

Quality, Safety & Experience Committee

Tuesday 22 September 2026, 09:00 - 12:00

Virtually via Microsoft Teams

Agenda

09:00 - 09:00
0 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

09:00 - 09:00
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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

09:00 - 09:00
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3. GOVERNANCE/COMMITTEE BUSINESS ACTIVITY

3.1. Action Log

Discussion

Carolyn Donoghue, Committee Chair

 3.1 Action Log QSEC 22 September 2026.pdf (2 pages)

3.2. Matters Arising not Contained within the Action Log

Discussion

Carolyn Donoghue, Committee Chair

09:00 - 09:00
0 min

4. IMPROVING CARE

4.1. Shared Listening & Learning Story - Transition of Care from Paediatrics to Adult Services - Epilepsy

Discussion

 Board Slide Deck - Iori's Journey Complete Slide Deck.pdf (12 pages)

4.2. Peoples Experience Activity Report April - May 2026

Discussion

Clare Ibbs, Interim Head of Corporate Nursing & People's Experience

 4.2 PE Activity Report April - May 2026 QSEC 22 September 2026.pdf (14 pages)

4.3. Report from the Clinical Executives

Discussion *Richard Hughes, Executive Director of Nursing*

 4.3 Clinical Executive Directors Report QSEC 22 September 2026.pdf (13 pages)

4.4. Care Group Highlight Reports

Discussion *Care Group Nurse Directors*

4.4.1. Planned Care Highlight Report

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

 4.4.1 Planned Care QSEC Highlight Report QSEC 22 September 2026.pdf (8 pages)

4.4.2. Unscheduled Care Highlight Report

Discussion *Deborah Matthews, Care Group Nurse Director*

 4.4.2 USC Highlight Report QSEC 22 September 2026 Final.pdf (15 pages)

4.4.3. DTPS Highlight Report

Discussion *Gary Howell, Clinical Director, Allied Health Professionals*

 4.4.3 DTPS Highlight Report QSEC 22 September 2026.pdf (15 pages)

4.4.4. Children & Families Highlight Report

Discussion *Suzanne Hardacre, Director of Midwifery*

 4.4.4 Children Families Care Group Highlight Report QSEC 22 Sept 2026.pdf (7 pages)

4.4.5. Primary Care & Community Highlight Report

Discussion *Lucie Owen, Care Group Nurse Director*

 4.4.5a Primary Care and Community Highlight Report QSEC 22 September 2026.pdf (10 pages)

 4.4.5b Paeds GA Update QSEC 22 September 2026.pdf (2 pages)

4.4.6. Mental Health & Learning Disabilities Highlight Report

Discussion *Lloyd Griffiths, Head of Nursing, Mental Health*

 4.4.6 MHLD QSEC Highlight Report QSEC 22 September 2026.pdf (10 pages)

4.5. Stroke Services Update

Discussion *Sarah Follows, Service Director, Unscheduled Care*

 4.5 Stroke Services Update QSEC 22 September 2026.pdf (17 pages)

4.6. Annual Duty of Quality Report 2025-2026

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

 4.6a Duty of Quality Annual Report QSEC 22 September 2026.pdf (6 pages)

 4.6b 2025-26 Draft Duty of Quality Annual Report Version 2 QSEC 22 Sept 2026.pdf (94 pages)

4.7. Redress Update

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

 4.7 Redress Case Management Report QSEC 22 September 2026.pdf (11 pages)

4.8. Mortality Update

Discussion *Dom Hurford, Executive Medical Director*

 4.8 Mortality Update QSEC 22 September 2026.pdf (14 pages)

4.9. Board Assurance Framework Report – September 2026

Discussion Louise Stait, Interim Assistant Director of Governance & Risk

-  4.9a BAF_QSEC_COVER QSEC 22 September 2026.pdf (6 pages)
-  4.9b BAF_QSEC_SUMMARY QSEC 22 September 2026.pdf (2 pages)
-  4.9c BAF_QSEC QSEC 22 September 2026.pdf (29 pages)

4.10. Organisational Risk Register (Risks assigned to the QSEC)

Discussion Louise Stait, Interim Assistant Director of Governance & Risk

-  4.10a ORR_QSEC_COVER QSEC 22 September 2026.pdf (14 pages)
-  4.10b QSEC_ORR QSEC 22 September 2026.pdf (12 pages)

09:00 - 09:00

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5. CREATING HEALTH

5.1. Avoidable Mortality and Health Inequalities

Discussion Philip Daniels, Executive Director of Public Health

-  5.1 HLE Avoidable Mortality and Health Inequalities QSEC 22 Sept 2026.pdf (18 pages)

5.2. Progress against CTMUHB's Research & Development Strategy Action Plan and Annual Review with Welsh Government

Discussion Rhian Beynon, Research & Development Manager

-  5.2 RD Strategic Action Plan Update QSEC 22 September 2026.pdf (22 pages)

5.3. CTMUHB Research and Development Annual Report 2025-26

Decision Rhian Beynon, Research & Development Manager

-  5.3a R&D Annual Report QSEC 22 September 2026.pdf (6 pages)
-  5.3b RD Annual Report Version 3 QSEC 22 September 2026.pdf (24 pages)

09:00 - 09:00

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6. CONSENT AGENDA

6.1. FOR APPROVAL

6.1.1. Unconfirmed Minutes of the meeting held on 21 July 2026

Decision Carolyn Donoghue, Committee Chair

-  6.1.1 Unconfirmed Minutes for QSEC 21st July 2026 QSEC 22 Sept 2026.pdf (15 pages)

6.1.2. Health, Safety & Fire Sub Committee Highlight Report

Decision Carolyn Donoghue, Sub Committee Vice Chair

-  6.1.2a HSFC Highlight Report QSEC 22 September 2026.pdf (6 pages)
-  6.1.2b App 1 Fire Policy 2026 QSEC 22 September 2026.pdf (32 pages)

