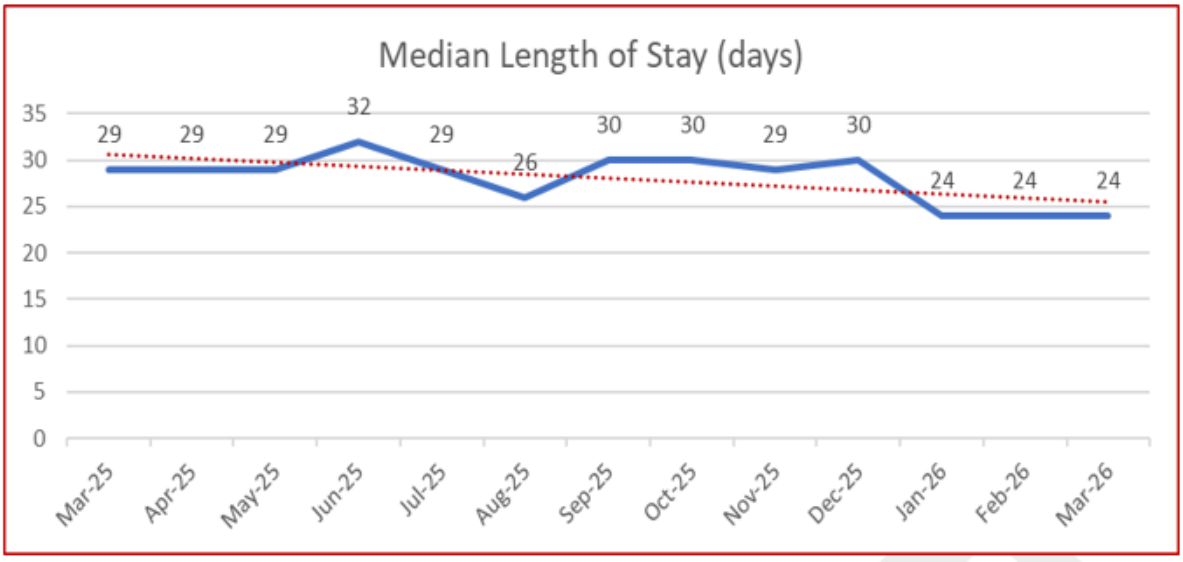


Fig 2: Length of Stay for Patients Discharged with Home Care



The biggest positive impact has been seen in the Bridgend area as shown below:

Fig 3: Number of People Waiting for Home Care in BCBC

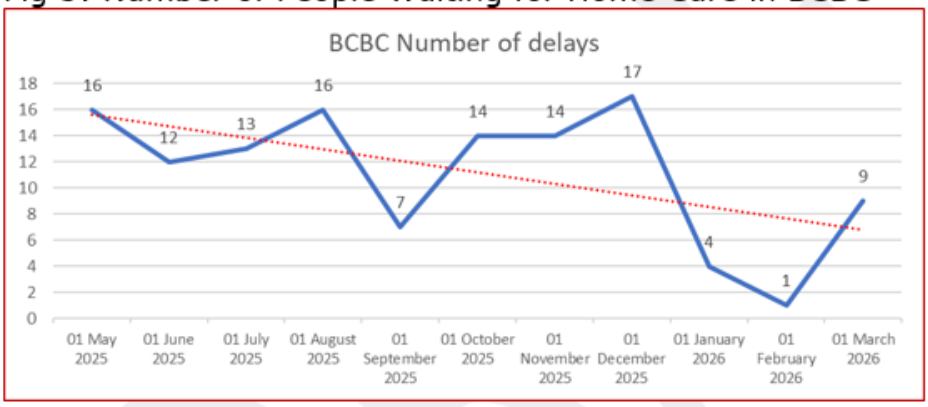
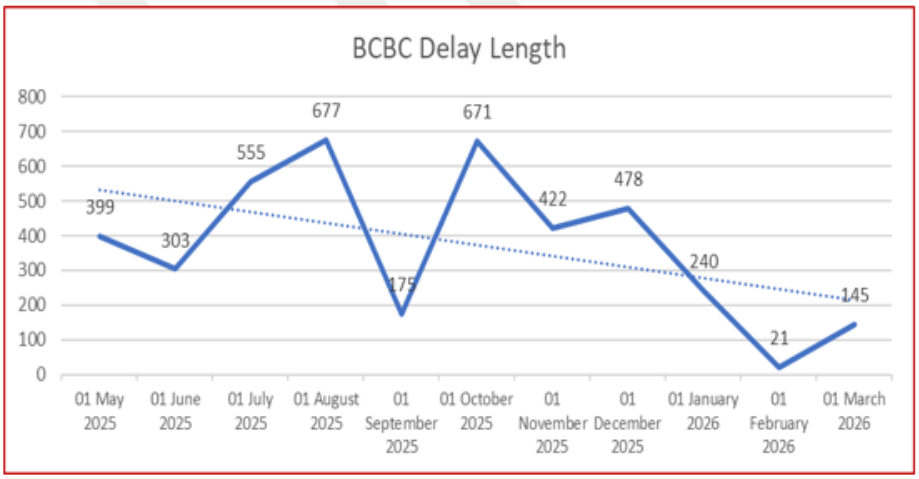


Fig 4: Total Bed Days Delayed for People Waiting for Home Care in BCBC



	Sep-25	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
People Discharged with home care	191	226	209	226	215	238	218
Median Length of Stay	30	30	29	30	24	24	24
Patients supported by H@H				38	39	38	42
% Discharged with H@H				15%	18%	15%	19%

Meeting Name:	**Quality and Safety Committee**
Report Title:	Patient-Centred Care on the Ward – Nutrition & Hydration
Agenda Item:	4.3
Date of Meeting:	21 July 2026
Publication Status:	PUBLIC
Report Prepared by:	Rhiannon Facey-Richards, Head of Catering
Report Presenter:	Stephen Gardiner, Service Director of Facilities Rhiannon Facey-Richards, Head of Catering
Report Executive Sponsor	Gethin Hughes, Chief Operating Officer
Report Purpose:	Information purposes Only
Action / Decision Required:	None Required
Strategic Context: **This report aligns to the following Strategic Pillars**	Improving Care Creating Health
Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (Reference relevant priority)	Equipment costs are provided

Executive Summary of what the report is describing: Start by <u>summarising briefly</u> the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
What (summary of current position / issue & why it matters and evidence to support that position etc)	Providing updates on the ongoing work in relation to the Nutrition and Hydration of patients.
So, what (provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)	To provide assurance around the existing and future provision of patient catering and hydration.
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)	Roll out the delivery process for the following; Procurement Centralisation – Catering Digitalisation Menu Development Food and Hydration Audits Patient Feedback Ward Based Catering Folder

Catering & Nutrition Updates January 2025 to July 2026

Theme	Information
Nutrition & Hydration Steering Group (NHSG)	The Nutrition and Hydration Steering Group (NHSG) was reinstated in 2025 to strengthen multidisciplinary oversight of nutrition and hydration across CTM UHB. Through strategic leadership, assurance and performance monitoring, the Group supports the delivery of high-quality, safe and person-centred nutritional care, contributing to improved patient outcomes and experience.
Nutrition and Hydration Related DATIX	Through the work of the Nutrition and Hydration Steering Group (NHSG), all nutrition and hydration-related DATIX incidents are now categorised and reported consistently across CTM UHB. This enhanced approach supports qualitative analysis of incidents, facilitates organisational learning, identifies priorities for targeted quality improvement initiatives, and enables the measurement of improvements in patient outcomes. Progress and key themes are reported through the Quality, Safety and Risk Executive (QSRE).
Catering Bed Plans	Following a SUS-QI project on the former PCH Stroke Ward, CTM UHB Catering led the development and implementation of an improved Bed Plan system in response to near-misses involving IDDSI requirements, allergens and dietary intolerances. The initiative has strengthened patient safety, improved communication between clinical and catering teams, and has subsequently been rolled out pan-CTM as a standardised approach to managing patient dietary needs.
Nutrition and Hydration Week – March 2026	During National Nutrition and Hydration Week, Catering delivered two ward-based sessions highlighting the range, preparation and service of IDDSI meals for patients with dysphagia. The sessions brought together nursing teams, catering staff and patients' relatives to promote awareness, improve understanding and support the delivery of safe, high-quality nutritional care.
Malnutrition Awareness Week – November 2025	Catering delivered a three-day multidisciplinary education programme on 'How to Access Specialist Diets', aimed at increasing awareness of specialist dietary provision across CTM UHB. The sessions showcased the support available through Catering Services and strengthened understanding of the processes in place to ensure patients receive appropriate, safe and individualised nutritional care.

Catering & Nutrition Updates January 2025 to July 2026

Theme	Information
Policy Updates	A programme of policy review and development is underway to strengthen Nutrition and Hydration governance across CTM UHB. Key documents include the Malnutrition Pathway for Hospital Inpatients, Protected Mealtimes Policy and Enteral Feeding Policy. Catering-led reviews of the Catering SOP, Food Safety Policy and HACCP processes are also being undertaken to support compliance, patient safety and continuous quality improvement. These are being written as part of working groups of the NHSG.
Education and Training	Catering Services continue to invest in workforce development to support high standards of patient care. Training delivered includes Food Safety Level 2 and 3 (100 delegates), Dementia Awareness (50 delegates) and IDDSI Awareness (130 delegates). An ongoing programme of education and skills development is in place to ensure Catering staff remain competent and confident in all aspects of food, nutrition and hydration provision. This is an evolving pieces of work.
Optimising nutrition and hydration for patients with dementia	12-month MDT knowledge transfer project established within Seren Ward (RGH) Older Persons Mental Health. Focused on nutrition, hydration and enhancing the patient experience through a person-centred approach. Co-produced project to be adopted as a **'Gold Standard'** model for wider implementation across CTM UHB dementia and older persons' services. Funding secured for dementia-friendly blue high-rimmed crockery, now implemented at Seren Ward, YCC Ward 7 and Angelton. Additional funding streams being pursued to improve dining environments and provide outdoor furniture to further enhance patient wellbeing and experience.

SWOT ANALYSIS

STRENGTH

- Re-establishment of the NHSG across CTM UHB
- Pan-CTM implementation of Catering bed plans to support nutrition and hydration
- Catering Specialist interest group run by dietetics
- All Wales Approach to Catering and food-provisions – economies of scale, collaborative approach
- The training undertaken by Catering to support nutrition and hydration: food safety, allergen, IDDSI, dementia awareness
- Central Production Unit (CPU) which produces all our patient soup, mains, potato-based sides and desserts – allows us complete control of quality and supply chain, allowing us to act quickly in case of disruption.
- Input into the All Wales Menu Framework

OPPORTUNITY

- All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (October 2011) – revised standards currently with WG for ratification. Chance for improved compliance to nutrition and hydration and patient centred care.
- Current Facilities OCP will bring Catering under one umbrella – meaning one standard of compliance and quality with uniform KPIs being developed and implemented.
- CPU will be able to formulate new recipes for patients in a proactive approach once new nutrition guidelines are published.
- Increased patient visiting hours have had a positive impact to patients in terms of support.

WEAKNESS

- All Wales Approach to Catering and food-provisions – can be restrictive to nutrition e.g. the purchasing of IDDSI meals, contract management does not sit within individual Health Boards.
- Catering staff and retention is a big challenge across the NHS.
- Revised All Wales Nutrition and Catering Standards will have a big impact on all disciplines involved in nutrition and hydration and the compliance that will be required.
- Catering staff have reported impacts in relation to the increased patient visiting hours including confusion over orders, food being sent back/asked to be swapped, approaching food regen trolleys and requesting food.

THREAT

- Funding for patient beverage and breakfast trolleys due to an ageing fleet (revenue budget does not meet requirement)
- CTM UHB does not have a Catering Dietician to support with the compliance and coding of menus – both patient feeding and retail (staff are our future patients)
- POWH – currently only has 4-wards that are WBC, remaining 16 are nursing led, paper submitted to OMB, subject to future funding, in relation to changing the service delivery model to a ward based catering model.

KEY WORKSTREAMS

Workstream	Commentary
1. Procurement Centralisation - Catering	Procurement processes are being centralised to reduce variation across sites and strengthen compliance with nutritional standards. Standardised ordering systems will ensure that all food products are sourced from approved suppliers, delivering greater consistency, quality assurance and equity of patient experience across CTM UHB.
2. Digitalisation	Work is underway to digitise patient meal ordering across CTM UHB. As part of Workstream 1, meal choices will be captured electronically at the patient's bedside, improving order accuracy, patient choice, operational efficiency and the overall patient experience.
3. Menu Development	New two-week patient menu cycle developed in line with anticipated national standards. Interim menu in development to support CPU stock-build requirements. Paediatric menu completed and approved, pending Dietetic endorsement. IDDSI picture menus (Levels 3–6, including finger foods) nearing completion and ready for rollout. Supports improved patient choice, accessibility, nutritional care and patient experience.
4. Ward Based Catering Folder	Development of a multidisciplinary nutrition resource is underway to support Catering and Nursing teams. The guide will provide an overview of specialist dietary requirements, including IDDSI, high-energy/high-protein, gluten-free, low-fibre and low-potassium diets, helping to strengthen staff knowledge and support safe, person-centred nutritional care.
5. Patient Feedback	A dedicated patient feedback mechanism is being developed to capture patient experiences of food, nutrition and hydration services. Currently, feedback is largely reliant on PALS reporting. The new approach will provide more timely and meaningful patient insight to support quality improvement, enhance patient experience and inform service development.
6. Food and Hydration Audits	Nutrition and Hydration Audit Tool developed to support quality assurance and service improvement. Pilot phase to be undertaken with support from Dietetic students. Designed as a multidisciplinary tool involving Nursing, Dietetic, Catering and clinical teams. Agreement required on audit frequency, governance and staff responsibilities. Aims to support continuous improvement in nutrition, hydration and patient outcomes.

Recommendation (Linked to the "What Next" section above).	For Assurance
Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Choose an item. **BAF Assurance framework Risk 2** If more than one applies please list below:
Link to Wellbeing of Future Generations Act – Wellbeing Goals	**A Healthier Wales** If more than one applies please list below:
Environmental Sustainability Impact (5Rs)	**Reduce** If more than one applies please list below:
Link to Enablers of Quality	**All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (October 2011) – revised standards currently with WG for ratification** If more than one applies please list below:
Impact Assessment	
Equality & Welsh Language Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	N/A
Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	N/A
Cyfreithiol / Legal	N/A
Enw da / Reputational	Failure to address Nutritional and Hydration requirements will result in reputational damage.
Resource Impact (People / Financial)	Not substantiated

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

The path to safer beginnings in Wales A national assurance assessment of Maternity and Neonatal Care Services (Holland 2026)

Cwm Taf Morgannwg Update July 2026

Eitem yr Agenda / Agenda Item	
Dyddiad y Cyfarfod / Date of Meeting:	21st July 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Suzanne Hardacre Director of Nursing & Midwifery, Children & Families Care Group
Cyflwynydd yr Adroddiad / Report Presenter:	Suzanne Hardacre Director of Nursing & Midwifery, Children & Families Care Group
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below: • Creating Health • Inspiring our People • Sustaining our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	**Safe Care** – Women, birthing people and babies receive care that minimises avoidable harm **Timely** – Care is received without unnecessary delays **Effective** – Care is evidence based and achieves the best outcomes **Efficient** – Resources are used effectively to maximise value and capacity

	Equitable – Outcomes and experiences are consistent regardless of background or geography **Person Centred** – Women, birthing people, and their families are listened to, respected and involved in decision making.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: **Executive Summary of what the report is describing:** Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Welsh Government commissioned an independent national assurance assessment of maternity and neonatal services across Wales, resulting in *The Path to Safer Beginnings in Wales* (February 2026). The review acknowledged many examples of high-quality compassionate care and committed staff but identified significant system-wide vulnerabilities requiring urgent action. Eight national priorities were established to improve quality, safety, governance, workforce sustainability, mental health provision and neonatal services across Wales
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	Cwm Taf Morgannwg University Health Board (CTM UHB) is well positioned to respond to the recommendations, with several areas of good practice already in place and a number of programmes underway. These include implementation of Digital Maternity Cymru/BadgerNet, workforce modelling using Birthrate Plus, development of enhanced governance arrangements, investment proposals for maternity and neonatal staffing, expansion of maternal wellbeing support, strengthened neonatal quality assurance processes and the establishment of Maternity Voices Partnership arrangements. While CTM demonstrates significant progress against the recommendations, key risks remain around workforce capacity, maternity triage and induction environments, theatre capacity, mental health provision, neonatal transitional care capacity

	and estate limitations. These mirror challenges identified nationally.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	• This report demonstrates that maternity and neonatal services continue to provide care in accordance with the Duty of Quality and are positively progressing many actions. Monitoring in place via Maternity and Neonatal Oversight and Assurance Group with escalation / exception reporting into other committees/boards as required.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	*Note the contents of the report, actions taken and recommendations to be progressed over the next 6-12 months.*

1. Background / Context

1.1 The national review was undertaken following concerns raised through UK maternity and neonatal reviews and aimed to provide a real-time assessment of safety, quality and governance across Wales. The review involved engagement with more than 600 families, communities, staff and stakeholders, alongside visits to maternity and neonatal services throughout Wales. Since the launch of the Holland report (Appendix 1, February 2026), two further national reports into maternity and neonatal services have been published:-

- The Ockenden Report - Review of Northampton University Health Trust (June2026) https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2026/06/ockenden-report-review-of-maternity-services-nottingham-university-hospitals-nhs-trust-web-accessible.pdf
- Independent Investigation into Maternity and Neonatal Services in England (July 2026) https://www.matneoinv.org.uk/wp-content/uploads/2026/06/WEBSITE_NMNI-Final-Report-and-Recommendations.pdf

2. Strategic Insights

2.1 The review identified key national strengths such as positive feedback from families, highly committed staff delivering care despite significant pressures, high quality environments with many midwife led units,

increased national focus on maternity and neonatal improvement resulting in measurable progress in some outcomes.

3. Risks and Opportunities

3.1 National risks include:

- Staffing numbers and skill mix not keeping pace with increasing complexity of care.
- Inconsistent maternity triage and induction of labour arrangements.
- Inadequate postnatal staffing and support.
- Delayed neonatal service reconfiguration and commissioning decisions.
- Significant gaps in perinatal mental health provision.
- Inconsistent incident review processes that do not consistently involve families.
- Fragmented oversight arrangements across organisations.
- Limited use of real-time data to identify risk, variation and inequalities
- Rising intervention rates, particularly induction and caesarean section rates, without robust evaluation of impact.

4. Compliance and Governance

4.1 The Executive Director of Nursing and Midwifery has implemented a Maternity and Neonatal Oversight and Assurance Group (MNOAG) to ensure that all priority areas are being progressed and to highlight any areas of risk or safety concerns. A summary report of meetings will be received at Improving Care Board and Quality, Safety and Experience (QSE) Committee meetings. The first meeting was held on 2nd July 2026.

5. Benchmarks

5.1 Holland (2026) outlined eight national priorities that provide a framework for health board planning, implementation and performance monitoring. A detailed position for CTM is attached as (Appendix 3).

5.2 Current assessment of CTM position demonstrates positive alignment through:

- Early implementation of Digital Maternity Cymru.
- Robust governance strengthening.

- Good practice in neonatal incident review.
- Established patient engagement arrangements.
- Population health and vulnerable family initiatives.
- Baby Friendly accreditation achievements.
- Workforce planning supported by Birthrate Plus methodology

5.3 Key risks requiring oversight:

- Midwifery and neonatal workforce capacity
- Estates limitations affecting maternity triage and induction of labour / planned elective surgery
- Limited clinical psychology provision
- Implementation of transitional care wards
- Reliance on national decisions regarding neonatal commissioning and transport services

6. Conclusion

6.1 Work is underway to progress all eight priorities however workforce challenges and estates constraints remain obstacles to compliance with national expectations.

6.2 The national review concludes that maternity and neonatal services in Wales are staffed by committed professionals delivering good care, but that significant vulnerabilities remain in workforce, governance, mental health, neonatal commissioning and safety-critical pathways. The Health Board has implemented a substantial programme of improvement and demonstrates strong alignment with the national direction of travel. Continued executive focus on workforce investment, estates, mental health provision, digital transformation and neonatal service development will be essential to achieving full compliance with the recommendations of The Path to Safer Beginnings in Wales and delivering consistently safe, high-quality care for women, babies and families across CTM.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	If more than one applies please list below: • Data to knowledge • Leadership • Culture and valuing people • Learning, improvement and research

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

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Policy/Plan/Proposal too broad Named Executive/Board member sign off for no EWLIA completion: Richard Hughes Executive Director of Nursing and Midwifery
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain*		

rationale for why it was not required)	
Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**
Enw da / Reputational	**There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report**
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**Yes (include further detail below)** Financial investment may be required to fully meet the requirements of the eight national priorities.

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	

Appendices:

- Appendix 1: Path to Safe Beginnings in Wales (Holland 2026)
- Appendix 2: Copy of national presentation provided by Professor Holland
- Appendix 3: Service position against each of the eight priorities.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

Sexual Health Safeguarding Issues - Closure Report

Eitem yr Agenda / Agenda Item	**4.5**
Dyddiad y Cyfarfod / Date of Meeting:	21 July 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Claire O'Keefe – Head of Safeguarding
Cyflwynydd yr Adroddiad / Report Presenter:	Claire O'Keefe – Head of Safeguarding
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to **NOTE** the safeguarding issues identified through the review of the Test and Post service, and **ENDORSE** CTMUHB's proposed local next steps in response to the learning identified.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	Public Health Wales identified significant weaknesses within the Sexual Health Test and Post (TAP) service, including patient safety risks, information governance failures and safeguarding concerns affecting children and young people. Key issues: Included failures to appropriately discharge Duty to Report responsibilities, limitations in age verification processes, and inconsistent sharing of safeguarding disclosures. A national incident response was established, including safeguarding MDT oversight and retrospective case reviews. CTMUHB completed local assurance reviews and confirmed safeguarding actions had been taken where required.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The review highlighted historic safeguarding system weaknesses, including poor information sharing, inconsistent professional curiosity, inadequate recognition of contextual safeguarding risks and unclear accountability between PHW and Health Boards. Although national and local assurance activity has provided confidence that risks identified to date have been reviewed and acted upon, residual risks remain where disclosures may previously have been missed or delayed. The incident demonstrates the importance of robust governance, clear escalation pathways and effective safeguarding processes within digital sexual health services.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	In response to the review findings and CTMUHB's local assurance work, the Health Board has identified proposed next steps to strengthen local governance arrangements. These include developing a Standard Operating Procedure for managing Test and Post safeguarding information, clarifying internal responsibilities and escalation pathways, enhancing safeguarding training with a focus on professional curiosity and contextual safeguarding, and implementing ongoing audit and assurance arrangements. CTMUHB will continue to work with PHW and national partners to embed learning,

	monitor outcomes and support consistent safeguarding standards across Wales. Detailed implementation arrangements, including named leads, timescales and monitoring arrangements, will be developed through the Health Board's safeguarding governance processes and incorporated into existing work programmes where appropriate.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	Members of the Quality, Safety & Experience Committee are asked to approve plans for next steps, detailed within the recommendations.

1. Background / Context

1.1 At the end of 2025, Public Health Wales (PHW) identified significant weaknesses within the Sexual Health Test and Post (TAP) service, triggering formal incident management arrangements and a full service review. Whilst there were a number of issues identified through the Test and Post review, the focus of this paper will be safeguarding children and young people who use the Test and Post service.

Key issues identified spanned:

Patient safety risks associated with manual processes, including incorrect or delayed communication of results due to human error.

Information governance failures, including incorrect routing of results between health boards and inappropriate data handling processes

Safeguarding failures, notably:

- Failure to discharge statutory Duty to Report (DTR) responsibilities appropriately, with safeguarding concerns shared with Health Boards rather than local authorities
- System limitations allowing under 18s to misreport age and bypass safeguarding questions
- Inconsistent or absent sharing of safeguarding disclosures, including high-risk indicators such as sexual assault or exploitation

Further issues were subsequently identified, including:

- **Hepatitis C testing omission** for some service users living with HIV due to system coding errors
- **Incorrect text message communications** sent to users, including where consent preferences were not followed

An Incident Management Team (IMT) and national Safeguarding Multi-Disciplinary Team (MDT) were established to manage the response and provide oversight.

2. Strategic Insights

2.1 A national retrospective multi-disciplinary team (MDT) review of 136 under 18 cases (Cohort 1) and 697 Cohort 2 cases who were aged under 18 years at the point of accessing the service who are now aged 18 years or over has been completed. Providing assurance that safeguarding risks were reviewed and actions taken, including retrospective DTR referrals where required.

Eight young people across Wales were identified as requiring safeguarding referral, with a combination of referrals made at the time and retrospectively.

Evidence confirms historic gaps in:

- Information sharing between PHW and Health Boards
- Professional curiosity and interpretation of risk
- Recognition of contextual safeguarding indicators

2.2 Service Model Changes

From 29 December 2025, a strengthened model ensures:

- Real-time contact with under-18s identifying safeguarding triggers
- Direct PHW safeguarding responsibility including DTR where required

2.3 Health Board (CTMUHB) Response

CTMUHB undertook local assurance review:

- Approximately 17 Cohort 1 cases and 176 Cohort 2 cases were reviewed between the integrated sexual health service (ISH) and safeguarding.
- Confirmed receipt of PHW information and safeguarding actions taken in line with Wales Safeguarding procedures and local policy.

Key learning identified locally:

- Lack of consistent information sharing during earlier service arrangements

- Limited face-to-face assessment for high-risk individuals
- Variable professional curiosity and multi-agency communication
- Identified need for strengthened governance and guidance in respect of management of information received by the health board from PHW.

3. Risks and Opportunities

3.1 Residual Safeguarding Risk

Risk of missed or delayed identification of harm due to:

- Historic non-sharing of disclosures
- Over-reliance on self-reported indicators and explicit disclosure
- No clear local guidance in respect of how to manage safeguarding information shared to CTMUHB by PHW.

3.2 System / Digital Pathway Risk

The system receiving PHW information is via an inbox, requiring each case to be opened individually, there is no alert to safeguarding concerns.

3.3 Governance and Accountability

Lack of clarity historically regarding responsibility for safeguarding action between PHW and Health Boards. There is also ongoing risk if roles, Standard Operation Procedures (SOP) and escalation pathways are not standardised.

4. Compliance and Governance

4.1 Overall, the TAP incident represents a multi-factorial system failure, encompassing:

- Process design flaws (manual systems, coding errors)
- Weaknesses in information governance and data flows

Significant safeguarding system failures were identified, primarily linked to:

- Lack of real-time safeguarding response
- Failure to enact statutory DTR responsibilities
- Inadequate interpretation of contextual safeguarding risk

However, evidence demonstrates that:

- A comprehensive national response has been implemented through IMT and MDT arrangements
- Retrospective safeguarding review is complete for Cohort 1, with defensible assurance achieved
- Service model reform has strengthened safeguarding, particularly through real-time intervention and direct PHW accountability
- CTMUHB has undertaken robust local assurance activity, identifying improvement areas aligned to national learning

The current risk position is therefore improving but not fully mitigated, with ongoing dependency on:

- Completion of remaining cohorts
- Embedding learning into practice
- Sustained governance oversight

5. Conclusion /Recommendations

~~6.1~~ 5.1 The recommendations below have been developed by CTMUHB in response to the findings and learning arising from the review of the Test and Post service, and from the Health Board's own local assurance work. They are intended to strengthen local governance, safeguarding practice, assurance arrangements and alignment with national developments.

Detailed implementation arrangements, including named leads, timescales and monitoring arrangements, will be developed through the Health Board's safeguarding governance processes and incorporated into existing work programmes where appropriate.

It is recommended that CTMUHB:

1. **Strengthens local governance arrangements**

- Implement a formal Standard Operating Procedure (SOP) for handling TAP safeguarding information
- Clarify internal escalation pathways and responsibilities, ensuring these are shared with all colleagues within ISH.

2. **Enhances safeguarding practice within sexual health pathways**

- Embed professional curiosity and contextual safeguarding training in bespoke sessions
- Promote multi-agency information sharing and escalation

3. **Strengthens assurance and audit**

- Establish annual audit and real-time monitoring of TAP referrals and outcomes
- Continue Board-level reporting through safeguarding governance structures

4. **Ensure alignment with national developments**

- Continue to engage with PHW Best Practice Advisory Group and Independent Review Panel
- Adopt consistent standards across Wales through partnership working with the National Safeguarding Service.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2
	If more than one applies please list below: Strategic Risk 3 Strategic Risk 4 Strategic Risk 5 Strategic Risk 6 Strategic Risk 8 Strategic Risk 10

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research
	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:

Asesiad Effaith Impact Assessment

Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate):NEUTRAL Summary of impact: Outcome for Welsh Language (delete as appropriate):NEUTRAL Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*		
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

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	
PHW	Public Health Wales
TAP	Test and Post
CTMUHB	Cwm Taf Morgannwg University Health Board
MDT	Multi Disciplinary Team
ISH	Integrated Sexual Health
DTR	Duty to Report

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

Patient Boarding within CTM UHB, Quality, Safety and Strategic Position

Eitem yr Agenda / Agenda Item	4.6
Dyddiad y Cyfarfod / Date of Meeting:	21 July 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care
Cyflwynydd yr Adroddiad / Report Presenter:	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to note the current position, recognise the balance that must be maintained between operational necessity and quality risk, and support the proposed Executive Director of Nursing-led programme of review and improvement.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	This work supports the Health Board's priorities for Improving Care, Patient Safety, Quality Governance, Patient Flow and the delivery of safe, effective and person-centred services. The review will strengthen assurance arrangements and support sustainable improvements in operational flow and quality of care.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: **Executive Summary of what the report is describing:** Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	Patient boarding continues to provide an important operational function in maintaining patient flow and supporting ambulance handover performance. Whilst no evidence of increased harm has been identified, recent review activity has highlighted variation in the application of controls intended to support safe boarding practices. The proposed Executive Director of Nursing led review seeks to strengthen assurance, improve consistency and ensure boarding remains a temporary and controlled intervention aligned to the Health Boards quality, safety and patient experience objective.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The paper highlights a growing strategic risk associated with the increased and sustained use of patient boarding across CTM UHB. While boarding has contributed to support in times of extreme pressure, to improvements in patient flow and ambulance handover performance, supporting key operational priorities, emerging evidence indicates that its use is becoming increasingly embedded within routine practice rather than remaining an exception-based intervention. This creates a risk of variation in care quality, patient experience and governance assurance. From a strategic perspective, the findings align directly with the Health Board's objectives to deliver safe, effective and person-centred care. Inconsistent application of risk assessments, variable documentation and environmental constraints have potential implications for patient dignity, safety, quality outcomes and regulatory compliance. If not addressed, this may increase exposure to organisational and regulatory risks, particularly

	relating to quality governance, patient experience, infection prevention and workforce pressures. The principal strategic concern is not evidence of widespread harm, but the normalisation of a practice intended for exceptional circumstances, potentially weakening the effectiveness of existing controls and reducing assurance regarding consistent standards of care across the organisation. To mitigate this risk, the Executive Director of Nursing, Executive Medical Director and Chief Operating Officer have set out to commission a Health Board-wide review of boarding practice. This review will strengthen the current status of assurance through standardised risk assessment processes, clearer operational thresholds, environmental reviews and reinforced governance arrangements. This will provide an opportunity to align operational delivery with strategic quality and safety objectives whilst identifying broader capacity, flow and infrastructure improvements required to reduce future reliance on boarding. Moderate assurance can be provided that governance arrangements exist; however, improvements are required to ensure consistent implementation, strengthen oversight and prevent the normalisation of boarding as a routine model of care.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	A Health Board-wide review of boarding practice will be undertaken to strengthen governance, standardise risk assessment, improve oversight and assess the suitability of boarding environments. The review will support improved patient safety, quality and experience, provide greater organisational assurance and identify opportunities to reduce reliance on boarding as part of a sustainable approach to patient flow.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The proposed review will strengthen governance, standardise risk assessment processes and improve environmental oversight to ensure patient boarding remains a controlled and justified intervention. The anticipated benefits include improved patient safety, quality and experience, enhanced organisational assurance and reduced reliance on boarding as a routine response to system pressures, supporting delivery of the Health Board's strategic objectives and regulatory responsibilities. The Committee is asked to note the current position, recognise the balance that must be maintained between operational necessity and quality risk, and support the proposed Executive Director of Nursing-led programme of review and improvement.

1. Background / Context

1.1 Patient boarding continues to play a material role in the Health Board's response to sustained operational pressure, most notably in supporting improvements in ambulance handover performance and maintaining patient flow across acute sites. The position presented to the Committee earlier in the year, through the Winter Wrap-Up report 2025/26, set out a balanced assessment, identifying both the benefits of improved system flow and the emerging consequences of increased boarding, including impacts on patient experience, ward environments and the potential for clinical risk. At that time, the Board was assured that these pressures had not translated into a measurable increase in clinical harm, reflecting the mitigating actions in place at the organisational level.

Since that report, further insight has been gained through local inspection activity and internal review. This additional evidence does not undermine the earlier position, but it does provide a more detailed view of how boarding is being applied in practice. In particular, it highlights variation in the consistency with which risk assessment, documentation and mitigation are undertaken at ward level, alongside a growing reliance on boarding as a means of managing ongoing system pressure.

As Executive Director of Nursing, this raises a proportionate concern that boarding, which is clearly defined within policy as an exception to standardised care delivery, risks becoming normalised within day-to-day operational practice. If left unaddressed, this trajectory has the potential to erode consistency in care standards, particularly in relation to patient dignity, environmental safety and the reliability of clinical oversight.

2. Risks and Opportunities

2.1 The previously presented Winter report also articulated the consequences of the current approach. It described the increasing use of uncommissioned capacity and ward-based boarding spaces, and it highlighted a series of environmental and

experiential impacts, including reduced privacy, constrained space for safe care delivery and challenges associated with manual handling and infection prevention. The report also acknowledged scenarios in which patients were placed in clinical environments not routinely designed or staffed to meet their specific needs, reinforcing that boarding, while managed, carries inherent risk.

Importantly, the Health Board has established a clear governance framework to mitigate these risks.

The Boarding Standard Operating Procedure and Escalation Policy set out explicit expectations regarding patient selection, individual risk assessment, daily senior review and ongoing oversight. In principle, this provides a robust mechanism for deploying boarding safely and proportionately.

3. Compliance and Governance

3.1 From a quality perspective, the principal concern is variability. Where boarding is supported by clear risk assessment, appropriate patient selection and regular senior review, it can be undertaken in a controlled manner. Where these processes are not applied consistently, there is potential for avoidable variation in patient outcomes, experiences, and safety.

From a patient experience perspective, the issues remain consistent with those previously reported. Boarding environments can compromise privacy and dignity, particularly where physical space is limited or where facilities such as curtains, lockers and appropriate seating are not available. The cumulative effect of these factors is a care experience that may fall short of the standards the Health Board seeks to provide.

From a workforce perspective, the continued reliance on boarding places an additional cognitive and operational burden on staff, who are required to manage patients outside of their usual clinical setting, often with limited environmental support. The absence of consistent frameworks for risk assessment further increases reliance on professional judgement, which, while valuable, is not a substitute for clear organisational standards.

Executive Response and Forward Programme

Considering this position and recognising both the necessity of boarding and the need to maintain its safe and proportionate use, the Executive Director of Nursing and Midwifery, along with the Executive Medical Director and Chief Operating Officer, will be commissioning a structured, Health Board-wide review of boarding practice. This work will be explicitly aligned to the existing governance framework and will seek to close the gap between policy intent and operational delivery.

This review will consider, in detail, how boarding is currently utilised across care groups, including the extent to which it reflects underlying capacity and demand pressures. It will also examine the consistency with which risk assessment processes are applied, with a particular focus on defining a clear, proportionate framework that is understood and used consistently across all sites.

Alongside this, a ward-level assessment of boarding environments will be undertaken, looking beyond process into the practical realities of care delivery. This will include consideration of occupancy levels, space utilisation, privacy and dignity, and the ability of clinical teams to deliver safe care, including in

emergency situations. The intention of this work is not solely to identify risks, but to identify opportunities for improvement, whether through operational change, redesign of space, or longer-term capital considerations.

Fundamentally, this programme will also reinforce the principle that boarding is an exception, not a substitute for standardised care delivery. It will seek to re-establish clear thresholds for its use, strengthen oversight of how and when it is applied, and ensure that decisions to board patients are consistently aligned with both clinical need and environmental capability.

4. Conclusion

4.1 Patient boarding remains an important and, at times, necessary component of the Health Board's response to sustained pressure. The organisation has previously demonstrated that it can be managed in a way that supports system flow without a corresponding increase in measurable harm. However, the emerging evidence presented here indicates that the context has evolved.

The risk is no longer solely associated with the use of boarding itself, but with the potential for its normalisation and the resulting variability in how associated safeguards are applied. This represents a more subtle, but no less important, challenge to the consistency of quality, safety and patient experience across the organisation.

The proposed programme of work provides a proportionate and constructive response, aimed at restoring consistency, strengthening assurance and ensuring that boarding remains a controlled and justified intervention, rather than an embedded feature of routine care delivery.

5. Recommendation

The Committee is asked to **NOTE** the current position, **RECOGNISE** the balance that must be maintained between operational necessity and quality risk, and **SUPPORT** the proposed Executive Director of Nursing-led programme of review and improvement.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework**	Strategic Risk 2
	If more than one applies please list below: Strategic Risk 3 Strategic Risk 6 Strategic Risk 9 Strategic Risk 10

(Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	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:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was 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)** There is no immediate reputational impact arising from this report; however, continued reliance on boarding and variability in controls reinforce the importance of maintaining robust oversight and improvement
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**Yes (include further detail below)** The review will be undertaken within existing resources; however, longer-term recommendations may identify operational or capital implications requiring further consideration

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	

Quality, Safety & Experience Committee

IPC Annual Report 2025–26

Eitem yr Agenda / Agenda Item	5.1
Dyddiad y Cyfarfod / Date of Meeting:	21 July 2026
Statws Cyhoeddi / Publication Status:	Public
	Not exempt from publication. No patient-identifiable or commercially sensitive information is included in this cover report.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Filipe Leitão, Head of Nursing – Infection Prevention and Control
Cyflwynydd yr Adroddiad / Report Presenter:	Becky Gammon, Interim Deputy Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Executive Director of Nursing, Midwifery and Patient Care
Diben yr Adroddiad / Report Purpose:	For Assurance and Endorsement
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Quality, Safety & Experience Committee are asked to receive the IPC Annual Report 2025–26, note the mixed assurance position, endorse the 2026/27 priorities and support onward submission through the Health Board governance route.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	All applicable strategic pillars
	Improving Care; Creating Health; Sustaining our Future; Inspiring People.

Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	The report supports the Annual Delivery Plan and IMTP priorities for safe, effective and person-centred care by providing assurance on HCAI prevention, outbreak management, IPC governance, workforce capability, environmental and decontamination risks, antimicrobial stewardship, community IPC and sustainability.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)*	The Annual IPC Report 2025–26 provides Health Board-wide assurance on infection prevention governance, surveillance, outbreak management, decontamination, environmental risk, audit, training and service development.
What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The overall assurance position is mixed. CTMUHB compares favourably with Wales for C. difficile, Pseudomonas aeruginosa and Staphylococcus aureus, but E. coli and Klebsiella spp. bacteraemia remain above the Wales benchmark. The IPC service model has strengthened through 12-hour acute-site cover, weekend and bank holiday on-call, Hub development, improved recruitment and an expanding Community IPC Team. Key assurance concerns remain: CDI improvement is not yet sufficient to meet the 25% reduction ambition; 86 outbreaks/periods of increased incidence affected 729 patients and 140 staff, with 652 bed days lost; Mandatory IPC training compliance remains below standard at 78.09%, with Medical and Dental staff at 38.22%; PPS findings demonstrate improvement in Bare Below the Elbow but continuing variation in hand hygiene and PPE/glove practice.

Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The report confirms that IPC improvement must be owned from ward to Board. Gram-negative bloodstream infection and CDI require cross-system action across acute care, primary care, community services, antimicrobial stewardship, catheter/device pathways, care homes and patient-flow decisions. Training compliance, ANTT assurance and blood-culture contamination should be treated as linked indicators of clinical practice reliability and leadership accountability. There are also active organisational risks relating to decontamination resilience, ventilation, isolation capacity, HCID preparedness, environmental compliance and digital capture of learning/actions. These risks require continued executive visibility, care group ownership and alignment between IPC, microbiology, pharmacy, estates, facilities, occupational health, PHW and local authority partners.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Priorities for 2026/27 are to: strengthen the Gram-negative and CDI reduction programmes; improve mandatory training compliance, particularly for Medical and Dental staff; embed the outbreak framework; expand Community IPC prevention work; use PPS as a recurring improvement and assurance tool for BBE, PPE, hand hygiene, devices and ANTT; progress decontamination, ventilation, isolation and HCID risk actions; and triangulate safety, sustainability and value from appropriate PPE/glove use. The Quality, Safety & Experience Committee are requested to Endorse the Annual Report and ensure care groups act on the priorities and risks described.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Quality, Safety & Experience committee is asked to: • RECEIVE and NOTE the IPC Annual Report 2025–26 and the mixed assurance position described. • ENDORSE the 2026/27 IPC priorities and the proposed focus on Gram-negative bacteraemia, CDI, training compliance, PPS, outbreak governance, community IPC and infrastructure risks. • SUPPORT onward submission through the Health Board governance route and ensure care group ownership of actions arising from the report.

1. Background / Context

The IPC Annual Report 2025–26 summarises CTMUHB's position across HCAI surveillance, outbreak management, audit, education, IPC service delivery, decontamination, water and ventilation safety, sustainability and community prevention. It provides assurance against the Welsh Government Code of Practice for the Prevention and Control of Healthcare Associated Infections and sets out the main improvement priorities for 2026/27.

2. Strategic Insights

The Health Board has strengthened IPC infrastructure and responsiveness through an enhanced acute-site model, weekend and bank holiday on-call, Hub coordination, improved recruitment and Community IPC development. Performance is favourable against Wales for CDI, Pseudomonas and Staphylococcus aureus, but Gram-negative bacteraemia remains the main epidemiological challenge, particularly E. coli and Klebsiella spp. Community-onset infection is a major driver; therefore, acute controls alone will not deliver the scale of reduction required.

3. Risks and Opportunities

Key risks include persistent Gram-negative bacteraemia, CDI trajectory, mandatory training compliance, ANTT and blood-culture contamination, outbreak pressure, PPE/hand-hygiene reliability, isolation capacity, decontamination resilience, ventilation and HCID preparedness. Opportunities include a stronger Community IPC offer, targeted PPS cycles, improved digital action tracking, care group accountability, antimicrobial stewardship and safer, lower-waste PPE practice.

4. Compliance and Governance

Core IPC governance is in place through IPCC, quarterly reporting, surveillance via ICNet/HARP, microbiology input, RCA/review processes, audit, policies,

water/ventilation and decontamination governance. Assurance is strongest where specialist oversight and audit are embedded, but several Code of Practice domains remain partially compliant and require continued oversight, particularly training, environment, isolation, antimicrobial stewardship and laboratory/pathway standardisation.

5. Benchmarks

The annual report benchmarks CTMUHB against all-Wales rates. CTMUHB is below or favourable to Wales for CDI, Pseudomonas, MRSA and MSSA/Staphylococcus aureus indicators, but remains above Wales for E. coli and Klebsiella spp. bacteraemia. Annual organism data show CDI 164 cases, Staphylococcus aureus 113, E. coli 364, Klebsiella spp. 138 and Pseudomonas 14, with community-onset cases representing a substantial proportion of the burden.

6. Conclusion

The report provides reasonable assurance that IPC governance and service resilience have strengthened, but it also demonstrates that sustained improvement requires Board-to-ward ownership, cross-system prevention and measurable impact. QSEC endorsement is requested to maintain executive visibility and support delivery of the 2026/27 priorities.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Quality and Safety; Patient Safety; Operational Resilience; Workforce; Estates and Infrastructure. The report impacts strategic risk relating to avoidable harm from HCAI, outbreak-related service disruption, IPC training and competence, decontamination/ventilation/isolation resilience, antimicrobial resistance and public confidence. The report strengthens mitigation by setting clear priorities, governance routes and actions for 2026/27.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales A Healthier Wales; A Resilient Wales; A More Equal Wales; A Wales of Cohesive Communities. IPC supports safer care, prevention, resilience and reduced avoidable harm.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, improvement and research
	Data to knowledge; learning, improvement and research; whole-system perspective; leadership, culture and valuing people. The report uses surveillance, audit, PPS and outbreak learning to drive improvement.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Positive / Reduce
	The report supports appropriate reduction in unnecessary glove/PPE use, waste reduction and value-based care. No adverse environmental impact is expected from receiving the report.

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality: NEUTRAL/POSITIVE Summary of impact: No negative equality impact identified. The report supports safer, more reliable IPC practice for all patients, staff and visitors, including vulnerable groups at higher risk of infection. Outcome for Welsh Language: NEUTRAL Summary of impact: No adverse Welsh Language impact identified. Communication materials and patient-facing information should continue to follow Health Board Welsh Language requirements.	Not applicable – EWLIA completion not required for this assurance cover report. Executive sponsor sign-off: Executive Director of Nursing, Midwifery and Patient Care

Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Positive. The report directly supports the Duty of Quality by strengthening assurance on safe, effective, person-centred care, reducing avoidable infection-related harm and identifying priority actions for 2026/27. A separate full QIA is not required for receiving the annual assurance report; individual improvement programmes or service changes should complete QIA/EQIA as required.
Cyfreithiol / Legal	Yes – supports compliance with the Welsh Government HCAI Code of Practice, Health and Care Standards, Duty of Quality and IPC governance requirements.
Enw da / Reputational	Yes – transparent assurance on HCAI, outbreaks, training and infrastructure risks supports public confidence. Failure to act could increase reputational risk.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes – delivery requires care group leadership time and continued specialist/partner input. Some infrastructure actions may require capital or service investment; appropriate glove use demonstrates financial and sustainability benefit.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Infection Prevention and Control Committee / IPC governance route	09/06/2026	Reviewed and supported for onward approval.
Executive Director of Nursing / DIPC and IPC Senior Leadership Team	2025/26 and 2026/27	Key risks, assurance position and priorities reviewed through routine governance and operational escalation.
Quality, Safety & Experience Committee	21 July 2026	Report submitted for receipt, discussion, endorsement and onward governance.