6.1.3. Pharmaceutical Needs Assessment

Decision Dom Hurford, Executive Medical Director

-  6.1.3a PNA Cover Paper QSEC 22 September 2026.pdf (7 pages)

6.1.4. Water Safety, Infection and Risk Prevention Policy

Decision Sally May, Executive Director of Finance

-  6.1.4a Water Safety Policy QSEC 22 September 2026.pdf (5 pages)

 6.1.4b Water Safety Infection and Risk Prevention Policy QSEC 22 Sept 2026.pdf (15 pages)

6.1.5. Policy and Procedure for the Prevention and Management of Adult Inpatient Falls

Decision *Richard Hughes, Executive Director of Nursing*

 6.1.5a Prevention Mment of Adult Inpatient Falls QSEC 22 September 2026.pdf (5 pages)

 6.1.5b Policy for the Prevention and Management of Adult Inpatient Falls.pdf (14 pages)

6.1.6. Water Cooler and Ice Machine Policy

Decision *Sally May, Executive Director of Finance*

 6.1.6a Water Cooler Policy QSEC 22 September 2026.pdf (4 pages)

 6.1.6b Water Cooler Policy QSEC 22 September 2026.pdf (18 pages)

6.1.7. Authorised External Personnel Policy

Decision *Richard Hughes, Executive Director of Nursing*

 6.1.7a Authorised External Personnel Policy PCS09 QSEC 22 September 2026.pdf (8 pages)

 6.1.7b Final Authorised External Personnel Policy (003) QSEC 22 September 2026.pdf (15 pages)

6.2. FOR NOTING

6.2.1. Healthcare Inspectorate Wales (HIW) Improvement Plan Tracker Report

Information *Richard Hughes, Executive Director of Nursing*

 6.2.1a HIW Tracker Cover Report QSEC 22 September 2026.pdf (8 pages)

 6.2.1b HIW Inspections Recommendations Actions Tracker_QSEC 22.09.2026.pdf (15 pages)

6.2.2. Individual Patient Funding Request Annual Report 2025-2026

Information *Philip Daniels, Executive Director of Public Health*

 6.2.2 IPFR Annual report 25-26 QSEC 22 September 2026.pdf (13 pages)

6.2.3. Decision Making and Consent Working Group Annual Report

Information *Dom Hurford, Executive Medical Director*

 6.2.3 DMacWG REPORT QSEC 22 September 2026 (002).pdf (10 pages)

6.2.4. Highlight Report from the Joint Commissioning Committee Quality, Safety & Outcomes Committee

Information

 6.2.4 QSOC Highlight Report 29 June 2026 QSEC 22 Sept 2026.pdf (12 pages)

6.2.5. CTM Carers Programme – End of Year Progress Report 2025/26

Information *Richard Hughes, Executive Director of Nursing*

 6.2.5a Carers Annual Report-Sept QSEC 22 September 2026.pdf (18 pages)

 6.2.5b Appendix 1 Carers Annual Report QSEC 22 September 2026.pdf (4 pages)

6.2.6. Quality Dashboard Report (To include an addendum relating to Ombudsman activity)

Information *Richard Hughes, Executive Director of Nursing*

 6.2.6 Patient Safety Experience Dashboard Report QSEC 22 September 2026.pdf (28 pages)

6.2.7. Annual Cycle of Business

Information *Carolyn Donoghue, Committee Chair*

 6.2.7 QSEC Cycle of Business QSEC 22 September 2026.pdf (9 pages)

6.2.8. Non-Routine Committee Business (Forward Plan)

Information

Carolyn Donoghue, Committee Chair

 6.2.8 QSEC Non Routine Bus QSEC 22 September 2026.pdf (4 pages)

09:00 - 09:00

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7. CLOSE OUT BUSINESS

7.1. Committee Highlight Report to the Board

Information

Carolyn Donoghue, Committee Chair

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

09:00 - 09:00

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8. Private/Closed Session Business

The following items will be received and discussion in closed session:

- Health Visiting
- Maternity Services (verbal update)
- Organisational Risk Register - Closed Risks

09:00 - 09:00

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9. Date & Time of Next Meeting

Carolyn Donoghue, Committee Chair

Thursday 24 November 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
21st July 2026									
21-jul-26	3,3	3	Committee Annual Self Effectiveness Survey Outcome 2025-2026 & Improvement Plan	Further discussions to take place with the Welsh Language Team to identify opportunities to increase the use of Welsh within Committee meetings, with feedback to be provided to the Committee in due course.	Assistant Director of Governance & Risk	Director of Corporate Governance	24-nov-27	Open	In progress The Corporate Governance Team has discussed this action with the Welsh Language Lead and are in the process of considering opportunities to increase the use of Welsh within Committee meetings
21-jul-26	4,2	6	Thematic Spotlight Presentation - Hospital at Home	A consolidated Hospital at Home action plan to be developed to support oversight and monitoring of service improvements, informed by the ongoing service evaluation, including future workforce requirements, admission avoidance pathways, pathway allocation, digital reporting and opportunities to support a broader range of patient cohorts. The action plan and evaluation report is to be presented to a future meeting.	Care Group Nurse Director – Primary Care & Community	Chief Operating Officer	24-nov-26	Open	In progress It has been agreed that this item will be presented to the November 2026 meeting of the Committee
21-jul-26	4,5	10	Sexual Health Safeguarding Issues - Closure Report	Clear mechanisms to be established for tracking, reporting and providing assurance that actions arising from Independent Member visits and assurance reviews are implemented and sustained.	Executive Director of Nursing	Executive Director of Nursing	22-sep-26	Proposed for Closure	Propose to Close Executive Director of Nursing, Midwifery & Patient Care is discussing this action with the health board Chair which will look at the current status to ensure that actions are implemented and sustained within the Care Group(s)
21-jul-26	4,6	12	Patient Boarding within CTM UHB, Quality, Safety and Strategic Position	A formal, comprehensive review of patient boarding arrangements to be undertaken across hospital sites and specialties, to assess compliance with existing policies, understand the quality, safety, workforce and patient experience risks, consider the suitability of boarding spaces and wider use of additional capacity, and identify opportunities to reduce reliance on boarding. The findings are to be considered by the Executive Management Board and reported back to the Committee for assurance.	Executive Director of Nursing	Executive Director of Nursing	24-nov-26	Open	In progress An update will be included in the Clinical Executives Report for the September 2026 meeting and a substantive update on Patient Board will come forward to the November 2026 meeting
21-jul-26	ADDITIONAL ITEM	13 /14	Health Visitor Industrial Action	Following Board consideration, the Health Visitor Industrial Action Position Paper to be brought back to the Committee to provide further assurance and enable Members to triangulate the information presented to Board with the Committee's ongoing quality, safety and safeguarding oversight responsibilities.	Executive Director of Nursing	Executive Director of Nursing	22-sep-26	Open	In progress An update on this item will be captured within the Children & Families Care Group Highlight report on the agenda for the September 2026 meeting of the Quality, Safety & Experience Committee. An update will also be provided in the closed session.
21-jul-26	7,2	15	Meeting Feedback	The revised format from this meeting to be considered for future agenda planning discussions.	Head of Corporate Governance & Board Business	Head of Corporate Governance & Board Business	24-nov-26	Open	In progress A discussion on the annual cycle of business for 2027 will be held on Tuesday 10 November 2026.
21-jul-26	Any Other Business	15	Any other business	Ongoing concerns raised by Llais Cymru regarding the sustainability of Special School Nursing provision to be referred to the Children and Families Care Group for consideration. Update to be provided to a future meeting of the Committee through the appropriate governance route	Care Group Service Director, DTPS and Children & Families	Executive Director of Nursing	22-sep-26	Open	In progress An update will be included in the Clinical Executives Report being presented to the September 2026 meeting.
3rd 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	21/07/2026 Now 22 September 2026	Proposed for Closure	Propose to Close The Head of Peoples Experience together with the 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 health board. An update is provided in the Peoples Experience report for Septembers QSEC 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	21/07/2026 Now 22 September 2026	Proposed for Closure	Propose to Close An update on the ongoing Bare Below the Elbows (BBE) / PPE behavioural change programme has been included in the clinical Executive Directors update report for September QSEC.
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	Proposed for Closure	Propose to Close An update has been included in the Primary Care & Community Care Group Highlight report on the agenda for the September 2026 meeting
03.06.2026	4.4.4	10	Mental health & learning Disabilities	Feedback and lessons learned to be circulated from the Police and Crime Commissioner.	Executive Director of Public Health	Executive Director of Nursing	21.07.2026	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. Update as at 18 August 2026 - Still awaiting roll out of the programme
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 Now 20/08/2026	Completed	Proposed for Closure A presentation on the Listening to People Framework was shared with Board members at a Board Briefing session held on 20 August 2026
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 22/09/2026 24/11 2026	Open	In progress A position update will be included in the Clinical Executives report for the September 2026 meeting ahead of a substantive update being presented to the November 2026 meeting
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	Proposed for Closure	Proposed for Closure There will be an opportunity for this to be discussed and agreed at the September QSEC meeting. An update is included in the Clinical Executive Director report for September where it is proposed that QSEC is to receive a substantive agenda item in November meeting in order to review the organisational learning from winter 2025/26 and consider the strategic approach to winter preparedness for 2026/27.
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	22/09/2026 Now 24 November 2026	Open	In progress A request has been made to the Care Group for an update to be provided to the November 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 Now October 2026	Open	In Progress The annual review meeting with Welsh Government is scheduled for 29 th July2026. Feedback from WG is expected to be provided at this meeting. Update as at 18 August 2026 - The draft actions have been shared with the Executive Director of Allied Health Professionals and Health Sciences who will now undertake a review of the actions with an aim to provide a response to HCRW mid September. It is therefore likely that feedback will not be available to share with Members until October.

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
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	Closed	Completed 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	4,3	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	Closed	Completed This has been added to the Forward Work Programme for the September 2026 meeting
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	Closed	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
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	Closed	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	Closed	Completed A review was undertaken and the report on the agenda for the July meeting now includes stronger audit outcomes and findings

Meeting Name:	Health Board
Report Title:	Iori's Epilepsy Journey
Agenda Item:	Patient Story
Date of Meeting:	22/09/2026
Publication Status:	Public
Report Prepared by:	Emma Probert, Senior Nurse, Paediatrics and Dean Packman, Directorate Manager, Specialty Medicine,
Report Presenter:	To be confirmed
Report Executive Sponsor	To be confirmed
Report Purpose:	To share Iori's lived experience of moving from paediatric to adult epilepsy care, recognise what worked well, and highlight learning to strengthen transition arrangements for young people and families.
Action / Decision Required:	For noting
Strategic Context: This report aligns to the following Strategic Pillars	Supports person-centred, safe and equitable care by using lived experience to identify transition gaps, promote coordinated working and inform service improvement.
Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (Reference relevant priority)	Aligns with delivery priorities for listening and learning from people's experience, improving continuity across care pathways, reducing inequity in access to specialist support, and supporting young people to manage their health confidently.