Acronyms / Glossary of Terms

ANTT	Aseptic Non-Touch Technique
BBE	Bare Below the Elbow
CDI	Clostridioides difficile infection
CTMUHB	Cwm Taf Morgannwg University Health Board
HCAI	Healthcare-associated infection
HCID	High Consequence Infectious Disease
IPC / IPCC	Infection Prevention and Control / Infection Prevention and Control Committee
OMB	Operational Management Board
PHW	Public Health Wales
PPE	Personal Protective Equipment
PPS	Point Prevalence Survey
IMTP	Integrated Medium Term Plan
EQIA	Equality Impact Assessment
QIA	Quality Impact Assessment

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

IPC Annual Report 2025-26

Creating Health, Sustaining our Future, Improving Care and Inspiring People

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Executive Summary

This Annual Infection Prevention and Control (IPC) Report provides the Health Board's review of infection prevention, healthcare-associated infection surveillance, outbreak management, decontamination, environmental risk, training, audit and strategic service development during the 2025/26 financial year. The report demonstrates a service that has strengthened its infrastructure and visibility during the year, while also operating within a complex infection prevention environment characterized by community-onset infection burden, winter pressures, antimicrobial resistance, estate constraints and variable compliance with core IPC behaviors.

The overall assurance position is mixed. CTMUHB compares favorably with the all-Wales position for several key organisms, including Clostridioides difficile, Pseudomonas aeruginosa and Staphylococcus aureus; however, Gram-negative bloodstream infection remains the most important epidemiological challenge, particularly E. coli and Klebsiella spp. bacteremia, where CTMUHB remains above the Wales benchmark. The Health Board achieved a reduction in hospital-onset E. coli and hospital-onset Pseudomonas aeruginosa, but the overall Gram-negative burden continues to be influenced by community-onset infection and device-related risks, especially urinary catheter-associated pathways.

C. difficile remains a central area of concern. Although the Health Board remains below the all-Wales rate, the annual position does not demonstrate the scale of improvement required to meet the 25% reduction ambition. The data show that the overall burden is predominantly community onset, while hospital-onset cases account for approximately 37% of cases. This means that acute controls remain essential, but they will not be sufficient on their own. A more ambitious cross-system Programme is required, incorporating antimicrobial stewardship, proton pump inhibitor review, primary care engagement, care-home and community pathways, postcode and deprivation analysis, timely isolation, environmental decontamination and strengthened case review.

The Health Board has made important progress in strengthening the IPC service model. The move towards a more integrated, Health Board-wide service has been supported by 12-hour IPC cover across acute sites, a weekend and bank holiday on-call arrangement, further development of the IPC Hub model, improved recruitment, and the continued growth of the Community IPC Team. These developments provide stronger resilience, better standardization and increased ability to respond to risk in real time. The Community IPC Team is particularly important because a sizable proportion of the infection burden is community onset, and sustainable improvement requires IPC influence beyond acute hospital settings.

The point prevalence survey Programme has provided valuable real-time assurance on the reliability of fundamental IPC behaviors. Bare Below the Elbows compliance improved in several areas and repeat survey work demonstrated that targeted feedback can produce measurable improvement. However, the expanded POW survey showed that high BBE compliance does not automatically translate into reliable hand hygiene or appropriate PPE use. PPE practice, particularly inappropriate glove use and failure to remove or change PPE between contacts, remains a key behavioural risk. These findings support the need for continued observational audit, leadership accountability, behavior-change methodology and integration of PPS findings with training, HCAI review, outbreak learning and sustainability work.

Financial stewardship and sustainability have also been strengthened through work on appropriate glove use. Non-sterile examination glove use reduced by approximately 605,800 individual gloves, with a related non-sterile spend reduction of approximately £20,658 and an overall examination-glove spend reduction of approximately £25,682 when sterile and non-sterile categories are combined. This

should be described as a quality, safety, sustainability and value outcome that is likely to have been at least partially supported by PPS and PPE/BBE improvement work. It should not be presented as solely caused by IPC intervention, as glove consumption is also affected by clinical activity, case mix, procurement, outbreak pressure and stock management.

Outbreaks and periods of increased incidence continued to place substantial operational pressure on the Health Board. The annual dataset records 86 outbreaks/PII, affecting 729 patients and 140 staff, with 652 bed days lost. Q4 was the most pressured period, reflecting winter viral activity and the system impact of influenza, norovirus and other transmissible infections. The report demonstrates that outbreak management requires a whole-system model, involving IPC, clinical teams, site management, patient flow, microbiology, facilities, estates, occupational health and executive leadership.

Training compliance remains one of the clearest Organisational risks. Overall IPC training compliance remains below the expected standard at approximately 78%, with particularly low compliance among Medical and Dental staff. This is not simply a training-delivery issue for the IPC team; it is a governance and leadership issue requiring care group ownership, professional accountability, and performance management. Low compliance weakens assurance that staff consistently understand and apply standard infection control precautions, ANTT, device care, antimicrobial responsibilities, isolation principles and PPE requirements.

The annual report also identifies continuing risks in blood culture contamination, ANTT assurance, decontamination resilience, ventilation safety, isolation capacity, HCID preparedness and the need for stronger digital capture of learning and actions. Work to improve caesarean section SSI surveillance, including standardization of training and linkage of SSI data with ICNet, is an important example of how the Health Board is seeking to strengthen case visibility, validation and timely investigation.

The following summary should support discussion at Infection Prevention and Control Committee and Executive level:

Assurance theme	Annual position	Executive implication
HCAI performance	Favorable against Wales for CDI, Pseudomonas and Staphylococcus aureus; above Wales for E. coli and Klebsiella spp.	Gram-negative reduction and CDI prevention require Board-level oversight and cross-system ownership.
Service model	12-hour acute-site cover, weekend/bank holiday on-call, IPC Hub development and improved recruitment have strengthened resilience.	The service is better placed to respond to risk, but impact evaluation and completion of remaining recruitment are required.
Community IPC support	Community IPC capacity has developed and links with PHW, local authorities, care homes and wider partners are improving.	Community-onset infection cannot be reduced through acute action alone; primary and community work must be central to 2026/27 plans.
Behavioral assurance	PPS work shows improvement in BBE but ongoing variation in hand hygiene and PPE use.	PPE misuse and variable HH require behaviour-change methods, ward leadership and repeated measurement.
Training compliance	Overall compliance remains below target, with Medical and Dental staff compliance particularly low.	This should be escalated as a leadership and care group accountability issue, not solely an IPC team issue.
Outbreak pressure	86 outbreaks/PII, 729 patients affected, 140 staff affected and 652 bed days lost.	Winter resilience and outbreak governance remain key operational risks.
Infrastructure and specialist systems	Decontamination, ventilation, isolation and HCID preparedness risks remain active.	Capital, estates, decontamination and IPC governance must remain aligned through risk registers and committees.
Sustainability and value	Substantial reduction in non-sterile glove use and overall glove spend.	Appropriate PPE use can support safety, sustainability and value, but attribution should remain cautious and evidence-based.

Key messages for the Committee and Executive Team

- IPC improvement must continue to be owned from ward to Board, with clear care group accountability for training, practice standards, outbreak response and delivery of actions arising from HCAI reviews.
- The Health Board should prioritize Gram-negative bloodstream infection and CDI as the major infection-reduction programmes for 2026/27, with explicit acute, community, primary care and antimicrobial stewardship components.
- PPS should remain a core assurance and improvement methodology because it provides direct evidence of observed practice, identifies behavioral risk and supports targeted intervention.
- Training compliance, blood culture contamination and ANTT assurance should be treated as linked indicators of clinical practice reliability.
- Decontamination, ventilation, isolation capacity and HCID preparedness should remain visible within Organisational risk and capital prioritization processes.
- The strengthened IPC service model provides a stronger platform, but the next phase must demonstrate measurable impact on infection outcomes, compliance, timeliness of review and sustained behavioral improvement.

0 - INTRODUCTION

This Annual Infection Prevention and Control Report presents the position of Cwm Taf Morgannwg University Health Board (CTMUHB) for the 2025/26 financial year. It provides assurance on the governance, surveillance, prevention and control arrangements in place to reduce healthcare-associated infections, protect patients, staff and visitors, and support safe, effective care across acute, community and wider health and care settings.

Infection prevention and control is a fundamental component of patient safety and quality. It is also a whole-system responsibility. The prevention of healthcare-associated infection depends on the reliability of everyday clinical practice, the quality of the care environment, safe antimicrobial use, effective surveillance, rapid outbreak response, safe decontamination, adequate ventilation and isolation capacity, and the ability of staff at every level to recognize and act on infection risks. This report therefore reviews not only infection rates, but also the systems, behaviors and infrastructure that determine whether infection prevention practice is reliably delivered.

The report is aligned to the Welsh Government Code of Practice for the Prevention and Control of Healthcare Associated Infections, Health and Care Standards, national surveillance requirements and local governance arrangements. It also reflects the strategic direction of the Health Board and the need to embed infection prevention as a core element of safe care, operational resilience, quality improvement and public confidence.

The year has been characterized by a mixed epidemiological position. CTMUHB has performed favorably against Wales for some organisms, including C. difficile, Pseudomonas aeruginosa and Staphylococcus aureus, and has achieved important reductions in selected hospital-onset infections. However, Gram-negative bloodstream infection remains a significant challenge, particularly E. coli and Klebsiella spp. bacteremia, where CTMUHB remains above the all-Wales benchmark. C. difficile also requires sustained focus, as the overall burden remains strongly influenced by community-onset cases and the Health Board is not yet improving at the pace required to meet the national reduction ambition.

Operationally, the year has also been shaped by winter viral activity, norovirus and other outbreaks, high bed occupancy, pressure on side rooms, environmental decontamination challenges and the continuing need to balance patient flow with infection prevention requirements. These pressures reinforce that IPC cannot be delivered by specialist teams in isolation. Effective prevention requires visible clinical leadership, operational ownership, estates and facilities support, microbiology and pharmacy input, occupational health engagement, partnership with Public Health Wales and local authorities, and executive-level accountability.

During 2025/26 the IPC service has continued to develop. The introduction of 12-hour acute-site support, weekend and bank holiday on-call arrangements, further development of the IPC Hub model, improved recruitment and expansion of the Community IPC Team have strengthened the Health Board's ability to provide timely advice, respond to outbreaks, support clinical areas and extend IPC influence beyond the acute hospital environment. These service changes are important because a large proportion of infection risk sit across pathways rather than within hospital walls alone.

A key feature of the year has been the increased use of point prevalence surveys to assess observed practice. These surveys have provided practical assurance on BBE, hand hygiene and PPE use and have identified areas where improvement is possible and necessary. They have also highlighted the link between safe practice, sustainability and value, particularly in relation to appropriate glove use. The findings demonstrate that improvement is achievable when local data are shared, leadership is

visible and staff receive clear feedback; however, they also show that some behaviours remain inconsistent and require ongoing challenge.

The annual report should therefore be read as both an assurance document and an improvement document. It records areas of progress, but it also sets out where the Health Board must strengthen its controls. The priorities for 2026/27 must focus on converting learning into reliable practice, strengthening cross-sector prevention, improving training compliance, reducing Gram-negative and *C. difficile* infection burden, embedding surveillance and review processes, and ensuring that infrastructure risks remain visible and actively managed.

1-COMPLIANCE WITH THE CODE OF PRACTICE FOR THE PREVENTION AND CONTROL OF HEALTHCARE ASSOCIATED INFECTIONS - WALES

The Health Board has continued to maintain the Organisational infrastructure required to support IPC governance. This includes the Infection Prevention and Control Committee (IPCC), quarterly reporting, escalation of risks through appropriate governance routes, microbiology and laboratory support, policy review, surveillance through ICNet and HARP, RCA/review processes, environmental auditing, water and ventilation safety groups and decontamination governance.
The annual position demonstrates evidence of compliance across the key domains of the Code of Practice. However, the assurance position is not static. Several areas require continued focus: training compliance remains below the desired threshold; site-level variation in testing and microbiology pathways continues to complicate standardization; decontamination and ventilation risks remain active; and infection review processes require further strengthening to ensure learning is captured and acted upon rapidly.

Code domain	Annual evidence and assurance narrative	Gaps in assurance, mitigation actions and comments	Compliance rating
1. Appropriate Organisational governance, accountability and management systems	Board-level IPC leadership is in place through the Nurse Director, IPCC, quarterly IPC reporting, annual reporting, risk-register review, IPC strategy implementation, daily IPC site plans, ICNet/HARP surveillance and access to microbiology advice. These arrangements provide clear core governance from Board to ward.	Assurance can be improved due to limitations derived by tightening RCA timeliness, incomplete electronic learning/action tracking, training compliance below target and the need to further strengthen ward-to-Board escalation. Mitigation is to embed a lessons-learned matrix. There are also plans to create a board assurance framework to further strengthen the assurances in this domain,	**2. Compliant**
2. Decontamination of care equipment and medical devices	A Decontamination Specialist/Officer is in post; decontamination committee/site meetings, traceability systems, policies, protein testing, sterile services and endoscopy workstreams provide a recognized assurance structure. The annual report also describes ongoing central decontamination planning and service improvement activity.	There are active risks linked to ventilation constraints, refurbishment programmes and unresolved learning from the CJD investigation. Aim will be to work towards progress central decontamination, standardize equipment and close action logs through decontamination governance.	**2. Compliant**
3. Physical environment, cleaning and maintenance	Cleaning policy, National Standards of Cleanliness monitoring, AMaT environmental audits, facilities engagement, HPV/UV capability and capital/refurbishment input demonstrate active environmental IPC controls. IPC is sighted on estates work and provides advice on refurbishment and risk management.	Variation in audit performance, side-room pressure and inconsistent cleaning schedules reduce assurance. Mitigation is to strengthen joint IPC/facilities audits, implement new cleanliness standards, ensure facilities attendance at outbreak meetings, and prioritize capital and ventilation risks.	**2. Partially compliant**
4. Suitable, timely and accurate infection information and communication	IPC policies, isolation signage, ICNet alerts, daily IPC site plans, safe-to-start/site escalation meetings and outbreak cells provide multiple routes for timely communication to staff, patients, visitors and those responsible for care.	Assurance is constrained by the need for more consistent intranet/internet updates, clearer outbreak action logs, improved escalation from ward to site and more mature digital sitreps. Mitigation is to refresh IPC content, embed the outbreak framework and improve real-time reporting.	**2. Partially compliant**

Code domain	Annual evidence and assurance narrative	Gaps in assurance, mitigation actions and comments	Compliance rating
5. Staff engagement in preventing and controlling infection	Staff engagement is supported through mandatory IPC training, ANTT training, targeted education, audit feedback, point prevalence surveys for BBE/PPE, Datix/RCA processes, uniform/dress-code expectations and local leadership engagement.	Local ownership and behavioral compliance remain variable, with recurrent issues in BBE/PPE, ANTT and training uptake. Mitigation is to strengthen care group and professional accountability, implement IPC champions/link workers, continue PPS cycles, and ensure prompt escalation of repeated non-compliance.	**2. Partially compliant**
6. Suitable and sufficient isolation facilities	Single rooms are available across acute sites and IPC supports placement decisions through daily site planning, safe-to-start meetings, ICNet alerts for CPE/previous CDI and direct advice to patient-flow teams. Funding has been identified for negative-pressure rooms at RGH and POW.	Side-room scarcity, patient- lack of operational negative-pressure rooms in emergency departments remain significant risks (HB with lower number of negative pressures than recommended by WG). Mitigation is to progress the funded negative-pressure capital developments, maintain escalation for isolation delays, strengthen Datix reporting for failure to isolate and use risk-based placement protocols.	**2. Partially compliant**
7. Evidence-based IPC policies, NIPCM adoption and organism-specific guidance	IPC policies are in place and reviewed through IPCC; the NIPCM for Wales is used as the policy framework; core policy topics include SICPs, hand hygiene, PPE, transmission-based precautions, outbreak management, ANTT, HCAI reporting, antimicrobial stewardship, water, ventilation, and decontamination. Local work includes CDI, CSARO/CPE, CJD, TB, Candida auris, ARI, gastrointestinal infection and HCID preparedness.	Implementation assurance not consistent across all policies and several areas require clearer triggers, action tracking and local standardization,, CDI review documentation and decontamination. Limited number of staff trained on HCID, which limits the safe response capacity. Mitigation is audit implementation of high-risk policies, aiming at future measurement of implementation criteria within policies as well as ensure that PPS are looking into main policies implementations. Essential Care Group ownership	**2. Compliant**
8. Occupational health systems protecting staff from infection risk	Occupational Health arrangements support pre-employment assessment, staff immunization, exposure management, vaccination programmes, OH advice routes and outbreak support. IPC, OH and PHW collaboration supports staff protection for respiratory infections, HCID and vaccine-preventable diseases.	OH assurance reports to inform on immunization dashboards, clarify as well as fit testing compliance across the organization.	**2. Compliant**
9. Staff training, education and competence in IPC and decontamination	IPC Level 1 and Level 2 training, ESR monitoring, targeted training, ANTT training and decontamination education are available. The IPC team has delivered bespoke sessions and supports practice-development activity.	The Q4 position shows overall IPC training compliance of 78.09%, below the expected threshold, with Medical and Dental compliance at 38.22%. ANTT competency also requires strengthening. Mitigation is monthly compliance reporting, care group escalation, mapping to the All-Wales IPC Training and specialist workforce frameworks and role-based competency review.	**2. Partially compliant**
10. Organisation-wide antimicrobial stewardship programme	AMS is linked to CDI reviews, PPI review, microbiology advice, antimicrobial pharmacy input, QI collaboration, prescribing review and antimicrobial consumption data. The CDI workstream has strengthened collaboration between IPC, AMS, microbiology, PHW and epidemiology. The HB continues to be one of the highest prescriber of Antibiotics albeit significant improvements.	Mitigation is to expand community CDI review as well as support current project on community aiming at PPI dose reduction as prevention of CDiff.	**2. Partially compliant**
11. Compatibility of IPC with net zero and sustainability	IPC contributes to sustainability through safe reduction of unnecessary PPE use. The glove-use review shows 605,000 fewer non-sterile gloves used in 2025/26 compared with 2024/25, with a £20,685 reduction in non-sterile glove spend, plus a further £5,000 reduction in sterile glove spend despite a small increase in sterile glove-pair usage due to price change.	Attribution to PPS/BBE/PPE improvement is plausible but not definitive without triangulation against clinical activity, procurement trends and audit results. IPC works closely with QI team to support decarbonization changes.	**2. Compliant**

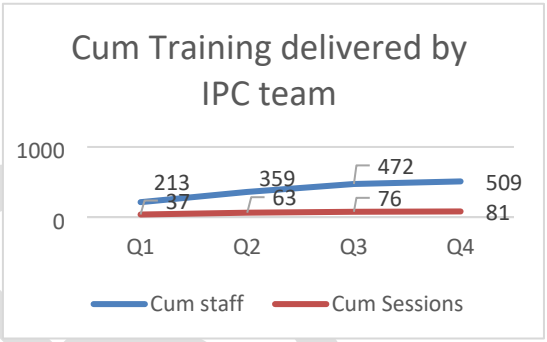
Code domain	Annual evidence and assurance narrative	Gaps in assurance, mitigation actions and comments	Compliance rating
12. Secure and adequate laboratory support	Accredited laboratory support, HARP/ICNet reporting, microbiology advice and surveillance data support IPC decision-making. Laboratory data underpin organism-specific monitoring, outbreak response and blood-culture contamination analysis.	Assurance is affected by laboratory capacity pressures, variation in diagnostic/testing methodology across sites and the need to standardize pathways for timely, equitable access. Mitigation is to review laboratory capacity, positivity and contamination rates, standardize testing pathways, and maintain microbiology escalation within IPCC and site governance.	**2. Partially compliant**

Table 1- Compliance review against the Code of Practice

2-TRAINING ACTIVITY AND WORKFORCE CAPABILITY

2.1-TRAINING DELIVERED

Training is in the core of the IPC role.
During the financial year the IPC team provided formal IPC training to 509 staff members (more 125 staff than last year - % increase) along the 4 quarters as shown in the following graphic:



Graphic 1 - IPC Cum Formal Training Provided per Quarter and staff attendance.

This only captures formal planned training delivery and not the opportunistic or delivered due to specific needs detected during IPC audits and investigations. IPC has supports other joint training initiatives such as Managing Safely, which is organized by the Heath and Safety department with a protected time for IPC training as well as the New Doctors Induction.

2.2-TRAINING ATTENDED

The IPC team continues to be an expert service to the Trust and have worked towards keeping their professional development up to date with the latest knowledge, enabling the team to provide a high level of support to the Health Board. It is essential that investment continues during this new financial year, to support the IPC team regarding it's knowledge development. For the new financial year, training should look into (not exclusively) preparing members of the team in key aspects such as water safety, decontamination and ventilations safety, due to the lack of expertise across the IPC team on this key areas. The IPC team will continue to endeavor to be present in other initiative such as National and Regional conferences and then ensure that all the learning is brought back to the organization, shared within the IPC team as well a broader audience and informs the IPC practices and advice.

Another internal initiative that has been put in place to ensure the team's knowledge is up to date and that all the team members possess the essential knowledge to be able to develop its role was the creatin of meeting every 2 months were several IPC teams are presented either by members of the team, other health experts within the Health Board and with some external speakers. The themes presented during the team meetings for shared learning were:

- *C. difficile* IPC Training
- ICNet Outbreak Management
- IPC in Mental Health
- Decontamination Endoscopes Ultrasound
- PPS BBE PCH
- ANTT Training for IPC team
- TB/NTM – A Whistle Stop Tour
- IPC Indications of CJD
- HLD Trophon Demonstration
- Legionella
- Consultation Project
- Multi Resistant Organisms
- HCID

The following table summarizes trainings attended by the team along the FY:

The following table summarizes other internal and external training attended by members of the IPC team - this is not an exhaustive list of training/courses attended:

Training	N staff attended
Decontamination and Sterilisation - Conference and discussion on current decontamination and sterilisation methods in use throughout healthcare,	1
Aspire - leadership and management course. - Cwm Taff provided leadership course covering the foundations of effective leadership and implementation in the workplace.	1
IP&C in Mental health - Conference discussing the challenges of IP&C practices in a MH setting. Demonstrations and ideas on overcoming these challenges.	2
MSc Module Epidemiology and Biostatistics - MSc module focusing on the epidemiology of disease and the impacts on population health. Focus on the transmission of pathogens and surveillance of emerging trends. Learning further focused on surveillance and collection of statistical data and utilising data to recognise emerging concerns.	1
Introduction to Hepatitis - Training course on being a compassionate leader and facilitating workshops to train others	1
Managing IPC in a mental health setting - Introduction to the complexities of managing IPC in a mental health environment.	1
Compassionate leadership course. - Training course on being a compassionate leader and facilitating workshops to train others	2
ANTT Assessor training - Training on principles of ANTT followed by practical assessment and assessment of assessing another colleagues	3
HCID – Train the trainer	1
Specialist ventilation systems for Healthcare	1
Specialist Decontamination for Healthcare	1

Combating CDI conference 2025 – Leeds	1
Cdiff learning session – PHW	1
Harp conference – IPC Summer Forum	3
IPC Conference 2025	2

Table 2- Training attended by the IPC team during the FY

2.3- IPC TRAINING COMPLIANCE

Training compliance remained one of the clearest Organisational risks throughout the year. The Q4 position reported overall IPC training compliance of 78.09%, which remains amber and below the expected target. Q2 compliance was 78.69%, indicating that improvement across the year was non-existent and therefore not sufficient to provide strong assurance.
The most concerning theme is the persistent low compliance among Medical and Dental staff. Q2 reported Medical and Dental compliance at 37.92%, the data indicated that there had been no significant improvement across the year (38.22% on Q4). This is important because clinical decision-making, antimicrobial prescribing, invasive device management, ANTT and patient placement decisions all require reliable IPC knowledge and ownership.
The report therefore concludes that training compliance cannot be treated as an IPC team issue alone. It requires care group leadership, professional group ownership, line-manager follow-up and integration into performance management. IPC can provide training, support, audit and specialist advice, but accountability for staff completion must sit clearly with clinical and managerial leadership.

The following tables and figures resume the data:

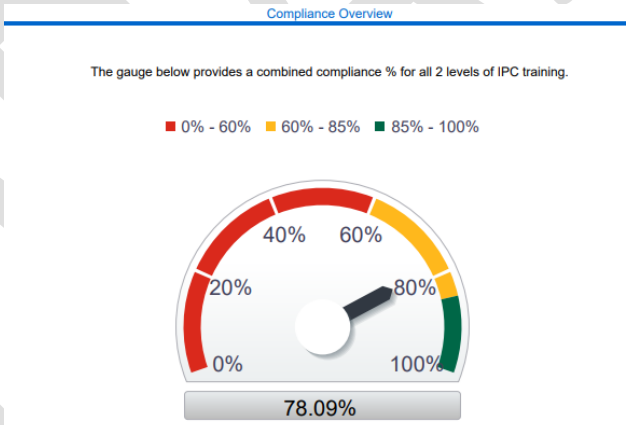


Figure 1 - Overall compliance with IPC mandatory training

As can be seen in above gauge, we have a sub-optimal compliance across both Level 1 and Level 2 training, leaving us in amber with only 78.09% with our staff completed the IPC training, if we look at both training by subject level:

Compliance by Subject Level

The table below provides a compliance percentage for each of the 2 levels of IPC training

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	4465	4465	3749	83.96%	75	83.02%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	8702	8702	6533	75.07%	413	71.87%

Table 3 - Compliance with IPC mandatory training per Level

We can see that the lowest compliance is at Level 2, which is particularly concerning, because it is aimed to those staff that will be doing more invasive techniques with the patients and therefore will incur in higher risk of both causing infection or getting themselves infected.
To further understand this information, it is important to look at the compliance per staff group:

Compliance by Staff Group

The Table below provides an overall combined compliance % for each Staff Group

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic	420	427	327	76.58%	29	70.26%
Additional Clinical Services	2580	2580	2090	81.01%	130	77.79%
Administrative and Clerical	2629	2643	2224	84.15%	57	82.97%
Allied Health Professionals	822	822	670	81.51%	36	79.08%
Estates and Ancillary	1377	1378	1145	83.09%	9	82.58%
Healthcare Scientists	223	223	186	83.41%	4	82.96%
Medical and Dental	874	874	334	38.22%	21	36.73%
Nursing and Midwifery Registered	4220	4220	3306	78.34%	202	75.05%

Table 4- Compliance with IPC mandatory training per Staff Group

The data clearly highlights that the Medical and Dental staff group has the lowest compliance by a significant margin, with only 38.22% (albeit an improvement of 9,63% from last FY), followed by the Professional, Scientific, and technical group at 76.58% (15.32% increase from last FY). Conversely, the Administrative and Clerical staff demonstrate the highest compliance, despite their typically lower risk of patient interaction. Nurses and Midwives also show suboptimal compliance at 73.94%.
If we look at the data from a care group perspective:

Compliance by Care Group

The Table below provides an overall combined compliance % for each Care Group

Care Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Bank Care Group	2	2	1	50.00%	0	50.00%
110 Chief Operating Officer Care Group	1302	1303	1051	80.66%	10	80.12%
110 Children & Families Care Group	1445	1454	1064	73.18%	54	70.63%
110 Corporates and Hosted Care Group	1372	1373	1177	85.72%	23	84.85%
110 Diagnostics, Therapies, Pharmacy & Sciences Care Group	1757	1757	1433	81.56%	77	78.49%
110 Mental Health & Learning Disabilities Care Group	1255	1259	1020	81.02%	45	79.03%
110 Planned Care Care Group	2399	2405	1757	73.06%	92	70.44%
110 Primary & Community Care Group	1646	1647	1382	83.91%	85	80.39%
110 Unscheduled Care Care Group	1967	1967	1397	71.02%	102	67.72%

Table 5- Compliance with mandatory training per Care group

With exception corporate and hosted care group, all the other areas have low scores, in particular Unscheduled care and Planned care (Bank care group shows 50% compliance but has only 2 staff members attributed).
This overall compliance picture is concerning. Without a robust understanding of their responsibilities and effective infection prevention practices, staff are inadvertently placing patients, themselves, and the wider community at unnecessary risk, contravening the fundamental Hippocratic principle of '*Primum non nocere*' (First, do no harm).
Strategies to improve the compliance have been discussed between IPC and the Executive Director of Nursing but will require active participation of the organizational leadership to find workable solutions to improve compliance to a level that can provide adequate assurance on the delivery of safe care

3 – IPC SERVICE MODEL, STAFFING AND STRATEGIC DELIVERY

3.1 - OVERVIEW AND STRATEGIC CONTEXT

The 2025/26 financial year represented a significant period of consolidation and development for the Infection Prevention and Control (IPC) service across Cwm Taf Morgannwg University Health Board (CTMUHB). The service has moved from a predominantly site-based and reactive model towards a more coordinated, resilient and strategically directed service model, designed to support consistent infection prevention practice across all three acute hospital sites and across wider community interfaces.

This development has been necessary because the infection prevention landscape facing the Health Board has become increasingly complex. The organisation continues to manage persistent healthcare-associated infection risks, increasing antimicrobial resistance, significant winter respiratory pressures, environmental and estate constraints, decontamination challenges, and a high burden of community-onset infection. These risks require an IPC model that is visible, responsive and clinically embedded, but also sufficiently strategic to influence organisational systems, workforce behaviours and partnership working beyond the acute hospital setting.

The revised service model is therefore based on three linked principles: consistent access to specialist IPC advice, greater operational resilience across sites, and stronger strategic alignment between acute, community, microbiology, antimicrobial stewardship, estates, facilities, decontamination, Public Health Wales and local authority partners. These principles underpin the work described in this chapter and provide the foundation for the wider infection reduction programme set out across the Annual Report.

3.2 - DEVELOPMENT OF THE ACUTE IPC SERVICE MODEL

During the year, the IPC service continued to embed a more integrated acute-site support model. The model has strengthened the ability of the team to provide timely advice to clinical areas, support outbreak management, attend site escalation discussions, advise on isolation and patient placement,

and respond to areas of concern identified through surveillance, audit, incident review or operational escalation.

A key development has been the provision of 12-hour IPC support across all three acute sites. This has significantly increased the visibility and availability of the IPC team, particularly at times when clinical and patient-flow decisions are most likely to require rapid specialist input. The enhanced model supports clinical areas during extended daytime operational hours and enables IPC advice to be more closely aligned with real-time bed management, escalation meetings, outbreak control, environmental risk assessment and urgent clinical decision-making.

The extended acute-site model also provides greater equity of access across Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital. This is important because each site has a different infection profile, estate configuration, patient-flow challenge and microbiology interface. A more consistent service model helps reduce variation in practice, strengthens the standardisation of advice, and supports a common approach to the implementation of Health Board policy and national guidance.

3.3 - ON-CALL SUPPORT DURING WEEKENDS AND BANK HOLIDAYS

In addition to the enhanced weekday model, the IPC service now provides an on-call service during weekends and bank holidays. This is a substantial improvement in service resilience and organisational response capacity. The on-call arrangement enables urgent IPC issues to be escalated and reviewed outside standard working patterns, including suspected or confirmed outbreaks, complex isolation decisions, significant environmental concerns, and urgent advice relating to transmissible infections.

This arrangement complements, rather than replaces, existing 24-hour microbiology advice. It provides a specialist IPC operational route for escalation when infection prevention decisions have immediate implications for patient safety, ward function, outbreak control or service continuity. The model has improved the Health Board's ability to maintain safe IPC practice during periods of reduced staffing, increased demand and heightened operational pressure.

The weekend and bank holiday provision has also improved continuity of advice. Previously, some IPC issues could only be reviewed retrospectively on the next working day unless urgent microbiology input was required. The new arrangement allows the organisation to act earlier, support clinical teams more consistently, and reduce the risk of delays in implementing transmission-based precautions, outbreak measures or environmental controls.

3.4 - CENTRAL COORDINATION, HUB WORKING AND STANDARDISATION

The development of the IPC Hub model has continued to be a central element of the service redesign. The Hub provides a coordinated point of oversight for operational IPC activity, supporting triage of requests, daily review of emerging risks, allocation of IPC resource, escalation of significant concerns and consistency of advice across the Health Board. This approach has strengthened the ability of the team to work as one Health Board service rather than as separate site-based functions.

Hub working supports resilience by enabling staff to be deployed according to risk, demand and capacity. It also supports improved governance because queries, outbreaks, audit findings, surveillance concerns and follow-up actions can be considered within a single operational framework.

This has helped improve situational awareness across the service and has supported more consistent communication with Heads of Nursing, site teams, patient-flow colleagues and operational managers.

The model has also supported the development of more standardised IPC processes. This includes alignment of outbreak recording, escalation routes, review documentation, audit feedback, surveillance follow-up and dissemination of learning. While further work remains to embed all elements of the model fully, the direction of travel is positive and has already increased the responsiveness and cohesion of the IPC service.

Service component	2025/26 position and assurance	Further development / next steps
Acute-site IPC support	A 12-hour IPC support model is now in place across all three acute sites, improving real-time access to specialist IPC advice, supporting patient-flow decisions and increasing visibility in clinical areas.	Continue to monitor demand, response times and consistency of advice across sites; ensure escalation pathways remain clear and sustainable.
Weekend and bank holiday on-call service	An IPC on-call service is now available during weekends and bank holidays, strengthening organisational resilience and enabling urgent infection prevention risks to be reviewed earlier.	Develop ongoing evaluation of call themes, frequency and learning to ensure the model remains proportionate and clinically effective.
Centralised Hub model	The Hub has improved triage, coordination, resource allocation, standardisation and oversight of emerging risks across the Health Board.	Continue to embed Hub processes, strengthen documentation and align digital systems to support robust governance.
Outbreak response	The strengthened model has improved responsiveness to outbreaks and incidents by supporting earlier advice, escalation, site ownership and multidisciplinary coordination.	Maintain focus on consistent outbreak documentation, lessons learned and post-incident review across all sites and community interfaces.
Community IPC Team	The Community IPC Team has been developed as a key strategic extension of the IPC service, with growing links to Public Health Wales, local authorities and community providers.	Further detail on CIPCT delivery is set out later in the report; priority work includes GP engagement, care home support and wider community surveillance.
Education and practice support	The IPC service has increased clinical-area visibility, supported targeted education, and contributed to staff awareness through site work, training and improvement initiatives.	Continue targeted education based on risk, audit findings, outbreak learning, HCAI reviews and areas of low compliance.
Strategic delivery and governance	IPC reporting through the Infection Prevention and Control Committee continues to provide formal oversight, escalation and assurance against national and local priorities.	Strengthen links between IPC strategy, Board Assurance Framework evidence, operational risk registers and measurable improvement outcomes.

Table 6 - IPC service model and assurance summary

3.5 - STAFFING POSITION, RECRUITMENT AND TEAM RESILIENCE

The staffing position within the IPC service has improved significantly during the year. Recruitment to vacant posts has progressed well and the service has now nearly recruited to all vacancies, with the exception of one Band 7 role. This represents a substantial improvement in the service's ability to maintain continuity, provide cross-site support and respond to both planned and unplanned infection prevention pressures.

The improved staffing position has had a direct impact on team resilience. Greater staffing stability has enabled more reliable site presence, improved cover arrangements, stronger internal support, increased capacity to participate in meetings and reviews, and better ability to maintain core functions during periods of annual leave, sickness absence or operational escalation. It has also supported the development of a more flexible workforce, with staff increasingly able to work across site boundaries and contribute to Health Board-wide priorities.

Although the position is substantially improved, the remaining Band 7 vacancy remains important. Band 7 capacity is central to senior operational leadership, complex case management, staff

supervision, escalation management, audit oversight and the translation of strategic priorities into day-to-day practice. Recruitment to this post should therefore remain a priority, both to complete the staffing establishment and to protect the sustainability of the expanded service model.

The service has also continued to strengthen internal ways of working. This includes clearer allocation of responsibilities, more consistent escalation, greater sharing of learning across sites, and improved coordination between acute and community IPC work. These developments are essential because the IPC agenda cannot be delivered through individual expertise alone; it requires a stable team infrastructure, consistent leadership, effective communication and an organisational model that allows specialist advice to be deployed where it is needed most.

Area	Current position	Assurance and continuing focus
Recruitment	Almost all vacancies have been recruited to, with one Band 7 vacancy remaining.	This provides significantly improved stability and capacity. The remaining vacancy should be prioritised to protect senior operational resilience.
Site coverage	The service now provides 12-hour support across all three acute sites.	This increases visibility, responsiveness and equity of specialist IPC advice across CTMUHB.
Out-of-hours resilience	Weekend and bank holiday on-call IPC support is in place.	This improves continuity and enables earlier action for urgent IPC risks outside standard working patterns.
Cross-site working	The Hub model enables more flexible deployment of IPC staff according to risk, capacity and demand.	Further embedding will support standardisation, reduce variation and improve organisational learning.
Community capacity	The Community IPC Team has become an increasingly important part of the service model.	Further development will support the Health Board response to community-onset infections and provider-facing IPC risks.
Leadership and supervision	Improved staffing has strengthened the ability to support staff, manage escalation and maintain core service delivery.	Continued focus is required on succession planning, staff development and senior clinical leadership.

Table 7- Staffing and resilience summary

3.6 - PROFESSIONAL LEADERSHIP, GOVERNANCE AND SPECIALIST ADVICE

The IPC service continues to provide specialist professional leadership across a broad range of infection prevention functions, including surveillance, outbreak management, HCAI review, audit, training, policy development, decontamination advice, environmental risk management and clinical practice improvement. The service operates within the governance structure provided by the Infection Prevention and Control Committee, which remains the primary forum for oversight, escalation and assurance.

Professional leadership has been strengthened through closer working with microbiology, antimicrobial stewardship, estates, facilities, decontamination, occupational health, patient safety and operational site teams. These relationships are critical because many infection prevention risks sit at the interface between clinical practice, infrastructure, patient flow, antimicrobial use and environmental management. The ability of IPC to influence these systems is therefore as important as the ability to provide direct advice to individual clinical areas.

The service has continued to support the development and implementation of Health Board policies, guidance and toolkits. This includes work to standardise outbreak management, support early escalation of transmissible infections, improve assurance on environmental decontamination, strengthen learning from HCAI reviews and provide advice on emerging risks. The continued alignment of IPC policy, surveillance, audit and governance is essential to ensuring that the Health

Board can evidence compliance with the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections.

3.7 - COMMUNITY IPC TEAM AND SYSTEM-WIDE PARTNERSHIP WORKING

The development of the Community Infection Prevention and Control Team (CIPCT) is one of the most strategically important changes to the IPC service model. The detailed work of the CIPCT is explored further later in this report; however, its establishment is also central to this chapter because it changes the reach and purpose of the IPC service. It recognises that infection prevention cannot be delivered solely through acute hospital interventions and that a significant proportion of the Health Board's infection burden is community onset.

Significant work has been undertaken to build effective working relationships with Public Health Wales and local authority partners. These relationships are essential to ensuring a coordinated response to infection risks across care homes, supported living settings, domiciliary care, community services and other non-acute environments. During the year, the team has supported partnership responses to outbreaks and incidents, including COVID-19 and scabies, helping to strengthen communication, clarify roles and improve consistency of advice across organisational boundaries.

The partnership approach with Public Health Wales and local authorities has also supported a clearer understanding of the respective responsibilities of each organisation in managing community infection risks. This is particularly important where outbreaks affect vulnerable populations, where care providers require practical IPC support, or where multiple agencies need to coordinate risk assessment, communication, control measures and recovery planning.

The service is now progressing work to establish stronger working relationships with general practices. This is an important next stage because primary care has a central role in antimicrobial stewardship, early identification of infection risk, management of long-term conditions, wound care, urinary catheter management, vaccination, patient advice and referral into wider services. Building effective links with GPs will support a more joined-up approach to community-onset infections and will help ensure that learning from surveillance and HCAI review can inform practice across the whole patient pathway.

The strengthening of community partnerships should also support future work on surveillance, education, risk-based visits, outbreak learning and targeted improvement in settings where IPC expertise has historically been more difficult to access. While the team is still developing, the direction is positive and the early investment in relationships is an important foundation for future delivery.

3.8 - EDUCATION, CLINICAL VISIBILITY AND PRACTICE DEVELOPMENT

Education and clinical visibility remain core functions of the IPC service. The expanded service model has created greater opportunity for IPC staff to work directly with clinical teams, reinforce standard precautions, support local risk assessment, provide targeted training and respond to practice issues identified through audits, outbreaks, HCAI reviews and incident investigations.

The service has continued to emphasise that infection prevention is everyone's responsibility and must be embedded into routine clinical practice. This includes hand hygiene, bare below the elbows, safe

use of personal protective equipment, appropriate specimen collection, early isolation, safe management of invasive devices, environmental cleanliness and timely escalation of suspected infection risks. The value of IPC education is greatest when it is linked to real clinical scenarios and delivered in a way that helps staff understand why specific practices are required.

The improved staffing position and extended site presence support this more practice-focused model. Rather than relying solely on formal training, the service is increasingly able to provide advice in context, reinforce learning at ward level, support local leadership and respond to areas where compliance or assurance is variable. This approach is particularly important where audit findings, outbreak investigations or HCAI reviews identify recurrent themes requiring immediate feedback and sustained behavioural change.

3.9 - STRATEGIC DELIVERY DURING 2025/26

The IPC service has made significant progress against the strategic direction set out for 2025/26. The main achievement has been the strengthening of the service infrastructure itself: extended acute-site support, an IPC on-call model for weekends and bank holidays, improved recruitment, greater team resilience, continued development of the Hub model, and the establishment and early growth of the Community IPC Team.

These developments have increased the Health Board's capacity to respond to infection risks in a more timely and coordinated way. They have also improved the ability of IPC to contribute to wider organisational priorities, including patient safety, quality improvement, winter resilience, safe patient flow, antimicrobial stewardship, care home support, decontamination assurance and compliance with national standards.

The strategic delivery of IPC during the year should therefore be viewed not only through individual infection outcomes, but also through the strengthening of the systems required to reduce infection risk. The service is now better placed to identify risk, escalate concerns, support clinical areas, work across organisational boundaries and provide assurance to the Health Board. This improved infrastructure will be essential to sustaining progress during 2026/27.

Strategic objective	Progress during 2025/26	Impact on assurance
Improve responsiveness	Introduced 12-hour support across all acute sites and weekend/bank holiday on-call IPC arrangements.	Improved ability to provide timely advice, support outbreak control and reduce delays in IPC decision-making.
Strengthen resilience	Recruitment has progressed significantly, with only one Band 7 vacancy remaining.	Improved continuity, cross-site cover, staff deployment and ability to maintain service delivery during periods of pressure.
Standardise practice	Continued development of Hub working, common escalation routes and consistent advice across sites.	Supports more equitable access to IPC expertise and reduces variation in practice.
Extend IPC beyond acute settings	Developed the Community IPC Team and strengthened links with Public Health Wales and local authorities.	Improves the Health Board's ability to influence community-onset infection risks and support providers outside hospital.
Develop system partnerships	Supported partnership management of COVID-19 and scabies outbreaks and began progressing GP relationship-building.	Strengthens multidisciplinary and multi-agency response to infection risks across the wider health and care system.
Embed strategic governance	Continued quarterly reporting and escalation through the Infection Prevention and Control Committee.	Provides Board-level assurance, visibility of risks and oversight of improvement actions.

Table 8 - Strategic delivery summary

3.10 - AREAS REQUIRING CONTINUED DEVELOPMENT

Although the IPC service model has strengthened considerably, further development is required to ensure that the new arrangements are fully embedded and sustainable. The priority is to complete recruitment to the remaining Band 7 vacancy and maintain the staffing stability required to deliver the expanded model. The service should also continue to evaluate the impact of 12-hour acute-site support and weekend/bank holiday on-call arrangements, ensuring that the model remains proportionate to demand and aligned to patient safety risk.

There is also a need to continue embedding the Hub model so that it becomes the consistent operating framework for the whole service. This includes strengthening documentation, improving the visibility of demand and response activity, standardising escalation pathways, and ensuring that learning from outbreaks, HCAI reviews and audits is translated into measurable action. A more structured approach to capturing themes and outcomes will support stronger assurance and allow the Health Board to demonstrate the impact of IPC interventions more clearly.

For the community service, the next stage is to consolidate relationships with Public Health Wales and local authorities while extending partnership working to general practice. This will be important in supporting antimicrobial stewardship, early recognition of infection risk, care home support, management of community outbreaks and targeted work on community-onset infections. The success of the community model will depend on clear pathways, shared expectations and practical mechanisms for joint working across Organisational boundaries.

- Complete recruitment to the remaining Band 7 vacancy and protect senior operational resilience.
- Evaluate demand, themes and outcomes from the 12-hour acute-site model and weekend/bank holiday on-call service.
- Continue embedding Hub processes, including triage, escalation, documentation and cross-site deployment.
- Strengthen community IPC pathways with Public Health Wales, local authorities, care providers and general practice.
- Improve the capture and dissemination of learning from outbreaks, HCAI reviews, audits and incident investigations.
- Ensure that staffing, service model and strategic delivery risks remain visible through IPCC, risk registers and the Board Assurance Framework.

3.11 - SUMMARY POSITION

The IPC service is now in a significantly stronger position than at the start of the reporting period. The introduction of 12-hour support across all three acute sites, the development of weekend and bank holiday on-call arrangements, the near-completion of recruitment to vacant posts, and the continued implementation of the Hub model have substantially increased the service's responsiveness and resilience.