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:

What (summary of current position / issue & why it matters and evidence to support that position etc)	Iori was diagnosed with epilepsy at 16 after his first seizure in March 2024. He and his family valued the support from the paediatric team, but as he approached 18 his epilepsy remained uncontrolled and transition exposed gaps in local adult specialist provision, timely clinical advice and medication guidance.
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 experience shows how uncoordinated transition can affect safety, confidence, independence, family wellbeing and future plans. It reinforces the need for early adult-service involvement, clear advice routes and joint working between paediatric and adult teams, while retaining and building on the support that worked well.
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)	Note Iori's experience and the learning identified. Support continued use of the standardised transition pathway and education session to strengthen continuity, self-management and assurance.



Recommendation (Linked to the “What Next” section above).	What is it you are asking the Board / Committee to do – APPROVE, ENDORSE, NOTE
	NOTE Iori’s lived experience, the positive contribution of the paediatric team, the transition gaps identified and the learning and proposed improvement activity described in the presentation.
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)	Relevant BAF reference to be confirmed against the current strategic risk register. Access to specialist advice and coordination during transition may affect safe, effective and person-centred care.
Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales; A More Equal Wales Supports better health and wellbeing through safer transition and more equitable access to coordinated advice and support.
Environmental Sustainability Impact (5Rs)	Refine; Reduce Refine transition processes and reduce avoidable delay, duplication and uncertainty through clearer pathways and advice routes.
Link to Enablers of Quality	Culture & Valuing People; Data to Knowledge; Leadership; Learning, Improvement & Research; Whole-System Perspective Uses lived experience as improvement intelligence and supports shared learning and coordinated action across paediatric and adult services.
IMPACT ASSESMENT	
Equality & Welsh Language Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	This patient story highlights the importance of equitable, age-appropriate access and communication. Welsh-language preference and any reasonable communication needs should be actively offered and recorded throughout transition.
Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	No QIA needed. No service change is being approved through this item. The story provides qualitative evidence of quality and safety risks during transition and supports structured improvement, evaluation and outcome measures.
Cyfreithiol / Legal	No legal decision is requested. Existing statutory and professional duties relating to quality, equality, Welsh language, consent, confidentiality and safe continuity of care remain applicable.
Enw da / Reputational	Listening and responding transparently provides an opportunity to strengthen confidence. Failure to address identified transition gaps may affect trust in the organisation’s ability to provide coordinated, age-appropriate care.
Resource Impact (People / Financial)	No immediate financial or workforce decision is requested. The proposed virtual clinic and education session will require scoping of clinical capacity, multidisciplinary input, digital support and evaluation arrangements.

Patient Story – Iori’s Journey

This story provides an insight to Iori and his family’s experience following his sudden diagnosis of epilepsy at 16 years old.

Patient Experience

The Transition from:
Child Health to Adult
Services





Iori's Story

I have twin boys, Iori and Hari Edwards who love their sport and they have been keen rugby and football players for Llantwit Fardre since the age of 5.

Background

- First seizure in March 2024
- Diagnosed with epilepsy at age 16
- Excellent support from the paediatric team
- Concerns began as transition to adult services approached as his epilepsy wasn't controlled



Challenges During Transition

No dedicated adult epilepsy service available locally and despite looking like a man, he was in a waiting room with 2-year-olds

Difficulty accessing clinical advice after turning 18

Delay in receiving guidance on his medication and dosage following further seizure

Family felt unsupported and uncertainty despite ongoing seizures

Impact on Iori and Family

- Emotional impact on Iori's independence and future plans
- Difficulty securing employment despite achieving distinction in plumbing
- Multiple seizures affected family wellbeing
- Time off work taken by parents



What Worked Well

Ongoing support from CTM paediatric team

Advice and support from the National transition lead

Specialist care provided by Professor Hamandi

New treatment plan developed by Professor Lawthom

Key Learning Points for ALL NHS Services

Importance of seamless transition arrangements

Need for coordinated working between paediatric and adult services

Early involvement of adult specialists

Value of listening to lived experience

Closing Message

"Today, we feel hopeful about the future, but I hope that other young people and their families will benefit from a transition into adult services that provides them with the support they need, reassurance throughout the process, and the same sense of hope and confidence for the future that we have now found."

This photograph shows Iori receiving his rugby club's Player of the Year award, reflecting his commitment, perseverance and positive attitude.

It shows that behind every patient is an individual with aspirations, talents and achievements, and highlights the importance of supporting people to live full and meaningful lives despite ongoing health challenges.



Improving Transition for Young People with Epilepsy

Standardised Transition Pathway Implemented Across CTMUHB:

The Paediatric Epilepsy Team has developed and implemented a Transition Standard Operating Procedure (SOP) to support a consistent, safe, and patient-centred transition into adult services.

Three Transition Pathways The SOP recognises the differing needs of young people and includes specific pathways for:

Epilepsy with Learning Disabilities (LD)

- Transition discussions in clinic, Ready steady Go, Enhanced multidisciplinary planning with Adult LD Team

Stable Epilepsy

- Ready Steady Go commences at 14 years, Structured transition discussion, referral to for primary care management..
- Focus on self-management and independence

Unstable /Complex Epilepsy

- Ready Steady Go commences at 14 years, Structured transition discussion.
- Individualised transition planning and support, Refer to Adult Neuro.

Transition Begins Early

Transition is not a single event but a gradual process commencing through the Ready, Steady, Go Programme and routine discussions within paediatric clinics.

Key topics include:

- ✓ Understanding epilepsy and medication compliance
- ✓ Sleep and seizure management
- ✓ Education, employment and future planning
- ✓ Lifestyle choices and socialising safely
- ✓ Participation in sports and physical activities
- ✓ Emotional wellbeing and independence
- ✓ Preparing for adult healthcare services

Resources and Education

Young people and families are provided with information and resources throughout their journey.

- Education and support are aligned with Epilepsy Action guidance and resources.
- Focus on empowering young people to become confident and informed in managing their own condition.