The growth of the Community IPC Team has also strengthened the strategic reach of the service. Although this work is described in greater detail later in the report, the development of relationships with Public Health Wales, local authorities and emerging links with general practice demonstrates a clear move towards a whole-system infection prevention model. This is essential if CTMUHB is to reduce the burden of healthcare-associated and community-onset infections across the full patient pathway.

Overall, the service model is now better aligned to the current infection prevention risk profile of the Health Board. It provides stronger acute-site support, improved out-of-hours resilience, greater standardization, better partnership working and a more stable staffing platform. The priority for 2026/27 will be to consolidate these improvements, evidence their impact, complete the remaining recruitment, and ensure that the enhanced IPC model continues to support safe, high-quality care across acute and community settings.

4-ANNUAL AUDIT AND INSPECTION PROGRAM

The IPC team continued to move away from a static annual audit schedule towards a more responsive 'areas of concern' model. This approach uses AMaT submissions, outbreak intelligence, incident data, environmental concerns and local knowledge to identify areas requiring targeted support or checkpoint audit. The model is better aligned to risk because it allows IPC resource to be deployed where assurance is weakest or where harm is most likely.
Point-prevalence surveys were a major feature of the year. They provided rapid, visible and practical assurance on whether expected standards were being delivered in day-to-day practice. BBE and PPE-focused PPS work provided direct feedback to wards, recognized areas of strong compliance and identified areas requiring focused intervention.
The PPS Programme is especially important because it converts policy expectations into observed practice. It also provides an evidence base for action: where compliance is high, the report can describe and celebrate good practice; where compliance is weak, it allows targeted improvement rather than generic messaging.

4.1 PPS - PURPOSE AND SCOPE

This chapter summarizes the point prevalence survey (PPS) Programme undertaken across Princess of Wales Hospital (POW) and Royal Glamorgan Hospital (RGH) during the reporting period and immediately following year-end. The surveys provide direct observational assurance on whether core infection prevention and control (IPC) standards are being translated into routine practice at ward and staff-group level.
The principal focus of the Programme was Bare Below the Elbows (BBE), with the later POW survey extended to include hand hygiene (HH) and personal protective equipment (PPE). Collectively, these studies provide a practical measure of staff behaviors that are fundamental to reducing healthcare-associated infection, preventing cross-transmission and supporting safe patient care. The findings also provide a useful bridge between surveillance data, audit, training compliance and the wider IPC improvement Programme.

4.2 - SUMMARY OF POINT PREVALENCE SURVEYS UNDERTAKEN

This chapter summarizes the point prevalence survey (PPS) Programme undertaken across Prince Charles Hospital (PCH), Royal Glamorgan Hospital (RGH) and Princess of Wales Hospital (POW) during the reporting period, together with immediate post-year checkpoint work where this forms part of the same improvement cycle. The PPS Programme provides direct observational assurance on whether core infection prevention and control (IPC) standards are being translated into routine practice at ward, department and staff-group level.
The principal focus during 2025/26 was Bare Below the Elbows (BBE), with later work expanding to include hand hygiene, personal protective equipment (PPE), and, at PCH, PVC and urinary catheter care bundle compliance. Collectively, these studies provide an important measure of staff behaviors

that underpin safe care, effective hand hygiene, prevention of cross-transmission, safe device management, sustainability, and compliance with the Health Board's IPC policies.
The Programme should be interpreted as a quality-improvement and assurance approach rather than a static audit exercise. Its value is that it identifies real-world practice variation, makes non-compliance visible, enables immediate feedback, and supports targeted intervention. It also provides evidence that improvement is achievable when findings are escalated, local leadership is engaged and repeat measurement is undertaken.

4.2.1. - Summary of point prevalence surveys and related IPC observational work

The table below brings together the PPS and related observational work in chronological order. Where the available documentation provided limited numerical detail, the table summarizes the key finding and the assurance implication rather than overstating precision.

Date	Hospital	Focus	Scope / method	Key finding	Assurance implication
April 2025	PCH	Initial BBE compliance PPS	BBE compliance across wards and staff categories. The report also set out the rationale for BBE as a core requirement supporting effective hand hygiene.	Variable baseline position. Ward 11 achieved the highest overall compliance score at 95%; CCU and Ward 32 were lowest at 50%. Variation was seen across doctors, nurses, HCSWs and other staff groups.	Established the baseline for PCH and identified the need for targeted training, regular audits, feedback, recognition of good practice, visual prompts and leadership engagement.
June 2025	RGH	BBE compliance PPS	Inpatient areas over two working days; all observed staff groups, including nurses, doctors, HCSWs, facilities, catering, portering, phlebotomy, admin and students.	Marked ward and staff-group variation. Only a smaller proportion of wards reached green status. Jewelry was the most frequently observed breach, followed by nails, watches/fitness trackers and long sleeves.	Provided a baseline for RGH and highlighted the need for visible leadership, senior role-modelling and escalation where repeated breaches were observed.
August 2025	PCH	Repeat BBE compliance PPS	Follow-up to the April 2025 PCH PPS across inpatient areas after escalation to senior management, increased surveillance, enhanced IPC presence and targeted training.	Compliance ranged from 50% to 100%. Highest compliance was CCU at 100%, Labour at 90% and AMU at 92%. Lowest compliance was ITU at 50%, Ward 3 at 50% and Ward 2 at 54%. Seven wards improved, one by 50%; seven wards showed a marginal decrease and one remained unchanged.	Demonstrated that targeted intervention can improve compliance, but also showed that improvement was not universal. Ward 3 deterioration was linked to service change and agency staffing, indicating that Organisational change and temporary staffing can affect IPC reliability.
August 2025	POW	BBE compliance PPS	Inpatient areas over one working day, assessing clinical and non-	Generally strong BBE position. Twelve wards achieved green status and seven	Good overall assurance for BBE at POW, with targeted action required for red-rated areas and

			clinical staff groups.	areas achieved 100% compliance, including AMU, Ward 5, Ward 8, Ward 12, NNU, A&E and ITU. Ward 14 at 67% and PICU at 13% remained red. Watches were the most frequent breach.	staff groups entering clinical areas, including non-registered and external staff.
January 2026	PCH	BBE follow-up PPS/poster summary	Follow-up assessment of BBE compliance at Prince Charles Hospital, highlighting high-performing teams, areas for improvement and actions to achieve consistent best practice.	Improvement was reported compared with earlier work. Eleven wards scored above 90%, nine wards achieved 100%, and Ward 32 was close to the green threshold. Fewer wards required urgent red-rated action than previously.	Shows a positive improvement trajectory at PCH. Continued monitoring remained necessary to prevent slippage in amber areas and sustain high performance.
February 2026	RGH	BBE follow-up PPS	One-day follow-up assessment across inpatient areas, comparing against the earlier RGH PPS.	Clear improvement. Most wards achieved green status. A&E improved from 52% to 100%. Ward 12 was the lowest scoring ward at 50%, showing deterioration from 79% in the previous audit. HCSWs accounted for the highest number of breaches.	Strong evidence that feedback and targeted work improved compliance, but residual ward-level and staff-group variation remained and requires continuing leadership attention.
April 2026	POW	Expanded BBE, hand hygiene and PPE PPS	Acute inpatient areas over 24 hours. Observations included BBE, hand hygiene and PPE compliance.	BBE remained strong, but hand hygiene was polarised and PPE was the weakest domain. PPE non-compliance included inappropriate glove use, failure to remove PPE between patient contacts and incomplete PPE use. Ward 7 recorded 0% PPE compliance at the point of observation.	Important finding: high BBE compliance does not guarantee reliable hand hygiene or correct PPE use. PPE behavior should be treated as a priority improvement workstream linked to quality, safety, sustainability and value.
April 2026	PCH	IPC Easter competition and device-care observation	Clinical areas across PCH; combined BBE, peripheral vascular catheter (PVC) and	Ward 12 achieved the highest combined score at 95% and was recognized as the	Useful engagement and recognition approach, but improvement may not be sustained

			urinary catheter (UC) care bundle compliance.	winner. However, the documentation identified a decline in BBE compliance, requiring renewed improvement focus.	without ongoing measurement and local ownership. Inclusion of device-care bundles reinforces the link to bloodstream infection prevention.

Table 9- PPS findings resume

During April 2026, the IPC team also conducted the easter IPC competition for device-care-observation, reports were not finaslised at the time this report was being produced and findings will be included in the next quarterly report.

4.2.2 - Overall interpretation

The expanded PPS evidence now gives a more complete Health Board picture because it includes all three acute sites. The Programme shows that BBE compliance can improve when data are shared, senior teams are sighted, IPC visibility increases and repeat measurement is undertaken. PCH and RGH both show evidence of improvement between baseline and follow-up work, while POW showed generally strong BBE compliance but identified important gaps in hand hygiene and PPE practice when the audit scope widened.

The principal assurance message is therefore balanced. The Health Board has evidence that PPS is an effective improvement mechanism, but the findings also confirm that compliance is not yet consistently embedded across every ward, staff group or IPC domain. Local culture, service change, temporary staffing, professional role-modelling and ward leadership appear to influence compliance as much as knowledge of policy. This means that improvement plans need to combine education with behavioral insight, leadership accountability and repeated observational measurement.

BBE compliance should be viewed as improving but fragile. Several areas achieved excellent compliance, including 100% ward-level scores, but red and amber areas persisted across the year, and PCH post-year observational work identified a decline in BBE compliance despite previous improvement. This suggests that BBE must remain a non-negotiable standard, supported by regular spot checks, ward-level ownership and escalation of repeated breaches.

The expanded POW survey is particularly important because it demonstrates that BBE alone is not a sufficient proxy for reliable standard infection control precautions. PPE compliance, especially glove use, was the weakest domain. The finding that staff used gloves for low-risk or non-clinical activities, failed to remove PPE between patient contacts and moved around ward environments wearing PPE is significant. Incorrect PPE use can increase cross-transmission risk, undermine hand hygiene, create a false sense of safety and contribute to avoidable waste and cost – support/advice is being sought with QI and behavioural team to find strategies to address the findings.

4.2.3 - SITE-LEVEL FINDINGS AND INTERPRETATION

PRINCE CHARLES HOSPITAL

PCH provides the clearest example of a repeat measurement cycle. The April 2025 PPS established a variable baseline, with Ward 11 achieving 95% and CCU and Ward 32 scoring 50%. The results supported targeted training, regular audit, staff feedback, visual reminders, recognition of good practice and leadership engagement.

The August 2025 repeat PPS demonstrated targeted improvement following escalation and enhanced IPC visibility. Seven wards improved, one by 50%, while seven wards declined marginally and one remained unchanged. Compliance ranged from 50% to 100%, with CCU at 100%, Labour at 90%

and AMU at 92%. The lowest scores were ITU at 50%, Ward 3 at 50% and Ward 2 at 54%. Ward 3's decline was linked to service change from Care of the Elderly to Elective Trauma and Orthopaedics and reliance on agency staffing, demonstrating that operational change can affect compliance culture and IPC reliability.

By January 2026, the PCH PPS reported further improvement, with 11 wards scoring above 90%, nine wards at 100% and Ward 32 narrowly missing the highest category. This suggests that the Programme had begun to embed more successfully. However, the April 2026 IPC Easter competition, which included BBE, PVC and urinary catheter care bundle compliance, identified a decline in BBE compliance, even though Ward 12 achieved an impressive combined score of 95%. This confirms that improvement requires maintenance and that compliance can regress when attention reduces or when ward conditions change.

The inclusion of PVC and urinary catheter care bundle compliance at PCH is a positive development because it links PPS methodology directly to bloodstream infection prevention. Given the Health Board's ongoing challenges with Gram-negative bacteraemia and blood culture contamination/ANTT assurance, future PPS work should continue to include device-care bundles where appropriate.

ROYAL GLAMORGAN HOSPITAL

The June 2025 RGH PPS showed significant variation in BBE compliance across wards and staff groups. Only a limited number of wards achieved green status, while many were in amber or red categories. Ward-level analysis suggested that culture and local leadership were important determinants of performance. Several wards achieved 100% compliance across nurses, doctors and HCSWs, but other areas recorded 0% compliance in at least one of these core patient-facing groups. A&E showed particular variability, with doctors at 42% compliance.

The February 2026 follow-up PPS showed clear improvement. Most wards achieved green status, and A&E improved from 52% to 100%, which is an important example of measurable improvement after targeted intervention. Residual concerns remained, including Ward 12, which scored 50% and deteriorated from 79% previously, and variable compliance in Ward 4, Ward 7, Ward 15 and CCU. HCSWs accounted for the highest number of breaches in the follow-up work, followed by nurses, with isolated breaches among doctors, pharmacy staff and physiotherapists.

The breach profile at RGH was dominated by jewelry, followed by nails, watches/fitness trackers and long sleeves. These remain important because they interfere with effective hand and wrist decontamination and can act as reservoirs for microorganisms. The RGH findings support continued real-time challenge, visible leadership and escalation where senior or registered staff are observed to be non-compliant, because role-modelling is essential to changing ward culture.

PRINCESS OF WALES HOSPITAL

The August 2025 POW BBE PPS demonstrated a generally strong position. Twelve wards achieved green status and seven areas achieved 100% compliance, including AMU, Ward 5, Ward 8, Ward 12, NNU, A&E and ITU. However, Ward 14 at 67% and PICU at 13% were red-rated and required immediate targeted intervention. The staff-group picture was also generally positive, with students, occupational therapy and physiotherapy at 100% and nurses, pharmacy, HCSWs and doctors also performing well. Lower compliance was identified in phlebotomy, ward clerks and outside social service workers, indicating the need to reinforce BBE expectations for all staff entering clinical areas, not only registered clinical staff.

The most common breach at POW in August was wearing watches, followed by nail-related breaches, long sleeves and jewelry. This differed from the RGH pattern, reinforcing that site-level improvement plans should be based on local breach types rather than generic messaging alone.

The April 2026 POW survey extended the PPS methodology to BBE, hand hygiene and PPE. This is the most mature PPS model in the current evidence base because it assessed multiple components of standard infection control precautions. BBE remained the strongest domain, with several wards achieving 100% or above 90%. Hand hygiene showed a polarised pattern, with some wards achieving 100% and others showing substantially lower compliance. PPE was the highest-risk domain, with widespread inappropriate practice and Ward 7 recording 0% compliance at the time of observation.
The April 2026 POW findings are important for the annual report because they provide direct evidence that PPE practice, particularly glove use, must remain a priority. The findings support the wider IPC sustainability narrative: appropriate glove use can reduce waste and cost, but the primary message must remain patient and staff safety. Gloves are not a substitute for hand hygiene and can contribute to cross-contamination when used incorrectly.

4.2.4 - Cross-cutting themes from the PPS Programme

Theme	Evidence from PPS findings	Implication for assurance	Recommended response
BBE compliance is improving but not consistently embedded	PCH and RGH repeat work showed improvement; POW demonstrated strong BBE compliance; however, red and amber areas persisted and PCH April 2026 work signalled possible decline.	Good evidence that PPS works as an improvement tool, but standards need sustained ownership and repeat measurement.	Continue regular PPS cycles, spot checks, feedback to ward managers and escalation of repeated breaches.
Local leadership and culture are major determinants	High-performing wards often performed well across staff groups; weaker areas showed cross-professional variation. Non-compliance among senior staff was specifically noted in RGH work.	Compliance is behavioural and cultural, not only educational.	Use ward leadership, senior nursing walk-rounds, medical leadership, IPC link roles and peer challenge.
Staff-group variation requires targeted responses	Doctors were low in some RGH areas; HCSWs had most breaches in the RGH follow-up; PCH and POW identified issues across clinical and non-clinical groups.	Generic messages will be insufficient.	Tailor interventions by staff group, including medical engagement, HCSW/nursing support and expectations for non-clinical staff entering clinical areas.
PPE practice and glove use are the weakest behavioral domains	The POW April 2026 expanded PPS identified inappropriate glove use, failure to remove PPE between contacts and inconsistent PPE use.	Incorrect PPE can increase transmission risk and undermine hand hygiene.	Develop a PPE/glove-use QI workstream using behavior-change methodology and link findings to sustainability and safe care.
Device-care bundle inclusion strengthens the Programme	The PCH Easter competition included BBE, PVC and urinary catheter care bundle compliance, with Ward 12 scoring 95%.	PPS methodology can support reduction of bacteremia and device-related infection risks.	Include PVC and urinary catheter care bundles in future risk-based PPS cycles, especially in areas with Gram-negative or line/device-related concerns.
Operational change can affect compliance	Ward 3 PCH deterioration was attributed to service change and agency staffing.	IPC compliance may deteriorate during service moves, staffing changes or periods of disruption.	Include IPC briefing, BBE/PPE/device-care expectations and early spot checks in service-change plans.
Breach-type analysis provides actionable intelligence	Common breach types included jewelry, watches/fitness trackers, nails, long sleeves and inappropriate PPE/glove use. Dominant breach type differed by site.	The Programme should not only report percentages; it should report what needs to change.	Track breach type over time and target communications accordingly.

Table 10- Cross-cutting themes from the PPS programme

ASSURANCE AND RISK ASSESSMENT

Assurance area	Current judgement	Rationale
BBE compliance	Moderate to good assurance, with local exceptions	Repeat work at PCH and RGH showed improvement and POW had generally strong BBE performance. However, persistent red/amber areas and post-year decline signals mean assurance is not complete.
Hand hygiene	Partial assurance	Only directly measured in the expanded POW survey, which showed strong performance in some wards but marked variation and missed opportunities after patient/environment contact.
PPE use	Limited assurance	The POW expanded PPS identified PPE misuse as the weakest domain, particularly inappropriate glove use and failure to remove/change PPE between contacts.
Device-care bundles	Emerging assurance	The PCH April 2026 work included PVC and urinary catheter care bundles and therefore provides a useful model for future IPC assurance linked to bacteremia prevention.
Improvement methodology	Good assurance	PCH and RGH repeat measurement demonstrated that targeted intervention, visible IPC presence and leadership engagement can improve compliance.
Sustainability of improvement	Partial assurance	Some areas improved, but others deteriorated or showed decline over time. Compliance requires continued measurement, escalation and local ownership.
Leadership and culture	Partial assurance	Strong ward-level performance appears linked to local culture and leadership, but senior staff non-compliance and cross-professional variation remain risks.

Table 11- Assurance and risk assessment

4.2.5 - Actions and Priorities for 2026/27 derived from PPS

- Continue scheduled and risk-triggered PPS cycles across all three acute sites using a consistent methodology, RAG approach and breach-type reporting.
- Create a standardized PPS template so that results can be compared by hospital, ward, staff group, domain and breach type over time.
- Retain BBE as a non-negotiable clinical standard, with real-time challenge, escalation of repeated breaches and visible support from senior nursing, medical and operational leaders.
- Prioritize PPE and glove-use improvement as a dedicated quality-improvement workstream, focusing on correct indications, hand hygiene before and after glove use, removal between patient contacts and prevention of environmental cross-contamination.
- Expand PPS methodology to include device-care bundles in targeted areas, especially PVC and urinary catheter care where Gram-negative bacteremia, line-related infection or ANTT concerns are present.
- Use PPS findings during service change, ward moves, staffing model changes and agency-heavy periods, as these conditions can affect practice reliability.
- Link PPS findings with mandatory IPC training compliance, ANTT assurance, blood culture contamination data, outbreak learning, HCAI review themes and PPE procurement data.
- Share learning from high-performing wards through local governance, safety huddles and IPC link roles, so that successful behaviors are spread rather than only correcting poor performance. Continue to create and distribute benchmark posters so each clinical setting can see how is performing in comparison with the remainer clinical areas
- Develop a PPS dashboard for IPCC and care group governance showing trends, actions completed, persistent red/amber areas and evidence of sustained improvement.
- Work with the Quality Improvement team to understand the behavioral drivers of PPE misuse, including perceived safety, habit, convenience, peer norms, equipment availability and local leadership expectations.

4.2.6 – Resume of Findings from PPS

The PPS programme has matured during 2025/26 and now provides meaningful ward-level and staff-group assurance across all three acute sites. It has demonstrated that improvement is achievable: RGH showed clear improvement between baseline and follow-up, PCH showed improvement across repeat cycles, and POW demonstrated generally strong BBE performance. The use of competition and recognition at PCH also shows how engagement can support improvement, provided that it is balanced with robust monitoring and escalation.

The programme also identifies important residual risks. BBE compliance is improving but remains vulnerable to local culture, service change, temporary staffing, role-modelling and loss of sustained attention. Hand hygiene and PPE require separate measurement because strong BBE compliance does not guarantee reliable standard infection control precautions. PPE misuse, particularly inappropriate glove use, is the clearest behavioural risk identified in the expanded POW survey and should remain a priority for 2026/27.

The annual report should therefore present PPS as a core IPC assurance and improvement mechanism. The next phase should focus on standardising methodology, embedding repeat measurement, strengthening escalation and linking PPS findings to broader infection prevention priorities, including Gram-negative bacteraemia reduction, blood culture contamination, ANTT assurance, device-care bundle reliability and sustainability. This will help ensure that observed practice becomes more consistently aligned with policy and that IPC improvement is owned from ward to Board.

5-SURVEILLANCE OF ALERT ORGANISMS AND OUTBREAKS

5.1 EPIDEMIOLOGICAL REVIEW AGAINST WELSH GOVERNMENT IMPROVEMENT GOALS

The epidemiological position presents a mixed picture. CTMUHB compares favourably with the all-Wales average for C. difficile, Pseudomonas aeruginosa, MSSA and MRSA rates, but remains above the Wales rate for E. coli and Klebsiella spp. bacteraemia. The key strategic conclusion is that Gram-negative bloodstream infection must remain a central priority for the Health Board.

The following table benchmarks the HB with all Wales:

Organism	CTM Rate/100,000	Wales/100,000	Dif%
E.Coli	81.52	68.1	-19.71%
P Aeruginosa	3.14	5.12	38.67%
Klebesilella sp.	30.01	23.70	-26.62%
Staph aureus (MSSA)	23.74	25.57	7.15%
Staph aureus (MRSA)	1.57	2.05	23.41%
Cdiff	36.73	42.12	12.8%

Table 12 - HCAI CTM rates and all-Wales benchmark

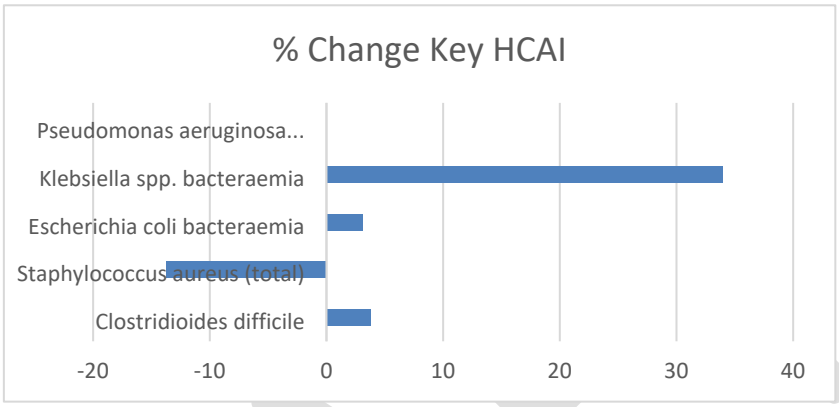
In the next table we can see the comparison of the number of cases with the previous financial year as well as a breakdown of CO and HO proportion:

Organism	2025/26 cases	2024/25 comparison	% change	CO	HO	HO %	Position
Clostridioides difficile	164	158	+3.8	103	61	37%	Below Wales; improvement not achieved for 25% goal
Staphylococcus aureus (total)	113	131	-13.74	74	39	35%	Slightly below Wales; HO cases

							require focused review
Escherichia coli bacteraemia	364	353	3.1	303	61	17%	Above Wales; HO reduction in line with goal
Klebsiella spp. bacteraemia	138	103	34	100	38	28%	Above Wales; Gram-negative concern
Pseudomonas aeruginosa bacteraemia	14	14	0	9	5	36%	Below Wales; HO reduction achieved

Table 13 - Annual organism-specific HCAI summary

The same data is condensed in the following graphic:



Graphic 2 - Change in key HCAI % compared with 2024/25

5.2 CLOSTRIDIOIDES DIFFICILE

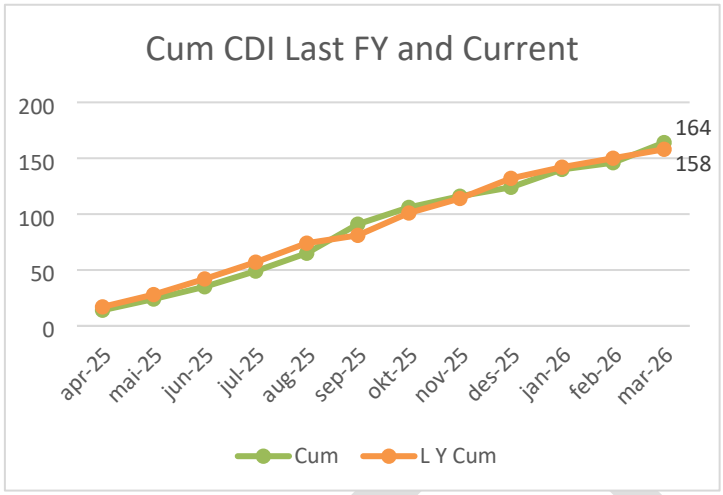
Improvement Goal: To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts

CTM has recorded 164 cases of Clostridioides difficile infection (CDI) during the financial year to date, compared with 158 cases for the same period last year, representing an increase of 13.7%. Of these, 103 cases were classified as community onset and 61 as hospital onset, meaning that hospital-onset infections account for 37% of the total burden. The current CTM rate is 36.73 per 100,000 population, compared with an all-Wales rate of 42.12, placing the Health Board 12.8% below the national average.

This remains a comparatively favorable benchmarking position; however, the current trajectory is not delivering the 25% improvement goal. The data indicate that there has been an increase in total cases. It is therefore important that the Health Board maintains focus not only on reducing hospital-onset infection, but also on understanding and addressing the significant contribution made by community-onset disease.

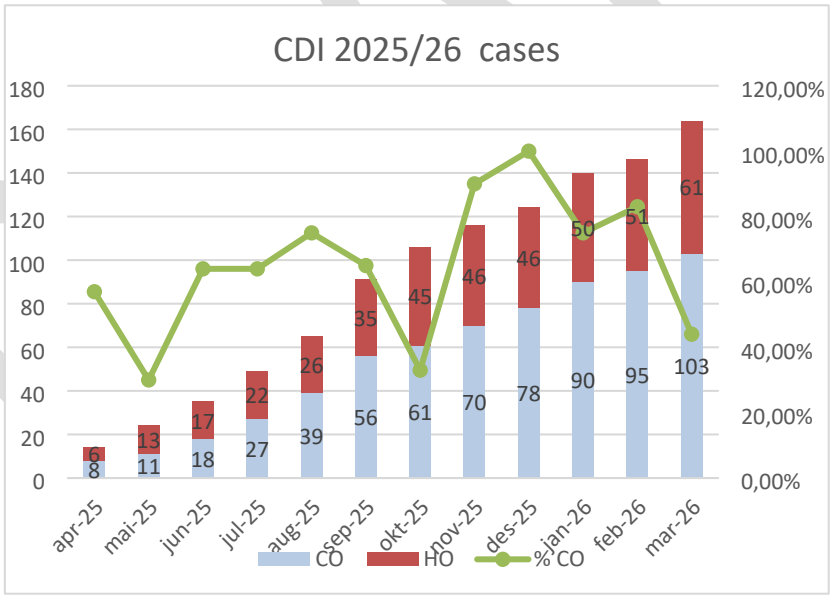
The graphics that follow provide a more detailed understanding of the cumulative trend, the relative contribution of community-onset and hospital-onset cases, and the variation seen across acute sites. Together, they show that progress has been made, but that sustained multidisciplinary action is still required if CTM is to translate this modest improvement into a more substantial and sustained reduction in CDI.

The following graphics summarize the current data:

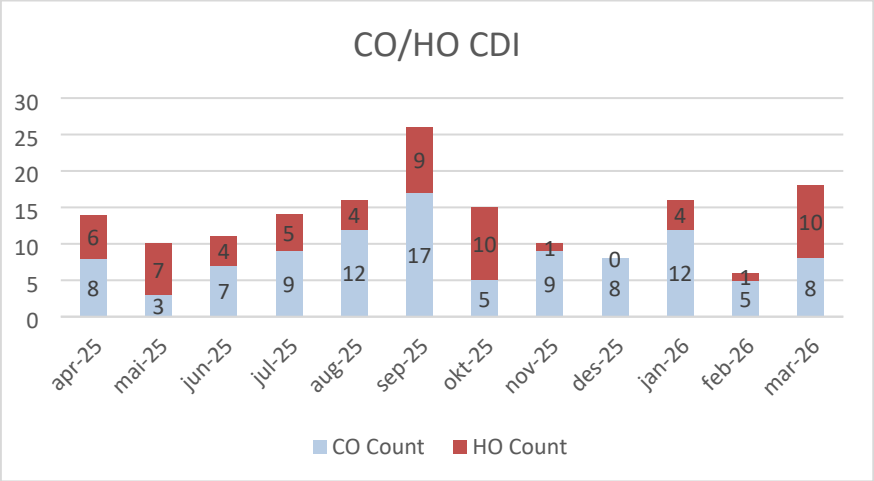


Graphic 3- Cumulative of CDI 2024/25 vs 2025/26

As we can see on Graphic 3, we currently more cases than same period last year by 3.8%, noting a trajectory change from November 2025.
The number of cases is significantly CO driven with 37% of cases being HO (Wales HO cases are 46%) and 63% CO. There has been a rising trend on CO cases as can be seen on Graphic 4 and 5:

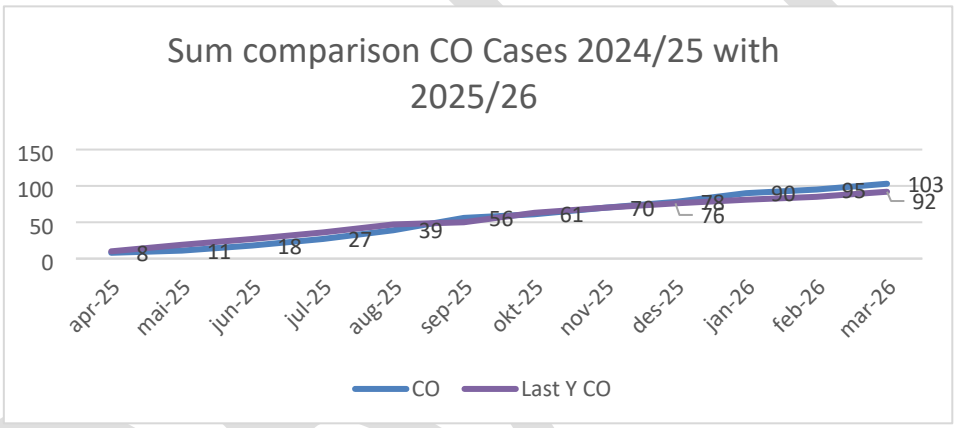


Graphic 4 - CDI 2025/26 HO and CO cases

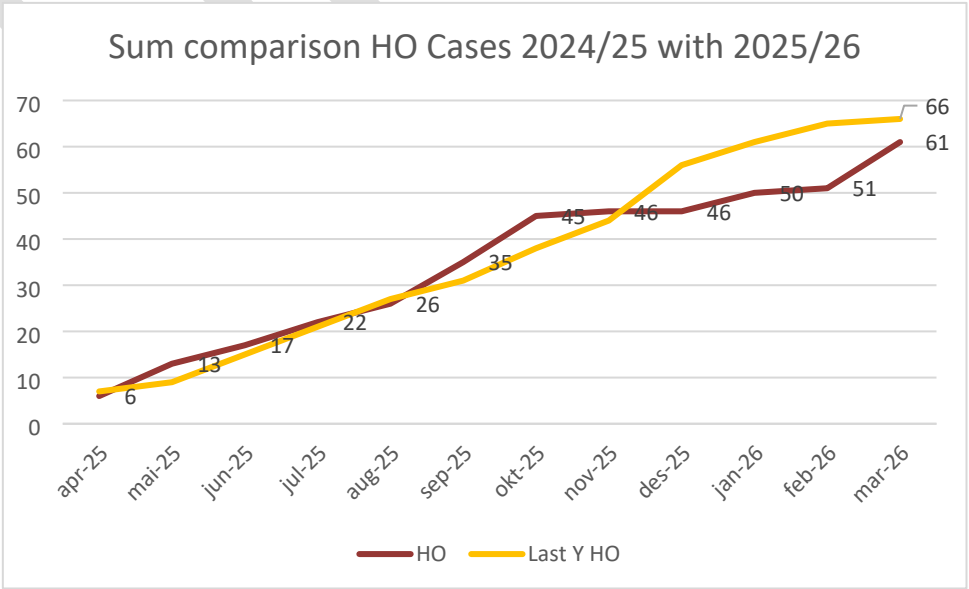


Graphic 5 - Ratio CO/HO cases 2025/26

If we look to compare the number of CO and HO cases from 2024/25 with 2025/26, we can see Graphics 6 and 7:



Graphic 6 -Sum Comparison of CO cases 2024/25 with 2025/26



Graphic 7- Sum Comparison of HO cases 2024/25 with 2025/26

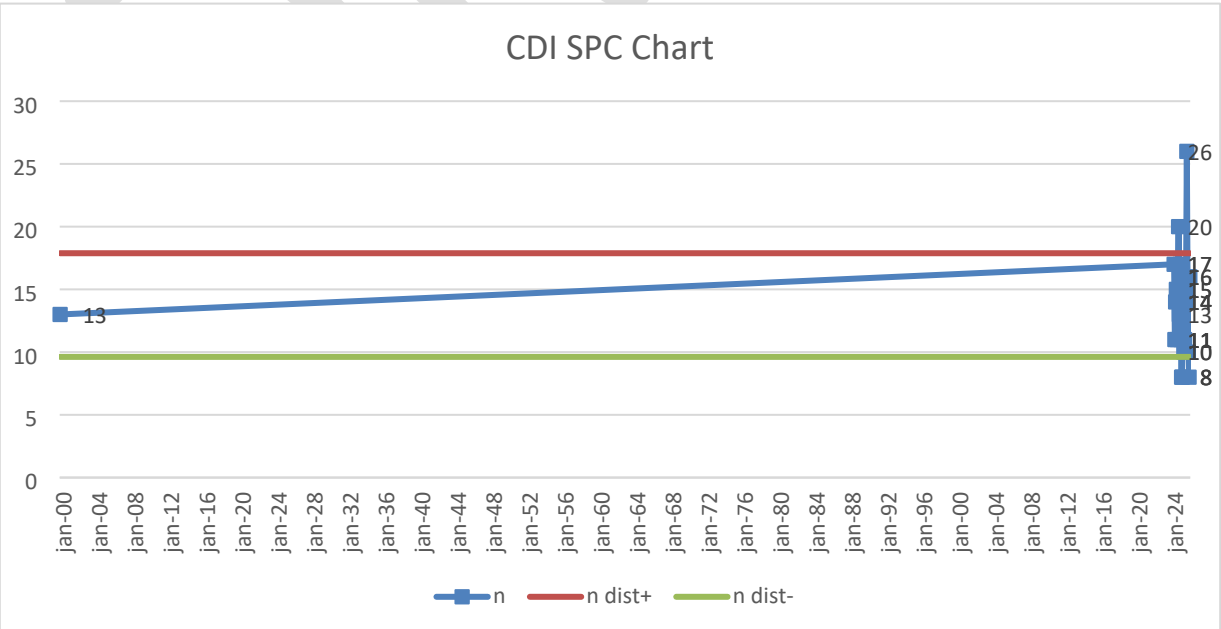
Graphics 3 to 7 show that the year-to-date CDI position is albeit the increase, from the point of view of HO cases the situation is slightly improved when compared with 2024/25, but that the pattern of reduction is uneven. Graphic 3 demonstrates that the cumulative total for 2025/26 has remained below the previous year for most of the reporting period, although the gap narrowed from November 2025 onwards. This suggests that the Health Board has achieved some improvement, but that the degree of reduction remains fragile and vulnerable to deterioration during periods of operational pressure.

Graphics 4 and 5 confirm that the overall CDI burden remains predominantly community onset. Community-onset cases account for 63% of all cases, while hospital-onset cases account for 37%. This is an important distinction, because it highlights that although acute-sector control measures remain essential, the total burden of disease cannot be fully understood or reduced through hospital-based action alone. The epidemiological picture continues to indicate that CTM must pursue an integrated approach spanning acute services, primary care and wider community interfaces, particularly in relation to antimicrobial stewardship, prescribing practice, case recognition and early response.

Graphics 6 and 7 show that reduction has only been driven by improvement in hospital-onset cases while in community-onset cases we saw an increase. Hospital-onset CDI has reduced by 17.9% compared with the same period last year, whereas community-onset CDI has increased by 12%. This is a positive signal in relation to acute-sector prevention and control, as it suggests that actions undertaken within inpatient settings are having some effect. However, it also reinforces that progress in community-onset infection has been limited, and that this is constraining the overall scale of improvement achieved by the Health Board.

Taken together, Graphics 3 to 7 indicate that CTM is moving in the right direction (albeit the total number increase of 3.8%), but not yet at the pace required to meet the annual improvement goal. The data support a dual analytical conclusion: first, the reduction in hospital-onset CDI is encouraging and should be protected through continued focus on timely isolation, environmental decontamination, antimicrobial stewardship and safe clinical practice; second, further work is required to understand the drivers of community-onset infection, as this remains the main determinant of the total CDI burden across the Health Board.

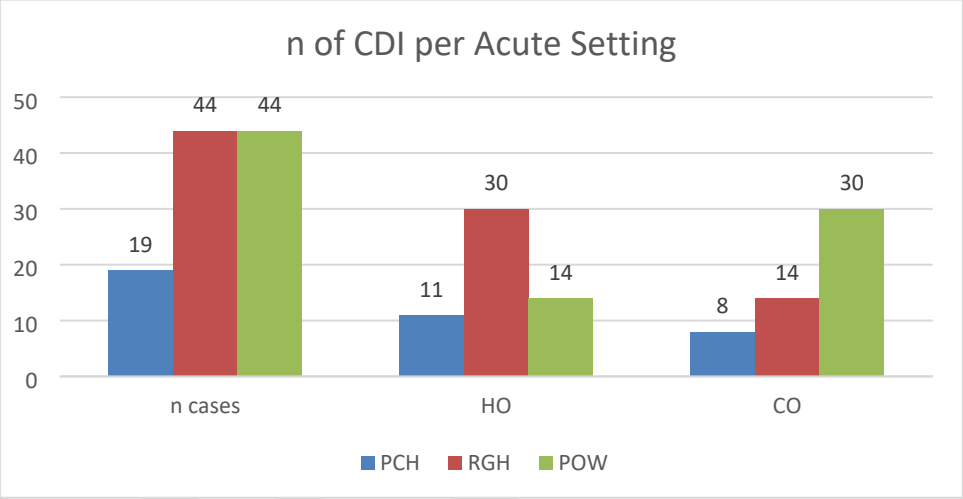
The following Graphic 8 shows the SPC chart for CDI during the financial year:



Graphic 8 - CDI SPC Chart

Graphic 8 shows the SPC chart for CDI during the financial year. Overall, the process appears to remain largely within expected control limits, with no clear evidence at this stage of a sustained step change or special-cause variation sufficient to confirm a stable improvement in performance. This is an important finding. Although the cumulative data show a reduction compared with the previous year, the SPC chart suggests that the observed improvement should still be interpreted cautiously.
From an assurance perspective, the chart indicates that CTMUHB has not experienced marked deterioration beyond expected variation, but neither has it yet demonstrated a consistently sustained shift that would confirm that improvement has become embedded in routine performance. In practical terms, this means that the current reduction should be regarded as encouraging but not yet secured. Continued surveillance over the coming months will be needed to determine whether current actions are strong enough to produce a durable change in the CDI trajectory.
The SPC chart therefore supports a balanced interpretation of the overall position: CTM is performing favorably and remains below the all-Wales rate, but further time and sustained control measures will be needed before the organisation can achieve a reliable long-term reduction.

The following graphic looks at the distribution of cases per acute site:



Graphic 9 - n CDI cases per acute site

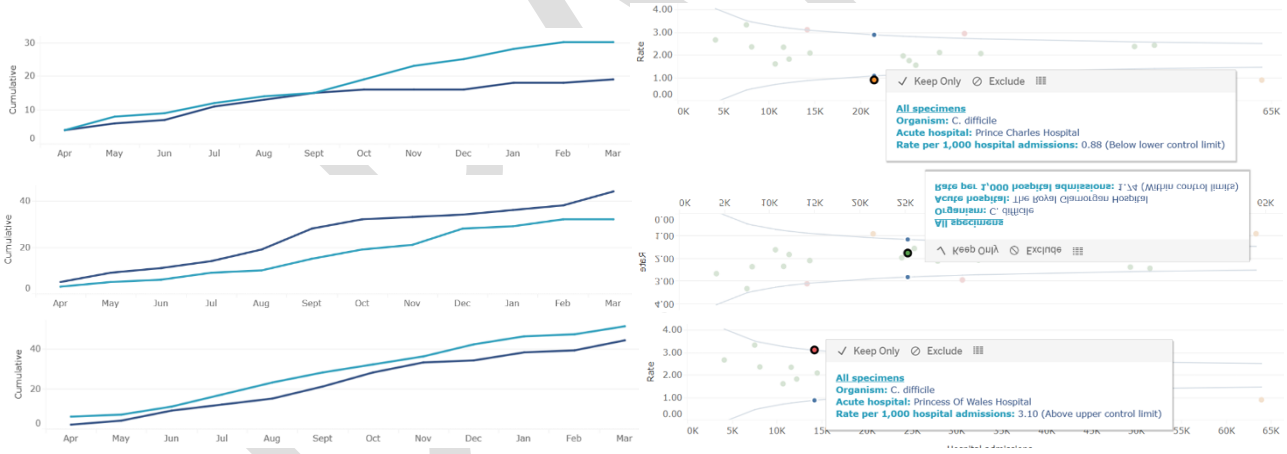
Hospital	n cases	HO	CO	Rate/100000 Hosp admissions	%HO
PCH	19	11	8	0.88	58%
RGH	44	30	14	1.74	68%
POW	44	14	30	3.1	32%

Table 14 - CDI per acute site

Graphic 9 and Table 14 demonstrate important variation across the three acute sites. Princess of Wales Hospital (POW) and Royal Glamorgan Hospital (RGH) each recorded 44 cases during the reporting period, while Prince Charles Hospital (PCH) recorded 19 cases. The case mix differs significantly between sites. At RGH, 30 of 44 cases were hospital onset, meaning that 68% of cases were acquired in hospital. At PCH, 11 of 19 cases were hospital onset, representing 58% of the site total. In contrast, at POW only 14 of 44 cases were hospital onset, with the majority of cases—30 in total—classified as community onset.

These differences are important because they suggest that the drivers of CDI are not uniform across CTM. RGH has the highest absolute number of hospital-onset infections, indicating the need for continued scrutiny of inpatient transmission risks, environmental decontamination, isolation practice and patient flow pressures. POW, by contrast, has a markedly higher burden of community-onset disease, which may reflect wider population factors, healthcare access patterns, testing practice, antimicrobial exposure, or other epidemiological influences that require further investigation. PCH currently records the lowest total number of cases and the lowest rate, suggesting a relatively more favourable acute-site position at this stage.

The following Graphics 10 provide additional context by comparing site-level performance over time and against all-Wales benchmarking. PCH has shown a more consistent reduction compared with the same period last year. POW increased above the previous year earlier in the reporting period, RGH has remained persistently above the previous year's cumulative line. Although this is concerning, the benchmarking element of Graphic 8 shows that both RGH and PCH remain within normal variation when compared with other acute sites across Wales, with RGH and PCH sitting within the lower to middle range of the national distribution. POW also remains within expected variation, but is positioned nearer the upper range and therefore compares less favourably.
The site-level analysis reinforces that CTMUHB does not have a single CDI problem but rather a mixed epidemiological picture requiring differentiated response. There is a need to maintain acute-site controls at RGH and PCH, while also deepening understanding of the factors driving the larger community-onset burden seen at POW. This site-specific interpretation is essential if the organisation is to move beyond broad generic action and target improvement efforts where they are most likely to reduce risk and case numbers.



Graphic 10 - Counts of CDI cases per acute setting and rates of CDI per 1,000 Hospital Bed admission all Wales

Key learning from the CDI reviews to date indicates that progress will depend on maintaining a strong focus on several recurrent themes.

1. Environmental decontamination remains a critical control measure. Rooms occupied by patients with CDI require cleaning with an appropriate sporicidal agent followed by hydrogen peroxide vapour (HPV) decontamination where indicated. Failure to complete HPV consistently, or difficulties in achieving this in high-turnover areas, risks reducing the effectiveness of terminal decontamination and may allow environmental persistence of spores.
2. Prescribing practice remains central to prevention. Reviews continue to demonstrate the need for better scrutiny of antimicrobial prescribing and proton pump inhibitor (PPI) use, including

clearer documentation of indication, dose and duration. Given the strong association between CDI and antimicrobial exposure, this remains one of the most important opportunities for sustainable prevention both in hospital and across the community.

3. Early recognition and prompt isolation are essential. Delayed identification of loose stools, delayed testing, or delayed placement of symptomatic patients into appropriate isolation increase the opportunity for onward transmission. Timeliness of response therefore remains as important as the technical quality of IPC measures themselves.
4. Baseline IPC practice must remain strong and reliable. Good hand hygiene, compliance with bare below the elbows principles, correct use of personal protective equipment and visible IPC leadership in clinical areas remain foundational requirements. These measures are particularly important during periods of bed pressure and high patient turnover, when the risk of compromised practice is greater.
5. Current learning reinforces that CDI should be viewed as a system issue rather than only an acute-site issue. The increase in community-onset infection suggests that action confined to inpatient settings will not be enough to deliver the required scale of improvement. Stronger alignment across primary care, antimicrobial stewardship, pharmacy, community services and epidemiological review will be necessary if CTM is to achieve a sustained reduction in total CDI burden.