Outcome

A consistent, equitable, and structured approach to transition that supports young people to move safely and confidently into adult epilepsy services.

What Next in Relation to Improving Transition for Young People with Epilepsy

Identified Gaps:

- No Adult Epilepsy Nurse Specialist within CTMUHB – creates a gap in transition.
- Adult Neurology services are provided within CTM via a Long-Term Agreement (LTA) by Swansea Bay UHB for Bridgend residents and Cardiff & Vale UHB for RCT residents. Following recruitment of a CTM employed neurologist in May 26, discussions are on-going with Cardiff & Vale UHB with a view to repatriating back some neurology activity and using potential funding associated with this activity to develop a more robust CTM employed neurology workforce.
- Discussions are progressing looking at options for providing dedicated CTM Consultant neurology support to transition clinics.

Propose QI project within Paediatrics:

- Teenage Epilepsy Virtual Clinic & education Session.
- Covers a large geographical area.
- Allows for flexibility.
- Input from MDT specialities
- Topical sessions
- In alignment with NICE NG217/Epilepsy 12 & the Ready Steady Go programme.
- Opportunity for evaluation & Measures.



Quality, Safety & Experience Committee

People's Experience Activity Report April – May 2026

Eitem yr Agenda / Agenda Item	4.2
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter:	Clare Ibbs, Interim Head of Corporate Nursing & People's Experience
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 report, progress made across the People's Experience portfolio and the actions being undertaken to strengthen the use of patient, carer and community intelligence to inform service improvement, organisational learning and assurance.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context:</i> <i>This report aligns to the following Strategic Pillars</i>	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 Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	The report provides an update on how patient, carer and community intelligence is being triangulated, escalated through established governance arrangements and translated into service improvement and organisational learning across CTMUHB. This supports delivery of CTM 2030, the Integrated Medium-Term Plan, Annual Delivery Plan, Duty of Quality and the All-Wales People's Experience Framework by strengthening person-centred care, experience governance and co-production. The developing People's Experience Work Plan and "You Said, We Did, Difference Made" approach will provide clearer evidence of actions taken and the resulting outcomes for patients, carers and 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)

This report provides an overview of activity, emerging themes and progress across the People's Experience portfolio, demonstrating how patient, carer and community intelligence is being used to inform service improvement, quality assurance and organisational learning.

During April and May 2026, 2,949 patient experience responses were received across 39 surveys, supported by Have Your Say feedback, 238 PALS contacts and engagement intelligence. Progress also continued across the Carers Passport, bereavement, Armed Forces, Chaplaincy and Spiritual Care, and the People's Experience Strategic Plan 2026–2028, with a stronger focus on evidencing actions and emerging outcomes through the “You Said, We Did, Difference Made” approach.

Felly, beth (darparu dadansoddiad ystyrllon 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)

Experience intelligence and improvement

Patient, carer and community feedback provides a broad evidence base for person-centred care and identifies recurring priorities for quality improvement, service development and organisational learning. This provides moderate assurance that experience intelligence is informing priorities and improvement activity; however, evidence of consistent, measurable impact across services is still emerging.

- Engagement with patients, carers, communities and Llais broadens the evidence base for co-production and ensures independent and lived-experience insight informs service planning and improvement.

Strategic implications

- Progress across the People's Experience Strategic Plan, carers, bereavement, Armed Forces and Chaplaincy priorities demonstrates continued activity and developing arrangements aligned with delivery against CTM 2030, the Integrated Medium-Term Plan, Duty of Quality and the All-Wales People's Experience Framework. This provides moderate assurance on direction of travel; however, measurable outcomes and evidence. The report highlights areas of sustained impact remain under progress, emerging themes and ongoing priorities for further development.



Beth Nesaf (<i>crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud</i>) What Next (<i>summary of intended action and benefits supporting the choices and recommendation(s) being made</i>)	The Health Board will continue delivery of the People's Experience Strategic Plan and Work Plan 2026-2028, embedding the All-Wales People's Experience Framework, strengthening co-production and further developing mechanisms to evidence the impact and outcomes arising from patient, carer and community feedback.
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Committee is asked to note the report and the progress being made to strengthen the collection, triangulation and use of patient, carer and community intelligence to inform service improvement, organisational learning and quality assurance across CTMUHB.

1. Executive Summary

Drawing on intelligence from patient experience feedback, Experience and Engagement Officer activity, Chaplaincy and Spiritual Care, Bereavement Services and Unpaid Carers activity, the report provides insight into how patient, carer and community perspectives are being used to inform quality improvement, service development and person-centred care. It also highlights the contribution of lived experience to organisational learning and identifies opportunities to strengthen the evidence of impact on patient outcomes and quality across the Health Board.

During the reporting period, the People's Experience Team maintained core service delivery while transitioning to the revised operating model.

2. Background / Context

Completed in May 2026, the Organisational Change Process redesigned the People's Experience portfolio to better align resources and expertise with Health Board priorities. The integrated service model brings together patient experience, engagement, volunteering and feedback functions to strengthen coordination and the use of experience insight. It aims to identify themes earlier, support service transformation and deliver measurable improvements in patient experience, outcomes and safety.

3. Strategic Insights

Key Themes Emerging Across Experience Intelligence

Analysis of experience intelligence gathered through patient feedback, Llais engagement activity, PALS contacts and community engagement demonstrate a consistent pattern of concerns relating to:

- communication,
- access to services,
- continuity of care,



- information sharing.

Whilst many themes are being addressed locally, their recurrence across multiple feedback channels reinforces the importance of robust organisational oversight and assurance. The People's Experience Forum provides a key governance mechanism for triangulating experience intelligence, identifying system-wide themes and monitoring improvement actions. This supports assurance that patient, carer and community feedback is informing decision-making, driving service improvement and supporting service improvement activity and organisational learning. Further work is underway to strengthen the demonstration of measurable improvements in quality, safety, experience and person-centred care.