IPC Actions:

The current action plan appropriately reflects the multifactorial nature of CDI prevention and should continue to be progressed with a focus on consistency, assurance and measurable impact.

Control of environmental risk is being reinforced through ongoing monitoring of HPV decontamination. Continued confirmation of completed and successful HPV cycles, which is essential both as an operational assurance mechanism and as evidence that expected standards of post-case decontamination are being achieved, nonetheless recent findings of linked cases in rooms that had completed cycles of HPV disinfection, highlight the need to keep attention to basics. No automated method is effective in isolation and requires highest levels of pre-cleaning by the domestics team.

Digital support within surveillance has improved through ICNet alerts for patients admitted with known CDI history. This allows the IPC team to identify risk earlier, contact clinical areas promptly and support timely isolation and review of relevant risk factors. This is an important example of how surveillance tools can support earlier intervention.

The review process is also being strengthened. Work to improve the robustness and timeliness of root cause analysis, revise CDI documentation and update the relevant ICNet experience packs should support more consistent learning, better thematic analysis and stronger governance. The proposed development of a matrix of common themes/thematic analysis is particularly important, as it would help convert case review learning into a clearer organisational improvement programme.

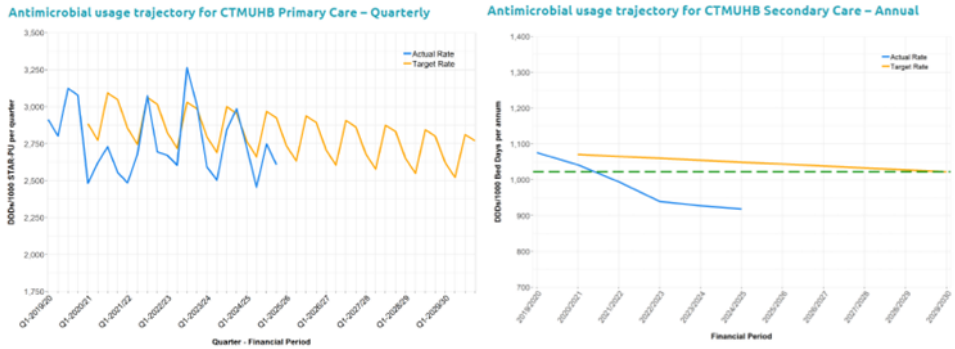
Collaboration with microbiology and gastroenterology on access to faecal microbiota transplantation where appropriate is essential. Currently FMT is available also at POW.

Point prevalence work and visible IPC support in clinical areas should continue, particularly where they can test whether expected standards are translating into day-to-day practice.

Overall, the actions identified are appropriate, but their impact will depend on disciplined implementation, regular monitoring, and a clear route for escalation where barriers remain unresolved.

While the actions outlined above are intended to reduce CDI within secondary care, the data presented shows clearly that improvement will only be partial unless equivalent attention is given to the community contribution. Community-onset infection remains the larger component of total CDI burden and, has not reduced. For that reason, CTM should continue to strengthen collaboration with

primary care, pharmacy, antimicrobial stewardship teams and Public Health Wales to ensure that prevention strategies extend beyond inpatient services.
The current reduction in antimicrobial prescribing across CTM is encouraging (Graphics 11) and should be viewed as an important enabling factor for long-term improvement. However, the persistence of CDI despite this positive direction indicates that prescribing alone does not fully explain the epidemiology. Continued work is needed to improve how learning is captured from case review, how common themes are identified, and how these themes are translated into practical action. The ongoing revision of CDI review documentation is therefore timely and should be supported as part of a stronger governance approach.



Graphic 11 - Antimicrobial trajectory primary and secondary care

Operational pressures continue to influence the ability to prevent transmission reliably. High bed occupancy, frequent patient movement and the practical difficulty of completing full cleaning and disinfection to the desired standard create conditions in which transmission risk may increase. This is especially relevant during winter and other periods of heightened service pressure, when the competing demands of patient flow and environmental safety become more difficult to balance. Sustained improvement will therefore depend not only on technical IPC interventions, but also on the wider operational environment in which those interventions must be delivered.
The variation seen across sites, particularly the larger community-onset burden at POW and the higher hospital-onset burden at RGH, suggests that a more nuanced epidemiological understanding is now required. CTMUHB should seek, with PHW support, to understand whether differences in testing practice, population characteristics, deprivation, access to care, prescribing patterns or other environmental and service factors are influencing the site-level distribution of disease. Without that deeper analysis, there is a risk that broad Health Board-wide conclusions may obscure local drivers and limit the effectiveness of improvement work.
In summary, the Health Board position is moderately improved and favourable when benchmarked against all-Wales rates, but not yet improving at the scale needed to meet the annual target. Progress has been achieved, in relation to hospital-onset CDI, but the overall burden remains strongly influenced by community-onset disease and by site-level variation. The immediate priority is therefore to sustain current acute-sector controls while strengthening the wider cross-sector response, so that the modest reduction already achieved can be translated into a more substantial and sustainable improvement over time.

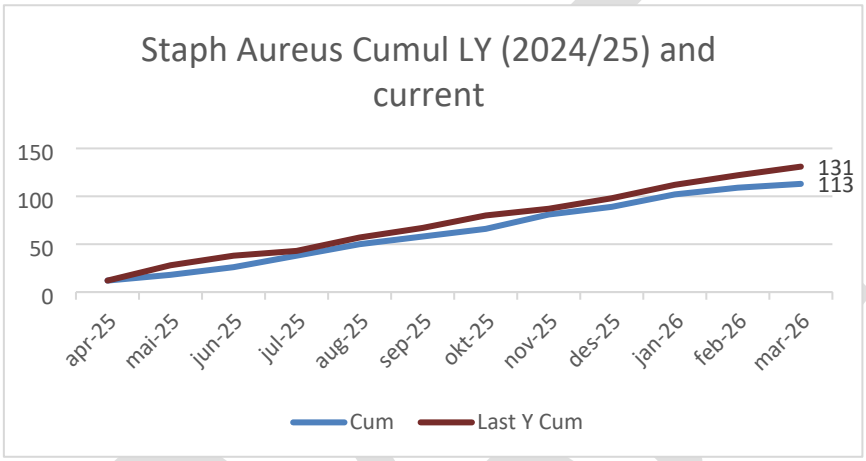
5.3 STAPHYLOCOCCUS AUREUS BACTERAEMIA

MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards.

MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25.

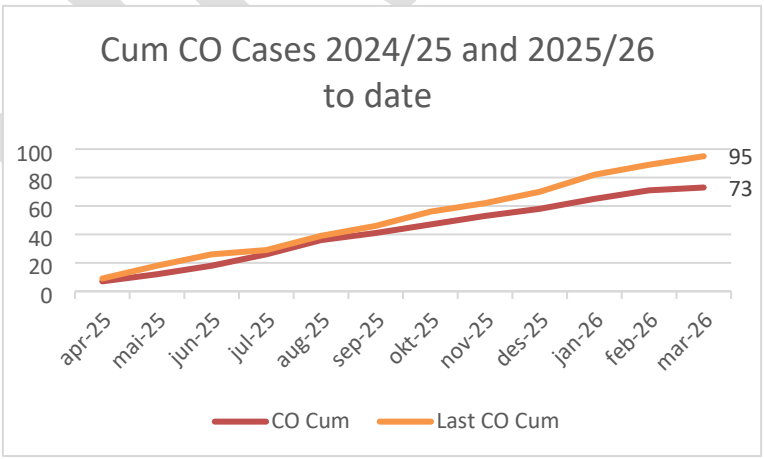
- MRSA bacteraemia is a never event but there were 7 cases this financial year – 6 HO and 1 CO
- Staph Aureus bacteraemia total of 113 against 131 last year – 13.7% reduction
- 74 cases Community onset and 39 Hospital onset (35% HO)
- All Wales rate/100 000 S. Aureus Bac – 25.31 CTM rate 27.62/100000 – 8.3% lower than lower than all Wales

The following graphic 12 shows the comparison between last year cases of Staph Aureus Bacteraemia compared to the current finantial year to date:

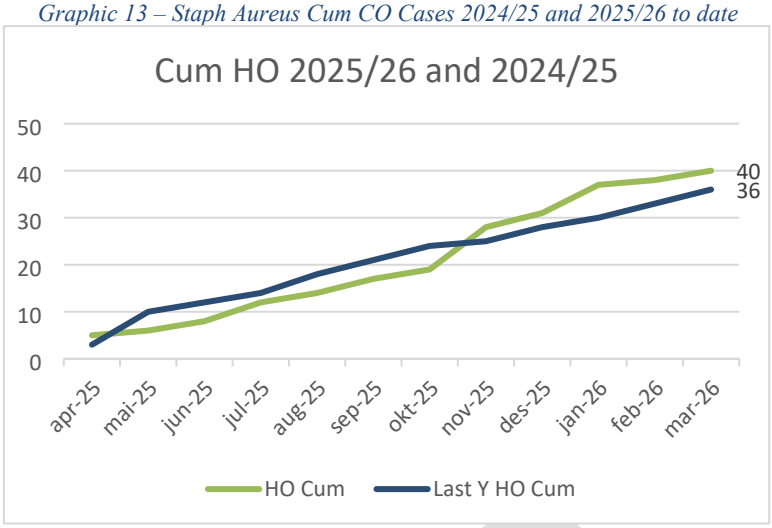


Graphic 12 - - Staph Aureus - cum 2025/26 and 2024/25

As we can see there has been a reduction on the total number of *Staphilococus Aureus* Bacteraemias of 18 cases to date (13.74% reduction), on the following Graphics 13 and 14 we can see the same data divided by CO and HO:

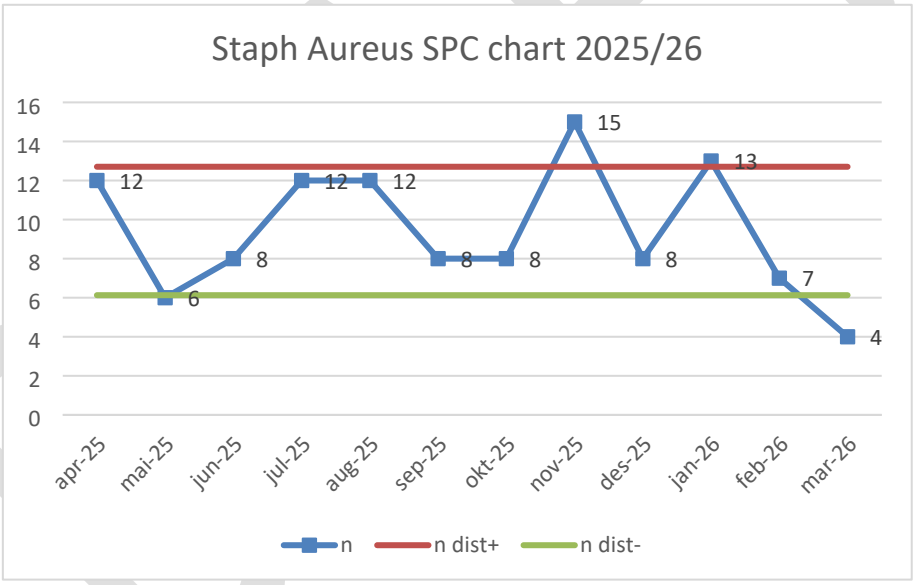


Graphic 13 – Staph Aureus Cum CO Cases 2024/25 and 2025/26 to date



Graphic 14 - Staph Aureus Cum HO 2025/26 and 2024/25

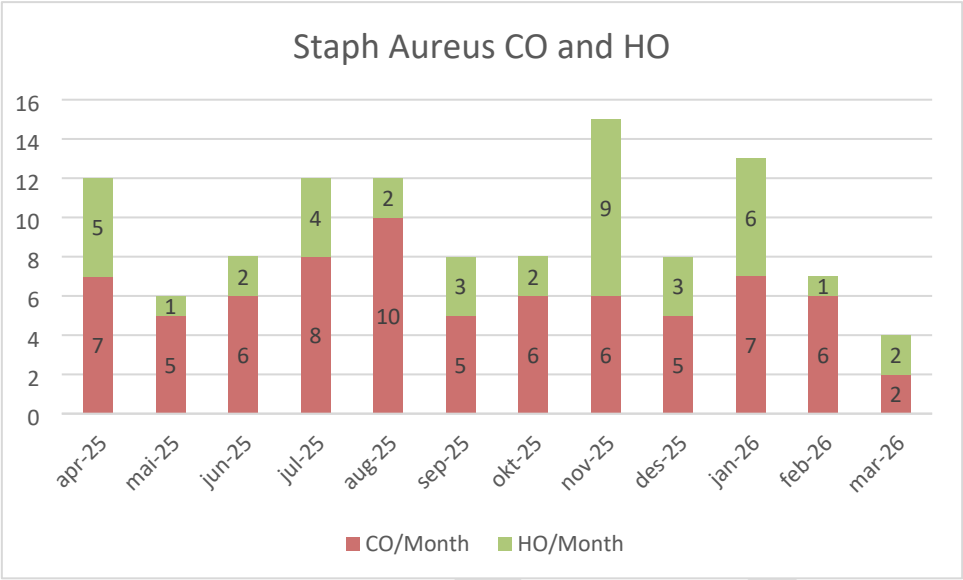
We can see thal albeit only 35% of the total number of cases being from HO cases, the reduction was achieved through reduction on CO cases, with 4 more cases of HO cases than last year same period. This shift on the higher number of HO cases compared to last year occurred in October, and can be also seen on the SPC chart:



Graphic 15 - Staph Aureus SPC chart 2025/26

According to the SPC chart, the point above the medium deviation interval occurred in November, likely a reflex of the rising on the number of cases but we can see a reduction from January. We will continue to monitor if this was a single event and we will continue on the path to reduction, since the overall SPC chart confirms the reduction trend that has been noted.
It is important to stress that while the overall reduction is a positive fact, it is concerning that we have not been able to achieve this reduction on HO cases.

On next graphic we can see the monthly distribution of CO and HO cases:



Graphic 16 - Staph Aureus CO and HO

As explained before, the HO cases account for a little more the 1/3rd of the cases with exception of November, where the number of HO cases surpassed the CO. The IPC team will continue to monitor this.

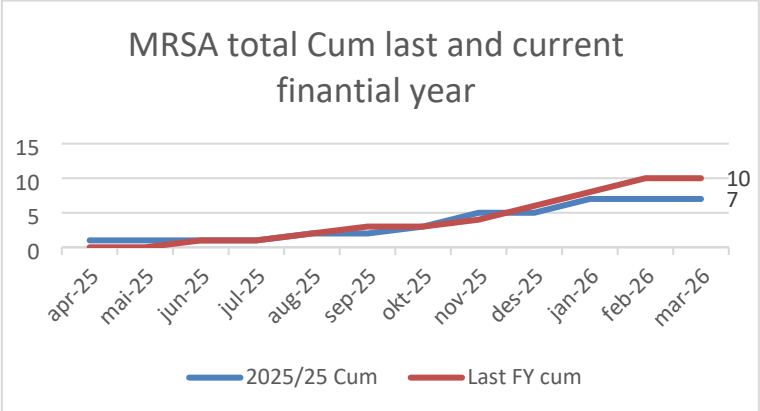
Preventable MSSA (Methicillin-sensitive Staphylococcus aureus) bacteraemia is currently categorized as a moderate risk. The Patient Care and Safety team has initiated rapid review meetings to evaluate these preventable infections and assess whether there have been breaches in the duties of candour and quality standards. The findings and lessons learned from these discussions are subsequently shared during site IPC meetings; however, additional efforts are needed to meet the established targets.

While it is crucial to focus on staff education regarding lessons learned and adherence to Aseptic Non-Touch Technique (ANTT) in the context of hospital-onset (HO) cases—especially concerning the insertion, maintenance, and removal of invasive devices—it is equally important to investigate the situation within the community. This should be conducted with the assistance of Public Health Wales (PHW) and the epidemiology team, particularly to identify the prevalence of infections in high-risk groups such as:

- Individuals with chronic wounds
- Diabetic patients
- Intravenous (IV) drug users
- Others at risk

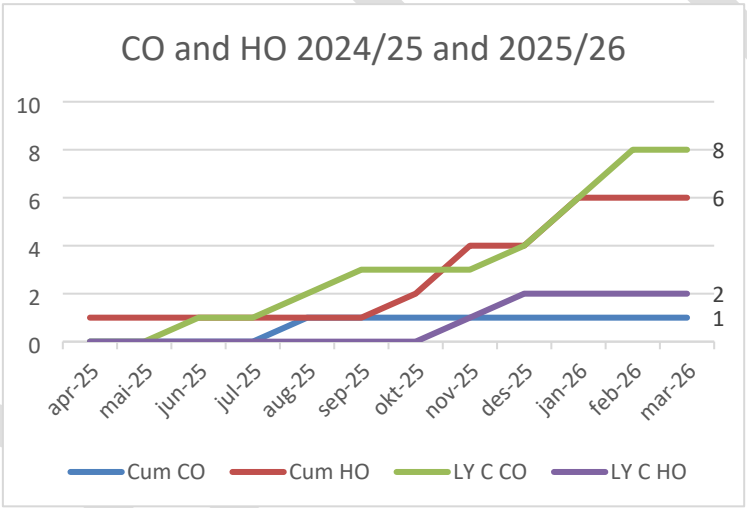
These factors may contribute to the elevated incidence of community cases. We are observing lower numbers to the previous year, and we continue to have lower rates than all Wales.

If we look at MRSA, we have a similar scenario. It is important to note that we are looking at a much smaller samples, which makes any analysis more complex. Looking at the total numbers, we had 7 cases reported this financial year, against a total of 10 last one, a reduction of 30% as can be seen on the next graphic:



Graphic 17 - MRSA total Cum last FY and current

While this aligns the HB with the National Reduction Goals we need to look into them with care since a deeper dive into the numbers reveals that this reduction, as already seen for Staphylococcus numbers as total, was mostly achieved through reduction on CO numbers from 8 to 2, while HO numbers have risen by 2 more cases from last year, as can be seen on the following graphic:



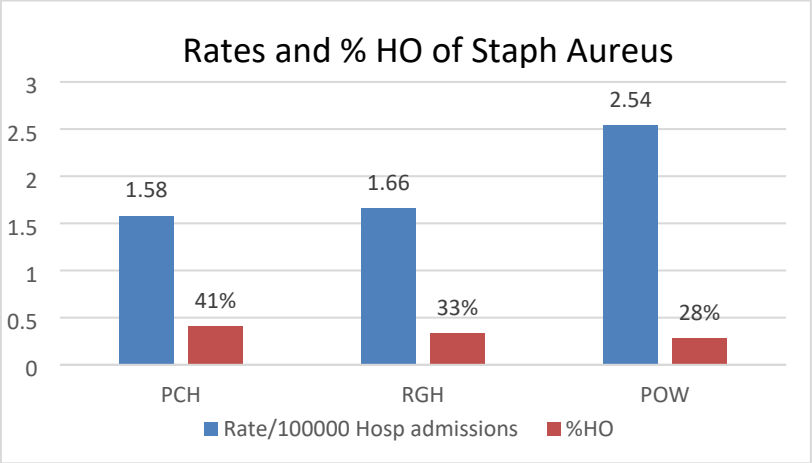
Graphic 18 - CO and HO 2024/25 and 2025/26

While this is concerning, it is important to stress the very small numbers of cases, which makes very difficult the interpretation of the numbers. It is more important to look at the current rates compared with last FY, where CTMUHB has seen a reduction for both MRSA (1.57/100 000 population – 23.41% lower than all Wales) and MSSA (23.41 per 100 0000 population).
MRSA rate has seen a reduction of 29.9% from last year 2.24 per 100 000 population and MSSA 12,4% as can be seen on the next table.

Organism	CTM 2024/25 rate/1000000CTM	2025/26 rate/Wales/100 00001000000	Reduction	Wales/100000	Dif% CTM?Wales
MSSA	27.1	23.74	12,4%	27.10	12.4%
MRSA	2.24	1.57	29.90%	2.09	24.88%

Table 15- MSSA and MRSA reduction and Wales Benchmark

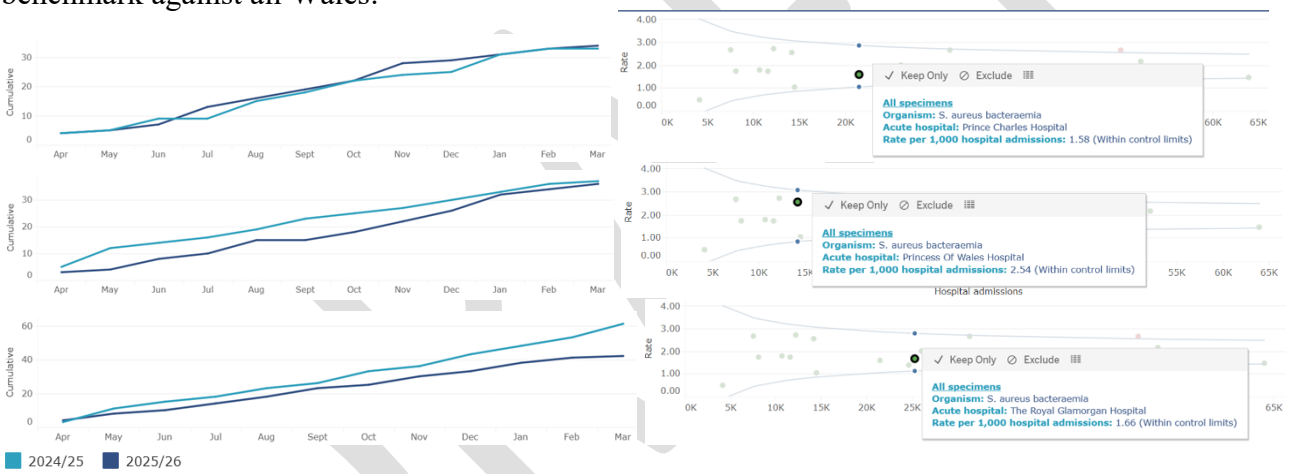
Looking again at Staphylococcus aureus bacteremia's by individual acute settings:



Graphic 19 - Cases and rate per site 2025/26

RGH had the highest total number of cases, but PCH had the highest total number of HO cases, nonetheless the lowest rate per 1000 admissions is RGH very close with PCH and the highest rate POW.

The following graphics will look into comparison with the previous financial year per site and benchmark against all Wales:



Graphic 20 - Cases per site 2025/26 and 2024/25 and benchmarking – Staphylococcus Aureus Bacteraemia

RGH and POW achieved a reduction on the number of cases compared to last year.
All 3 acute sites are within control limits with both PCH and RGH positioned on the lower than average compared to Wales and POW on the upper limits.
The IPC team has planned to continue the Point Prevalence reviews and will focus on the completion and accuracy of bundles for invasive devices. The result of the first PPS undertaken will be discussed later in this report.

5.3.1 – MRSA PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	1	0	1
Q2	1	0	0
Q3	3	3	3
Q4	2	1	2
Totals for Cwm Taff financial year 25-26	**7**	**4**	**6**

Table 16 - MRSA Preventability

The preventable MRSA infections were attributed to :

- PVC
- Picc Line
- Post surgical graft site
- Hospital Acquired Pneumonia
- Skin lesion.

5.3.2 – MSSA PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	25	1	11
Q2	31	3	13
Q3	28	2	11
Q4	14	6	6
Totals for Cwm Taff UHB financial year 25-26	**98**	**12**	**41**

Table 17 - MSSA Preventability

Regarding MSSA Bloodstream infection, about 12% were preventable, those were attributed to:

- PVC
- Urinary Catheters
- Arterial Line
- Total Hip Replacement

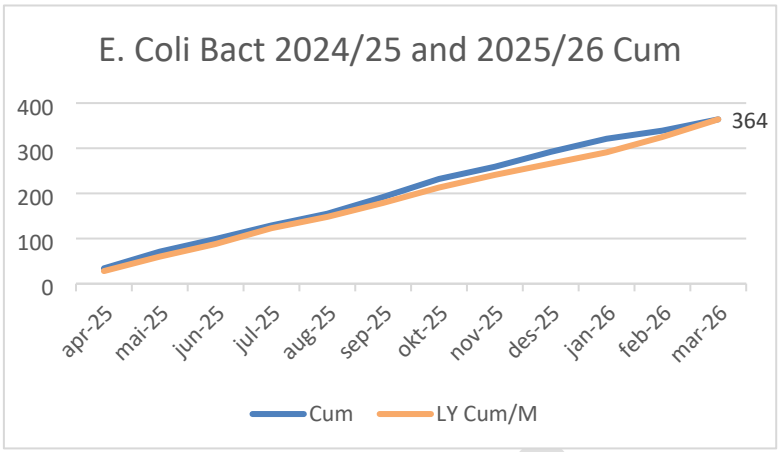
5.4 ESCHERICHIA COLI BACTERAEMIA

Improvement Goal: A reduction of at least 10% in cases of hospital onset E. coli BSI is expected vs the cases in 2024-2025.

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of *E. coli* bacteraemia

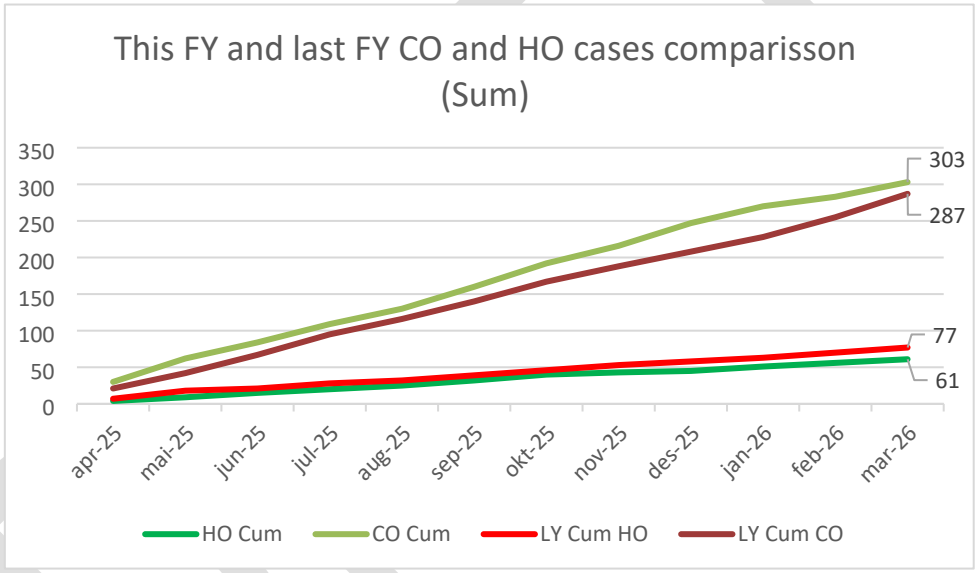
- This financial year we had a cumulative 364 cases, an increase of 3.1% from last year 353 cases
- HO cases reduction of 16 cases (20.8%)
- CO cases increase of 16 cases (5.6%)
- 303 cases Community onset and 61 Hospital onset (17% of cases are HO)
- All Wales rate/100 000 – 68.1, CTM rate 81.52 – 19.71% higher than all Wales

On Graphic 21 we can see the Sum comparison of all cases (CO and HO) cases for both 2025/25 and 2025/26:



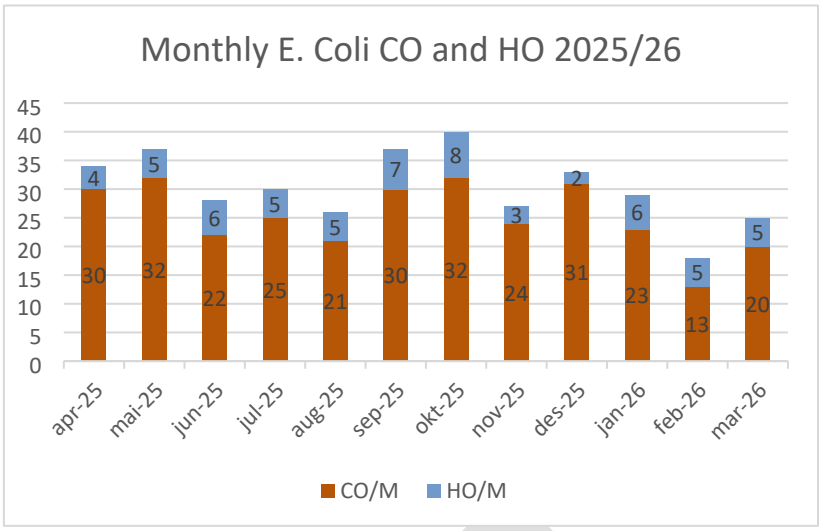
Graphic 21 - E. Coli Bact 2024/25 and 2025/26 Cum

We currently have a the same number of cases than same period last year, the following Graphic 22 shows how this is distributed between HO and CO cases:



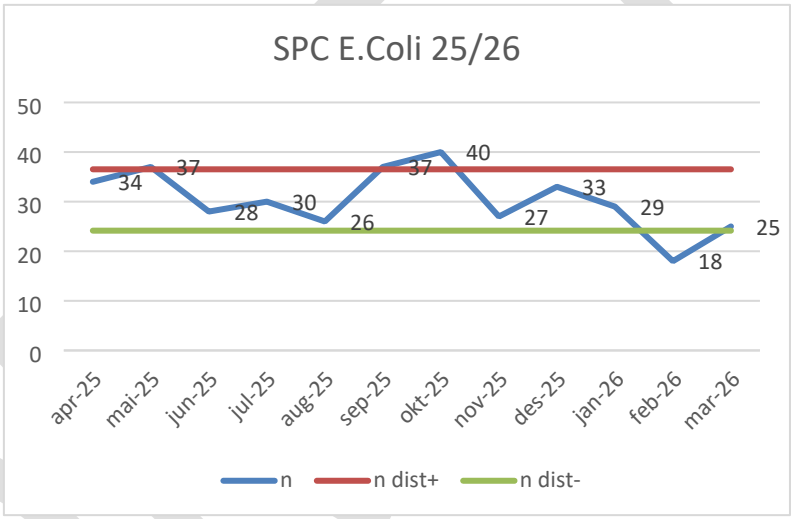
Graphic 22 – Financial years 2024/25 and 2025/26 Cum CO and HO comparison

As we can see the higher number of cases is mostly related with CO cases where there was an increase of 16 cases from last year same period (5.6%).
Regarding HO Cases there has been a reduction of 16 cases (20.8% reduction).
We are current in line with the expected reduction target for *Escherichia Coli* Bacteraemia, nonetheless it is important to point that CTM has a higher rate than all Wales, which is common also to *Klebsiella* Sp., making it an important priority for the HB to reduce the rates of Gram-bacteraemia's.
The following graphic shows monthly distribution between CO and HO cases 205/26 per month:



Graphic 23 - Monthly E. Coli CO and HO 2025/26

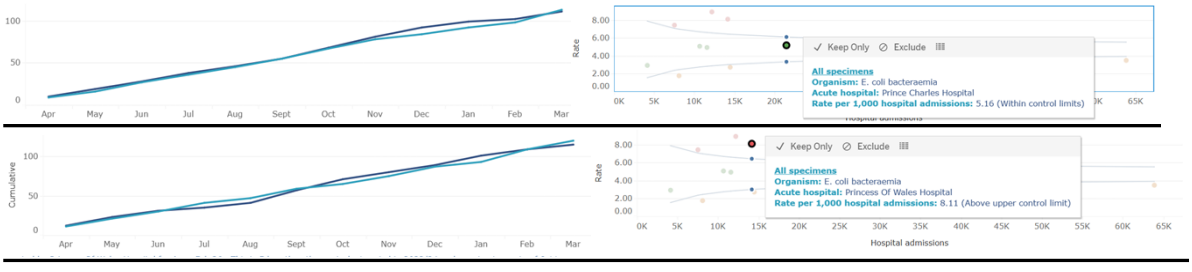
To better understand the current situation, it is important to look into the following SPC Chart:



Graphic 24 - SPC E.Coli 25/26

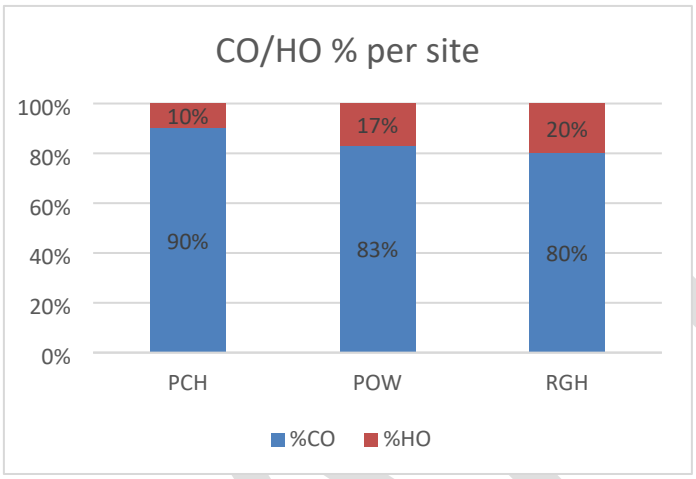
The SPC chart shows a process mainly inside the control limits with September and October passing the higher threshold for normal distribution and since then gradual reducing under the average with lowest point during February 2026.

The following graphics show the distribution per acute site:



Graphic 25 - Cases per site 2025/26 and 2024/25 and benchmarking – Escherichia Coli Bacteraemia

As we can see, RGH had a higher number of cases than last year, POW saw a small reduction and PCH had nearly the same number of cases. The lowest rate on hospital admissions is PCH, very closely with RGH. Both RGH and PCH are within control lines but POW is above the control limit line with an rate per 1000 admissions of 8.11.
If we look at ratio CO/HO per site:



Graphic 26- CO/HO % E.Coli admissions per site

We can see that POW and RGH have very similar % of cases that are HO, while this is nearly halved by PCH, nonetheless the big majority of cases are CO cases. While the reduction target focus on HO cases, we need to acknowledge that CO will necessarily condition the HO cases and therefore it is essential to work towards an integrated strategy to tackle both.
More work will need to be put towards continue the reduction of Gram-negative blood stream infections and in particular E. Coli. Such as:

- Increase PPE awareness through online training and face-to-face sessions
- Strengthen ANTT training – ANTT training advised to be reinstated as mandatory for all staff doing invasive procedures, which will refocus the importance and compliance or embed this into all insertion and maintenance of invasive devices training
- Catheter insertion and management continues to remain a focus, with a planned point prevalence study to be completed to provide a gap analysis to target an improvement plan
- Continue to increase compliance with IPC training, with current compliance at 74%. The target goal for CTM will be to achieve at least an average compliance of 85% by the end of Q3.
- Joint work with bowel and bladder team to explore ways to ensure better implementation of catheter passport as well as identify other joint actions to support reduction of CAUTI
- Understand the impact of invasive device bundles move to digital may have had in clinical practice.

5.4.1 – ECOLI PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	97	8	22
Q2	93	3	21
Q3	100	7	14
Q4	74	6	16
Totals for Cwm Taff UHB financial year 25-26	**364**	**24**	**73**

Table 18- E.Coli preventability

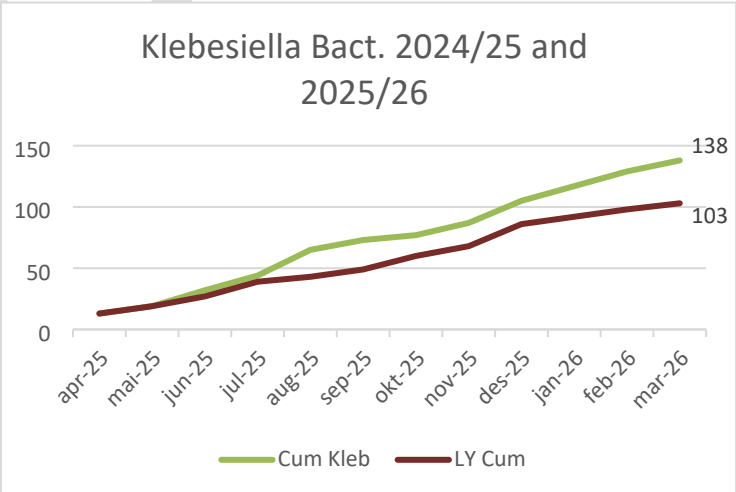
In table 18 we see a larger number of HO cases than the ones reported, this was due to a difference between the definition used by the IPC team and PHW on HO cases, this has now been corrected and confirmed HO cases – 61 cases.
Only about 6.6% of the total of bloodstream infections were deemed as preventable, nonetheless albeit the low number it is important that the HB continues to monitor and work towards reducing the rate of E.coli and other Gram negative bacteremia's.

5.5 KLEBSIELLA SPP. BACTERAEMIA

Improvement Goal: A reduction of at least 10% in cases of hospital onset Klebsiella spp BSI vs the cases in 2024-2025.

This financial year CTMUHB has recorded a cumulative 138 Klebsiella spp. bacteremia cases compared with 103 during the same period last year, representing an increase of 34.0%. Of these, 100 cases were community onset and 38 were hospital onset, meaning 28% of cases were hospital onset. CTMUHB's rate remains above the all-Wales rate (30.01 per 100,000 population compared with 23.70), confirming that Klebsiella spp. bacteremia continues to be a significant challenge for the Health Board. Although the national improvement measure is focused on hospital-onset cases, the overall pattern indicates that community-onset burden is also contributing materially to the position and must be considered within the wider response.

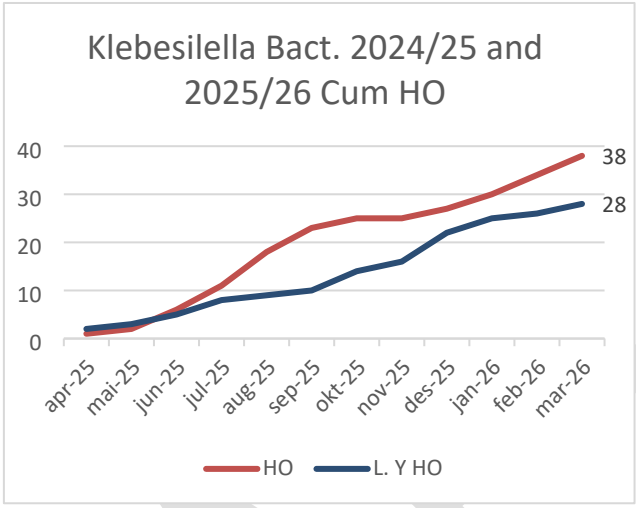
We can see this data on the following graphics:



Graphic 27- Klebsiella Bact. 2024/25 and 2025/26 Cum

The cumulative trend graphic (graphic 25) shows a clear divergence from the previous financial year, with case numbers remaining consistently above the 2024/25 comparator. This indicates that the increase is not attributable to a single isolated period, but rather reflects sustained pressure across the year. From an analytical perspective, this is important because it suggests a persistent epidemiological signal rather than short-term random fluctuation, reinforcing the need for continued investigation of both acute and community drivers of infection.

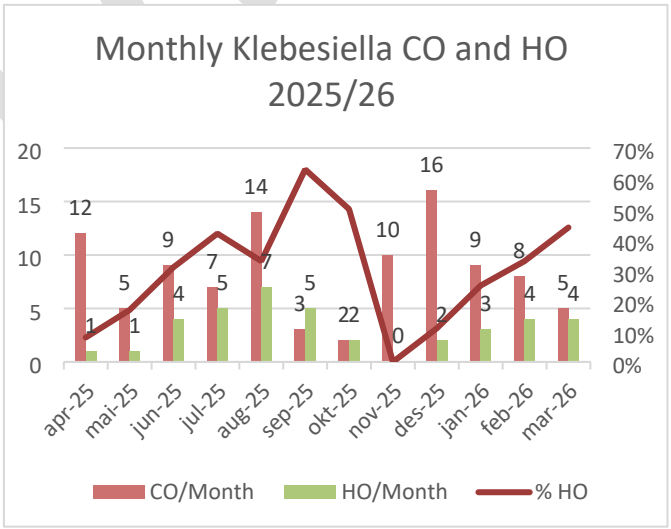
If we look only to HO cases, we can see the same:



Graphic 28- Klebsiella Bact. 2024/25 and 2025/26 Cum HO

The hospital-onset cumulative graphic (28) shows that hospital-onset Klebsiella spp. bacteraemia has also increased compared with the same period last year. This is particularly important in the context of the improvement goal, as it indicates that CTMUHB is not yet on the required trajectory for reduction. While the increase in hospital-onset cases is smaller in absolute terms than the overall increase, it remains operationally significant because these cases are more likely to reflect factors such as invasive device management, hydration, antimicrobial exposure, patient vulnerability and the challenge of maintaining consistent IPC standards.

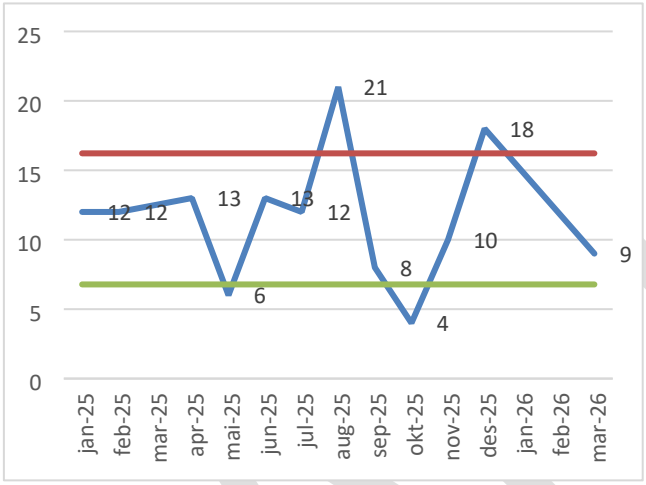
The following graphic shows the break between HO and CO per month during the current financial year:



Graphic 29- Monthly Klebsiella CO and HO 2025/26

The monthly distribution graphic (26) demonstrates that most Klebsiella spp. bacteremia cases remain community onset, but it also shows that the proportion of hospital-onset cases is not static across the year. Periods of higher overall activity appear to be accompanied by a rise in hospital-onset burden, suggesting that acute services are under greater risk when community prevalence is elevated. This supports the view that hospital-onset and community-onset cases should not be considered in isolation. A purely acute-based response is unlikely to deliver sustained reduction unless it is accompanied by stronger work across community services, catheter care, bowel and bladder pathways, hydration, antimicrobial stewardship and early recognition of patients at higher risk of deterioration or infection.

Looking into the SPC Chart:

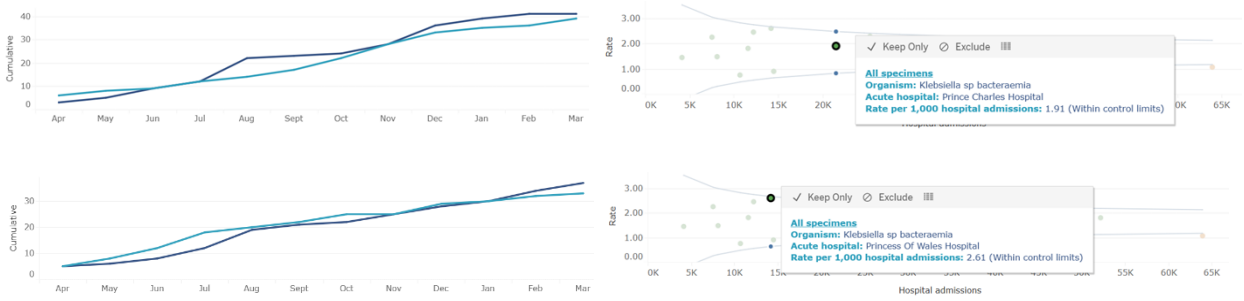


Graphic 30- Klebsiella SPC Chart

The SPC chart suggests a process that has shown instability over the year, with variation that merits further review rather than reassurance. This pattern indicates that the Health Board should continue to examine whether specific services, pathways, seasonal pressures or case-mix factors are influencing the increased burden. The purpose of this analysis is not only to explain past performance, but to identify where preventive action is likely to have the greatest impact. In practical terms, this means strengthening review of avoidable factors where possible, while also improving epidemiological understanding of the wider drivers behind the increase.

Klebsiella-related infections reductions actions has already been explored regarding *E.Coli* bacteraemia.

If we look into the next graphics, we will see the situation for each acute site:



Graphic 31 - Cases per site 2025/26 and 2024/25 and benchmarking – Klebsiella Bacteraemia

The site comparison and benchmarking graphic shows that all three acute sites have reported more cases than during the same period last year. Princess of Wales Hospital has the highest rate, although all three acute sites remain within control limits when benchmarked against comparable sites across Wales. This is an important distinction: although the position remains statistically within expected variation, it does not diminish the operational and clinical significance of the increase seen locally. The findings therefore support a balanced interpretation - CTMUHB is not an outlier in benchmarking terms, but the sustained rise in cases means that targeted local action remains necessary, particularly in relation to catheter-associated urinary tract infection prevention, invasive device practice, hydration and integrated work between acute and community teams.

5.5.1 – KLEBESIELLA PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	32	3	10
Q2	41	7	13
Q3	32	8	4
Q4	33	7	11
Totals for Cwm Taff UHB financial year 25-26	**138**	**25**	**40**

Table 19- Klebsiella Preventability

There is a small difference on the number of HO cases in table 19 compared to the reported number, as explained previously for E.Coli, this is due to different case definitions between IPC team and PHW, this has now been corrected.
About 18% of the total number of cases investigated was deemed as preventable. Albeit the low %, it is important to note the lack of improvement regarding Gram negative bacteraemia's across CTM and therefore essential to work towards improvement. All preventable bacteremia have CAUTI as a source with the exception of 2. One of these was thought to be an infected PICC line and another due to urology stents.