Positive themes remain strongly associated with compassionate staff behaviours, professionalism, dignity and respect.

- Compassionate staff interactions, dignity and respect remain consistent strengths reported by patients and families.
- Experience intelligence continues to identify both opportunities for improvement and areas of good practice, informing service planning, quality improvement and organisational learning.
- The integrated People's Experience model provides enhanced ability to triangulate intelligence from multiple feedback sources and escalate emerging concerns through governance arrangements.

Activity, Outputs and Developing Arrangements

- Provides continuing insight on patient experience and service quality through the systematic review of experience intelligence.
- Improves the visibility and escalation of themes affecting patient care and experience through the People's Experience Team's participation in Care Group QSRE meetings.
- Strengthens governance oversight through regular reporting and triangulation of experience intelligence at Care Group QSRE meetings and the People's Experience Forum.
- The People's Experience Forum is transitioning from a feedback review group to a strategic experience intelligence function. It brings together data, feedback and engagement insight from across Care Groups to strengthen triangulation, identify system-wide themes, coordinate improvement activity and provide assurance that lived experience informs quality, safety and person-centred service development across CTMUHB.

3.1 Workforce and Leadership

The Organisational Change Process has strengthened the Health Board's capability to capture, analyse and utilise patient, carer and community insight through the introduction of dedicated Senior Patient Experience and Engagement Officer and Patient Experience and Engagement Officer roles.

These roles increase capacity to gather intelligence from PROMPTLY, patient stories, engagement activity, Have Your Say feedback, Llais representations and community engagement. The developing arrangements strengthen the team's ability to identify and triangulate themes, support organisational learning and work with Care Groups to translate feedback into improvement activity. At this stage, this provides moderate assurance on capability and governance; evidence that the model is delivering consistent, measurable

improvements in patient experience, quality and person-centred care is still emerging and will be tested through portfolio measures and the 'You Said, We Did, Difference Made' methodology.

Activity, Outputs and Developing Arrangements

- Strengthened arrangements for collecting and coordinating patient, carer and community insight.
- Enhanced capability to identify, triangulate and escalate recurring themes and emerging risks. Ongoing discussions in place with Value Base Healthcare team to support through Promptly system.
- A more coordinated approach to linking patient feedback with organisational learning and quality improvement activity.
- Increased capability to demonstrate how lived experience informs service development and decision-making.
- A stronger foundation for systematic experience intelligence, outcome reporting and assurance.
- Exploration of key performance indicators across the whole portfolio to demonstrate impact.

3.2 People's Experience Framework

People's Experience activity continues to support the principles of the All-Wales People's Experience Framework by ensuring the voices of patients, carers, families and communities are heard, understood and used to influence care delivery and improvement. By November 2026, the People's Experience Team will complete structured scoping meetings with each Care Group to assess current alignment with the All-Wales People's Experience Framework, agree priority improvement actions, named leads and measures of success, and report progress through Care Group QSRE meetings and the People's Experience Forum.

Activity, Outputs and Developing Arrangements

- Continued patient engagement across a broad range of clinical services, providing a foundation for more systematic assessment of alignment with the All-Wales People's Experience Framework.
- Improved arrangements for identifying and reporting what matters most to patients and unpaid carers.
- A stronger foundation for positioning experience alongside safety and clinical effectiveness within quality governance and assurance.

3.3 Engagement, Co-production and Inclusion

Significant engagement activity was undertaken during the reporting period to support inclusion and widen opportunities for people to influence service development. Patient Experience Week provided an opportunity to engage with staff and showcase improvement activity across CTMUHB through the Simply Do platform and ICTM initiatives.

The period also included ongoing engagement with unpaid carers, veterans, community representatives and third-sector partners to ensure a broader range of voices contributed to improvement activity.

Llais remains a valued strategic partner, providing independent insight into the experiences of patients, carers and communities across CTMUHB (see Appendices 1.0). Its engagement,



representations and community feedback have identified recurring themes relating to access, communication, continuity of care, service quality and patient experience.

Llais Intelligence: Themes and Implications for CTMUHB

Recurrent Theme	What This Means
Access to services	Ongoing public concern across several communities
Communication	Consistent opportunity for improvement
Continuity of care	Requires ongoing assurance
Travel and accessibility	Impacts patient experience and equity
Staff compassion	Consistent positive theme

Llais intelligence indicates that access, communication, continuity of care and travel remain recurring concerns across communities, while staff compassion remains a consistent strength. The recurrence of these themes requires systematic triangulation with PROMPTLY, PALS and engagement intelligence, clear escalation through the People's Experience Forum and Care Group QSRE meetings, and monitoring of agreed improvement actions and outcomes.

Whilst individual issues are being addressed through service-specific actions, the recurrence of these themes across multiple engagement activities provides valuable intelligence to support organisational learning, service planning and executive oversight.

Activity, Outputs and Developing Arrangements

- Greater organisational visibility of People's Experience activity and the intelligence it provides to support service planning and improvement via different forums across the HB footprint
- Broader opportunities for staff, patients and partners to contribute insight and co-produce service improvements.
- Strengthened engagement with under-represented communities, providing a broader evidence base on experience, access and inequalities.
- Stronger partnership with Llais to bring independent community insight into the early design and review of Health Board projects and service developments.

3.4 Partnership working

This remains a key feature of delivery throughout the reporting period. The team continued to work collaboratively with Llais, regional carers networks, third-sector partners, Welsh Government consultation processes and community organisations to ensure patient and community perspectives inform service development.

These partnerships continue to provide valuable intelligence regarding population needs, inequalities and opportunities for service improvement, while enabling CTMUHB to influence regional and national developments relating to people's experience.