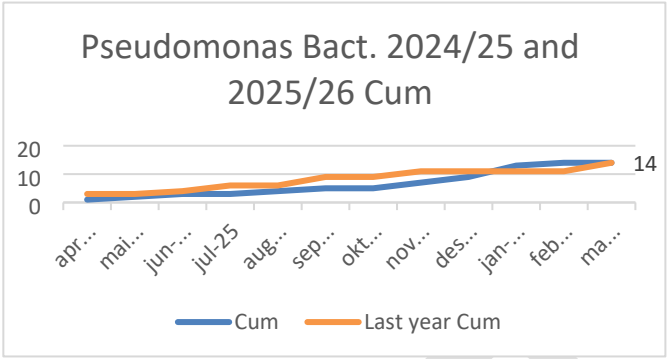
5.6 PSEUDOMONAS AERUGINOSA BACTERAEMIA

Improvement Goal: A reduction of at least 10% in cases of hospital onset Pseudomonas aeruginosa BSI vs the cases in 2024-2025 for the Health Boards that achieved the hospital onset improvement goal in 2024/25

This financial year CTMUHB has recorded 14 Pseudomonas aeruginosa bacteremia cases, unchanged from the same period last year. Of these, 9 were community onset and 6 were hospital onset. Hospital-onset cases have reduced by one compared with last year, equivalent to a 16.7% reduction, meaning that the Health Board is currently achieving the required improvement target for hospital-onset reduction. In addition, CTMUHB continues to compare favorably with the all-Wales position, with a rate of 3.14 per 100,000 population compared with 5.12 nationally. Taken together, these findings

suggest that, although vigilance remains essential, Pseudomonas aeruginosa bacteremia is n area of strength for the organization when compared with other bloodstream infection priorities.

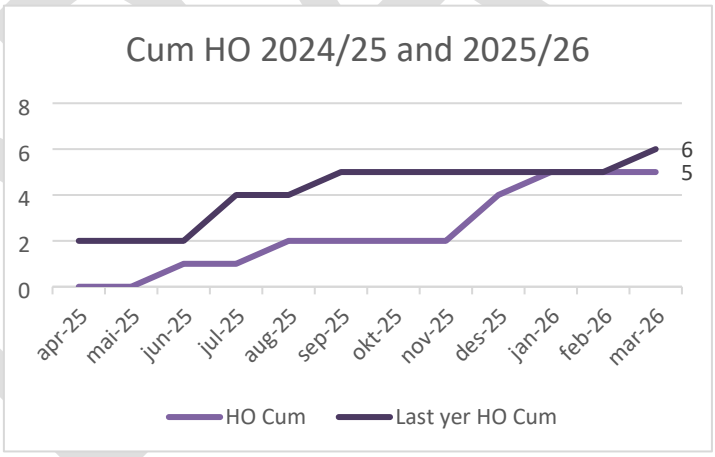
The following graphic shows the total number of cases (HO and CO) from last financial year compared to same period this financial year:



Graphic 32 - Pseudomonas bact. 2024/25 and 2025/26 Cum

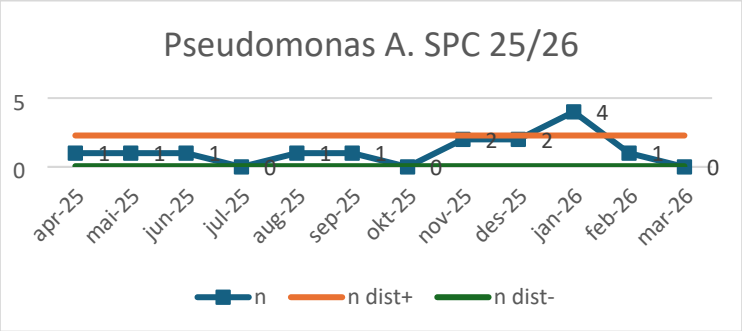
The cumulative total graphic (32) shows a broadly stable position year on year, with no evidence of a sustained upward drift. Stability is important in this context because case numbers are low and even small numerical changes can produce disproportionately large percentage movements. For that reason, interpretation should be cautious and should focus on the overall direction of travel rather than over-interpreting individual monthly changes. The key message from the cumulative trend is that CTMUHB has maintained control of this organism over the reporting period.

The following graphic compares the HO case (Cum) along the financial year:



Graphic 33 - Cum HO 2024/25 and 2025/26

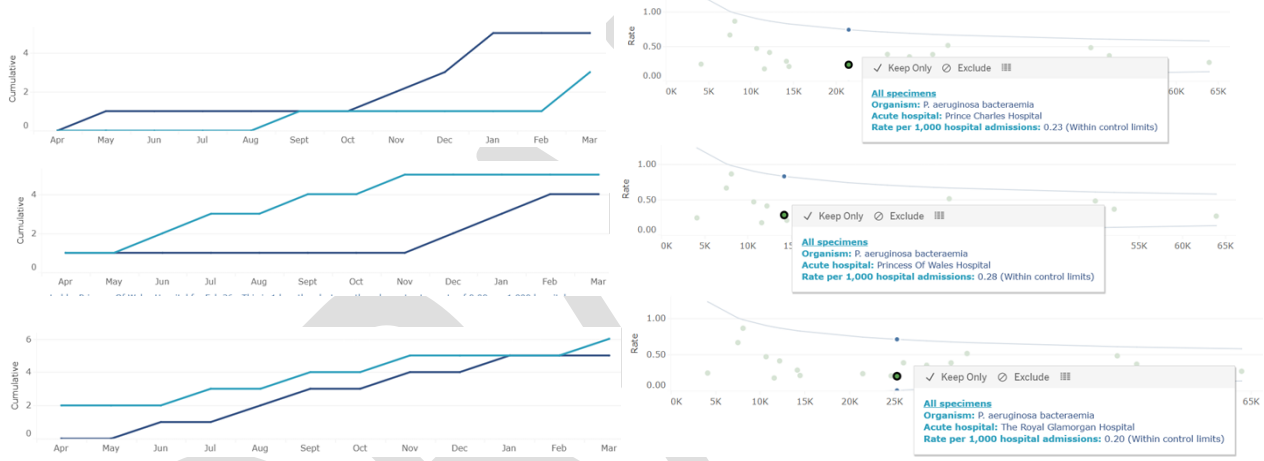
The hospital-onset cumulative graphic (30) demonstrates a small reduction compared with the previous financial year. Although numerically this represents only one fewer case, it remains consistent with the national improvement requirement. However, the very small number of cases means that performance should not be judged on percentages alone. The more meaningful interpretation is that hospital-onset burden has remained low and that CTMUHB has sustained a comparatively favorable position with a lower rate than all Wales, while continuing to monitor for any emerging change in pattern.



Graphic 34 - Pseudomonas Bact. SPC Chart

The SPC chart shows a stable process within control limits, with no sustained signal of special cause variation. This provides some reassurance that the current position is not being driven by an underlying deterioration in performance. Nevertheless, because the case volume is small, the chart should be interpreted alongside clinical intelligence and local review of individual cases. Continued emphasis on water safety, environmental controls, appropriate device management and adherence to standard IPC practice remains important to preserve this favorable position.

Looking at benchmarking our 3 acute sites within Wales:



Graphic 35- Cases per site 2025/26 and 2024/25 and benchmarking – Pseudomonas Bacteraemia

The site benchmarking graphic indicates that all three acute sites remain within control limits when compared with equivalent sites across Wales. This supports the view that the Health Board's overall position remains favorable. At site level, however, small case numbers can create apparent variation that may not be statistically meaningful, so interpretation should remain proportionate. The most appropriate conclusion is that current arrangements appear to be containing risk effectively, but that this should not lead to complacency. Ongoing surveillance, case review and reinforcement of core practice are still required to maintain the present standard.

PCH had more cases than last FY with 2 HO cases, while the past financial year there were 0 cases. The IPC team continues to monitor this closely, both cases were deemed as unavoidable after investigation.

From an improvement perspective, the priority for Pseudomonas aeruginosa bacteremia is to sustain performance. That means maintaining attention on water safety governance, invasive device practice, ANTT, hand hygiene, cleaning and staff compliance with IPC fundamentals. In contrast with areas such as Klebsiella spp. or E. coli, this section reflects a more positive performance narrative for CTMUHB. The challenge for the next FY is therefore to preserve the gains already achieved while ensuring that the organization continues to identify and respond quickly to any change in pattern.

5.6.1 PSEUDOMONAS PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	2	1	1
Q2	2	0	1
Q3	4	0	2
Q4	6	0	1
Totals for Cwm Taff UHB financial year 25-26	**14**	**1**	**5**

Table 20 - Pseudomonas Bacteremia Preventability

Only one preventable pseudomonas bacteremia which has a source of a CAUTI – this was CO and managed in the community.

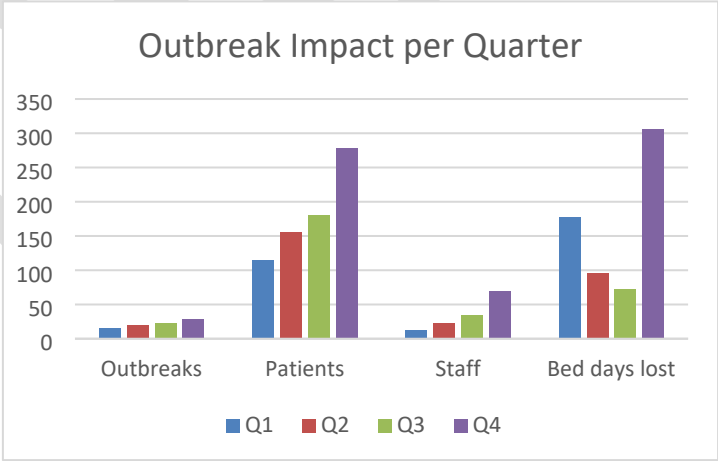
5.7 ACUTE RESPIRATORY INFECTIONS, NOROVIRUS AND OTHER OUTBREAKS

Winter pressures significantly affected IPC activity and operational resilience. Q4 acute respiratory infection data showed that respiratory pressure was driven by multiple pathogens, with Influenza A the most common recorded ARI, followed by RSV and COVID-19. This mixed-pathogen profile increased the complexity of patient placement, cohorting and escalation.
Norovirus was the most operationally disruptive organism during Q4. The annual outbreak data shows that norovirus was the largest contributor to bed-day loss across the year.

Quarter	Outbreaks	Patients	Staff	Bed days lost
Q1	16	114	13	178
Q2	19	156	23	96
Q3	23	181	35	72
Q4	28	278	69	306

Table 21 - Annual outbreaks/PII by quarter

The same information can be seen on the following graphic:



Graphic 36 - Outbreak Impact per Quarter

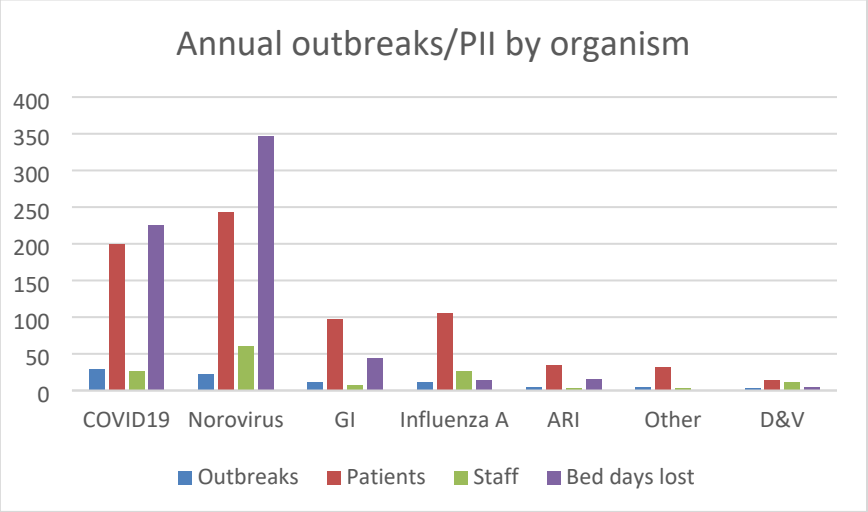
Where we can see that Q4 was the most affected quarter by combined number of outbreaks.
Looking into the following table we can see this same information by Organism/type of outbreak:

Organism	Outbreaks	Patients	Staff	Bed days lost
COVID19	29	200	26	226
Norovirus	22	244	61	347
GI	11	98	7	44
Influenza A	11	106	27	14

ARI	5	35	4	16
Other	5	32	3	0
D&V	3	14	12	5

Table 22 - Annual outbreaks/PII by organism

For easier understanding of the data, it has been compiled on the following graphic:



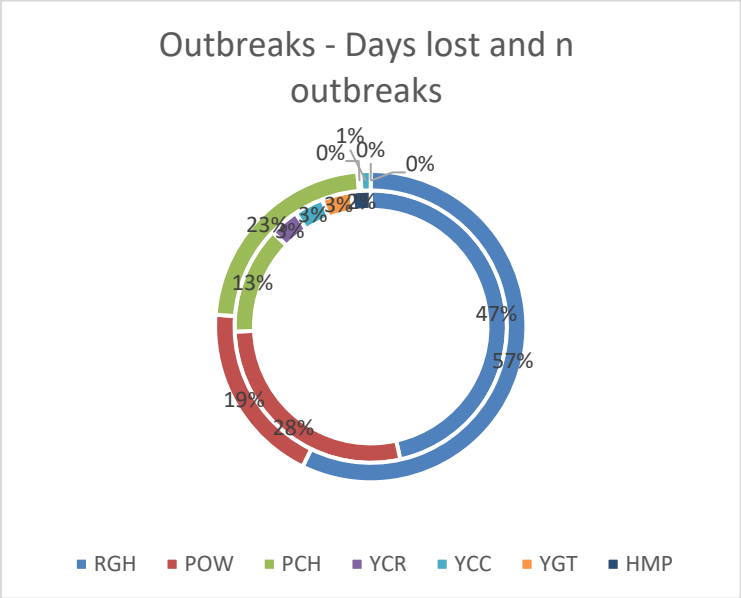
Graphic 37 - Annual outbreaks/PII by organism

Norovirus was the microorganism that affected the highest number of patients. It is important to point that very likely the number of positive cases in patients is under-represented due to limitations on testing in RGH, the site that had the highest number of outbreaks. The second most relevant was COVID-19, in both patients affected and bed days lost.
Influenza seems to have caused a more limited impact when looking into the data being presented, nonetheless, there have been 10 deaths from Influenza (HO) – 6 Flu A on part 1a of death certificate and remaining 1b or 1d. All cases were reviewed as part as a multidisciplinary team, with 2 cases identified as moderate harm and the remaining 8 cases, identified with low or no harm related to the increased incidence of Influenza. All cases were part of outbreaks and all of them occurred in Royal Glamorgan Hospital. Reflecting on the limited impact of influenza, we believe this was mainly related with the rapid response with quick setup of the IPC cell meetings, Universal use of masks and heighted IPC awareness across the organization, limiting the outbreaks mostly to RGH hospital and significantly reducing the impact in the remaining settings. This information validates the options taken during the height of flu infections.
Some factors prevented to reduce further the impact of the influenza outbreaks across the organization, in particular the fact that the first cases were detected earlier than in previous years and before what was in the winter modeling by PHW as well as the onset of cases following the severe scenario in the modeling, which was seen as a quick onset and wide spread at RGH.
The following table shows the distribution of outbreaks per site:

Site	Outbreaks	Patients	Staff	Bed days lost
RGH	40	352	77	373
POW	24	176	23	124
PCH	11	105	27	146
YCR	3	26	3	2
YCC	3	19	10	7
YGT	3	20	0	0
HMP	2	31	0	0

Table 23 - Annual outbreaks/PII by site

In the following graphic we can see the information regarding bed days lost per site:



Graphic 38- Outbreaks - Bed days lost and n Outbreaks

As has been discussed prior, RGH was the site most affected, with 57% of all days of bed lost and 47% of the total number of outbreaks. The reason for this is not fully clear and will require further investigation, but very likely is related with the very high activity on this site compared to the remainer, in conjunction with a very limited number of isolation space compared to PCH. Further reflection and investigation is advised to understand if there are any other variables contributing to this.

The key learning is that outbreak response requires a structured operational model, not an IPC advisory process alone.

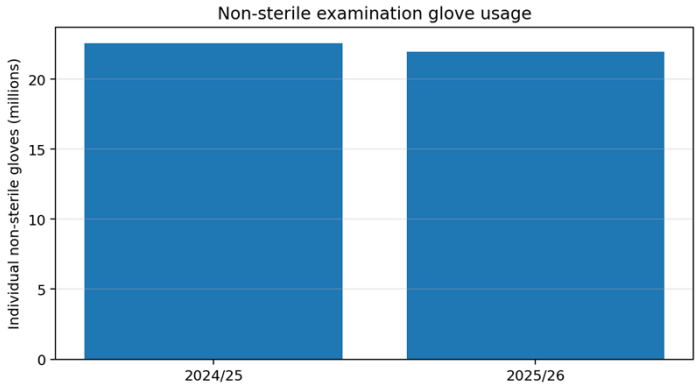
The IPC team has been working on the development of an outbreak response framework, to enable a quicker deployment of the IPC cell, with better governance and improved capacity for decision making. In parallel to this, the IPC team is also working into the development on an out of hours ARI guidance to support decision making when IPC is not available.

6. FINANCIAL STEWARDSHIP, SUSTAINABILITY AND GLOVE-USE REDUCTION

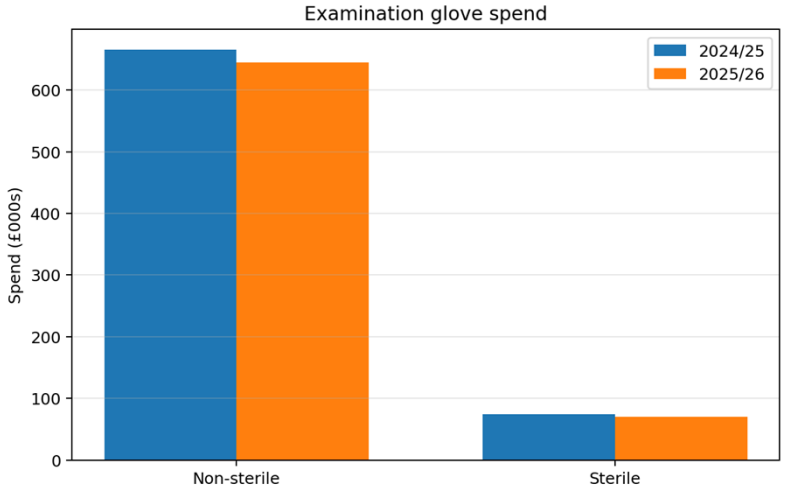
A separate review of non-sterile and sterile examination glove usage and spend compared 2024/25 with 2025/26. The data show a substantial reduction in non-sterile glove usage and spend, while sterile glove usage increased slightly but total sterile spend fell because of price reduction.

Category	Unit of issue	2024/25 quantity	2024/25 value	2025/26 quantity	2025/26 value	Quantity diff	Value diff
Non-sterile	BOX50	222	£1,740.16	136	£1,070.56	-86	-£669.60
Non-sterile	BOX100	225,623	£663,280.18	219,608	£643,291.55	-6,015	-£19,988.63

Table 24- Examination glove usage and spend comparison



Graphic 39- Reduction in non-sterile examination glove usage



Graphic 40- Examination glove spend by category

Non-sterile glove usage reduced from 22,573,400 individual gloves to 21,967,600 individual gloves, a reduction of 605,800 individual gloves. Non-sterile glove spend reduced by approximately £20,658.23. Sterile glove usage increased by 181 pairs, but spend still reduced by £5,024.27 due to price reduction. Overall examination-glove spend reduced by approximately £25,682.50.

The IPC point-prevalence Programme has visibly improved staff awareness and compliance with BBE and PPE standards, and the February 2026 follow-up PPS demonstrated marked improvement compared with July 2025, with most wards moving into green compliance and several areas achieving 100%.

In summary

During 2025/26, CTMUHB recorded a material reduction in non-sterile examination glove usage and spend. This reduction is very likely to have been supported, at least in part, by IPC point-prevalence surveys and targeted improvement work on the PPE use and Bare Below the Elbows. These interventions increased visibility of expected standards, enabled direct feedback to clinical areas and helped challenge unnecessary or inappropriate glove use. Because glove consumption is also influenced by clinical activity, case mix, outbreaks, procurement and stock management, the reduction must be described as a quality, sustainability and financial-efficiency benefit to which IPC improvement work made a credible contribution.

7. COMMUNITY IPC TEAM AND SYSTEM-WIDE PREVENTION

Community IPC Team Update (June 2025 – March 2026)

The Community IPC Team was set up in June 2025 and significant progress has been made to build a comprehensive service which is designed to support community settings across CTM. The Community IPC Team have built strong working relationships with Public Health Wales and local authority colleagues to improve IPC standards.
The Team's resource has recently been extended with plans to expand the current resource further. This will improve capacity and accelerate development of robust workplans whilst improving resilience within the team to respond to increased demands during outbreaks of infection. The enhanced workforce also enables the team to provide support consistently during the working week. Going forward, microbiologist support will also be needed to enable direct support to the team and the review of Community Onset Cdiff and bacteremia.

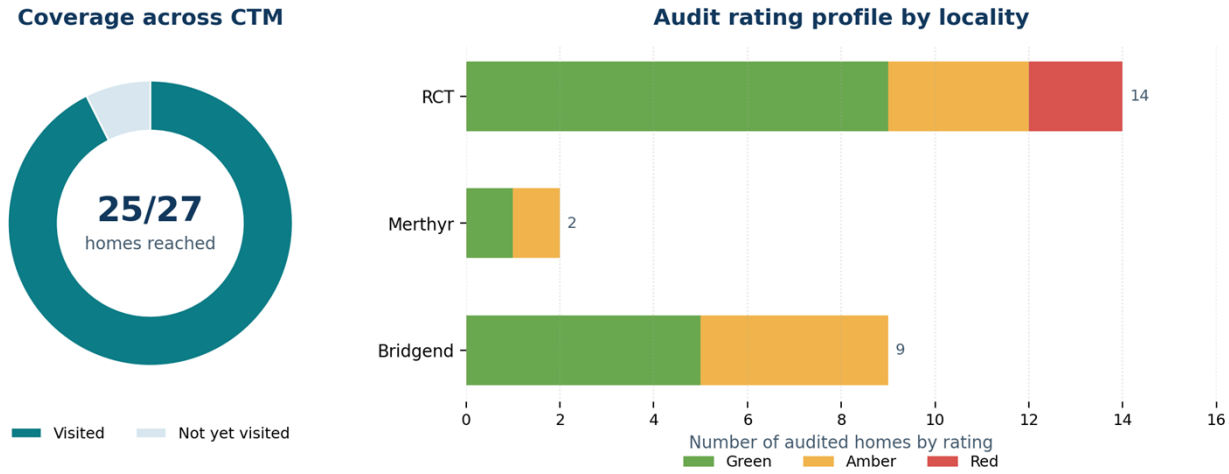
Nursing Homes

The Team have visited 25 of the 27 Nursing Homes across the CTM boundary. An IPC audit has been conducted in each of the homes and overall, the standards of IPC observed have been very good. A summary of the audit findings have been shared with the Care Home Managers for consideration and action.
A follow up offer of support has been shared with both care homes who initially declined the offer of support.

	Number of homes	Homes audited	Green rating (>90%)	Amber rating (80 - 90%)	Red rating (<80%)
RCT	15	14	9	3	2
Merthyr	2	2	1	1	0
Bridgend	10	9	5	4	0
TOTAL	**27**	**25**	**15**	**8**	**2**

Table 25 - CIPCt - Nursing Homes Visited

The following graphics display the coverage by the CIPCt for Nursing homes and the audit rating by locality:



Graphic 41- Nursing Homes Coverage and Audit rating profile by locality

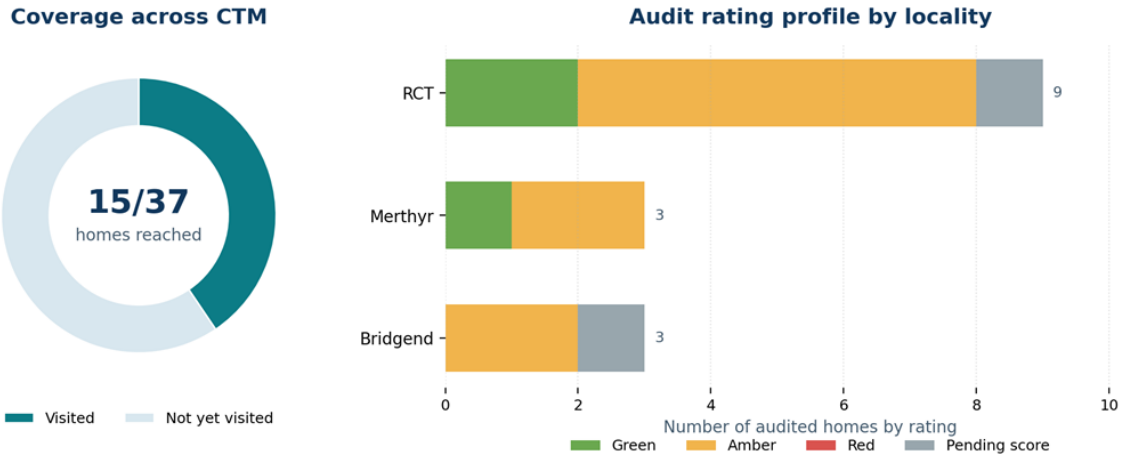
Residential Homes

The offer of an introductory visit and IPC audit has been extended to all residential homes.
An IPC audit has been carried out in 15 of the 37 residential homes. The team is working with commissioning teams in the local authorities to encourage Care Home Managers to access IPC support.
Follow up emails have also been sent to all care homes and further visits have been arranged in 2026.

	Number of homes	Homes audited	Green rating (>90%)	Amber rating (80 - 90%)	Red rating (<80%)	Score to be calculated
RCT	13	9	2	6	0	1
Merthyr	8	3	1	2	0	0
Bridgend	16	3	0	2	0	1
TOTAL	37	15	3	10	0	2

Table 26 - - CIPCt - Residential Homes Visited

The following graphic shows the IPC coverage at the moment this report was being produced and the audit rating profile by locality:



Graphic 42- CIPCt – Coverage and Audit rating by locality

Further work is needed to improve uptake of IPC support in the Bridgend and Merthyr areas. The support from the commissioning teams will be essential to support the IPC team on being able to visit and build a champions network across the Residential home Universe.

Training
An IPC training package has been developed and face to face sessions have been offered to all Home Managers. The training focuses on consistent use of standard infection prevention and control precautions and management of winter viruses including ARI and D&V.

The Community Team have delivered 20 sessions and delivered training to 201 care home staff. Excellent feedback has been received for the content and delivery of the sessions.
Further training will be developed through a shared electronically presentation to support face to face sessions.

Many of the larger care provider companies have a full Programme of education which includes IPC.

Outbreak management.
Scabies

The Community Team were notified of 11 outbreaks of Scabies in Care Homes between June 2025 and March 2026 which reflects the national increase reported. Being able to provide a timely response to support care homes to access treatment in a timely manner is critical during an outbreak to minimise further transmission. It is extremely difficult for Care Home staff to access treatment quickly which delays treatment for cases and contacts.

To reduce the delay, the Community Team is working collaboratively with Health Board colleagues to adapt a national PGD for treatment of contacts during outbreaks of Scabies in long term care facilities.

An information pack is being developed to support care homes during outbreaks.

D&V/ARI
PHW have requested support from the Community IPC Team during outbreaks of D&V/ARI. This proved difficult initially due to the limited resource but has now been agreed and an SOP for COVID-19 outbreaks is being developed to support the communication between community settings, local authorities, PHW and IPC as well as escalations.
The
Team has provided IPC advice over the telephone and visited the care homes in person where workload allows. This has been expanded with the increase of the number of staff allocated to the community team.

Networking.
The CIPC Team have developed links with local authority colleagues to support community settings. The Team have attended various meetings with commissioning teams in RCT, Merthyr and Bridgend and work is ongoing to support improvement in a variety of settings. The Team have attended a variety of care home and care provider meetings to offer support as can be seen on previous tables.

The Team is also present at national IPC and community setting meetings to enable sharing of ideas, participation in quality improvement projects and enables contribution to documentation/audit development to support improvements and standardization.

Recruitment.
The Community team is expanding following successful recruitment into a number of posts. There has been a limited resource since June 2025 but the additional resource has enabled the Team to be more proactive to support existing priorities and future work plans relating to IPC.
There is 1 vacant post and there are plans to relocate an IPC Nurse from the acute team into the community team to provide further support.

Community Vaccination Centers
The Team has visited the 6 community vaccination centers and shared recommendations with service leads. IPC recommendations relating to environmental issues and medicines management concerns have been identified and escalated.

ANTT

The Community IPC Team is working with District Nursing Teams across CTM to improve compliance with ANTT. Additional assessors have been trained to improve compliance with an aim to work towards bronze accreditation. This will be the first accreditation achieved within Cwm Taf Morgannwg UHB for ANTT and the Team will work with QI colleagues on the project.

Planned work for 2026/27 -

- From 1/4/26, provide IPC advice and support to Care Homes during outbreaks of Scabies and COVID. The Team will develop standardized information and supporting materials to share with care home staff during outbreaks of COVID and Scabies to ensure consistent messaging.
- Extend community IPC service to include community clinics, HMP Parc and GP surgeries.
- Develop an IPC link/Champion Programme.
- Review cases of CDI linked to care homes.
- Support domiciliary care teams
- Support Care Homes with COVID

At a glance, the CIPCt:

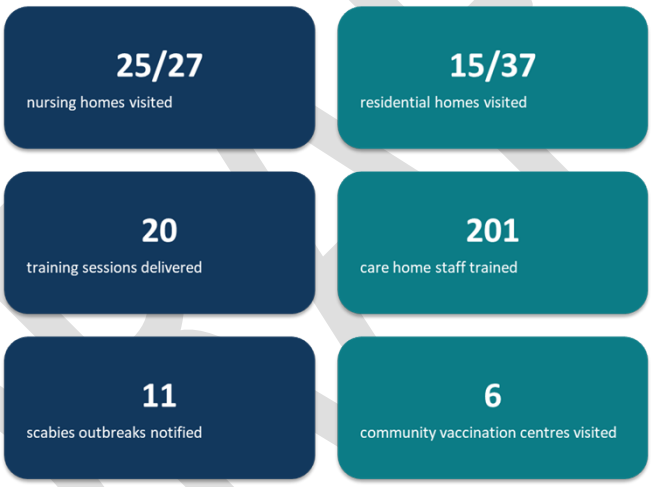


Figure 2- Resume CIPCt Activity

From a training, assurance and quality improvement work, the CIPCt work can be resumed as follows:

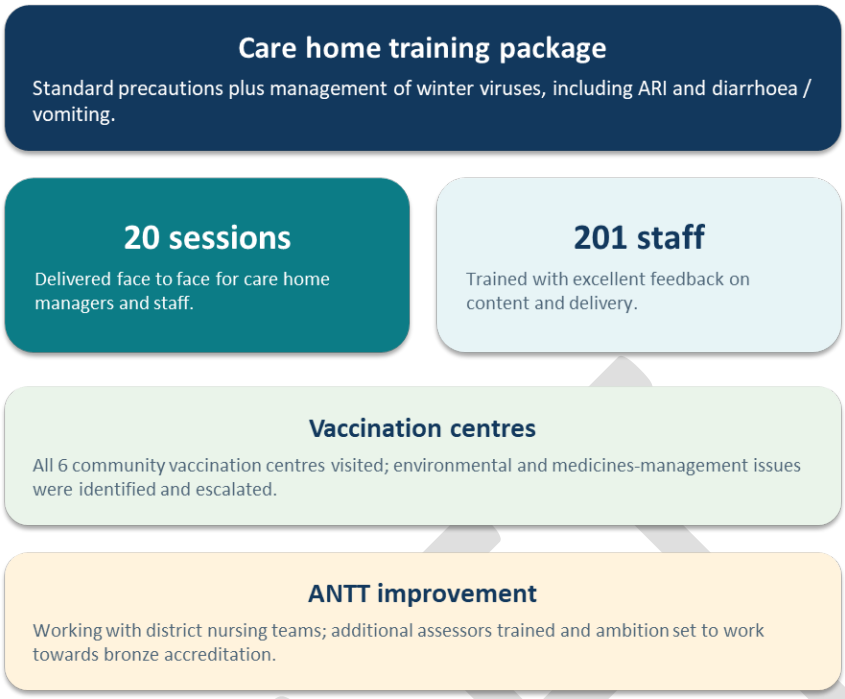


Figure 3- - CIPCt - Training, assurance and quality improvement work.

8. CAPITAL WORKS, DEVELOPMENTS AND REFURBISHMENT

Capital and infrastructure work remained closely linked to IPC risk. Key developments included continued involvement in the Llantrisant Health Park project, funding approval for central decontamination for CTM and Welsh Government funding for two negative-pressure rooms, one at RGH and one at POW. These developments are central to strengthening preparedness for highly infectious diseases, measles, airborne infections and future respiratory pressures.
Infrastructure risk is not limited to new builds. Existing estates constraints, ventilation limitations, decontamination capacity and side-room pressure all affect the Health Board's ability to deliver safe IPC practice. IPC involvement in capital planning must therefore remain early, visible and formally documented.

9. DECONTAMINATION

9.1 PURPOSE AND SCOPE

This chapter summarises the main decontamination governance, assurance, infrastructure and risk themes for inclusion within the IPC Annual Report. A separate Decontamination Annual Update Report, covering May 2025 to May 2026, has been prepared by the Decontamination Officer is be presented as an appendix/supporting report due to its technical complexity and level of detail required for decontamination assurance.

The purpose of this chapter is therefore not to duplicate the full technical report. It provides a concise Health Board-level overview of the key assurance messages, major service developments, principal risks and priority actions requiring continued oversight through the Decontamination Committee, Infection Prevention and Control Committee, estates governance, capital planning and the organisational risk register.

9.2 OVERALL ASSURANCE POSITION

Decontamination remains a critical component of patient safety, infection prevention and regulatory compliance. During the reporting period, CTMUHB maintained essential decontamination services across acute and community settings, including sterile services, endoscopy decontamination, ultrasound probe decontamination, ENT and maxillofacial scope decontamination, transoesophageal echocardiography probe reprocessing and community dental instrument decontamination.

The overall position is best described as partially assured. There is evidence of strengthened governance, improved professional oversight, approved audit tools, active engagement with Authorising Engineers and Welsh specialist networks, and significant progress on long-standing capital schemes. However, assurance is limited by non-compliant or ageing built environments, obsolete or end-of-life equipment, manual or paper-based traceability in some areas, variation in practice between sites, AP(D) capacity pressures, ventilation and air-change limitations, and reliance on interim mitigation where strategic solutions are not yet in place.

Area	Assurance judgement	Summary rationale
Governance and professional oversight	Improved assurance	Decontamination Officer in post; local decontamination meetings; Decontamination Committee reporting; engagement with AE(D), AP(D), NWSSP SES and All-Wales groups.
Audit and quality assurance	Improved assurance	CTMUHB decontamination audit tools approved; full audit rollout completed May-August 2025; action plans issued; next audit cycle scheduled from May 2026.
PCH CSSD refurbishment	Controlled but high-impact operational change	PCH CSSD closed from January 2026 for a major two-year refurbishment; interim activity decanted to RGH and POW HSDU; mobile endoscope decontamination unit installed to maintain endoscopy service continuity.
POW centralised decontamination facility	Strategic priority	Long-standing need now progressing through agreed enabling works, EBME relocation and redevelopment of the old pathology laboratory into a centralised decontamination unit. Target operational date is March 2027, subject to delivery of enabling works.
Built environment and equipment	Significant residual risk	POW endoscopy, urology and ENT arrangements remain dependent on ageing equipment, single-room environments, end-of-life storage cabinets or local manual processes pending centralisation.
Traceability and standardisation	Partial assurance	Robust paper systems are in place in some areas, but electronic tracking and fully standardised approaches are not yet consistently implemented.
Engineering support and AP(D) capacity	Limited assurance	AP(D) capacity is fragile, with limited site resilience and increasing demand from CSSD, endoscopy, capital works and maintenance requirements.

9.3 GOVERNANCE, COMPLIANCE AND ASSURANCE ARRANGEMENTS

Governance arrangements have strengthened during the year. The Decontamination Officer provides specialist oversight, chairs or attends local decontamination meetings, contributes to the Decontamination Committee, participates in the Authorised Person (Decontamination) group, and supports service, estates and capital discussions. The Health Board has also developed a positive and transparent working relationship with NWSSP Specialist Estates Services Authorising Engineers and the wider Welsh decontamination community.

The CTMUHB decontamination audit tools have been formally approved, with the IPC component separated so that IPC-specific elements can be monitored through the IPC audit programme. A comprehensive audit rollout was undertaken across CTMUHB between May and August 2025. Action plans were issued to services, feedback and support were provided, and progress is being

monitored through local decontamination governance. The next audit cycle is scheduled to recommence from May 2026.

Quality assurance reporting remains essential. Departments are expected to audit their decontamination traceability systems and provide continuing assurance to the Decontamination Officer through local quality assurance reports. Timely and consistent QA reporting should remain an explicit requirement during 2026/27.

9.4 SITE AND SERVICE-LEVEL SUMMARY

Service / site	Current position	Annual report implication / next step
Princess of Wales Hospital	The most significant strategic issue is the need for a centralised decontamination facility. Current endoscopy, urology, ENT and TOE probe arrangements remain operational but rely on mitigation within non-compliant or ageing environments. The centralised facility is planned for the old pathology laboratory once EBME is relocated.	Maintain risk register oversight; progress enabling works; monitor end-of-life equipment; confirm contingency options if centralised facility is delayed.
Royal Glamorgan Hospital	Centralised endoscope decontamination within CSSD supports endoscopy, theatres, urology, cardiology TOE and theatres. The temporary Vanguard unit used during POW roof-related disruption has been decommissioned and removed. ENT and Maxillofacial continue to use local Tristel Trio manual processes; additional ENT nasoendoscopes have been approved through TEF.	Use new ENT scopes to support movement towards safer centralised processing where feasible; maintain audit of manual processes; review scope capacity constraints for Maxillofacial.
Prince Charles Hospital	PCH CSSD closed in January 2026 for a major refurbishment expected to last approximately two years. Interim sterile services are supported through RGH and POW HSDU, with a mobile decontamination unit installed to support endoscopy. Service user feedback on the mobile unit has been positive to date.	Continue validation, testing, audit and IHEEM assurance; maintain oversight of decanted activity and ensure refurbishment governance remains connected to IPC and decontamination assurance.
Community and satellite sites	YCR and YCC ENT services use Tristel Trio for nasoendoscopes. Walkabouts are required to review probes and reusable medical device processes. Llantrisant Health Park requires stronger decontamination and IPC involvement during design and delivery.	Ensure Decontamination Officer and IPC are included in future LHP design decisions; confirm track and trace, compliant transport containers, storage, audit requirements and service model assurance.
Community Dental Service	Dewi Sant Health Park and Quarella Road decontaminate instruments within HSDU environments; other CDS sites currently undertake local decontamination. The traceability TEF bid was not approved. The strategic direction is movement towards centralised ISO 13485-accredited decontamination where feasible.	Develop phased centralisation plan, secure stakeholder engagement, identify instrument capacity requirements and ensure Sunnyside development pathways are fully planned with POW HSDU.

9.5 KEY DEVELOPMENTS DURING THE REPORTING PERIOD

Several important developments have improved the decontamination assurance framework during the reporting period:

- The PCH CSSD refurbishment programme commenced in January 2026, supported by Welsh Government funding. Interim arrangements have been established using RGH and POW HSDU capacity and a mobile endoscope decontamination unit on the PCH site.
- The long-standing centralised decontamination facility requirement at POW has been formally re-engaged, with the Decontamination Officer actively involved in design, planning and tender

discussions. Enabling works have been approved, an external contractor appointed, and the old pathology laboratory has been identified as the proposed location once EBME has been relocated.

- A CTMUHB-wide decontamination audit programme was delivered between May and August 2025, supported by approved audit tools, action plans and local meeting structures.
- The Health Board has strengthened external professional relationships with NWSSP SES, AE(D) colleagues and All-Wales decontamination forums, supporting greater technical challenge and transparency.
- Welsh Government Targeted Estates Funding submissions have supported progress in several areas, including the POW centralised endoscope decontamination scheme, decontamination equipment for SSD, ENT scopes at RGH and selected departmental improvements.
- Work is ongoing with HEIW and All-Wales colleagues on decontamination training and audit initiatives, including a standardised induction programme for Band 2 and Band 3 staff working within decontamination and sterilisation services.

9.6 PRINCIPAL RISKS REQUIRING CONTINUED OVERSIGHT

The Decontamination Annual Update identifies several risks that should remain visible within the IPC annual report narrative and organisational risk management processes. These risks are interdependent and require coordinated ownership between decontamination, IPC, estates, capital planning, service management and clinical teams.

Risk theme	Evidence / concern	Potential impact	Required mitigation
Non-compliant built environments	POW endoscopy single-room decontamination, urology layout limitations and wider infrastructure constraints do not fully meet current standards.	Patient safety, JAG/regulatory compliance and reputational risk.	Progress POW centralised decontamination facility; maintain interim controls and contingency planning.
Obsolete or ageing equipment	Discontinued Getinge Poke Yoke automated reprocessors in POW urology; end-of-life ENT controlled environment storage cabinets; ageing decontamination infrastructure.	Equipment failure, inconsistent reprocessing, lack of manufacturer training and limited resilience.	Maintain risk register entries; replace equipment through capital routes; ensure contingency if equipment fails.
Traceability limitations	Paper-based traceability remains in use for some Tristel manual processes; some reusable screws and plates at RGH/PCH do not support individual tracking.	Reduced auditability and potential future non-compliance with medical device traceability requirements.	Implement electronic tracking where feasible; standardise implantable device management; review reusable screws and plates.
CJD/sCJD screening and reusable devices	CJD policy is under review and mandatory pre-use reusable medical device screening has faced local pushback.	Prion transmission risk, device quarantine/destruction risk and governance risk if screening is inconsistent.	Secure senior endorsement, clear implementation timeline and escalation pathway for non-compliance.
AP(D) and engineering resilience	Limited AP(D) provision at sites and estates capacity pressures, including inability to provide expanded seven-day/24-hour support.	Reduced ability to maintain compliant engineering governance, permit-to-work processes and timely technical support.	Review AP(D) capacity, consider pan-CTMUHB decontamination support model and identify investment requirements.
Ventilation and air changes	Tristel wipe systems require a minimum of five air changes per hour; some areas have insufficient mechanical or natural ventilation.	COSHH, staff safety and decontamination compliance risk.	Risk assess areas, use alternative decontamination arrangements where standards cannot be met, and move towards validated automated systems where possible.
Insourcing and agency governance	Concerns were raised about agency or insourced staff undertaking or being present in decontamination areas without	Patient safety, regulatory, IPC, governance and reputational risk.	Mandate training evidence before decontamination activity; require formal project governance for all insourcing arrangements.

Risk theme	Evidence / concern	Potential impact	Required mitigation
	validated manufacturer-approved training evidence.		

9.7 PRINCESS OF WALES HOSPITAL CENTRALISED DECONTAMINATION FACILITY

The development of a centralised decontamination facility at POW is the single most important strategic decontamination scheme described in the annual update. The requirement has been recognised since Welsh Government audits in 2016 and was reflected in a Red/Amber JAG compliance position from 2018. The core issue is that existing local arrangements remain operational but rely on interim process controls rather than a fully compliant built environment with appropriate dirty-to-clean segregation.

The proposed centralised decontamination unit will support Endoscopy, Urology, ENT and Cardiology, while HSDU sterilisation services remain separate due to their different technical requirements. The facility is expected to provide a dedicated and purpose-designed environment with controlled workflows, centralised processing, standardised practice and improved quality assurance. Current planning is based on redevelopment of the old pathology laboratory after EBME relocation, with enabling works approved and an external contractor appointed. Subject to completion of the enabling works, the expected operational date is by March 2027.

Because this scheme has a long history and delays would prolong existing risks, the annual report should explicitly state that the centralised decontamination facility requires continued committee oversight. If short- or medium-term delays occur, alternative options should be actively explored, including relocation to another suitable on-site department or use of a modular decontamination facility capable of supporting Endoscopy, Urology and ENT activity.

9.8 CJD/SCJD AND REUSABLE MEDICAL DEVICE GOVERNANCE

CJD and suspected CJD present specific decontamination risks because prions are resistant to standard disinfection and sterilisation processes. The decontamination report highlights the need to manage all known, suspected or increased-risk patients in line with national TSE guidance and local policy. The CTMUHB CJD policy is under review, and this should remain a priority for approval and implementation.

The Decontamination Officer has requested that all services using reusable medical devices implement a mandatory pre-use patient checklist, including relevant CJD/sCJD screening questions before device use. Implementation has been delayed because of local challenges. The annual report should therefore make clear that senior leadership support is required to endorse the requirement, communicate expectations to operational managers and clinical teams, agree a timeline, and establish an escalation process for non-compliance.

9.9 MEDICAL DEVICE TRACEABILITY, ULTRASOUND PROBES AND IMPLANTABLE DEVICES

Traceability is a recurring assurance theme across the decontamination report. POW has transitioned fully to single-use implantable screws and plates, which removes the need for decontamination and reduces traceability risk. In contrast, RGH and PCH continue to use mainly reusable screws and plates, with some items still in circulation that do not support individual tracking. This requires review

because individual track and trace of implantable medical devices is expected to become a mandatory regulatory requirement.

Ultrasound probe decontamination is undertaken using a mixture of Trophon automated high-level disinfection systems, ultraviolet disinfection machines and approved detergent/disinfectant wipes for non-critical use. The report recommends engagement with Clinical Engineering to apply RFID tagging to mobile ultrasound machines. This would improve visibility of device movement, support audit and strengthen assurance that appropriate decontamination has occurred in each clinical setting.

9.10 INSOURCING, AGENCY AND TRAINING GOVERNANCE

An important governance concern is in relation to insourcing and agency activity in Endoscopy services. Manufacturer-approved training is a fundamental requirement for safe flexible endoscope and probe decontamination, including manual cleaning, endoscope washer-disinfector use and controlled environment storage cabinet operation. The report identifies gaps in documented assurance that all agency or insourced staff involved in decontamination had completed the required training.

This is a governance learning point. The Health Board should reaffirm that no agency or insourcing staff may undertake decontamination activity unless full manufacturer-approved training evidence is available and validated. Future insourcing arrangements should include a formal project governance structure with decontamination, IPC, AE(D), service management and senior nursing involvement. This is required to maintain patient safety, regulatory compliance and organisational assurance.

9.11 PRIORITIES FOR 2026/27

No.	Priority	Expected action
1	Maintain Board and committee oversight of high-risk decontamination issues	Ensure decontamination risks remain visible through IPCC, Decontamination Committee, AP(D) group, estates/capital governance and the organisational risk register.
2	Deliver POW centralised decontamination facility milestones	Monitor enabling works, EBME relocation, technical specification, equipment tendering, construction and contingency planning March 2027 target.
3	Maintain safe interim arrangements during PCH CSSD refurbishment	Continue validation, audit, QA reporting and IHEEM assurance for the mobile endoscope decontamination unit and decanted sterile services activity.
4	Strengthen AP(D) and engineering resilience	Review authorised person capacity, permit-to-work governance, estates support and potential pan-CTMUHB decontamination engineering model.
5	Improve traceability and standardisation	Progress electronic tracking where feasible, review reusable implantable device traceability and standardise decontamination systems across sites.
6	Implement CJD/sCJD screening for reusable medical devices	Secure senior endorsement, update policy, implement pre-use checklists and monitor compliance through local governance.
7	Address ventilation and air-change risks	Identify areas using Tristel or other chemical systems without adequate ventilation, risk assess, and implement alternative arrangements or capital solutions.
8	Strengthen insourcing and agency governance	Require validated manufacturer training and formal project governance before any non-CTMUHB staff undertake decontamination activity.
9	Continue audit and QA programme	Recommence audit cycle from May 2026, monitor action plans, and require departments to evidence traceability and equipment assurance through QA reports.

9.12 SUMMARY CONCLUSION FOR THE IPC ANNUAL REPORT

Decontamination services across CTMUHB have remained operational during a period of significant change, service pressure and capital development. The annual update provides evidence of strengthened specialist oversight, improved audit arrangements, constructive external relationships and meaningful progress on major strategic schemes. These are important positive developments and

should provide the IPC Committee with assurance that decontamination is receiving increased focus and governance attention.

However, the assurance position remains qualified. The Health Board continues to carry significant decontamination risks associated with ageing or obsolete equipment, non-compliant built environments, manual and paper-based systems, ventilation limitations, CJD/sCJD screening implementation, AP(D) resilience, and the governance of insourced or agency activity. The POW centralised decontamination facility and the PCH CSSD refurbishment are particularly important because their successful delivery will materially change the Health Board's risk profile.

The full Decontamination Annual Update Report should therefore be read alongside this IPC Annual Report chapter. It contains the detailed technical evidence, site-by-site assurance, risk descriptions, audit findings and recommendations required for specialist review. The role of this chapter is to summarise the key organisational messages and ensure that decontamination remains visible as a core IPC, patient safety, estates and regulatory priority for 2026/27.

10. WATER SAFETY AND VENTILATION SAFETY

Water and ventilation safety remain core IPC risk domains. Pseudomonas performance is favorable, but ongoing vigilance is required because water systems, drainage, outlets, ventilation and environmental conditions remain relevant to infection risk, especially for vulnerable patient groups and specialist areas.
Ventilation remains on the risk register. Decontamination areas also continue to be affected by ventilation and air-change issues. The Health Board should continue to maintain close alignment between IPC, Estates, Facilities, Decontamination and Capital teams.

11. BLOOD CULTURE CONTAMINATION AND ANTT ASSURANCE

Month	% contaminates over total samples	RGH A&E % contaminates over total samples	Target
Oct	7.60%	5.26%	3.00%
Nov	7.60%	5.88%	3.00%
Dec	6.23%	3.86%	3.00%
Jan	6.33%	3.43%	3.00%
Feb	8.89%	6.02%	3.00%
Mar	6.70%	4.82%	3.00%
Average	7.23%	4.88%	

Table 27 - Blood culture contamination rates, all hospitals/departments and RGH A&E

Blood culture contamination is a significant assurance concern. The average contamination rate was 7.23% across the reported hospitals/departments and 4.88% in RGH A&E, both above the 3% target. Contamination rates may indicate inadequate ANTT practice.
The data reinforces the need to improve IPC and ANTT training compliance, review blood culture practice in high-volume areas, widen data collection to include POW and PCH and extend it from A&E to ICU/ITU comparators across sites, and ensure clinical areas investigate local drivers of contamination.

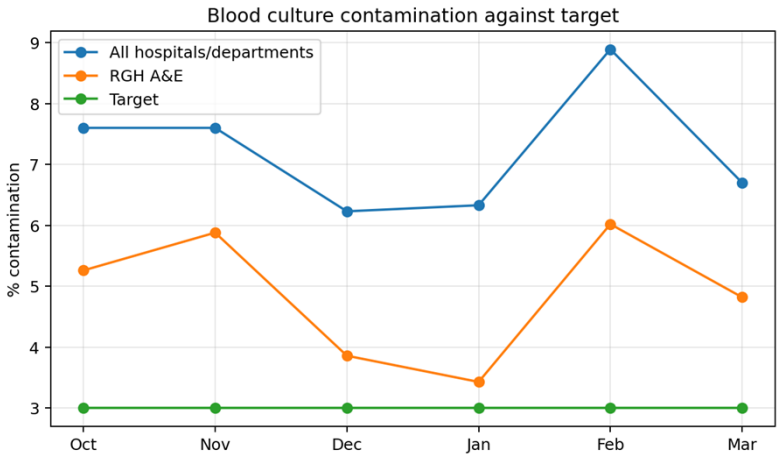


Figure 4 - Blood culture contamination rates against 3% target

IPC during the FY has work towards creating more awareness and become more visible. The IPC team concluded several PPS, with the majority regarding BBE and PPE, with significant improvement observed along the year. The IPC team also continues to deliver ANTT training but to enable the reduction on rates to the 3% mark, it is advisable that ANTT is re-instated as mandated for staff doing invasive procedures. Also it is essential that the care groups take leadership on their improvement trajectories and work, with IPC support, towards a sustained reduction in the contamination rates.

12 – SSI C-SECTION OVERVIEW

12.1. CONTEXT AND PURPOSE

This chapter summarizes the 2025 caesarean birth surgical site infection (SSI) surveillance position for Cwm Taf Morgannwg University Health Board (CTMUHB), with specific reference to Princess of Wales Hospital (POW), Prince Charles Hospital (PCH) and the overall Health Board position. It is intended for inclusion in the 2025-26 IPC Annual Report and should be read alongside the Public Health Wales HARP caesarean birth SSI reports and the CTMUHB SPC workbook.

Surgical site infection following caesarean birth remains an important patient safety, quality and experience indicator. Although many cases are identified after discharge and in the community, the prevention of infection is a whole pathway issue. Reliable surveillance, consistent diagnostic criteria, effective post-discharge reporting, robust wound care standards and prompt review of identified cases are essential to ensure that trends are interpreted accurately, and improvement action is targeted appropriately.

The current analysis is particularly important because the 2025 data show an increase in reported SSI rates at Health Board level and at both POW and PCH. The key question for assurance is whether the observed increase represents a signal of sustained deterioration or whether it remains within expected statistical variation. The analysis below indicates that, although the increase is real and should not be dismissed, the SPC data do not currently demonstrate a clear special-cause shift. This supports a proportionate response: continued caution, stronger standardization and enhanced validation rather than a conclusion that the process is definitively out of control.

12.2- DATA SOURCES, REPORTING METHOD AND INTERPRETATION

The Public Health Wales HARP report for POW covers the rolling year 1 January 2025 to 31 December 2025 and provides both POW and CTMUHB figures. The report confirms that the quarterly caesarean birth SSI report now uses a rolling-year reporting period and that Wales rates have been removed from quarterly reports. Instead, an aggregate baseline from the three years prior to the reporting period is provided for local comparison. This is an important methodological point because it means the most appropriate comparator for this chapter is the local baseline rather than an all-Wales quarterly rate.

The POW report also notes that the POW maternity unit was closed from 2 September 2024 until 17 February 2025, with redirection of activity during that period. This affects the interpretation of POW quarter-level data, particularly the absence of POW Q4 2024 data and the lower volume of POW activity in Q1 2025. For that reason, quarterly changes should be interpreted cautiously and the rolling-year and SPC views are more informative than any single quarter.

PCH quarterly values have been derived from the CTMUHB total less POW where required and checked against the supplied CTMUHB SPC workbook. This produces a coherent PCH profile for 2025: 1,033 valid procedures, 44 reported SSIs and an annual SSI rate of 4.26%. This is consistent with the PCH SPC series supplied in the workbook.

12.3- HEADLINE POSITION FOR 2025

Table 1 provides the headline annual position. The reported rate increased in each site-level view compared with the 2022-2024 baseline. The increase was greatest for POW and CTMUHB by relative percentage change, although the PCH rate remained the highest in absolute terms.

Measure	POW	PCH	CTMUHB
Baseline period	Q1 2022-Q4 2024*	Q1 2022-Q4 2024	Q1 2022-Q4 2024
Baseline valid procedures	1,824	2,745	4,569
Baseline SSIs	43	109	152
Baseline SSI rate	2.36%	3.97%	3.33%
2025 valid procedures	616	1,033	1,649
2025 SSIs	16	44	60
2025 SSI rate	2.60%	4.26%	3.64%
Change vs baseline	+10.17%	+7.3%	+9.31%
Predicted/expected cases	8 predicted	41 predicted	Approx. 55 expected on baseline rate
Variance from prediction/expectation	+8 cases	+3 cases	Approx. +5 cases

Table 28 - Headline caesarean birth SSI position, 2025 compared with the 2022-2024 baseline

**POW Q4 2024 was recorded as no data due to maternity unit closure. PCH values are derived from CTMUHB totals less POW values and aligned with the supplied SPC workbook.*

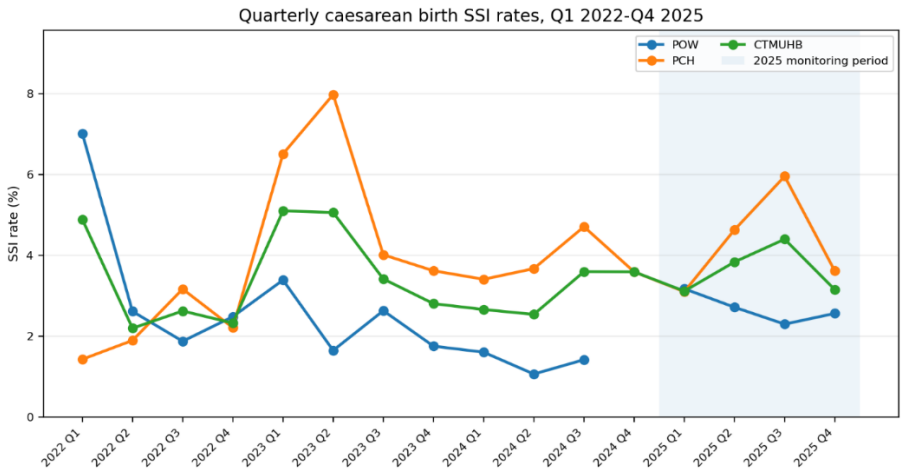
The data show that CTMUHB recorded 60 caesarean birth SSIs from 1,649 valid procedures in 2025, giving an annual SSI rate of 3.64% compared with a 3.33% baseline. POW recorded 16 SSIs from 616 valid procedures, giving a rate of 2.60% compared with a baseline of 2.36%. PCH recorded 44 SSIs from 1,033 valid procedures, giving a rate of 4.26% compared with a baseline of 3.97%. These figures confirm an increase across the Health Board, but they also show that the absolute numbers are small enough for quarterly variation to have a visible effect on the rate.

12.4- QUARTERLY PROFILE

Quarterly data are set out below. For POW, the first quarter should be interpreted in the context of the maternity unit reopening on 17 February 2025. For PCH, the highest quarterly rate in 2025 was seen in Q3. For CTMUHB, the highest quarterly rate was also seen in Q3, followed by a reduction in Q4.

Quarter	POW procs	POW SSIs	POW rate	PCH procs	PCH SSIs	PCH rate	CTMUHB procs	CTMUHB SSIs	CTMUHB rate
2025 Q1	63	2	3.17%	290	9	3.10%	353	11	3.12%
2025 Q2	184	5	2.72%	259	12	4.63%	443	17	3.84%
2025 Q3	174	4	2.30%	235	14	5.96%	409	18	4.40%
2025 Q4	195	5	2.56%	249	9	3.61%	444	14	3.15%

Table 29 - quarterly caesarean birth SSI activity



Graphic 43 - Quarterly caesarean birth SSI rates, Q1 2022-Q4 2025.

12.5- SPC INTERPRETATION AND ASSURANCE

The SPC review supports the user's interpretation, with one important caveat. The annual rates have increased compared with baseline; however, the quarterly rates do not currently demonstrate a pattern consistent with special-cause deterioration when assessed against conventional control limits based on the 2022-2024 baseline. In practical terms, this means the increase should be treated as an adverse signal requiring action and surveillance, but not as definitive evidence that the process has moved outside expected statistical variation.

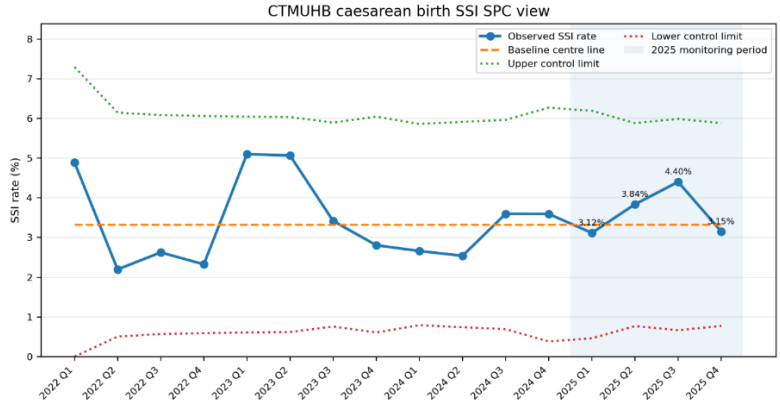
The PCH Q3 2025 point is the highest 2025 quarterly rate and sits above the baseline center line. It should therefore remain a focus for prospective review. However, the Q4 2025 PCH rate reduced to 3.61%, and no 2025 PCH, POW or CTMUHB point breached the calculated upper control limit in the SPC view. This supports a cautious but proportionate conclusion: the 2025 increase is concerning, but the data do not yet demonstrate a sustained special-cause shift.

The conclusion should be revisited as additional 2026 data become available. If the rate remains persistently above the center line, if successive quarters move towards the upper control limit, or if a single quarter breaches the upper control limit, this would strengthen the case for escalation and a more detailed case-level review.

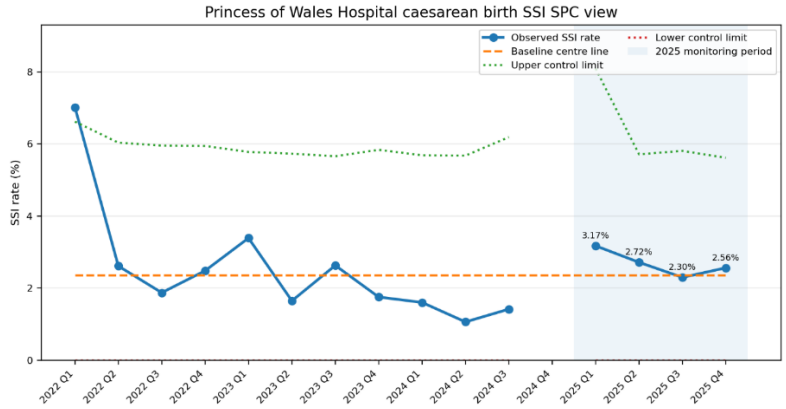
Site	Baseline center line	2025 annual rate	Highest 2025 quarter	SPC interpretation
CTMUHB	3.33%	3.64%	Q3: 4.40%	Above baseline annually, but all 2025 quarters remain within control limits.
POW	2.36%	2.60%	Q1: 3.17%	Above baseline annually; no 2025 quarter breaches the upper control limit.
PCH	3.97%	4.26%	Q3: 5.96%	Highest absolute rate; Q3 should be monitored, but the rate remains within

Site	Baseline center line	2025 annual rate	Highest 2025 quarter	SPC interpretation
				control limits and reduced in Q4.

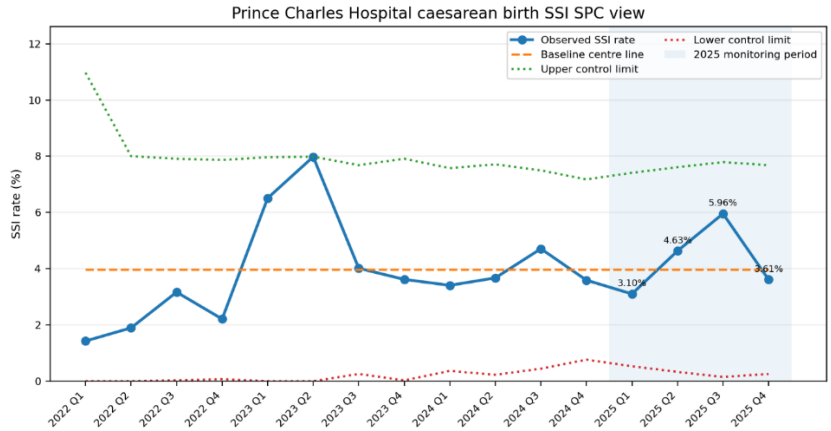
Table 30- . SPC interpretation summary



Graphic 44 - CTMUHB caesarean birth SSI SPC view.



Graphic 45- POW caesarean birth SSI SPC view.



Graphic 46 - . PCH caesarean birth SSI SPC view

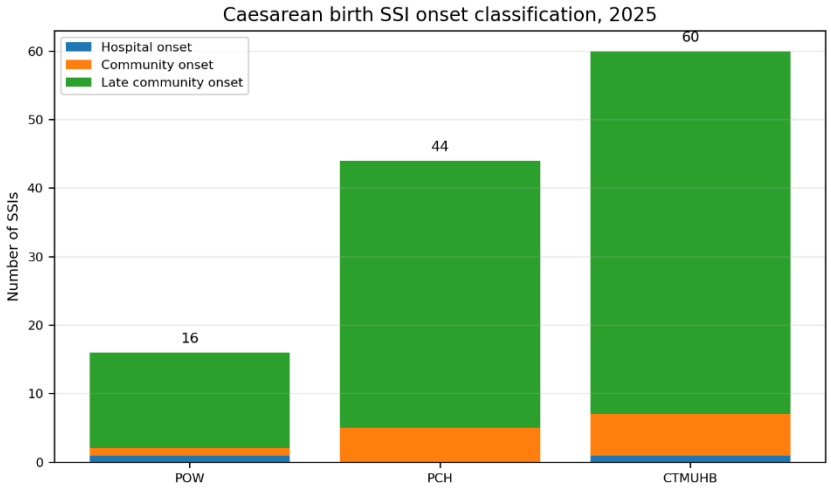
12.6. INFECTION ONSET, TYPE AND CASE CHARACTERISTICS

The majority of reported caesarean birth SSIs were late community onset. This is a key finding for governance and improvement. At CTMUHB level, 53 of 60 SSIs were classified as late community onset, representing 88.3% of reported infections. POW recorded 14 of 16 SSIs as late community onset, representing 87.5%. PCH recorded 39 of 44 SSIs as late community onset, representing 88.6%. This means the main opportunity for improved assurance is not limited to the inpatient episode, but

extends across discharge advice, wound surveillance, community midwifery review, GP identification and feedback of reported cases into the IPC and maternity governance systems.
Only one hospital-onset caesarean birth SSI was recorded across CTMUHB in 2025, and this was recorded at POW. There were six community-onset infections across CTMUHB, with one at POW and five at PCH. There were no infections with unknown onset. This pattern supports the need for stronger post-discharge surveillance and timely case review, while also recognizing that the infection prevention bundle begins before, during and immediately after the caesarean birth episode.
In terms of infection type, CTMUHB recorded 34 superficial SSIs and 26 complicated/deep infections. POW recorded a higher proportion of deep infections, with 9 deep infections and 7 superficial infections. PCH recorded 17 deep infections and 27 superficial infections. No organ-space infections were recorded in the POW or CTMUHB data.

Site	Hospital onset	Community onset	Late community onset	Total SSIs	% late community onset
POW	1	1	14	16	87.5%
PCH	0	5	39	44	88.6%
CTMUHB	1	6	53	60	88.3%

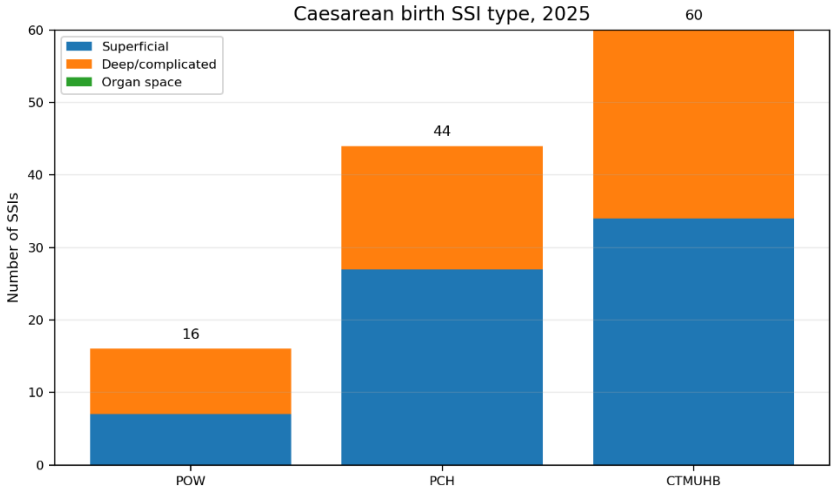
Table 31 - Onset classification of caesarean birth SSIs, 2025.



Graphic 47- Onset classification of caesarean birth SSIs, 2025

Site	Superficial	Deep/complicated	Organ space	Total SSIs	% deep/complicated
POW	7	9	0	16	56.3%
PCH	27	17	0	44	38.6%
CTMUHB	34	26	0	60	43.3%

Table 32 - Type of caesarean birth SSI, 2025.



Graphic 48 - Type of caesarean birth SSI, 2025.

12.7- DEMOGRAPHIC AND CLINICAL RISK PROFILE

The HARP demographic section provides useful context for targeted improvement. At CTMUHB level, the SSI rate was higher in the obese BMI group than in the healthy weight group: 42 SSIs from 790 procedures in the obese group, a rate of 5.32%, compared with 4 SSIs from 338 procedures in the healthy weight group, a rate of 1.18%. A similar pattern was seen at POW, where the obese BMI group recorded 11 SSIs from 309 procedures, a rate of 3.56%, compared with 1 SSI from 127 procedures in the healthy weight group, a rate of 0.79%. This does not imply that BMI alone explains the increase, but it does support targeted wound care, patient information and escalation advice for higher-risk groups.

Urgency of operation does not appear to be a strong differentiator in the 2025 data. At POW, elective and emergency caesarean birth rates were almost identical at 2.61% and 2.59% respectively. At CTMUHB level, the elective rate was 3.75% and the emergency rate was 3.54%. The data therefore suggest that the improvement focus should be broader than emergency caesarean births alone and should include the whole pathway and consistency of wound care practice across both elective and emergency activity.

Skin closure data should be interpreted with caution due to very small denominators in some categories. The overwhelming majority of procedures used dissolvable sutures. The apparently high SSI rate in the staples category reflects only two procedures across CTMUHB and should not be over-interpreted statistically. Nevertheless, the variation in materials and wound care products reinforces the importance of the work being progressed through the all-Wales SSI working group and local maternity governance to standardize procedure, materials and post-operative care.

Risk/domain	POW observation	CTMUHB observation	Interpretation
BMI	Obese: 11/309, 3.56%; healthy weight: 1/127, 0.79%	Obese: 42/790, 5.32%; healthy weight: 4/338, 1.18%	Higher SSI rate in obese BMI group supports targeted prevention and wound-care advice.
Urgency	Elective 2.61%; emergency 2.59%	Elective 3.75%; emergency 3.54%	No major difference by urgency; prevention should apply consistently to all caesarean birth pathways.
Skin closure	Dissolvable sutures used in 611/616 procedures	Dissolvable sutures used in 1,641/1,649 procedures	Dominant closure method; small numbers in other closure categories limit interpretation.
Onset	14/16 late community onset	53/60 late community onset	Post-discharge surveillance, wound review and feedback loops are central to improvement.

Table 33- Demographic and clinical interpretation points

12.8- SURVEILLANCE GOVERNANCE, CASE VALIDATION AND ICNET

Data completeness for 2025 was 100% for both POW and CTMUHB, compared with 97% during the 2022-2024 baseline period. This is a positive assurance point because it reduces the likelihood that the observed annual increase is simply due to incomplete denominator or form completion. However, data completeness does not, by itself, assure diagnostic consistency. The correct identification of SSI requires consistent application of surveillance definitions and reliable differentiation between expected wound healing, superficial wound concerns, and true SSI.

The annual report for the previous year identified a concern regarding possible over-reporting at PCH and noted that Public Health Wales supported validation work. The current year therefore needs to be interpreted within that wider surveillance-development context. The aim of the current improvement work is not only to reduce true infection risk, but also to ensure that reported SSI data are accurate, comparable and consistently defined across CTMUHB.

Work is underway to link caesarean birth SSI reporting data with ICNet. This is a significant governance development. Linking the SSI data to ICNet will allow IPC teams to view reported cases more directly, support timely review of case details, identify any clustering or recurring themes, and

provide earlier scrutiny where classification, onset or criteria require validation. It should also strengthen the feedback loop between maternity services, community midwifery, IPC and the Public Health Wales surveillance process.
The ICNet linkage should be developed as more than a data-transfer exercise. It should be embedded into a clear review pathway, including defined triggers for IPC review, agreement on which cases require multidisciplinary scrutiny, and a mechanism for feeding learning back to midwifery, obstetric, theatre and community teams.

12.9- IMPROVEMENT PROGRAMME: TRAINING AND STANDARDISATION

The all-Wales SSI working group has reviewed the caesarean birth SSI surveillance position and developed a package of training for midwives. The purpose of the training is to improve reliability of SSI identification and reporting, reduce the risk of over-reporting or inconsistent reporting, and support standardization of key procedures and materials across CTMUHB. This includes attention to wound assessment, surveillance criteria, dressings, documentation, escalation routes and consistency of post-discharge advice.
IPC and the Head of Midwifery are working together to deploy the agreed training package across CTMUHB, this will be first piloted at POW before deployed to PCH and with the end goal of all Wales adoption. This is an important mitigation because the majority of SSIs are being identified after discharge and because maternity, community midwifery, GP and IPC reporting pathways all influence the quality of surveillance. Standardizing practice should improve both infection prevention and the quality of the data used to assess the impact of prevention work during 2026.
The training should be positioned as a joint patient-safety and data-quality intervention. Better surveillance alone may initially appear to increase reported numbers if cases are identified more reliably; however, consistent criteria and documentation will ultimately provide a clearer and more accurate picture of true SSI burden. This will allow CTMUHB to distinguish between genuine deterioration, improved ascertainment and variation caused by inconsistent reporting.

Workstream	Purpose	Expected assurance gain	Suggested timescale
Midwifery SSI training package	Standardize identification, reporting and escalation of caesarean birth SSI.	Reduces variation and supports reliable case classification.	Deploy during 2026 with compliance monitoring.
Standardization of materials and procedure	Ensure consistent use of dressings, wound care advice and post-operative practice across CTMUHB.	Reduces unwarranted practice variation and supports fair comparison between sites.	Align with all-Wales SSI working group outputs.
ICNet linkage	Enable IPC teams to view SSI reports and support timely investigation and scrutiny.	Improves visibility, case review, cluster recognition and learning feedback.	Prioritize implementation and test reporting workflow.
Quarterly SPC monitoring	Review POW, PCH and CTMUHB rates against baseline and control limits.	Supports early recognition of sustained change or special-cause variation.	Report quarterly to maternity governance and IPCC.
Case-level thematic review	Review late community-onset and deep infections for common themes.	Identifies preventable factors across discharge, wound review and follow-up.	Begin with 2025 cases and repeat prospectively.

Table 34 - . Improvement work Programme for caesarean birth SSI surveillance and prevention.

12.10- PRIORITIES FOR 2026

The following priorities are recommended to maintain proportionate but robust assurance during 2026:

1. Complete deployment of the all-Wales SSI working group training package for midwives, with attendance and completion monitored through maternity governance – to be first deployed at POW and then PCH with end goal to be adopted all Wales.
2. Standardize agreed wound care procedures, dressings and post-operative advice across CTMUHB, ensuring that clinical practice and surveillance criteria are aligned.
3. Implement the ICNet linkage for SSI reporting so that IPC teams can view cases in a timely way and support case validation, investigation and thematic analysis.
4. Continue quarterly SPC monitoring for CTMUHB, POW and PCH, using the 2022-2024 baseline and reviewing whether any points breach control limits or whether sustained runs above the center line develop.
5. Undertake focused review of late community-onset cases, including the route of diagnosis, timing of symptoms, whether the woman was reviewed in person, criteria used, treatment given and any opportunities for earlier advice or escalation.
6. Use the demographic findings to strengthen targeted patient information and wound care support for higher-risk groups, particularly women with obesity or other risk factors that may affect wound healing.
7. Ensure that learning from reported cases is fed back through maternity, theatre, community midwifery, IPC and quality governance routes rather than remaining solely within surveillance reporting.

12.11- OVERVIEW ON CURRENT SITUATION AND WAY FORWARD

The 2025 caesarean birth SSI data show an increase in reported infection rates at CTMUHB, POW and PCH when compared with the 2022-2024 baseline. POW recorded 16 SSIs against 8 predicted, while PCH recorded 44 SSIs against 41 predicted. CTMUHB recorded 60 SSIs from 1,649 valid procedures, representing an annual rate of 3.64% and an increase from the 3.33% baseline.
The increase should be taken seriously, particularly because the majority of cases were late community onset and therefore depend on reliable post-discharge surveillance and communication across Organisational boundaries. However, the SPC review indicates that the current rates remain within expected control limits and do not yet provide clear evidence of special-cause deterioration. This supports the analysis that the increase should currently be interpreted as variation within the expected range, albeit adverse variation requiring caution and active management.
The agreed response is appropriate: deployment of the midwifery SSI training package, standardization of procedures and materials, improved validation of reported cases, and development of ICNet linkage to allow IPC teams to view reports and support timely investigation. These actions should improve both prevention practice and surveillance reliability. The 2026 data will be important in determining whether the 2025 increase resolves as common-cause variation or evolves into a sustained trend requiring escalation.

13. PRIORITIES FOR 2026/27

The priorities for 2026/27 should consolidate the progress achieved while addressing the persistent risks identified during the year.

- **Strengthen Gram-negative reduction:** focus on E. coli and Klebsiella spp. through CAUTI prevention, catheter care, hydration, antimicrobial stewardship, early recognition and community pathway work.

- **Deliver a more ambitious CDI Programme:** maintain acute controls while expanding community-onset analysis, including primary care prescribing, PPI review, postcode/deprivation mapping and care-home links.
- **Improve training compliance:** achieve a clear trajectory toward target, with particular focus on Medical and Dental staff and other low-compliance groups.
- **Embed the outbreak framework:** standardize OCC triggers, quorum, cadence, action logs, debriefs and digital reporting.
- **Build the Community IPC offer:** extend to residential homes, community clinics, GP settings, HMP Parc and domiciliary care, and develop an IPC link/champion network.
- **Strengthen decontamination resilience:** progress central decontamination, PCH refurbishment, AP(D) oversight, protein testing and risk register actions.
- **Use PPS as a quality-improvement tool:** continue BBE/PPE, device and ANTT point-prevalence reviews, linked to local ownership and measurable improvement.
- **Formalize financial and sustainability benefits:** report glove-use reduction as a credible quality, sustainability and financial-efficiency outcome with appropriately cautious attribution.

14. CONCLUSION

CTMUHB has demonstrated sustained commitment to infection prevention and control during a demanding and complex year. The Health Board has maintained core IPC governance, strengthened the specialist IPC service model, expanded community-facing IPC capacity, progressed point prevalence survey work, supported outbreak management and continued to provide expert advice across acute, community and strategic workstreams. The introduction of 12-hour acute-site IPC support, weekend and bank holiday on-call arrangements, improved recruitment and ongoing Hub development represent important improvements in resilience and responsiveness.

The annual infection position remains mixed. There are clear areas of progress, including reductions in hospital-onset E. coli, sustained favorable Pseudomonas performance and an overall reduction in Staphylococcus aureus bacteremia. These improvements indicate that targeted action, surveillance, clinical review and partnership working can make a difference. However, the report also demonstrates that improvement is not yet consistent or sufficient across all infection measures. Gram-negative bacteremia remains above the all-Wales benchmark, Klebsiella spp. has increased, and C. difficile remains below the Wales rate but is not improving at the pace required to meet the national reduction ambition.

The data also show that infection prevention is now increasingly a pathway issue. Community-onset infection accounts for a substantial proportion of CDI, E. coli, Klebsiella spp. and Staphylococcus aureus burden. This means that acute hospital controls, while essential, cannot deliver the full scale of improvement required. Sustainable reduction will depend on stronger alignment with primary care, community services, antimicrobial stewardship, pharmacy, care homes, local authorities and Public Health Wales. The developing Community IPC Team provides a strong foundation for this work and should remain a strategic priority during 2026/27.

The report identifies several Organisational risks requiring continued leadership attention. IPC mandatory training compliance remains below the expected standard, with particularly low compliance among Medical and Dental staff. Blood culture contamination rates indicate variation in ANTT and specimen collection practice. PPS findings show that BBE compliance is improving, but hand hygiene and PPE use remain variable, with inappropriate glove use a specific concern.

Decontamination, ventilation, isolation capacity and HCID preparedness risks also remain active and require sustained governance and investment.

The point prevalence survey Programme has been one of the most useful assurance developments during the year. It has demonstrated that observed practice can improve when data are collected, fed back and linked to targeted action. It has also shown that the Health Board must not rely solely on policy, training completion or annual audit to infer compliance. Direct observation, ward-level feedback, local ownership and repeated measurement are required to understand whether IPC standards are reliably embedded in practice.

The reduction in non-sterile glove use is a positive quality, sustainability and financial stewardship outcome. It is reasonable to conclude that PPS work and improved conversations about appropriate PPE use are likely to have contributed to this reduction, while recognizing that glove consumption is also affected by activity, case mix, outbreak pressure, procurement and stock management. The next phase should link safety, sustainability and value more explicitly by triangulating glove use, PPE compliance, hand hygiene data, HCAI outcomes and clinical activity.

The overarching conclusion is that CTMUHB has strengthened its IPC infrastructure and has clear examples of improvement, but the organization must now move from assurance of activity to assurance of sustained impact. The IPC team can provide expertise, surveillance, challenge, training, review and support, but the consistent prevention of infection depends on clinical teams, managers, care groups and corporate services owning infection prevention as part of everyday safe care. The priorities for 2026/27 should therefore focus on reducing Gram-negative bacteremia and CDI, improving training and ANTT assurance, embedding PPS and behavior-change work, strengthening community IPC pathways, maintaining outbreak readiness, and ensuring that decontamination, ventilation and isolation risks remain visible through Organisational governance.

With continued executive support, strong clinical leadership and a whole-system approach, CTMUHB is well placed to build on the progress made during 2025/26 and to translate the learning from this year into more reliable practice, stronger assurance and safer outcomes for patients, staff and communities.

INFECTION CONTROL DOCTOR – ANNUAL STATEMENT FOR 2025/26

As Infection Control Doctor for Cwm Taf Morgannwg University Health Board, I am pleased to provide this annual statement for the 2025/26 Infection Prevention and Control Report. The statement reflects my professional assessment of the Health Board's IPC position, the progress made during the year and the areas where continued improvement, clinical leadership and Organisational accountability will be required.

Infection prevention and control remains central to the delivery of safe, effective and high-quality care. Healthcare-associated infections cause avoidable harm, increase antimicrobial use, prolong hospital stay, contribute to operational pressure and affect confidence in services. Preventing infection is therefore not only a specialist IPC function; it is a core responsibility of every clinical team, every service and every professional group across the Health Board.

The 2025/26 report demonstrates that CTMUHB has strengthened several important IPC systems. The IPC service is more resilient than in previous years, with expanded acute-site support, weekend and bank holiday on-call arrangements, improved recruitment and continued development of the Hub model. The Community IPC Team is also an important development, reflecting the reality that many infection risks and many infection-prevention opportunities sit outside acute hospitals and across the wider patient pathway. These developments should improve the Health Board's ability to identify

risk earlier, support clinical areas more consistently and strengthen prevention across acute, community and partner settings.

There are areas of positive performance. CTMUHB compares favorably with Wales for C. difficile, *Pseudomonas aeruginosa* and *Staphylococcus aureus* rates. Hospital-onset *E. coli* has reduced, and *Pseudomonas* performance remains encouraging. There has also been useful progress in using point prevalence surveys to test whether core IPC practices are being delivered in real clinical environments. The improvement seen in BBE compliance following targeted work demonstrates that local data, visible leadership and repeated measurement can influence practice.

However, there are also important concerns. Gram-negative bloodstream infection remains a significant challenge, especially *E. coli* and *Klebsiella spp*. bacteremia. Although national targets focus on hospital-onset cases, the wider epidemiology makes it clear that community-onset burden strongly influences the overall infection picture. Prevention therefore needs a broader approach, including catheter care, hydration, wound and skin care, antimicrobial stewardship, primary care engagement and community pathway improvement.

C. difficile also requires sustained and more ambitious action. The Health Board remains below the all-Wales rate, but this should not create false reassurance. The current position is not sufficient to meet the reduction ambition, and the burden remains substantially community onset. Acute controls must continue, including prompt isolation, environmental cleaning and decontamination, antimicrobial review, PPI review and robust case investigation. However, these controls must now be matched by stronger community and primary care work, supported by pharmacy, microbiology, epidemiology and Public Health Wales.

I remain concerned about the reliability of some core clinical practices. Mandatory IPC training compliance remains below the expected level, and the particularly low compliance among Medical and Dental staff is a significant governance issue. Medical engagement is essential to antimicrobial stewardship, diagnostic decisions, device management, escalation, isolation decisions and clinical leadership of infection prevention. Improvement in training compliance must therefore be treated as a professional and managerial accountability issue, not simply as an IPC education issue.

Blood culture contamination rates and ANTT assurance also require continued attention. High contamination rates can lead to unnecessary antimicrobial treatment, diagnostic uncertainty, avoidable patient harm and increased laboratory and clinical workload. They may also indicate inconsistent aseptic technique. Strengthening ANTT competency, invasive device insertion and maintenance practice, and blood culture collection standards should remain a priority.

The PPS findings on PPE and glove use are particularly important. Inappropriate glove use can increase cross-contamination risk and may give staff a false sense of protection. Gloves are not a substitute for hand hygiene. The observed reduction in glove use and related spend is encouraging and is consistent with better conversations about risk-based PPE use, sustainability and value; however, it must be supported by assurance that glove reduction reflects safer, more appropriate practice rather than underuse where PPE is indicated.

Decontamination, ventilation, isolation capacity and HCID preparedness remain important areas of Organisational risk. These are not peripheral IPC issues: they are core safety systems. Continued investment, risk-register oversight, clear accountability and specialist advice will be required to ensure that services remain safe, compliant and resilient.

My professional view is that the Health Board has made meaningful progress in strengthening IPC infrastructure, but the next phase must focus on measurable impact. The priorities for 2026/27 should

be to reduce Gram-negative bacteremia and CDI, improve training compliance, strengthen ANTT and blood culture practice, embed PPS and behavior-change methodologies, develop community IPC pathways, improve digital capture of learning and actions, and ensure that infrastructure risks remain visible to the Board.

Infection prevention must continue to be owned from ward to Board. The IPC team will continue to provide specialist advice, surveillance, investigation, training and challenge, but sustained improvement will depend on clinical ownership, operational leadership, executive support and partnership across the wider health and care system. I would like to thank the IPC team, microbiology colleagues, antimicrobial stewardship colleagues, clinical teams, estates, facilities, occupational health, Public Health Wales and wider partners for their commitment during the year. Continued collective effort will be essential to protect patients, staff and communities and to deliver safer care during 2026/27.

Dr. Alexandra Tsitsopoulou
Microbiologist

Agenda Item	6.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Wednesday 3rd June 2026 at 09:00am.
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Patsy Roseblade	Independent Member
	Neil Mesher	Independent Member
In Attendance	Sarah James	Deputy Chief Operating Officer
	Richard Hughes	Executive Director of Nursing, Midwifery and Patient Care
	Philip Daniels	Executive Director of Public Health (In part)
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Science
	Hywel Daniel	Executive Director for People (In part)
	Becky Gammon	Interim Deputy Director of Nursing
	Anthony Gibson	Deputy Medical Director
	Emma Walters	Head of Corporate Governance and Board Business
	Louise Stait	Interim Assistant Director of Governance & Risk
	Deborah Matthews	Nurse Director, Unscheduled Care
	Carl Verrecchia	Care Group Service Director, DTPS & Children & Families
	Kellie Jenkins-Forrester	Lead for Legal Services
	Nigel Downes	Assistant Director of Quality & Safety
	Hannah Wilton	Director of Pharmacy & Medicines Management
	Mohammed Elnasharty	Medical Director - Children & Families Care Group (In part)
	Suzanne Hardacre	Director of Midwifery
	Daniel Price	Regional Director, Llais Cymru
	Zoe Ashman	Interim Care Group Nurse Director
	Gary Howell	Clinical Director of Allied Health Professionals

	Stephanie Muir	Assistant Director of Concerns & Claims
	Sharon O'Brien	Care Group Nurse Director-Planned Care
	Chris Beadle	Assistant Director of Health Safety & Fire
	Lloyd Griffiths	Head of Nursing, Mental Health & Learning Disabilities
	Clare Ibbs	Interim Head of Corporate Nursing and People's Experience
	Lucie Owen	Nurse Director, Primary Care & Community Care Group
	Victoria Healey	Head of Quality & Patient Safety
Meeting Observers	Jenny Oliver	Head of Peoples Experience
	Farhan Naqib	Aspiring Board Member
	Rachel Gilmore	Senior Nurse Integrated Sexual Health Services

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. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Kath Palmer, Vice Chair • Rhys Goode, Independent Member • Dom Hurford, Executive Medical Director • Gaynor Jones, Staff Side Representative • Hayley Proctor, Independent Member • Gethin Hughes, Chief Operating Officer
1.3	**Declarations of Interest**
	Neil Mesher declared that he is Non-Executive Director for the Life Science Hub in Wales and Special Advisor to Ibex Medical Analytics.
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 5) that the Committee

	Members wished to bring forward to the main agenda for discussion. There were no items brought forward.
3.	**MATTERS ARISING**
3.1	**Action Log**
	The Committee reviewed the action log and agreed the proposed actions for closure. P Roseblade raised a query regarding the WAST (Welsh Ambulance Services NHS Trust) investigation framework, and the level of triangulated assurance provided. It was noted that current reporting primarily offered reassurance, with limited evidence of triangulation, and it remained unclear whether the required level of assurance could be achieved. Members noted that a further update would be provided in the closed session regarding this action.
Resolution	The Committee **NOTED** the Action Log
Action	None Identified
3.2	**Matters Arising Not Captured on the Action Log**
	No further matters were raised
3.3	**Committee Annual Report**
	C Donoghue presented the annual report to Members and highlighted that it has been drafted by the Corporate Governance Team and was being presented to the Committee for endorsement prior to Board approval in July.
Resolution:	The Committee **ENDORSED** the report.
Action:	None Identified
4.	**IMPROVING CARE**
4.1	**Executive Director and Independent Member Quality & Safety Walkabouts**
	R Hughes presented the report and highlighted that the Executive Walkabout Programme was evolving, with plans to introduce clearer theming, forward planning and measurable outputs. The Committee supported proposals to enhance engagement, including consideration of training for Independent Members to support interactions with patients and carers. P Roseblade highlighted that an IT issue identified during a walkabout, relating to the need for manual recording due to system limitations, had not been reflected within the report and emphasised the importance of ensuring that operational issues identified through walkabouts were consistently captured and reported. R. Hughes acknowledged the point raised and confirmed that he would ensure that this was reviewed and amended for completeness. He clarified that responsibility sits with the relevant Director to ensure operational issues identified through walkabouts are captured and fed back appropriately and agreed to follow this up outside the meeting.
Resolution:	The Committee **NOTED** the report.
Action:	The Executive Director and Independent Member Quality & Safety Walkabouts report to be amended to highlight the IT issues identified during the walkabout.
4.2	**Highlight Report for People's Experience Activity Report – February – April 2026**

	C Ibbs presented the People's Experience Activity Report, highlighting progress, current activity, and key areas of focus across patient experience and the Patient Advisory Liaison Service (PALS). Members noted that a new workforce model had been implemented, aligning the team more closely. C Donoghue acknowledged the achievements identified within the report and queried the challenges being faced within the chaplaincy workforce to which C Ibbs responded to advise that a workforce redesign was underway following staff changes which aimed to strengthen and modernise the service while maintaining visibility and support. Members noted that a proposal was expected shortly. R Hughes noted that the changes reflected a maturing service aligned to community need, including broader representation, and added that this work was consistent with the national strategic direction for spiritual care. L Edwards noted that there was a need to ensure themes and feedback from patient experience work were systematically captured and suggested developing a bank of patient stories to support committees and Board. C Donoghue agreed this was an important point, noting the need to improve alignment between patient experience themes and their consideration within committee agendas and strategic risks.
Resolution:	The Committee **NOTED** the report.
Action:	Consider how patient experience themes and feedback can be better captured and aligned to Committee agendas and strategic risks, including the potential development of a repository of patient stories.
4.3	**Report from the Clinical Executives**
	R Hughes and his Clinical Executive Director colleagues presented the report and highlighted the key matters for Members' attention. N Mesher queried whether the Interim Medical Director appointment would become permanent. In response, A Gibson confirmed that a permanent appointment had not been made at this stage. P Roseblade queried Regulation 28 and why items issued to Welsh Government were included in the report. R Hughes advised that, although issued to Welsh Government, CTM still had operational responsibility to respond and deliver associated actions. The inclusion of this within the report provides transparency and oversight. P Roseblade raised concerns regarding Personal Protective Equipment (PPE), specifically "bare below the elbows" and instances where PPE was not being changed between patients and asked when the work would be completed in order to provide assurance. In response, A Gibson advised that this represents an ongoing behavioural change programme rather than a time-limited action and confirmed that an update would be provided at the next meeting, including actions relating to training, auditing and monitoring.