Development of the External Visitors Policy was supported through a multidisciplinary Task and Finish Group approach, enabling input from key stakeholders and ensuring the final policy reflects both organisational requirements and the role external partners play in supporting patient care, experience and wellbeing across CTMUHB.

The development of the People and Patient Strategic Plan 2026-2028 has been informed through extensive stakeholder engagement, enabling contributions from patients, carers, staff, community representatives, third-sector organisations and strategic partners. This collaborative approach has helped ensure that the priorities identified within the strategy reflect the needs and experiences of the populations served by CTMUHB.

Activity, Outputs and Developing Arrangements

- Strengthened partnership arrangements with Llais, carers networks, third-sector organisations, community groups and regional partners.
- Broader intelligence on community priorities, population needs and inequalities to inform service planning and improvement.
- Increased opportunity for CTMUHB to contribute patient and community perspectives to regional and national developments.
- A standardised approach to external visitor management, clarifying responsibilities and supporting consistent collaboration between services and external partners.
- Meaningful stakeholder input into the priorities and delivery framework for the People's Experience Strategic Plan 2026–2028.

To support continuity of assurance and demonstrate measurable improvement over time, the People's Experience report will use the same strategic headings across each reporting period. The narrative describes current activity and developing arrangements, while the forward-look table identifies (see Appendices 2.0) the priority action, measure of success and intended outcome to be reviewed in subsequent reports.

3.5 Experience Insight and Improvement

Experience intelligence remains one of the most significant sources of information regarding how care is experienced across CTMUHB. Between April and May 2026:

- 2,949 patient experience responses were received.
- Have Your Say responses provided additional qualitative insight.
- PALS managed 238 contacts, supporting early resolution of concerns.
- Positive themes consistently related to kindness, compassion, communication, professionalism, respect and support.

3.5.1 PROMPTLY Themes and Trends

KEY THEMES	
Positive	Improvement
Compassion and Kindness	Communication
Professionalism	Access and waiting times
Dignity & Respect	Continuity of care
Feeling supported during care	Information sharing

These themes are broadly consistent with intelligence gathered through Llais representations, community engagement activity and PALS. The consistency strengthens confidence in the identification of common strengths and improvement priorities but does not in itself demonstrate that improvement actions have produced measurable outcomes. Ongoing scrutiny and outcome monitoring are therefore required.

3.5.2 Have Your Say Programme

Utilisation of 'Have your say' cards across the sites via QR code and paper format support feedback on an ad hoc basis to complement the SMS/survey program supported in Promptly. A redefined process (see Appendices 3.0) has been established following the OCP and Patient Experience & Engagement Officers to ensure the below:

- Standardised collection arrangements
- Central oversight
- Theme identification process
- Escalation routes
- "You Said, We Did, Difference Made" reporting methodology

Activity, Outputs and Developing Arrangements

- The redesigned process is at an early stage; therefore, evidence of impact and outcomes is not yet mature.
- Standardised collection and central oversight provide a stronger foundation for consistent recording, review and reporting of Have Your Say feedback.
- Clearer arrangements for theme identification and escalation strengthen the capability to identify recurring concerns and direct them to the appropriate service or governance forum.
- The "You Said, We Did, Difference Made" proposed methodology establishes a consistent approach to evidencing actions taken and the resulting difference for patients, carers and services.
- Discussions ongoing with Value Base Healthcare team to review Promptly system and reporting measures that can be developed to support Care Group/Corporate oversight going forward.

3.5.3 Patient Stories

The People's Experience Team is strengthening the practical resources available to Care Groups and corporate services to support the consistent and sensitive collection, use and sharing of patient stories. This includes clearer guidance, templates and facilitation support to help teams identify learning, translate insight into improvement action and apply the "You Said, We Did, Difference Made" methodology, ensuring each story is linked to the response taken and the resulting difference for patients, carers or services.

Activity, Outputs and Developing Arrangements

- Clearer guidance, templates and facilitation support provide Care Groups and corporate services with a more consistent approach to collecting, using and sharing patient stories.
- Strengthened capability to capture qualitative insight sensitively and identify learning, good practice and recurring themes from lived experience.
- A more structured approach to translating insight from patient stories into named improvement actions across services.
- The "You Said, We Did, Difference Made" methodology provides a consistent framework for linking each story to the action taken and evidencing the resulting difference for patients, carers or services.

- Strengthened attendance at QSRE Forums via People's Experience team to consolidate process and collation of patient stories.

Output

- Patient Information Leaflets, Consent forms and CTM Toolkit on Sharepoint for staff to access.
- Patient Story training provided to Llais and remains on PE QRSE slide deck to reinforce awareness of patient stories and collation within the Care Groups.

4.0 Strategic Priorities and Development

The CTMUHB Palliative and End of Life Care (PEOLC) Board agreed to establish a Bereavement Task and Finish Group. The group will provide organisation-wide oversight of bereavement priorities, support implementation of the Welsh Bereavement Framework and develop consistent standards, pathways, training and assurance arrangements across CTMUHB.

The Carers Service advanced implementation of the Carers Passport programme, contributed to Welsh Government consultation activity and strengthened support for carers of people living with dementia and stroke.

Carers Passport Implementation - Implementation of the Carers Passport is progressing across CTMUHB following pilot testing in ward areas. The passport supports recognition of carers as partners in care by establishing a clear agreement on their involvement during an inpatient stay, supporting person-centred care, improved communication and more effective discharge planning. The initiative also complements the Health Board's revised visiting arrangements and broader commitment to improving the experience of patients, families and carers.