	P Roseblade queried when work would be completed on the negative pressure rooms. P Daniels, supported by B Gammon, confirmed that funding is in place and work is progressing. Members noted that a detailed timeline was not yet available and would be provided outside the meeting. C Donoghue queried whether the relationship with, and assurance from, the Coroner's Office had improved. R Hughes confirmed that improvement is demonstrable through enhanced collaboration and case management, with joint training in place and ongoing engagement. C Donoghue sought clarification on the timescales and approach to maternity reconfiguration and how this aligned to the wider clinical services plan. In response, R Hughes advised that current work is focused on strengthening operational structures and leadership within existing service arrangements, with any significant service reconfiguration to be considered through formal Board processes as part of the wider clinical services plan. S Hardacre added that this work was being shaped by national developments, including the Safer Beginnings programme and the perinatal service framework, alongside closer integration with community services. C Donoghue queried the reduction in workforce training numbers for Allied Health Professionals (AHP) including Occupational Therapists. In response, L Edwards advised that Occupational Therapy was not currently identified as a profession where there were difficulties in placing newly qualified staff, although reductions in commissioned training numbers are being observed more broadly across several AHP professions. L Edwards confirmed that this was an emerging national theme and that ongoing discussions were taking place. R Hughes added that this is a multi-professional issue linked to wider workforce planning, with Health Boards responsible for commissioning training numbers based on historic forecasting projections of future workforce need. R Hughes advised that further work was ongoing in this area and that additional information was expected to be brought forward. R Hughes suggested that a future paper on workforce planning and training posts may be beneficial for the Committee which C Donoghue supported.
Resolution:	The Committee **NOTED** the report
Action:	A paper on multi-professional workforce challenges, including training, commissioning and retention, to be added to the forward work programme.
Action:	An update on the ongoing Bare Below the Elbows (BBE) / PPE behavioural change programme to be provided, including details of training, auditing and monitoring arrangements.
4.4	**CARE GROUP HIGHLIGHT REPORTS**
4.4.1	**Unscheduled Care**
	D Matthews presented the Unscheduled Care report, advising that overall assurance was maintained despite significant operational pressures. The key highlights contained within the report were outlined.

R Hughes provided a reflective overview of performance across Care Groups, advising that quality and safety indicators were broadly being maintained, with no significant escalation in levels of harm despite increasing system pressures.

R Hughes added that current measures do not fully capture the impact on patient and staff experience, particularly in relation to prolonged waits and system strain and advised that whilst Care Groups were demonstrating resilience in maintaining standards, the position was fragile, and there was a limited window to address underlying system challenges prior to further seasonal pressures arising.

P Roseblade raised concern that 57% of stroke patients present outside normal hours and queried how services support these patients. In response, L Edwards advised that stroke performance was a recognised area of concern and an improvement plan was in place, supported by a dedicated operational lead. Members noted that work was ongoing to extend service provision beyond the current weekday model, with clinical nurse specialist hours already extended and noted that whilst workforce challenges remained, cases were being reviewed individually alongside proactive bed capacity management.

N Mesher queried what "good" looks like within the data, how performance will improve and what actions are in place. In response, A Gibson advised that medical cover had improved through recruitment and return from sickness, including the appointment of a neurologist to support the rota and provide additional weekend capacity. Members noted that delivery of a fully compliant 7-day consultant-led model is constrained by workforce and financial limitations, and that longer-term improvement will require development of a regional stroke model across health boards.

H Daniel noted the impact on the nursing workforce following earlier service changes and queried how stability was being addressed. In response, D Matthews advised that previous vacancies (circa 12 WTE) had now been filled, strong leadership is in place at ward level, and nursing Key Performance Indicators (KPIs) and quality indicators had improved, with sustained improvements being embedded through Multi-Disciplinary Team (MDT) working and targeted interventions.

D Matthews also highlighted the introduction of a Stroke Café, providing an opportunity for patients and families to share feedback on their care and experiences following discharge. L Edwards added that the quality of care on the stroke unit is high, with very few recent concerns, noting that the primary challenge remains timely access to the unit.

H Daniel expressed concern that performance remains stable at a low level and highlighted the need for greater clarity on improvement trajectories. In response, L Edwards advised that a detailed improvement plan was being developed, with further work underway to define trajectories and expected improvements. Members noted that monitoring and reporting would be strengthened to provide clearer oversight.

	C Donoghue raised concerns regarding low paediatric (BLS) Basic Life Support training compliance and significant variation in sepsis form utilisation, noting that this had featured less prominently in recent Committee discussions.
Resolution:	The Committee **NOTED** the report.
Action:	None Identified
4.4.2	**Planned Care**
	S O'Brien presented the Planned Care update and highlighted the key matters for Members' attention. C Donoghue queried whether the visual repositioning board used on Ward 8 to reduce pressure damage was being shared and rolled out across other areas. In response, S O'Brien advised that the initiative was introduced following an increase in pressure ulcers and added that the visual repositioning board identifies patients requiring regular repositioning and supports monitoring of care delivery, which has led to a reduction in avoidable pressure ulcers on the ward. It was further noted that there were plans to roll this approach out more widely across services. R Hughes acknowledged that pathways across sites are complex and may be confusing for patients and advised that pathways are designed to ensure patients can access the most appropriate clinical setting regardless of their point of entry. R Hughes added that this was currently challenged by capacity constraints, resulting in delays and inter-site transfers and confirmed that work was underway to improve pathways through the urgent and emergency care programme, with the expectation that this will support improved flow, more formal reporting and better oversight over time. C Donoghue queried the current position regarding boarding and whether the situation is improving. In response, R Hughes advised that boarding continues at similar levels to those previously reported, confirmed that there had been no increase in harm incidents associated with boarding and noted concern that the practice was becoming normalised due to ongoing system pressures. Members noted that a recent audit had been completed, with findings to inform any further action. C Donoghue emphasised the importance of continued oversight, noting her concern that the practice should not become normalised and that it should remain a focus for the Committee.
Resolution:	The Committee **NOTED** the report.
Action:	None Identified
4.4.3	**Primary Care & Community**
	L Owen presented the report which highlighted several key issues and developments across the service. P Roseblade queried whether there was a timeframe for the Welsh Government contract negotiations with GPs. In response, L Owen advised that there was no confirmed timeframe at present. A Gibson added that the most recent offer was not accepted by the British Medical Association (BMA), and internal work is ongoing whilst awaiting the outcome of national negotiations. C Donoghue

	noted that this matter should be escalated through the QSEC highlight report to Board. C Donoghue queried the paediatric dental General Anaesthetic (GA) waiting list, noting that the longest wait remains at 100 weeks and sought clarification on the position given previous reports of improvement. In response L Owen confirmed that whilst performance had improved, a cohort of longer waits would remain due to patient complexity. C Donoghue requested that future reports include a clearer breakdown of patient numbers within the waiting list. D Price highlighted that paediatric dental GA remains a longstanding concern for Llais and suggested that future reporting should distinguish between standard and complex cases within the longest wait cohort.
Resolution:	The Committee **NOTED** the report.
Action:	To escalate the risks associated with Welsh Government GP contract negotiations through the QSEC highlight report to Board.
Action:	To include a breakdown of patient numbers in future reports, distinguishing between standard and complex cases within paediatric dental GA waiting times to provide clarity on waiting time pressures.
4.4.4	**Mental Health & Learning Disabilities**
	L Griffiths presented the Mental Health & Learning Disabilities update on behalf of the Care Group and highlighted current pressure points and areas of improvement. The Committee noted positive developments, including national recognition of the forensic adolescent consultation service, which recently led a national interest group on counterterrorism and extremism. R Hughes acknowledged that whilst immediate assurance actions had been addressed, this should not detract from the level of improvement identified since the previous inspection, particularly in relation to documentation and patient restraint practices. The positive evidence observed by inspectors was noted, including the manner in which care and dignity were maintained during the application of restraint. R Hughes thanked L Griffiths for his service as Interim Nurse Director for the Care Group as he returns to his substantive role, with Jackie Francis taking up the Nurse Director position. C Donoghue confirmed that the Committee echoed these thanks. H Wilton highlighted the effective partnership working between the Community Drug and Alcohol Team (CDAT) and probation services, noting the significant mobilisation required to maintain service delivery. H Wilton queried how multi-agency learning would be captured and wondered whether CTM would have a stronger role in the commissioning arrangements. In response, L Griffiths confirmed that the service was commissioned through the Police and Crime Commissioner's Office and that a formal multi-agency review will be undertaken to capture learning, which would include CTM as a key stakeholder.

	P Daniels, in his role as Chair of the Area Planning Board, confirmed that correspondence had been issued to the Police and Crime Commissioner and that a review of lessons learned would take place. L Edwards noted that the positive feedback from the Healthcare Inspectorate Wales (HIW) inspection may not have been fully reflected in the report, highlighting strong patient care, discharge planning and patient and family engagement. C Donoghue noted that estates issues identified through the HIW inspection appear to be longstanding and had been raised repeatedly and queried whether further action could be taken to ensure these are resolved, given the ongoing impact on services. In response, L Griffiths confirmed that work was progressing, with senior-level engagement in place to address the key estates issues and remove barriers to resolution.
Resolution:	The Committee **NOTED** the report.
Action:	Feedback and lessons learned to be circulated from the Police and Crime Commissioner.
4.4.5	**Children & Families**
	S Hardacre presented the Children & Families Care Group Highlight report and highlighted the key matters for Members attention. C Donoghue queried whether there was any further progress on the specialist school nursing issue, as previous discussions suggested possible improvement. R Hughes confirmed that progress had been made, filling vacancy posts adding that a gap remains in the service model. Welsh Government guidance had been issued outlining roles and responsibilities between health and education. Members noted that work is underway with partners (education and commissioning) to define the future model, and a further substantive update is expected in the coming months. D Price raised concerns regarding inconsistent public messaging in relation to the Health Visitors' strike, including references to a Band 7 job description being agreed, and highlighted a potential impact on parental attendance for immunisations following local communications. H Daniel confirmed that no job description has been agreed and that this position has been communicated publicly, noting the limitations in influencing external messaging. S Hardacre reported that queries had been raised via the Single Point of Access regarding immunisations and confirmed that they are not affected by the industrial action, noting that any inconsistent messaging would be addressed via established arrangements to ensure clarity and consistency. She further noted that staff had raised concerns regarding public perception of services, including the respective roles of nursery nurses and health visitors, and that communications were being prepared to provide clarity to the public. L Owen noted that immunisations are delivered by practice nurses within GP practices and are therefore not impacted by the industrial action.

Resolution:	The Committee **NOTED** the report.
Action:	None Identified
4.4.6	**Diagnostics, Therapies, Pharmacy & Sciences (DTPS)**
	G Howell presented the DTPS update, highlighting several significant risks and developments across the Care Group. C Donoghue noted that it was positive to see that the rolling replacement programme for mattresses is now being progressed.
Resolution:	The Committee **NOTED** the report.
Action:	None Identified
4.5	**Quality Dashboard Report**
	N Downes presented the Quality Dashboard and highlighted the key matters for Members' attention. D Matthews queried whether pressure damage figures included patients who present with pressure damage on admission and whether the data was appropriately adjusted. N Downes advised that this would require further review and confirmed he would follow up outside the meeting to ensure the data was accurate. H Wilton noted that, following the Electronic Prescribing and Medicines Administration (EPMA) implementation, the dashboard should be used to support benefits realisation and assess any impact on medication incidents. She confirmed that there has been no increase in medication incidents at Princess of Wales Hospital (POW) since EPMA implementation, with anticipated safety benefits expected over time. P Roseblade queried whether Duty of Candour was being triggered where initial assessments of harm are subsequently found to be inaccurate, and at what stage families are informed. N Downes clarified that Duty of Candour was not triggered by inaccuracies in initial assessment but follows a review process in which the level of harm is confirmed. R Hughes added that initial conversations with families at an early stage, with the formal Duty of Candour process triggered once harm was confirmed as moderate or above following the review. P Roseblade requested a future synopsis and explanation of the Listening to People framework, including legal implications. R Hughes suggested that, given its significance, this should be considered as a Board Development session topic rather than limited to committee discussion. P Roseblade queried whether differences exist between Health Board data and Public Services Ombudsman for Wales (PSOW) data on open cases. N Downes confirmed that reconciliation work is being undertaken to ensure alignment between datasets and to strengthen working relationships with PSOW.
Resolution:	The Committee **NOTED** the report.
Action:	Listening to People Framework be considered at a Board Development session.
4.6	**Organisational Risk Register (Risks Assigned to the QSEC)**
	L Stait presented the Organisational Risk Register and referenced queries raised by Members in advance of the meeting.

	P Roseblade emphasised the importance of ensuring risk descriptions within the register are clear, consistent, and reflect a shared position across the Executive team, noting that this is particularly important for a public-facing document. She highlighted the need to ensure that risk descriptions consistently articulate the primary risks, including patient safety where relevant. L Stait confirmed that a moderation process was in place and that the descriptions would be reviewed and refined in the next iteration. C Donoghue highlighted the need for timely and complete updates within the register to support effective Committee scrutiny, noting that repeated entries of "no update received" limit the Committee's ability to gain assurance. The importance of ensuring consistent and meaningful updates was emphasised.
Resolution:	The Committee NOTED the report.
Action:	None Identified
4.7	**Healthcare Inspectorate Wales (HIW) Improvement Plan Tracker Report**
	R Hughes presented the report advising that the majority of actions arising from HIW activity are either fully complete and approved or awaiting final approval. A smaller number of actions remain outstanding, including some overdue items. C Donoghue acknowledged the significant progress made and highlighted the importance of clear and consistent reporting to support Committee scrutiny. She noted the repeated use of "no update received" and emphasised the need for meaningful updates to provide assurance on progress.
Resolution:	The Committee **NOTED** the report.
Action:	None Identified
4.8	**Highlight report from the Harm Free Care Agenda**
	B Gammon presented the Harm Free Care Agenda report and highlighted the key matters for Members' attention. B Gammon expressed thanks to V Healey for her contribution to the Committee, noting that this was her final meeting prior to taking up a new role in Velindre NHS Trust with the Committee echoing those wishes.
Resolution:	The Committee NOTED the report.
Action:	None Identified
4.9	**Mortality Indicators and Mortality Reviews**
	A Gibson presented the report and highlighted the key matters for Members attention. C Donoghue welcomed the progress made, particularly the approach to triangulating data and strengthening learning across the system.
Resolution:	The Committee **NOTED** the report.
Action:	None Identified
4.10	**Redress Case Management**
	K Jenkins-Forrester presented the report and highlighted key matters for Members' attention.

	Members supported the proposal to provide regular standalone updates to the Committee to ensure continued oversight of this area. C Donoghue queried whether engagement with the Ombudsman was being viewed as punitive or collaborative to which K Jenkins- Forrester confirmed that a positive and constructive relationship had been maintained with regular communication improving engagement, particularly following previous concerns about lack of updates. R Hughes clarified the distinction between day-to-day case management engagement which had improved and the formal Public Services Ombudsman for Wales (PSOW) investigation which was a separate process. N Mesher queried how redress activity links to wider pressures on the Welsh Risk Pool and whether there were opportunities to better manage costs. K Jenkins-Forrester confirmed that a previous paper on Welsh Risk Pool (WRP) costs had been presented and suggested this may need to be revisited. R Hughes acknowledged that further work was required in this area highlighting that improving redress processes could reduce escalation to full claims as well as lower legal costs and support earlier resolution.
Resolution:	The Committee **NOTED** the report.
Action:	None Identified
5.	**SUSTAINING OUR FUTURE**
5.1	**Commissioning Quality Arrangements and Individually Commissioned Packages of Care**
	R Hughes presented the report and highlighted key matters for Members' attention. C Donoghue highlighted the complexity of commissioning arrangements and emphasised the importance of ensuring sufficient capacity and oversight to support effective management of commissioning, quality and outcomes. R Hughes acknowledged the complexity of the arrangements and advised that, whilst processes are in place, further strengthening and prioritisation is underway to enhance assurance and oversight.
Resolution:	The Committee **NOTED** the update
Action:	None Identified
6.	**CONSENT AGENDA**
5.1	**FOR APPROVAL**
6.1.1	**Unconfirmed Minutes of the Meeting held on 24 March 2026**
	The Unconfirmed Minutes of the Committee Meeting held on 24 March 2026 were **APPROVED.**
6.1.2	**Policies for Approval – Unlicenced Medicines Policy**
	Unlicenced Medicines policy were **APPROVED.**
6.1.3	**Policies for Approval – Ventilation Policy**
	Ventilation policy was **APPROVED**
6.1.4	**Pharmaceutical Needs Assessment**
	Pharmaceutical Needs Assessment was **APPROVED**
6.2	**FOR NOTING**

6.2.1	**Non-Routine Committee Business (Forward Plan)**
	The Committee **NOTED** the Forward Plan.
6.2.2	**Annual Cycle of business**
	The Committee **NOTED** the Annual Cycle of Business
6.2.3	**Cancer Services Annual Report**
	The Committee **NOTED** the report.
6.2.4	**Bi-Annual Report CTM Radiation Safety Committee**
	The Committee **NOTED** the report.
6.2.5	**Antimicrobial Stewardship Report – June 2026**
	The Committee **NOTED** the report
6.2.6	**Annual Report of the Decision – Making and Consent Working Group**
	The Committee **NOTED** the report
6.2.7	**RADAR Programme – Outline of Activities, Areas of Focus and Roles**
	The Committee **NOTED** the report
6.2.8	**Update: Explosion of Pacemaker at Glyntaff Crematorium**
	The Committee **NOTED** the report
7.	**CLOSE OUT BUSINESS**
7.1	**Committee Highlight Report to the Board – Verbal**
	The Chair and Committee noted the update to the Committee Highlight Report. The Committee escalated concerns regarding unscheduled care fragility, stroke performance, GP contract negotiation risks and Organ Donation Committee reporting arrangements, with further clarification being sought in relation to Ophthalmology reporting.
7.2	**Meeting Feedback**
	C Donoghue advised that she welcomed feedback outside this meeting
7.3	**Any Other Business**
	There was no other business to report. The Committee discussed the reporting arrangements from the Organ Donation Committee, noting concerns regarding the lack of reporting from Ophthalmology. It was agreed that this matter would be clarified with the relevant Committee Chair and escalated through the Quality, Safety and Experience Committee to Board as appropriate. R Hughes advised that this would be A Gibson's final meeting prior to taking up a national role as Medical Director with NHS Performance & Improvement (P&I). He expressed his thanks on behalf of the Executive team and the Committee, acknowledging A Gibson's significant contribution to services within CTMUHB, particularly his expertise and support in complex areas, and noted that he will be greatly missed.
8.	**PRIVATE / CLOSED SESSION BUSINESS**
	There were no items requiring discussion in closed session on this occasion.
9.	**DATE & TIME OF THE NEXT MEETING**
	Tuesday 21st July 2026 at 9:00am

Agenda Item	6.1.2

Unapproved Minutes of the Quality, Safety & Experience In Committee

Date and Time of Meeting	Wednesday 3 June 2026 at 12:00pm
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member University (Committee Chair)
	Patsy Roseblade	Independent Member
	Neil Mesher	Independent Member
In Attendance	Richard Hughes	Executive Director of Nursing
	Becky Gammon	Interim Deputy Director of Nursing
	Anthony Gibson	Deputy Medical Director
	Nigel Downes	Assistant Director of Quality & Safety
	Lauren Edwards	Executive Director of Allied Health Professionals & Health Sciences
	Philip Daniels	Executive Director of Public Health
	Gethin Hughes	Chief Operating Officer
Meeting Observers		

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: • Kath Palmer, Vice Chair • Rhys Goode, Independent Member • Hayley Proctor, Independent Member • Dom Hurford, Executive Medical Director
1.3	**Declarations of Interest**
	There were no declarations identified
2.	**MAIN AGENDA**
2.1	**Organisational Risk Register – Closed Risks**

	L Stait presented the report and highlighted the key matters for Members attention.
Resolution:	The report was **REVIEWED, DISCUSSED and NOTED**
Action:	None identified.
3.	**ANY OTHER BUSINESS**
	R Hughes provided an update in relation to action taken by the NMC following the identification of failings in its approach to a number of cases, including instances where due process had not been followed. Members noted that a review had identified a small number of Welsh cases requiring ongoing consideration, all of which had been assessed as low risk. It was further noted that the Health Board had not been provided with case-level detail and therefore could not determine whether any cases related to CTM. Members discussed the potential patient safety implications of the lack of detailed information, noting the assurances received that the cases had been assessed as low risk. The Committee discussed the need for further assurance on early settlements, redress arrangements and claims activity, including the associated quality, safety and financial context and requested that a report is prepared for discussion in closed session of the next Quality, Safety & Experience Committee. Members discussed the need to clarify governance and quality requirements in relation to WAST and noted that formal correspondence would be issued to the WAST Chief Executive seeking clarification on this. It was agreed that this letter would be shared with Committee members for awareness.
Actions:	Report to be prepared for discussion in closed session of the next Quality, Safety & Experience Committee providing further assurance on early settlements, redress arrangements and claims activity, including the associated quality, safety and financial context Correspondence being sent to WAST to be shared with Committee Members for awareness.
4.	**DATE AND TIME OF NEXT IN COMMITTEE SESSION**
	The next In Committee meeting is to be confirmed

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
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 June 2026**	**In progress** An update on the current position has been included in the Clinical Executives Report being presented to the June 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	**July 2026**	**In progress** Date to be confirmed with Carers Lead
23 September 2025	Request made at the meeting held on 23 September 2025	QSEC Committee Chair	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 Safeguarding	Executive Director of Nursing	22 September 2026	**In progress** Scheduled for September 2026
23 September 2025	Request made at the meeting held on 23 September 2025	QSEC Committee Chair	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	Planned Care Group Nurse Director	Executive Director of Nursing	22 September 2026	**In progress** Will be presented to the September 2026 meeting
16 December 2025	Request made at agenda planning session held on 16 December	QSEC Committee Chair & Executive Lead	Spotlight Presentation – Hospital at Home	To be presented to Committee for discussion	Chief Operating Officer	Chief Operating Officer	24 March 2026 Was June 2026 **Now July 2026**	**On agenda** On agenda for the July 2026 meeting
13 January 2026	Reference made in the Clinical Executives Report presented to the January 2026 meeting	Interim Executive Director of Nursing	Maternity & Neonatal Services Performance Report for 2025/2026 plus	To be presented to the Committee for discussion	Director of Midwifery	Director of Midwifery	24 March 2026 **Now July 2026**	**On agenda** On agenda for the July 2026 meeting

			outcome of the national assessment					
20 January 2026	Captured as an action at the January 2026 meeting	Executive Medical Director	Physicians Associates	Report to be presented to a future meeting of the Committee in relation to Physicians Associates outlining training, governance and patient communication.	Executive Medical Director	Executive Medical Director	22 September 2026	**In progress** Scheduled for the September 2026 meeting
10 February 2026	Request made at the agenda planning session held on 10 February 2026	Executive Director of Nursing	Welsh Risk Pool and Medical Negligence Claims – Quality Update	To be presented to the Committee for discussion	Executive Director of Nursing	Executive Director of Nursing	3 June 2026 **Now 22 September 2026**	**In progress** This will now be presented to the September 2026 meeting
28 April 2026	Request made at agenda planning that this item is added to the agenda for the July meeting	Executive Director of Nursing	Sexual Health Safeguarding Update	To be presented to the Committee for discussion	Head of Safeguarding	Executive Director of Nursing	21 July 2026	**In progress** Scheduled for the July 2026 meeting
28 April 2026	Request made at agenda planning that this item is added to the agenda for the July meeting	Executive Director of Nursing	Winter Wrap Up – Themes and Trends	To be presented to the Committee for discussion	Executive Director of Nursing	Executive Director of Nursing	21 July 2026 **Now 22 September 2026**	**In progress** Scheduled for the July 2026 meeting. Now deferred to the September 2026 meeting
28 April 2026	Request made at agenda planning that this item is added to the agenda for the September meeting	Committee Chair	Eye Care Update	To be presented to the Committee for discussion	Planned Care Nurse Director	Executive Director of Nursing	22 September 2026	**In progress** Scheduled for the September 2026 meeting
3rd June 2026	Request made in the Clinical Executives Report presented to the June 2026 meeting.	A paper on multi-professional workforce challenges, including training, commissioning and retention.	To be presented to Committee for discussion	To be presented to Committee for discussion	Executive Director of Nursing	Executive Director of Nursing	22nd September 2026	This item is scheduled for the September meeting.
16 June 2026	Item agreed at the agenda planning session held on 16 June 2026	Executive Director of Nursing	Karen Wingfield's research of nursing staff in the acute oncology service	To be presented to the Committee for information	Executive Director of Nursing	Executive Director of Nursing	24 November 2026	**In progress**
16 June 2026	Item agreed at the agenda planning session held on 16 June 2026	Executive Director of Nursing	AI Improving Quality of Care - broader piece on digital and health – a useful case study might be rolled out EPMA for prescribing and a snapshot of new approaches to monitoring and assurance / ways of working	To be presented to the Committee for information	Director of Digital	Director of Digital	For 2027	**In progress**
Completed Items								

10 March 2026	Email request received from the Assistant Head of Assets, Governance and Technical Services	Assistant Head of Assets, Governance and Technical Services	Ventilation Policy	To be presented to the Committee for approval	Assistant Head of Assets, Governance and Technical Services	Executive Director of Finance	3 June 2026	**Completed** Received and approved at the June 2026 meeting
31 March 2026	Email request received from the Principal Pharmacist- Quality and Safety. Medication Safety Officer	Principal Pharmacist- Quality and Safety. Medication Safety Officer	Unlicensed Medicine Policy	To be presented to the Committee for approval	Principal Pharmacist- Quality and Safety. Medication Safety Officer	Executive Medical Director	3 June 2026	**Completed** Received and approved at the June 2026 meeting
13 April 2026	Email request received from the Medical Directors Business Manager	Executive Medical Director	Update: Explosion of Pacemaker at Glyntaff Crematorium	To be presented to the Committee for information only	Executive Medical Director	Executive Medical Director	3 June 2026	**Completed** Received at the June 2026 meeting
14 May 2026	Email request received from the Lead for Legal Services asking for this item to be added to the agenda for the June 2026 meeting	Lead of Legal Services	Redress Case Management	To be presented to the Committee for discussion	Lead for Legal Services	Executive Director of Nursing	3 June 2026	**Completed** Received at the June 2026 meeting
27 May 2026	Email request received from the PCC Advisor	PCC Advisor	Pharmaceutical Needs Assessment	To be presented to the Committee for endorsement	PCC Advisor	Executive Medical Director	3 June 2026	**Completed** Received at the June 2026 meeting

Quality, Safety & Experience Committee – Annual Cycle of Committee Business

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

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Quality, Safety & Experience Committee meets at **least 6 times per annum**.

Committee Chair:	**Committee Vice Chair**	**Executive Leads for Agenda Planning**
• Carolyn Donoghue, IM University	• Kath Palmer, Vice Chair	• Richard Hughes, Interim Executive Director of Nursing

Link to: Board Assurance Framework Dashboard

CTMUHB Committee Business:

Improving Care Strategic Goal aligned to Committee Business
- Delivering Safe and Compassionate Care
- Developing new models of care
- Digital Transformation for patients and staff
- Ensuring timely access to care

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF
Shared Listening & Learning Story	Executive Director of Nursing	All Regular Meetings						Defer to July	Falls Story						X		No	N/A – Separate Shared Stories are received at Board	• Strategic Risk 2
Listening & learning Stories – Annual Evaluation of Lessons Learnt	Executive Director of Nursing	Annually													X		No	N/A	• Strategic Risk 2
Outcome reports – Board Member Patient Safety Walkabouts	Executive Director of Nursing	Twice per annum.													X		ELG (when required if contentious issues identified)	N/A	• Strategic Risk 2

Improving Care Strategic Goal aligned to Committee Business Contd.

- Delivering Safe and Compassionate Care
- Developing new models of care
- Digital Transformation for patients and staff
- Ensuring timely access to care

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF
Peoples Experience Activity Report *(to include an annual update on CTM Carers End of Year Progress Report)*	Executive Director of Nursing	All Regular Meetings							Not required						X		No	N/A	• Strategic Risk 2
Thematic Spotlights – Learning and Improvement Outcomes	Lead Clinical Executive	All Regular Meetings	Compassionate Care		Quality Impact of the new Escalation Framework & Hospital at Home			Not required	Nutrition & Catering & Hospital at Home		TBC		TBC		X		N/A	N/A	Will be assigned to a strategic risk dependent on topic
Report from the Clinical Executives *(to include bi-annual updates on Coroners Inquests – activity & lessons learnt)*	Clinical Executives	All Regular Meetings							Not required						X		N/A	N/A	It is anticipated that this report will crosscut several strategic risks.
Care Group Highlight Reports	Care Group Nurse Directors/Care Group Medical Directors	All Regular Meetings							Not required						X		N/A	N/A	Each Care Group Highlight Report will crosscut several of the strategic risks
Quality Dashboard Report *To include an addendum relating to Ombudsman activity*	Executive Director of Nursing	All Regular Meetings							Not required						X		N/A	N/A	• Strategic Risk 2
Ombudsman's Letter & Annual Report	Executive Director of Nursing	Annually														X	EMB	Yes	Strategic Risk 2
Organisational Risk Register *Risks assigned to the QSEC*	Director of Corporate Governance/Board Secretary	All Regular Meetings			Verbal				Not required						X		Yes – EMB	No – uploaded to AC for information	Organisational risks aligned to BAF Strategic

																		Risks where applicable.
Improving Care Strategic Goal aligned to Committee Business Contd. • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																		
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**	**Alignment to Strategic Risks on the BAF**
Health Inspectorate Wales (HIW) Audit Tracker Report	Executive Director of Nursing	All Regular Meetings			**Consent**			**Main**	Not required		**Main**					(to be added to the main agenda on a 6-monthly basis)	Yes - EMB	No	• Strategic Risk 2
Mortality Board Report *(including indicators, reviews and the highlights from the Mortality Board)*	Executive Medical Director	Twice Per Annum			Deferred to June										X		Yes - EMB	N/A	• Strategic Risk 2
Infection, Prevention and Control Annual Report	Executive Director of Nursing	Annually													X		N/A	N/A	• Strategic Risk 2
Putting Things Right Annual Report	Executive Director of Nursing	Annually														X	N/A	N/A	• Strategic Risk 2
Safeguarding & Public Protection Report	Executive Director of Nursing	Annually													X		N/A	N/A	• Strategic Risk 2
Nurse Staffing Levels Wales Act	Executive Director of Nursing	Twice Per Annum						N/A as went to May Board							X		N/A	Yes	• Strategic Risk 2
Medicines Management *(Including Controlled Drugs Local Intelligence Network (CDLIN) / Prescribing Annual Report) Prescribing errors captured in quality dashboard)*	Executive Medical Director	Annually plus exception reporting														X	N/A	N/A	• Strategic Risk 2
Cancer Services Annual Report	Executive Medical Director	Annually														X	EMB	N/A	• Strategic Risk 2

RADAR Committee Highlight Annual Report *ICB x 2 – Clinical Exception Report then at QSEC*	Executive Medical Director	Annually plus exception reporting														X	Improving Care Board	N/A	• Strategic Risk 2
Improving Care Strategic Goal aligned to Committee Business Contd. • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																			
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**	**Alignment to Strategic Risks on the BAF**
Clinical Audit update – for awareness on clinical outcomes from audits	Executive Medical Director	Twice Per Annum														X	EMB	Yes	• Strategic Risk 2
Individual Patient Funding Request Annual Report	Executive Director of Public Health	Annually														X	N/A	N/A	• Strategic Risk 2
Radiation Safety Committee Annual and Mid-Year Updates	Executive Director of Allied Health Professionals & Health Science	Twice Per Annum														X	N/A	N/A	• Strategic Risk 2
Human Tissue Act Authority – Progress Report	Executive Medical Director	Twice Per Annum														X	EMB	N/A	• Strategic Risk 2
Anti-Microbial Resistance Reports	Executive Medical Director	Twice Per Annum														X	N/A	N/A	• Strategic Risk 2
Harm Free Care Agenda	Executive Director of Nursing	Twice Per Annum													X		N/A	N/A	• Strategic Risk 2
Annual Duty of Quality Report	Executive Director of Nursing	Annually							Defer to Sept 26						**X**		EMB	Yes	• Strategic Risk 2
Consent to Examination for Treatment Annual Report	Executive Medical Director	Annually						Defer to Sept 26								**X**	EMB	N/A	• Strategic Risk 2

Creating Health Strategic Goal aligned to Committee Business • Reducing Health Inequalities • Equal focus on Mental Health and Physical Health • Supporting our communities • Being a Healthy Organisation																			
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**	**Alignment to Strategic Risks on the BAF**
Health Inequalities Population Inequality Service Inequality *(Quality & Safety impact of services we currently run – differential in quality)*	Executive Director of Public Health	Twice Per Annum						Defer to July	Defer to Sept						X		N/A	N/A	• Strategic Risk 8
Infection, Prevention & Control Strategy Implementation Plan	Executive Director of Nursing	Annually													X		Yes – EMB	Yes	• Strategic Risk 2 • Strategic Risk 8
Research, Development & Innovation – Oversight on delivery of the strategic direction	Executive Director of AHP's and Health Science	Twice Per Annum							Defer to Sept						X		N/A	N/A	• Strategic Risk 2 • Strategic Risk 8

Inspiring People Strategic Goal aligned to Committee Business • Visible and inspiring leadership • Promoting diversity and inclusion • Embedding our values and behaviours • Encouraging local employment																			
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**	**Alignment to Strategic Risks on the BAF**
Clinical Education Annual Report	Executive Director of Nursing	Annually														X	EMB	Yes	• Strategic Risk 3

Sustaining our Future Strategic Goal aligned to Committee Business • Becoming a green organisation • Ensuring our services have financial sustainability • Embedding value-based healthcare • Ensuring our estate is fit for the future																			
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**	**Alignment to Strategic Risks on the BAF**
Commissioned Services *Quality Reporting Process – Annual Appraisal*	Executive Director of Nursing	Annually													X		N/A	N/A	• Strategic Risk 2 • Strategic Risk 11
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Director of Nursing	Annually						An update is included in the Commissioned Services Report							X		N/A	N/A	• Strategic Risk 2 • Strategic Risk 11

Governance / Committee Business Governance Activity • To support a strong governance framework to support effective and efficient Board Business. • Creating a culture of integrity, transparency, and accountability																		
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**
Policy Approval	Relevant Executive Lead	All Regular Meetings as required													Unless significant changes	X	Yes – See policy approval process.	No – unless there is a specific requirement
Health, Safety & Fire Sub Committee Highlight Report	Executive Director for People	All meetings following a Sub Committee							Defer to Sept						Unless there is an area for escalation	X	N/A	N/A
Health, Safety & Fire Sub Committee - Annual Committee Report	Executive Director for People	Annually							Defer to Sept							X	N/A	N/A
Organ Donation Sub Committee Highlight Reports	Executive Medical Director	All meetings following a Sub Committee													Unless there is an area for escalation	X	N/A	N/A
Organ Donation Sub Committee - Annual Committee Report	Executive Medical Director	Annually														X	N/A	N/A
Hosted Organisations Quality, Safety & Experience Updates	JCC Chief Commissioner NIAW Programme Director	All Meetings following a Quality, Safety & Outcomes meeting						N/A for this meeting	N/A for this meeting						Unless there is an area for escalation	X	N/A	N/A
Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings													If all actions are complete	If there are actions in progress / overdue actions	N/A	N/A
Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings														X	N/A	N/A
Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings														X	N/A	N/A

Governance / Committee Business Governance Activity • To support a strong governance framework to support effective and efficient Board Business. • Creating a culture of integrity, transparency, and accountability																		
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**
Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings													Except for the annual review in November	Annual Review only	N/A	N/A
Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually													X		N/A	Yes
Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually						Defer to July							X		N/A	N/A
Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually						Defer to July							X		N/A	Yes – via the Committee Highlight Report

CTMUHB Board Assurance Framework Dashboard

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee
1.	Improving Care, Sustaining our Future  Click Here for Risk 1a Click Here for Risk 1b	**a) Enough capacity to meet elective demand** **b) Enough capacity to meet emergency demand**	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee
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
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
4.	Creating Health, Sustaining our Future  Click Here for Risk 4	**Effective Community and Partner Engagement in service changes and developments**	Director of Communication, Engagement & Fundraising	Strategic Development Committee
5.	Improving Care, Sustaining our Future  Click Here for Risk 5	**Delivery of a digital and information infrastructure to support organisational transformation**	Director of Digital	Operational Delivery Committee and Strategic Development Committee
6.	Improving Care, Sustaining our Future  Click Here for Risk 6	**Ability to maintain a safe and fit for purpose estate infrastructure**	Executive Director of Finance	Operational Delivery Committee
7.	Sustaining our Future, Creating Health  Click Here for Risk 7	**Fulfilling our Environmental and Social Duties and ambitions**	Executive Director of Strategy & Transformation	Strategic Development Committee
8.	Creating Health, Sustaining our Future  Click Here for Risk 8	**Prevention and early Intervention to support Healthy Life Expectancy**	Executive Director of Public Health	Strategic Development Committee
9.	Sustaining our Future  Click Here for Risk 9	**Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)**	Executive Director of Finance	Operational Delivery Committee
10.	Sustaining our Future, Improving Care  Click Here for Risk 10	**Ability to develop a fit for the future estate to reflect our future clinical service model**	Executive Director of Finance	Strategic Development Committee
11.	Creating Health, Sustaining our Future, Improving Care  Click Here for Risk 11	**Delivery of an Integrated Care Model**	Chief Operating Officer	Strategic Development Committee

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

Controlled Drug Accountable Officer (CDAO) Report: April 2025 – March 2026

Eitem yr Agenda / Agenda Item	6.2.3
Dyddiad y Cyfarfod / Date of Meeting:	21/07/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Meinir Davies- Medicine Management Support Officer Huw Carson- Principal Pharmacy Quality and Safety
Cyflwynydd yr Adroddiad / Report Presenter:	Hannah Wilton- Clinical Director Pharmacy and medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For noting only
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:

Executive Summary of what the report is describing: Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The CDLIN is a multi-agency forum, which each Health Board is required to have, as set out in the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008. It is chaired by the CDAO and includes representation from the police, General Pharmaceutical Council (GPhC), counter fraud, local authority and ambulance service along with primary care contractors and private care providers within the Health Board area. Meetings are held on a quarterly basis and have received excellent attendance. The role of the CDLIN is to share intelligence around the use/misuse of CDs, direct policies and procedures to ensure the safe use of CDs and to minimise risk to patients. The Terms of Reference for the CDLIN can be found in Appendix 1.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	This report provides an update of activity undertaken at the direction of the CDAO and CDLIN throughout the last financial year. It also outlines planned activity over the coming year designed to improve CD governance.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The main areas of focus for 2026-27 are: • Implementation of the self-declaration process for GP/ Dental Contractors • Completing the actions of the CD Internal Audit • Implementing a monitoring system for controlled drugs in secondary care • Private prescriber process review

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).*	The Board should note the CDAO Annual report

Recommendation (Linked to the "What Next" section above).	

1. Background / Context

The introduction of the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 which came in to force in Wales in January 2009, made provision under the Health Act 2006 to strengthen the systems for managing controlled drugs.

Both Cwm Taf Morgannwg University Health Board (CTMUHB), as a Designated Body and the Controlled Drug Accountable Officer (CDAO) have statutory responsibilities laid out in the regulations to ensure robust arrangements for the management and use of Controlled Drugs (CDs) to minimise patient harm, misuse and criminality across community, primary and secondary care. The CDAO for CTMUHB is Hannah Wilton, Clinical Director of Pharmacy and Medicines Management.

Under the aforementioned regulations, CDAO's are required to establish and operate appropriate arrangements for ensuring the proper sharing of information in accordance with regulation 25 or 26, by their designated body with other responsible bodies regarding the management and use of controlled drugs.

For a CDAO nominated or appointed by a Local Health Board, those arrangements must include establishing a network (a "local intelligence network") for sharing information regarding the management and use of controlled drugs. This network is known as the Controlled Drugs Intelligence Network (CDLIN).

The CDLIN is a multi-agency forum, which each Health Board is required to have, as set out in the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008. It is chaired by the CDAO and includes representation from the police, General Pharmaceutical Council (GPhC), counter fraud, local authority and ambulance service along with primary care contractors and private care providers within the Health Board area. Meetings are held on a quarterly basis and have received excellent attendance. The role of the CDLIN is to share intelligence around the use/misuse of CDs, direct policies and procedures to ensure the safe use of CDs and to minimise risk to patients. The Terms of Reference for the CDLIN can be found in Appendix 1.

This report provides an update of activity undertaken at the direction of the CDAO and CDLIN throughout the last financial year. It also outlines planned activity over the coming year designed to improve CD governance.

2. Strategic Insights

2.1 Controlled Drug Local Intelligence Network (CDLIN)

In 2025/26, the CDLIN met 4 times: April 2025, July 2025, October 2025 and January 2026. The first LIN of the new financial year was held on 30th April 26.

CDLIN attendance rates (2025-26)

Organisation	**CD LIN attendance rate**	**No of Occurrence Reports Submitted (including "nil to report")**
CTMUHB – secondary care	100%	4
CTMUHB – primary care	75%	4
CTMUHB – community services	100%	4
CTMUHB – HMP Parc	75%	3
Counter Fraud	100%	
South Wales Police	50%	
Kaleidoscope	100%	4
WAST	50%	4
Area Planning Board	100%	
GPhC	50%	
CDAT	100%	
Care Fertility	75%	3
Heatherwood Court	25%	1
Ty Cwm Rhondda	0%	0
Priory Group	0%	0
Rushcliffe	25%	2
Cardiff & Vale	100%	
Velindre	75%	
Aneurin Bevan	100%	
Swansea Bay	50%	
All Wales CDLIN lead	100%	
Powys	25%	

The organisations with 0% attendance in 24-25 were contacted via email with renewed invitations to participate and to submit occurrence reports.

- Heatherwood Court have now attended LIN and are submitting occurrence reports
- Ty Cwm Rhondda have agreed to attend from Q2 26/27

Neighbouring Health Boards attend regularly for information sharing. Both Swansea Bay and Powys have sent representatives to LIN meetings for the first time in 2025/26

2.2 CD Authorised Witnesses (CDAW)

A number of the Medicines Management Team are currently trained to witness the destruction of controlled drugs. These individuals are known as Authorised

Witnesses. All CDAWs are subject to a professional code of conduct and/or have undergone a DBS check in the last 3 years. Additionally, all CDAWs witnessing destruction of controlled drugs in premises with a Home Office License are required to have an enhanced DBS check. CTMUHB also have a number of independent contractors approved to act as CDAWs in community pharmacies within the CTM locality

Number of CDAWs on active register:

- CTM staff with Enhanced DBS (secondary and primary care) = 6
- CTM standard (primary care only) = 1 (+1 in training)
- Community Pharmacy staff (CTM approved):
    - Well = 4
    - Boots = 2
    - Knights = 2 (+1 awaiting approval)
    - Miah R Ltd = 2

Number of destruction visits completed in 2025/26

Organisation/CDAW	No. of visits	No. of items destroyed
Community		
CTM CDAW	9	180
Well Pharmacy	20	124
Boots Pharmacy	2	22
Avicenna Pharmacy	5	62
Secondary Care		
YCR	1	Data stored locally
PCH	8	Data stored locally
RGH	15	Data stored locally
POW	4	Data stored locally
HMP Parc	1	Data stored locally

Internal staff approved as CDAW will need to resubmit for their enhanced DBS checks as part of the routine cycle. The Medicines Management team will also increase the number of staff available to carry out CD destruction in order to ensure that CD destruction visits can be carried out in a more timely manner, improving the governance and security of CDs within the CTM area.

2.3 Procedures

There has been an update to the following procedure with regards to controlled drugs this year. These include:

- A WP10HP (controlled stationery) procedure which will detail the process that needs to be followed to request, issue and audit the use of WP10s

For 2026/27 the following procedures are being reviewed/ finalised

- A Prison controlled Drug Policy- this has been drafted and is going through final Health Board approval/ ratification processes
- Clarification given regarding transfer of patients and their medication- this is going through final Health Board approval processes
- The Medicines Management team will consult on unifying the Ward CD policy and Theatres/ICU CD procedure

2.4 Controlled Drugs Home Office Licenses

A joint letter from Welsh Government and Home Office issued previously stated

"Health boards and NHS trusts should as a matter of priority, review all services where they possess controlled drugs and arrangements where they supply controlled drugs to different services within their organisation or to other organisations and assure themselves of compliance with the requirements for controlled drugs licensing".

Supply licences are now in place in the 3 acute sites and possession licences in place in GP Out of Hours (GPOOH) and the prison. Possession licences for dental and Community Drug and Alcohol Team (CDAT) clinics are still in progress but named patient supply is in place to ensure compliance with legal requirements.

2.5 Self- assessment and controlled drug declarations

Healthcare organisations providing clinical services, and relevant social care organisations, are required to complete a periodic declaration (at least every 2 years) on whether they, or their organisation, keep stocks of controlled drugs and whether there are any special circumstances that might explain any seemingly unusual patterns of prescribing or supply. The CDAO is responsible for asking primary care clinicians, on the health board's Performers List, to complete a CD declaration/self-assessment.

CD self-declarations have not been completed in CTM for a number of years. An electronic form has been developed to replace the former paper-based declaration with the aim of increasing compliance which has historically been quite low. Rollout has been planned for early September 2026.

2.6 Action/work arising from CD LIN meetings

Action/work identified from CD LIN

Supporting set-up of CDAO forum by the All-Wales LIN representative and identification of issues to be discussed	Completed
Purchase of rulers for liquid CDs to reduce discrepancies	Completed
Information sharing of a number of concerns (fraudulent prescriber, violent patient, stolen prescriptions, divergence)	Ongoing
Private prescriber process review	For 26/27
Development of Home Office licence tracker	Completed
Review of inter-hospital transport CD process	Awaiting finalisation
Facilitating link between APB harm reduction team and unscheduled care	Completed

3. Risks and Opportunities

The main areas of focus for 2026-27 are:

- Implementation of the self-declaration process for GP/ Dental Contractors

- Completing the actions of the CD Internal Audit
- Implementing a monitoring system for controlled drugs in secondary care
- Private prescriber process review

4. Compliance and Governance

4.1 CD Internal Audit

As reported in the previous annual report, a review of the management of controlled drugs process was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board.

'Reasonable' assurance was provided for each of the objectives, and an action plan developed that has been agreed by the Clinical Director of Medicines Management and Assistant Director of Quality and Safety.

	Objectives	Assurance
1	Policies and procedures are in place.	Reasonable
2	Relevant staff have been a trained.	Reasonable
3	Ordering, delivery and receipt of controlled drugs is in with the procedures.	Reasonable
4	Controlled drugs registers are in place	Reasonable
5	Controlled drugs are securely stored.	Reasonable
6	Appropriate checks and audits are performed.	Reasonable
7	Monitoring and reporting takes place.	Reasonable

There were 17 actions to be completed. 15 of the 17 have been fully completed. The two remaining actions at the start of this year were:

- 6.3 Consideration should be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.
- 7.1 A central electronic record should be retained of those staff that have undertaken Controlled Drugs training and refresher training. Consideration should be given to using ESR for this purpose.

With regard to action 7.1, Medicines Management have engaged with the ESR team to get this point added to the ESR. This course has now been added to ESR.

With regard to action 6.3, work is still ongoing to implement a monitoring system for controlled drugs across secondary care. This will require engagement with Digital Pharmacy team to setup suitable reports on Wellsky that can be used by the Deputy Heads of Pharmacy- Operational Services to review the issue of CD to clinical areas.

5. Conclusion

5.1 The Committee should note the CDAO Annual report

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A More Equal Wales If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Leadership 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:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact: Outcome for Welsh Language (delete as appropriate): NEUTRAL Summary of impact:	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)*	Not undertaken as this is a paper to be noted	

Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	
Cyfreithiol / Legal	**Yes (Include further detail below)** If no monitoring system implemented it could have legal implications if any diversions of controlled drugs went undetected
Enw da / Reputational	**Yes (include further detail below)** If no monitoring system implemented it could have reputational implications if any diversions of controlled drugs went undetected
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**

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
CDAO	Controlled Drugs Accountable Officer
CDLIN	Controlled Drugs Local Intelligence Network
CD	Controlled Drug

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 1

Controlled Drugs Local Intelligence Network-

Terms of Reference

January 2026

1. CONSTITUTION

The Controlled Drugs Local Intelligence Network (CDLIN) will be chaired by the Controlled Drugs Accountable Officer (CDAO) for Cwm Taf Morgannwg University Health Board (CTMUHB). Activity will be reported, via the Quality and safety Committee of the Health Board and monitored by Health Inspectorate Wales (HIW)

The Network will cover Health Board employed staff, primary care contractors, all hospitals (NHS and private), private prescribers, hospices, drug and alcohol agencies and care homes within CTMUHB area.

2. ROLE OF THE LOCAL INTELLIGENCE NETWORK

The purpose of the LIN is to share information about incidents and concerns relating to the use and possible abuse of controlled drugs including potential or actual systems failures.

The Network will:

- agree local principles for sharing controlled drug (CD) intelligence between agencies
- actively share intelligence regarding use and potential abuse of CDs
- agree systems for reporting concerns
- agree procedures for investigation and participate in incident panels
- agree on the management of incidents affecting more than one agency
- receive reports from an investigation subgroup/ Incident Panel and decisions of the LIN Chair
- advise on monitoring processes and audits of CD management
- advise on training requirements for CD handling and undertake joint training
- advise on policy requirements
- update its membership as required

3. MEMBERSHIP

3.1 Membership

Membership will include, but will not be limited to:

- Controlled Drugs Accountable Officer, Cwm Taf Morgannwg UHB (Chair)
- Deputy Director Medicines Management- Governance, Cwm Taf Morgannwg UHB (Deputy Chair)
- Deputy Director Medicines Management- Primary Care and Communities, Cwm Taf Morgannwg UHB
- Principal Pharmacist Quality and Safety, Cwm Taf Morgannwg UHB
- Principal Pharmacist Community Services, Cwm Taf Morgannwg UHB
- Principal Pharmacist Prison Services, Cwm Taf Morgannwg UHB
- Lead Nurse Advisor Medicines Management and Medication Safety, Cwm Taf Morgannwg UHB
- Medicines Management Support Officer (CDs & Community Pharmacy), Cwm Taf Morgannwg UHB
- Assistant Director Quality & Patient Experience, Cwm Taf Morgannwg UHB
- Deputy Executive Director of Nursing, Cwm Taf Morgannwg UHB
- Service Director of Primary Care and Community Care Group, Cwm Taf Morgannwg UHB or representative
- Primary Care Development Manager – Dental, Cwm Taf Morgannwg UHB
- Controlled Drugs/Chemical Liaison Officer, South Wales Police
- NHS Wales Shared Services Partnership Counter Fraud Officer
- Area Planning Board (APB) representative
- Health Inspectorate Wales representative
- Care and Social Services Inspectorate Wales (CSSIW) representative
- General Pharmaceutical Council (GPhC) Inspector
- Welsh Ambulance Service representative
- Local Authority Substance Misuse Representative
- CDAT representative Cwm Taf locality
- CDAT representative Bridgend locality
- Neighbouring LIN representatives
    - Cardiff and Vale
    - Swansea Bay
    - Aneurin Bevan
    - Powys
- Kaleidoscope representative
- Velindre representative
- Care Fertility representative
- Heatherwood Court representative
- Ty Cwm Rhondda representative
- Priory Church Village representative
- Rushcliffe Hospital representative

Organisations required to have an Accountable Officer will normally be represented by that person.

Representatives from Contractor Bodies will be invited as required (CPW, LMC LDC).

3.2 Nominated Deputies

Members should have a nominated deputy who will attend Network meetings. If members are unable to attend the meeting, they must make every effort to ensure a deputy attends.

The deputy must be available to action intelligence passed on by the Network. It is noted that for some posts, there are no deputies who could reasonably be asked to attend, but the CDAO should be informed in advance.

All participants should be aware of the confidential nature of some of the issues discussed.

The nominated deputy chairperson for the meeting will be Deputy Director Medicines Management- Governance

3.3 Observers

Observers may from time to time be invited to attend but may be excluded where confidential issues are discussed.

3.4 Resignation

Membership may end by resignation at any time by notice to the chair

4. QUORUM

The quorum for the Network is six members, including the Chair or Deputy Chair.

In the event of non-compliance with quorate requirements this will be noted at the start of the meeting and documented in the minutes.

5. FREQUENCY OF MEETINGS

Meetings will be held as and when deemed necessary at the discretion of the Chairperson but no less than four times per year.

6. CONFIDENTIALITY

All members of the Network and their deputies are bound by an agreement of confidentiality to enable the sharing of identifiable information in the assured knowledge that named information or sources will not be revealed outside the network.

7. AGENDAS

The agendas for each meeting will be agreed by the Accountable Officer and will be despatched to all members no later than five days prior to the meeting. The minutes and action log will be completed after each meeting.

Quality, Safety & Experience Committee

National Prescribing Indicators

Eitem yr Agenda / Agenda Item	6.2.4
Dyddiad y Cyfarfod / Date of Meeting:	21/07/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kate Crandon-Lewis
Cyflwynydd yr Adroddiad / Report Presenter:	Hannah Wilton (For noting only)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	N/A
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below: Creating Health Sustaining our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	Improvements in National Prescribing Indicator (NPI) performance correlates to improved quality and cost effectiveness of prescribing for our patient population.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:

Executive Summary of what the report is describing:
Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The NPI report provides an overview of CTMs prescribing against key indicators highlighting performance against the Welsh average and other HBs. Based on the latest AWTTC NPI report CTM demonstrates improvement in opioids prescribing, antimicrobial stewardship, and strong performance in 4C antibiotics and Respiratory Tract Infection (RTI) prescribing. Key risks include highest Gabapentinoid prescribing and reduced Yellow Card reporting.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	CTMUHB Medicines Management team will continue to deliver targeted medicines optimisation programmes focused on high-risk and high-volume prescribing areas. Emphasis will be placed on reducing Gabapentinoid, Opioid and hypnotic/anxiolytic prescribing through structured medication review and deprescribing support, while maintaining improvements achieved in antimicrobial stewardship and respiratory prescribing. Work is also underway to increase Yellow Card reporting across all sectors and reduce low-value prescribing expenditure through targeted practice-level engagement and prescribing reviews. Performance will continue to be monitored through routine governance arrangements, with focused support provided to practices and clusters demonstrating the greatest opportunity for improvement.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	CTMUHB shows strong improvement trajectory but with ongoing high baseline prescribing and safety risks requiring targeted intervention. Resources have been reallocated within the antimicrobial stewardship team to create dedicated support for Primary Care where there is a need for ongoing intervention and support for our GMS contractors. There is targeted activity being scoped within the Primary Care Medicines Management Team to address the ongoing challenges across the Gabapentinoid, Opioid and anxiolytic NPI categories.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).*	For noting.

Recommendation (Linked to the "What Next" section above).	

1. Background / Context

The National Prescribing Indicators (NPIs) are endorsed by the All-Wales Medicines Strategy Group and provide a nationally recognised framework for assessing safe, effective and value-based prescribing across Wales. The indicators support NHS organisations in identifying opportunities to improve patient outcomes, reduce medicines-related harm and optimise the use of healthcare resources.

This report summarises CTMUHB performance against the NPIs using data up to December 2025 (the most recently published dataset available). The indicators cover a range of prescribing priorities including analgesics, antimicrobial stewardship, respiratory prescribing, medicines safety, Yellow Card reporting and prescribing efficiency. The report highlights areas of strong performance, identifies recognised challenges and outlines actions in place to support continued improvement.

2. Strategic Insights

CTM UHB continues to demonstrate positive progress in several priority prescribing areas. As highlighted in the graphs below, opioid burden reduced by 4.0% Q3 25/26 vs Q3 24/25, exceeding the all-Wales reduction of 3.46%, while tramadol prescribing reduced by 8.53% for the same period. These improvements suggest that established medicines optimisation and deprescribing programmes are having a positive impact on reducing exposure to medicines associated with dependence and medicines-related harm.

Figure 1. AWTTC Report Graph. Trend in opioid burden UDG OME 9mg) per 1,000 patients.

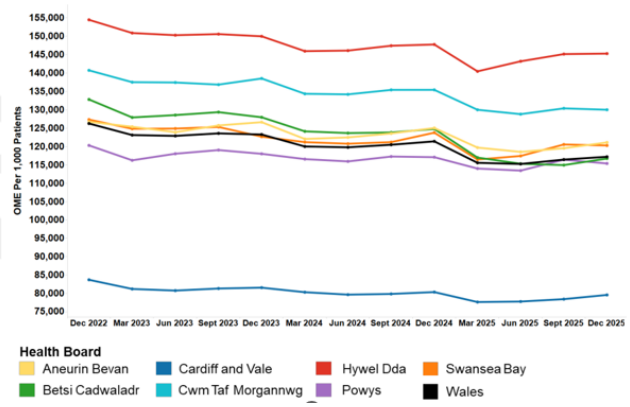
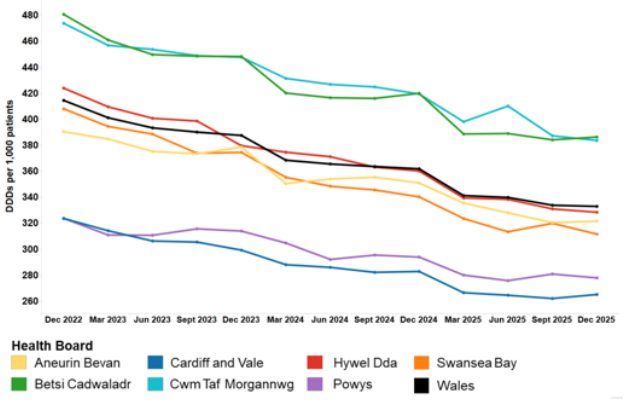


Figure 2. AWTTC Report Graph. Trend in Tramadol DDDs per 1,000 patients



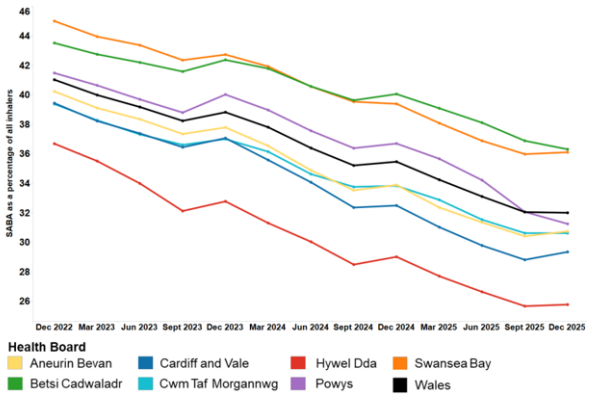
Antimicrobial stewardship remains an area of significant strength. CTM achieved the largest reduction in Wales for total antibacterial prescribing when compared with the 2019 baseline and continues to demonstrate the lowest 4C antimicrobial prescribing levels in Wales (as illustrated in the table below). Prescribing of shorter antibiotic courses for respiratory tract infections has also improved substantially, reflecting implementation of national guidance and local stewardship initiatives.

Figure 3. Table from AWTTC Report. Total antibacterial DDDs per 1,000 STAR-PUs

	2019–2020 Qtr 3	2025–2026 Qtr 3	% Change
Cwm Taf Morgannwg	3,056	2,398	-21.5%
Swansea Bay	2,826	2,348	-16.9%
Betsi Cadwaladr	2,663	2,272	-14.7%
Aneurin Bevan	2,795	2,417	-13.5%
Hywel Dda	2,723	2,362	-13.3%
Cardiff and Vale	2,674	2,339	-12.5%
Powys	2,422	2,168	-10.5%
Wales	**2,762**	**2,343**	**-15.2%**

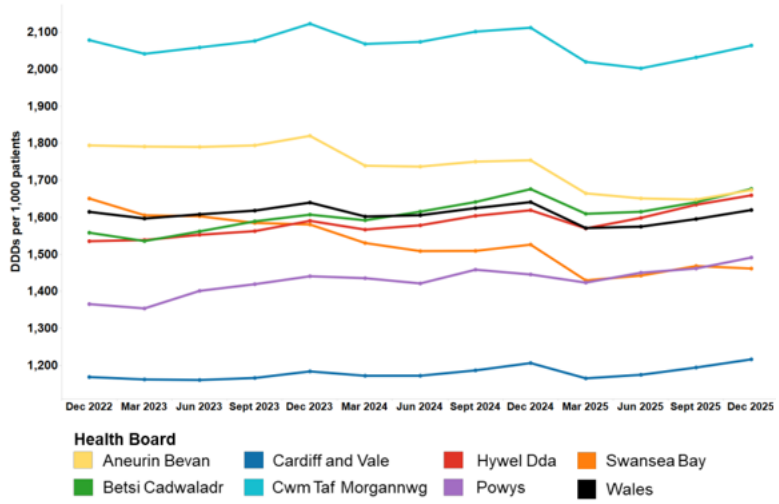
Respiratory indicators show continued progress, with increased use of lower carbon inhalers and a reduction in Short-Acting Beta2 Agonist (SABA) prescribing, supporting both improved asthma management and environmental sustainability objectives.

Figure 4. AWTTC Report Graph. Trend in SABA items as a percentage of all inhalers prescribed.



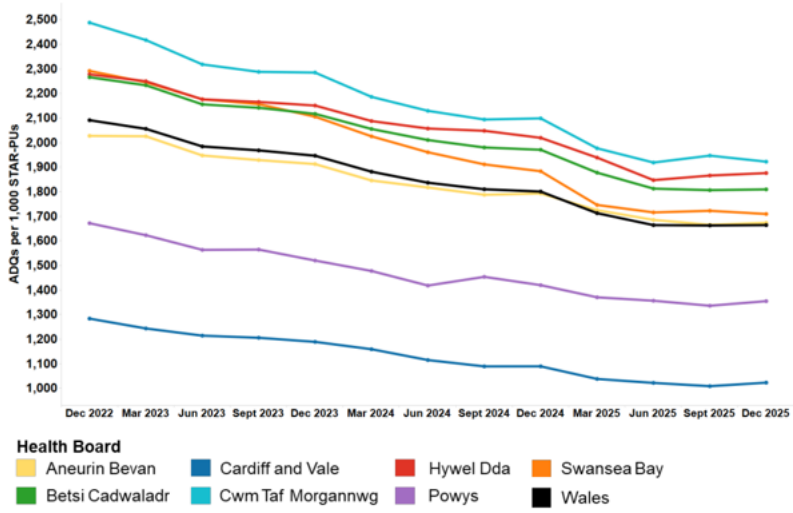
Whilst performance has improved across a number of indicators, CTMUHB continues to face challenges associated with historically high prescribing volumes. Gabapentinoid prescribing remains the highest in Wales despite a reduction from the previous year.

Figure 5. AWTTC Report Graph. Trend in Gabapentin and Pregabalin DDDs per 1,000 patients



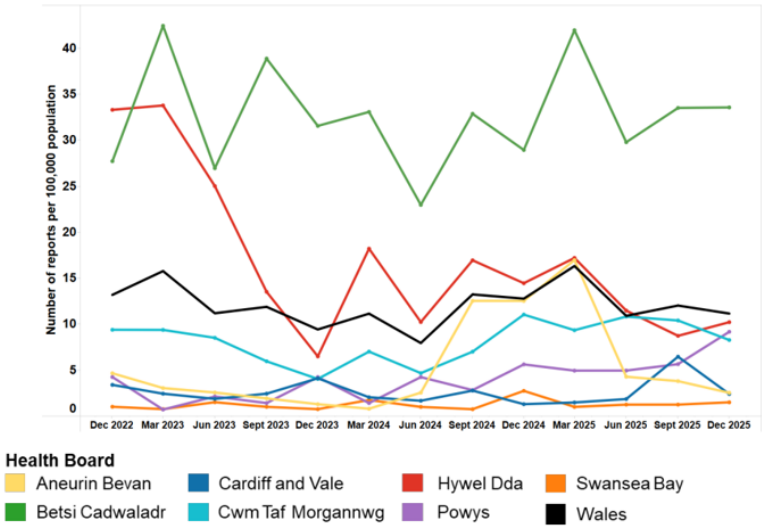
Similarly, prescribing of hypnotics and anxiolytics remains the highest in Wales, although prescribing has reduced by 8.4% year-on-year.

Figure 6. AWTTC Report Graph. Trend in hypnotic and anxiolytic UDG ADQs per 1,000 STAR-PUs



These indicators remain priorities due to the risks associated with long-term dependence, falls and medicines-related harm.

Figure 7. AWTTC Report Graph. Trend in number of Yellow Cards submitted by GP practices per 100,000 health board population



Yellow Card reporting also reduced across primary care, secondary care and health board reporting, highlighting an opportunity to strengthen organisational reporting culture and pharmacovigilance awareness.

3. Risks and Opportunities

The principal risks relate to continued high prescribing of medicines associated with dependence, misuse and avoidable harm, particularly Gabapentinoids, Opioids and hypnotics/anxiolytics. Whilst positive reductions have been achieved, CTM remains an outlier in several of these categories and sustained improvement will be required to reduce associated patient safety risks. Ashgrove Medical Group, a CTMUHB GMS practice was highlighted within the *AWTTC NPI 25/26 Analysis of Prescribing Data to December 2025* for its work to reduce Gabapentinoid prescribing.

Good practice spotlight

Ashgrove Medical Group (in Cwm Taf Morgannwg UHB) took action over the increasing safety concerns regarding the prescribing of gabapentinoid medications for chronic pain. A dramatic increase in the number of deaths where gabapentin or pregabalin was mentioned on the death certificate in England and Wales were reported, from 272 deaths registered in 2018 to 552 deaths registered in 2022.

There are a plethora of safety concerns relating to the use of gabapentinoids, ranging from dependence, diversion and misuse, to dizziness, somnolence and potentially fatal respiratory depression.

A multidisciplinary approach was taken to review patients taking gabapentinoids, identify the indication and manage any appropriate reductions accordingly.

Initially patients prescribed a gabapentinoid alongside an opioid or a benzodiazepine were prioritised. A template letter was devised, providing written information to patients, regarding the risks associated with the combination of their medications. Patients were then invited to book an extended appointment with the pharmacist to address any concerns they may have and establish a shared approach to a tailored reduction of their medication.

For further information regarding this initiative, please contact awttc@wales.nhs.uk.

Reduced Yellow Card reporting may limit opportunities to identify emerging adverse drug reactions and could indicate reduced engagement with pharmacovigilance processes.

There are significant opportunities to build on established improvement programmes. Existing antimicrobial stewardship work provides a strong foundation for maintaining national leadership in this area. Structured medication reviews, prescribing safety searches and cluster-level engagement offer further opportunities to reduce high-risk prescribing and improve patient outcomes. Wider use of data-driven medicines optimisation approaches will support ongoing delivery of prudent healthcare principles.

4. Compliance and Governance

Performance against the National Prescribing Indicators is monitored through established medicines governance arrangements across CTMUHB. The Medicines Management Team routinely reviews prescribing data at Health Board, cluster and practice level to identify variation, prioritise interventions and provide targeted support where required.

Prescribing improvement activity aligns with national AWMSG guidance, antimicrobial stewardship requirements, prudent prescribing principles and NHS Wales medicines optimisation priorities. The Health Board remains compliant with national monitoring requirements and continues to utilise recognised prescribing intelligence tools to support governance and assurance processes.

Specific governance focus during 2026/27 will include medicines associated with dependence, prescribing safety indicator reviews, antimicrobial stewardship, pharmacovigilance reporting and low-value prescribing reductions.

5. Conclusion

The latest National Prescribing Indicator data demonstrates that CTMUHB is delivering measurable improvements across several priority prescribing areas, particularly antimicrobial stewardship, opioid reduction, respiratory prescribing and prescribing efficiency through biosimilar adoption.

Notwithstanding these achievements, challenges remain in relation to medicines associated with dependence and Yellow Card reporting. Robust improvement plans are already established and are being delivered through the Medicines Management Team and wider multidisciplinary partners.

Overall, the Health Board can provide assurance that prescribing performance is subject to ongoing scrutiny, targeted interventions are in place for recognised areas of risk and improvement activity remains aligned to national priorities for safe, effective and value-based prescribing.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Yes - Reduce If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact: No impact. Outcome for Welsh Language (delete as appropriate): NEUTRAL Summary of impact: No impact.	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not required.	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Acronyms / Glossary of Terms	
NPI	National Prescribing Indicators
AWTTC	All Wales Therapeutic and Toxicology Centre
DDDs	Defined Daily Doses
UDG	Units of Drug Group
OME	Oral Morphine Equivalent
ADQ	Average Daily Quantity
STAR-PUs	Specific Therapeutic Group Age-Sex Related Prescribing Units

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality, Safety & Experience Committee

Human Tissue Act Compliance Report

Eitem yr Agenda / Agenda Item	**6.2.5**
Dyddiad y Cyfarfod / Date of Meeting:	21/7/26
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Dr Paul D Davies Assistant Director (Operational Support) & HTA Designated Individual
Cyflwynydd yr Adroddiad / Report Presenter:	Dr Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For noting only
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	Providing legally complaint and safe services.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	*The Health Board has a licence for undertaking Post Mortem at the Royal Glamorgan Hospital with satellite centres at both Prince Charles Hospital and the Princess of Wales Hospital. To maintain the licence and be legally compliant with the Human Tissue Act (2004), the Health Board maintains 72 key standards which are subject to inspection by the Human Tissue Authority (HTAuth).*
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	***Risk;*** *There is a plan to relocate Post Mortem services from the Royal Glamorgan Hospital to Prince Charles Hospital in 2026 due to risks with the ventilation system and reduced capacity for storage.* ***Quality Control;*** *There are currently no significant shortfalls in standards to report from the three HTA licensed Mortuary Departments, however there have been three significant security breaches in 2026.* ***Maintaining Compliance;*** *The Designated Individual has put in place a number of continual actions within a governance framework to ensure the services maintain compliance including on-going audit and local inspections. The responsibility for the two community hospital body stores has now been transferred to the Pathology Directorate.* ***Incident analysis;*** *In the last 5 years there has been a general reduction in Human Tissue Act related incidents. During 2026 there have been three reportable incidents to the HTAuth. The first incident has been determined to be a near-miss, the second a HTARI and the third is currently being assessed.*
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	*This report demonstrates on-going compliance with the Human Tissue Act (2004) and a number of actions taken where there are temporary shortfalls in standards.*

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).*	*The committee is requested to **note** the report and be assured of compliance.*

Recommendation (Linked to the "What Next" section above).	

1. Background / Context

1.1 The Health Board is licensed by the Human Tissue Authority (HTAuth) through unannounced compliance inspections which are undertaken every three years.

1.2 This report presents an updated status regarding compliance since January 2006.

2. Strategic Insights

2.1 The report will present narrative and data to assure the committee that it is compliant with the Human Tissue Act (2004) including benchmarking activity.

3. Risks and Opportunities

3.1 There has been a long-standing risk of compliance at the Royal Glamorgan Hospital Mortuary due to an ageing ventilation system and reduced storage capacity.

3.2 A strategic plan is in place to relocate Post Mortem services to Prince Charles Hospital later in 2026, due to this site having significantly greater capacity for storage and being more compliant with standards for the built environment.

3.3 The Royal Glamorgan Hospital is proposed to continue as a mortuary body store and will remain compliant within the overall licence requirements.

4. Compliance and Governance

Quality Control

4.1 The Quality Control Department within Pathology conduct a cyclical audit programme around the specific standards within the HTAuth Codes, predominantly items regarding consent, tissue traceability, governance, quality control, protection, environment and facilities.

4.2 This quality system is augmented through inspections of a range of services by the Designated Individual (DI) including Mortuary Departments, Maternity Services, Emergency Departments, Theatres and Gynaecology Wards.

4.3 During 2023 and in 2024 there has been a focus upon security following the Fuller Inquiry Phase 1 and this has continued into 2025 and 2026 following the Phase 2 recommendations.

4.4 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)

4.5 All non-conformances are followed up by the Quality Department and the DI.

4.6 There are currently no significant shortfalls in standards to report from the three HTA licensed Mortuary Departments, however there have been three significant security breaches (see 4.17).

Table 1 Security audits for 2026

Audit Objective	Frequency	Number of completed audits for 2026 to date	All Finding Actioned
Verification of Mortuary CCTV	Monthly	8	Yes
Unauthorised Access	Monthly	2 (3 in progress)	Yes
Time spent in Mortuary OOHs	Quarterly	1 (1 in progress)	Yes – Datix raised regarding one finding
Mortuary Swipe Card Access	Quarterly	1	Yes

Maintaining Compliance

4.7 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.

4.8 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).

4.9 The DIs local inspection focuses upon the HTA standards for security, temperature monitoring, traceability, cleanliness, equipment, competence and patient dignity.

4.10 The Pathology Directorate are now responsible for the body stores at both Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon to ensure consistency of standard compliance across the Health Board.

4.11 Whilst the HTAuth post mortem licence does not apply to these sites, the DI has taken the responsibility for overseeing compliance.

4.12 Since the change in responsibility the following has been implemented;

- Regular cleaning regime of the fridges and body store areas
- Regular audit of overall compliance
- The transfer of the deceased to Funeral Directors by Registered Nurses checking the 3 unique identifiers for each patient

Incident Analysis

4.13 All Human Tissue Act related incidents are collated by the DI and presented on a quarterly basis to the Human Tissue Act Board and Persons Designated. Table 2 presents data for the last two years.

4.14 The importance of collating such data is primarily to analyse trends and seek improvements within clinical areas

4.15 Each reported incident is diligently followed up and learning post-incidents implemented.

Table 2

		PLR	Deceased	Equipment	Security	PCH	RGH	POW	Other	TOTAL	HTARI	Near-Miss
2024/25	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
	Q1	1	2	0	0	1	2	0	0	**3**	0	0
2025/26	Q2	2	2	0	0	0	2	1	1	**4**	0	0
	Q3	5	8	0	0	3	7	3	0	**13**	0	2
	Q4	0	2	0	3	0	4	1	0	**5**	1	1
2026/27	Q1	2	2	0	2	3	1	2	0	**6**	0	1 [1]
		23	**25**	**0**	**6**	**19**	**22**	**11**	**2**	**54**	**1**	**6**

[1] Currently under review by HTA

4.16 There has been a general downward trend of reported incidents over the last 5 years and this has continued in 2026.

4.17 During 2026 there have been three reportable incidents to the HTAuth regarding significant breaches in security.

4.18 During the first incident the back door of the visitor's area of the Royal Glamorgan Hospital mortuary was temporarily left unlocked by a staff member and a visitor entered the building but not the clinical area.

4.19 The DI reported the incident to the HTAuth and it was assessed as a Near-Miss HTARI following submission of a Corrective & Action Preventative Plan.

4.20 The door is currently being assessed by Capital Planning to change from a thumb lock mechanism to a magnetic lock type entry.

4.21 The second incident involved a staff member mistakenly escorting a courier collecting blood samples into the body store area at the Royal Glamorgan Hospital Mortuary.

4.22 The DI reported the incident to the HTAuth and it was assessed as a HTARI following submission of a Corrective & Action Preventative Plan.

4.23 The third incident occurred at the Prince Charles Hospital Mortuary where an Estate staff member entered the corridor near the office via an adjoining door to the ventilation plant room.

4.24 The staff member remained in the corridor for a 5 minute period (verified by CCTV) before being discovered by mortuary staff.

4.25 The DI reported the incident to the HTAuth and a Corrective & Action Preventative Plan has been submitted which is currently under assessment by the HTAuth.

4.26 An extra security measure has been installed by the estates department to the door to prevent a recurrence

4.27 All three security incidents were due to human error and there is no systemic or process theme identified as being the cause.

4.28 The reporting of the incidents reflect the heightened awareness of the importance of providing a secure mortuary environment since the Fuller Inquiry recommendations.

4.29 An incident occurred in May 2026 where a patients transfer from a ward to the mortuary at the Princess of Wales Hospital was delayed for 11 hours, due to a late verification of death.

4.30 A number of actions have been identified following a Rapid Review by the nursing team and an escalation process published to all clinical teams.

4.31 Whilst the incident did not involve any licensable activity, the DI discussed the matter with the HTA who agreed it was not a HTARI.

5. Benchmarks

5.1 There has been a general trend of a reducing number of incidents regarding compliance to standards over the last 5 years, reflecting the outcomes of robust incident follow-up, enhanced training and cyclical audit.

5.2 HTARI reporting is at a similar level to other Health Boards in Wales.

5.3 Pathology managers and the DI attend the regular All-Wales Anatomical Pathology Compliance group where HTARIs are discussed and lessons learnt are shared.

5.4 The DI attends the annual HTAuth national event in London where policy and practice is presented and shared, networking with DI colleagues across the United Kingdom to benchmark services.

5.5 An external UKAS inspection of the Mortuary at the Princess of Wales Hospital in June 2026 found only two minor discrepances and the team were complimented.

5.6 The recent *National Learning Event: Post-Death Care Across NHS Wales Summary Report (June 2026)* stated;

'CTMUHB's Designated Individual (DI) engagement model recognised as exemplary practice'

5.7 This observation reflects the dedicated work the whole mortuary team implement every day to ensure that standards are compliant with the Human Tissue Act (2004).

6. Conclusion

6.1 This compliance report is for **Noting** and has demonstrated on-going compliance with the Human Tissue Act (2004) as well as a number of actions taken where there were temporary shortfalls in standards.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 1b If more than one applies please list below: Strategic Risk 2, 3, 6 and 10

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Leadership

	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:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Policy/Plan/Proposal too broad Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	No Quality Impact Assessment undertaken. Compliance with the Human Tissue Act (2004) is statutory.	
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)** On-going capital requirement to maintain mortuary security and high standards of estate and equipment.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Mr Carl Verrecchia Care Group Director	24/06/2026	Approved

Acronyms / Glossary of Terms	
DI	Designated Individual
HTARI	Human Tissue Act Reportable Incident
HTAuth	Human Tissue Authority

Quality, Safety & Experience Committee

Organ Donation Sub-Committee Highlight Report

Eitem yr Agenda / Agenda Item	6.2.6
Dyddiad y Cyfarfod / Date of Meeting:	21/07/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Corinna McNeil Specialist Nurse Organ Donation David Deekollu, AMD (Governance & Quality)
Cyflwynydd yr Adroddiad / Report Presenter:	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For noting only
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below: Inspiring People
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	Aligned to NHSBT key performance Indicators

1. Introduction

1.1 This report has been prepared to provide the Quality, Safety and Experience Committee with details of the key issues considered by the Organ Donation Sub Committee at its meeting on 22nd June 2026.

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

2. Purpose of this Meeting

2.1 The purpose of the Organ Donation Sub Committee is to influence policy and practice to ensure that Organ Donation is considered in all appropriate situations, and to identify and resolve any obstacles to this

2.2 The Organ Donation Sub Committee will:
Ensure that a discussion about organ donation features in all end of life care, wherever located and whenever appropriate, recognising and respecting the wishes of the individuals. Maximise the overall number of organs donated, through better support to potential donors and their families

3.0 Highlight Report

Alert / Escalate	There are no matters requiring escalation on this occasion.
Advise	Corneal Transplant Capacity: Ophthalmology capacity has reduced from 4 to 2 corneal transplants per month due to workforce constraints. Consultant capacity is the primary constraint rather than donor supply. There are currently 74 patients waiting, with waits exceeding 3 years.
Assure	• CTM UHB has a well-attended Organ Donation Committee (ODC), which has representation from all relevant internal and external stakeholders, including patient and family representatives. The ODC is the forum in which Health Board performance is reported, missed opportunities discussed, a communication strategy developed, and education sessions are planned. • When compared with national data, during the time period (2025- 26) our Health Board was in line with the national average for the referral of potential organ donors and in line

	with the national average for Specialist Nurse presence when approaching families to discuss organ donation • From 8 consented donors, Cwm Taf Morgannwg University Health Board facilitated 8 actual solid organ donors resulting in 23 patients receiving a transplant during the time period. Additionally, 12 corneas were received by NHSBT Eye Banks from your Health Board. • 46% of the population in Wales have registered an NHS Organ Donor Register (ODR) opt in decision. This compares to 43% of the population nationally. • A continued effort by clinicians, clinical staff and support workers to ensure that organ and tissue donation is a positive end of life opportunity that is offered to families of anyone meeting donation criteria. Early recognition of potential donors aids SNOD workforce planning to ensure that we are present to assess donation potential before offering it to a family, and being present for conversations to ensure families give informed consent/decline.
Inform	• A revised Forward Action Plan is being developed, aligned to the national *Bolder and Braver* strategy, with clear timelines and delivery milestones. • A range of communication strategies are being explored. These include a monthly newsletter, podcasts, social media campaigns and local patient stories to increase impact. A recent national television patient story was well received and highlighted the value of personal narratives.
Appendices	• Minutes of the meeting 22nd June 2026 (available on request) • NHSBT report May 2026 (available on request)

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework**	Not applicable If more than one applies please list below:

(Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A More Equal Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	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:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): NOT APPLICABLE Summary of impact: Outcome for Welsh Language (delete as appropriate): NOT APPLICABLE Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	NOT APPLICABLE	
Cyfreithiol / Legal	Yes (Include further detail below)	

	All practices are performed in-line with the Human Tissue Act and Welsh "Deemed Consent" law.
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Organ Donation Sub-Committee)	22/06/2026	

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

4 Recommendation

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

Quality, Safety & Experience Committee

Clinical Audit Update – for Awareness on Clinical Outcomes from Audits Report (January – June 2026)

Eitem yr Agenda / Agenda Item	6.2.7
Dyddiad y Cyfarfod / Date of Meeting:	21/07/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	David Morgan – AMD Clinical Audit & Effectiveness, Mark Townsend – Lead for Clinical Audit
Cyflwynydd yr Adroddiad / Report Presenter:	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action/decision required
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	Not applicable

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The purpose of this report is to provide assurance to the QSEC regarding progress in delivering the CTMUHB Clinical Audit Forward Plan 2026–2027.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The report highlights strategic priorities identified through the audit programme centred on workforce capacity and the organisation's ability to respond to increasing patient complexity, particularly frailty. These areas are further influenced by pathway variation and infrastructure constraints.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	While strong MDT working and improvement initiatives are evident, sustained progress will require coordinated, CTMUHB-wide action focused on standardisation, workforce investment, and strengthening governance and digital capability.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	QSEC is asked to note the progress made in delivering the Clinical Audit Forward Plan 2026–2027 and the assurance provided through the work of the Clinical Effectiveness Committee.

1. Background / Context

1.1 This report provides a summary of assurance gained through the Clinical Effectiveness Committee's oversight of national clinical audit activity during the period **1 January to 30 June 2026**. The report reflects audit findings and associated improvement activity across the **Acute Surgery and Critical**

Care, **Falls and Fragility Fracture**, and **Children and Young People** audit themes.

1.2 **Key Themes Emerging from National Clinical Audits**

Acute Surgery & Critical Care

- Continued improvement in national emergency laparotomy outcomes, with CTMUHB demonstrating improvement but ongoing variation across sites.
- Critical care mortality remains within expected limits; however, capacity pressures, delayed transfers of care, and workforce challenges continue to impact performance.
- Key improvement priorities include strengthening perioperative care for frail patients, improving patient flow, expanding critical care capacity, and reducing variation in emergency surgical pathways.

Children and Young People

- Strong performance demonstrated across epilepsy, paediatric diabetes and asthma services, supported by effective multidisciplinary team working and high-quality clinical governance.
- Challenges remain in access to diagnostics, specialist services, psychology support, and reducing variation between sites.
- Priorities include development of Health Board-wide service models, improving access to diagnostics, and addressing inequalities affecting patient outcomes.

Falls, Frailty and Fragility Fracture

- Audit findings reflect the growing impact of frailty and complexity across trauma, orthopaedic and inpatient care pathways.
- Improvements have been seen through enhanced multidisciplinary team working and orthogeriatric involvement; however, variation persists in falls prevention, delirium assessment, rehabilitation and trauma response standards.
- Priorities include strengthening frailty pathways, expanding orthogeriatric support, improving compliance with patient safety processes, and enhancing audit data quality.

2. Strategic Insights

2.1 The national clinical audit programme continues to provide independent assurance regarding the quality, safety and effectiveness of services across CTMUHB. Findings presented during the reporting period indicate that overall performance remains broadly consistent with national expectations, with evidence of improvement in several key areas including emergency surgery outcomes, specialist paediatric services and multidisciplinary management of frailty and fragility fracture patients.

2.2 A recurring theme across all audit programmes is the increasing complexity of patient need. The growing prevalence of frailty, multiple co-morbidities and

long-term conditions is influencing demand across acute, community and specialist services and reinforces the importance of integrated, person-centred models of care.

2.3 The audits also highlight the critical relationship between workforce, capacity and clinical outcomes. Whilst many services continue to demonstrate good performance despite operational pressures, workforce shortages, diagnostic delays and capacity constraints within theatres, inpatient services and critical care remain important factors influencing variation in performance and the pace of improvement.

2.4 Several audits identified variation in compliance with national standards between sites and specialties. Although much of this variation does not represent systemic quality concerns, it provides an opportunity to further reduce unwarranted variation through standardised clinical pathways, strengthened governance arrangements and enhanced sharing of best practice across the Health Board.

2.5 The findings align closely with the Health Board's strategic objectives relating to quality, safety, clinical effectiveness, value-based healthcare and reducing health inequalities. They demonstrate the continued importance of national clinical audit as a source of assurance whilst identifying areas where targeted improvement activity is required to strengthen patient outcomes and experience.

3. Risks and Opportunities

3.1 **Workforce Capacity and Capability**

Workforce shortages across key specialist, diagnostic and clinical roles continue to impact service delivery, compliance with national standards and the pace of improvement.

3.2 **Increasing Frailty and Complexity**

A growing proportion of patients are older, frail and living with multiple co-morbidities, placing increasing pressure on acute, surgical and community services and highlighting the need for integrated frailty pathways.

3.3 **Variation in Care Pathways**

Differences in service models, clinical processes and access to specialist support across sites contribute to unwarranted variation in patient experience and outcomes.

3.4 **Patient Safety and Quality**

Audit findings identified opportunities to improve compliance with core safety processes, including falls prevention, delirium screening, consent processes, timely treatment and rehabilitation.

3.5 **Capacity and Infrastructure Constraints**

Constraints within theatre, critical care, diagnostic and inpatient capacity continue to affect patient flow, timeliness of care and organisational resilience.

3.6 **Governance, Data Quality and Assurance**

Improvements are required in audit participation, data quality, consent processes and compliance with national audit standards to strengthen organisational assurance and support improvement activity.

3.7 **Health Inequalities**

Several audits highlighted the impact of deprivation and access barriers on clinical outcomes, reinforcing the need for targeted action to reduce inequalities and improve equity of access across CTMUHB.

4. Compliance and Governance

4.1 The national clinical audit programme forms an important component of the Health Board's overall quality governance framework and supports compliance with statutory duties relating to quality, safety and continuous improvement.

4.2 During the reporting period, participation in national clinical audits remained broadly in line with expectations across the services reviewed. Most audits demonstrated compliance with relevant national reporting requirements and provided evidence of organisational engagement in benchmarking and quality improvement activities.

4.3 Where audits identified gaps in compliance with national standards, these were generally associated with workforce availability, service capacity constraints, variation in documentation processes and data completeness. Action plans have been developed within services to address identified areas for improvement and progress will continue to be monitored through established governance structures.

4.4 A recurring governance theme relates to the quality and completeness of clinical data. Ensuring robust clinical documentation, accurate coding and timely data submission remains essential to providing reliable assurance and supporting organisational learning.

4.5 The Clinical Effectiveness Committee maintains oversight of audit participation, recommendations and resulting improvement actions, providing assurance that audit findings are appropriately reviewed, escalated where necessary and incorporated into service improvement plans. No significant governance concerns requiring escalation beyond existing monitoring arrangements were identified during the reporting period.

5. Benchmarks

5.1 National clinical audits provide valuable comparative information that enables the Health Board to assess its performance against national standards and peer organisations across Wales and the wider United Kingdom.

5.2 The audits reviewed during this reporting period demonstrated that CTMUHB performance is generally comparable with national averages across most indicators. Areas of notable strength include aspects of paediatric diabetes, epilepsy and asthma care, where services continue to demonstrate strong multidisciplinary working and positive performance against national measures.

5.3 In acute surgery and critical care services, outcomes were largely consistent with national benchmarks, although some variation was identified in relation to pathway efficiency, capacity utilisation and perioperative care processes. Similarly, audits relating to frailty and fragility fracture services demonstrated improving performance but identified opportunities to strengthen compliance with key standards relating to falls prevention, rehabilitation and comprehensive geriatric assessment.

5.4 Whilst benchmarking confirms that CTMUHB is not a significant outlier for the majority of measures, the variation identified within individual audits highlights opportunities to learn from higher-performing organisations and further improve consistency of care across sites and specialties.

5.5 The Clinical Effectiveness Committee will continue to use national benchmarking information to support organisational learning, identify emerging risks and target improvement activity where performance falls below expected standards.

6. Conclusion

6.1 The Clinical Effectiveness Committee has received assurance from the national clinical audit reports presented during the period January to June 2026 that services across the Acute Surgery and Critical Care, Children and Young People, and Falls and Fragility Fracture audit programmes continue to deliver care that is broadly aligned with national standards.

6.2 Audit findings demonstrate a number of areas of good practice and continued improvement, particularly in multidisciplinary working, specialist clinical services and the management of increasingly complex patient populations. The reports also identify recurring challenges relating to workforce capacity, service variation, infrastructure constraints, data quality and the growing impact of frailty and complexity on healthcare delivery.

6.3 The Committee should be assured that appropriate governance arrangements are in place to monitor findings, oversee improvement actions and provide ongoing assurance regarding clinical effectiveness. Continued focus on reducing unwarranted variation, strengthening frailty pathways, improving audit data quality and addressing workforce and capacity pressures will be required to support further improvement.

6.4 The Committee is therefore asked to note the contents of this report and take assurance from the oversight undertaken through the national clinical audit programme during the reporting period, whilst recognising the improvement priorities identified for continued organisational focus.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd	Strategic Risk 2

(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg) **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research
	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:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion: This is not a policy or service review
Canlyniad Asesiad Effaith Ansawdd	Although a formal Quality Impact Assessment has not been undertaken, the report provides	

(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen) **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	assurance regarding quality, safety and clinical effectiveness through review of national clinical audit findings. The audit themes considered identified opportunities to improve patient outcomes, reduce unwarranted variation, strengthen patient safety processes and support continuous quality improvement across CTMUHB.
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

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	