Armed Forces – The Armed Forces workstream continued to strengthen how CTMUHB identifies, understands and responds to the experiences of veterans and Armed Forces community members. Activity focused on improving awareness of how veteran status may affect access, communication, treatment pathways and continuity of care, with experience insight used to identify opportunities for more responsive and person-centred services. This work supports the Armed Forces Covenant and the Health Board's commitments to veterans and reservists.

People's Experience Strategic Plan - Significant progress has also been made in the development of the CTMUHB People Experience Strategic Plan 2026-2028. During the reporting period, work continued to refine the strategic vision, priorities and delivery framework, supported by engagement with patients, carers, communities, staff, partner organisations and internal stakeholders. The draft strategy seeks to establish a clear organisational approach to embedding the voice of patients, families and communities within service planning, improvement and decision-making and is currently progressing through the final stages of consultation and approval.

Chaplaincy & Spiritual Care Service Review - Progress has continued in relation to the review and redesign of Chaplaincy and Spiritual Care Services. Following workforce changes, the service model is being reviewed to align with UK Board of Healthcare Chaplaincy standards, Health Board priorities and the People's Experience Strategic Plan 2026–2028. The proposed model will provide more visible, integrated and responsive spiritual, emotional and pastoral support for patients, families and staff across care settings.

Activity, Outputs and Developing Arrangements

- The Carers Passport provides a clearer framework for recognising unpaid carers as partners in care and supporting their involvement in communication, care planning and discharge.
- Establishment of the Bereavement Task and Finish Group creates organisation-wide oversight to progress priorities and develop consistent standards, pathways, training and assurance arrangements.
- Strengthened focus on understanding how veteran status affects access, communication, treatment pathways and continuity of care, supporting more responsive and person-centred services.
- The developing People's Experience Strategic Plan 2026–2028 provides an organisation-wide framework for embedding patient, carer and community insight in service planning, improvement and decision-making.
- The proposed Chaplaincy and Spiritual Care model establishes a stronger foundation for more visible, integrated and responsive spiritual, emotional and pastoral support across care settings.
- Collaboration with Cardiff University and the CTMUHB Racial Equality Network will contribute organisational insight to the national "Faith in the NHS" work and strengthen understanding of how faith and professional roles intersect.

5. Strategic Forward Look: actions, measures and future outcomes

The next phase of People's Experience activity will focus on embedding the revised operating model and delivering the People's Experience Work Plan. Priorities include implementing the All-Wales People's Experience Framework, developing a People's Experience Assurance Framework, strengthening engagement and co-production with under-represented groups, and evidencing the impact of feedback through a consistent "You Said, We Did, Difference Made" approach.

Focused work will also continue across strategic priorities including unpaid carers, bereavement care, volunteer services and Armed Forces initiatives, alongside strengthening partnership arrangements with Llais, community organisations and regional networks. Collectively, these actions aim to improve the use of experience intelligence in service planning and quality improvement, strengthen assurance, and deliver measurable improvements in patient experience, outcomes and person-centred care (see Appendices 2.0).

6. Risks and Opportunities

As the revised operating model becomes embedded, experience intelligence must be consistently translated into measurable improvement and evidenced through established governance arrangements. Continued development of the People's Experience Work Plan and reporting processes will be central to demonstrating how patient, carer and community feedback informs service improvement and organisational learning.

Risks

Risk 1: Recurring themes relating to communication and access may remain unresolved without sustained organisational oversight. Current controls include triangulation of PROMPTLY, PALS, Have Your Say, engagement and Llais intelligence through Care Group QSRE meetings and the People's Experience Forum.

Mitigating actions are to assign service-level actions, measures and completion dates, with exceptions escalated through established governance routes. Care Group leadership teams' own delivery, with oversight by the Head of People's Experience through the People's Experience Forum.

Risk 2: Experience intelligence may not be consistently translated into measurable quality improvement outcomes across all services. Current controls include routine review through Care Group QSRE meetings and the People's Experience Forum, supported by developing 'You Said, We Did, Difference Made' reporting.

Mitigating actions are to implement the People's Experience Assurance Framework, agree portfolio performance measures and require named actions, measures of success and intended outcomes in Care Group reporting. The Head of People's Experience owns the assurance framework, while Care Group leadership teams' own delivery and evidence of local outcomes.

Risk 3: Increasing volumes of feedback may exceed current capacity for timely escalation, monitoring and demonstration of impact. Current controls include the revised operating model, standardised collection routes and central review of intelligence by the People's Experience Team.

Mitigating actions are to strengthen prioritisation criteria, standardise reporting across PROMPTLY, PREMs and engagement intelligence, and monitor demand, timeliness and outstanding actions through portfolio performance measures. The Head of People's Experience owns capacity and performance oversight, with escalation through the relevant corporate nursing and governance forums where demand exceeds available resource.

Current controls include routine review of experience intelligence through Care Group QSRE meetings and the People's Experience Forum, with intelligence triangulated from PROMPTLY, PALS, Have Your Say feedback, engagement activity and Liaison intelligence.

Taken together, these controls provide moderate assurance that experience risks are identified, triangulated and escalated through established governance arrangements. Assurance remains limited by variable outcome measures to support the identification, escalation and monitoring of recurring themes and the emerging maturity of portfolio reporting. The effectiveness of mitigation will be monitored through delivery of the People's Experience Work Plan risks.

Further mitigating actions include implementation of the People's Experience Assurance Framework, agreed delivery of the People's Experience Work Plan, development of portfolio performance measures and exception reporting. Consistent application of the "You Said, We Did, Difference Made" methodology to the People's Experience Forum strengthen the demonstration of actions, outcomes and Care Group QSRE meetings. Responsibility for oversight rests with the Head of People's Experience, with Care Group leadership teams accountable for local actions and evidence of impact within relevant governance forums (see Appendix 4.0).

Opportunities

- Opportunity 1: Use the People's Experience Forum and Care Group QSRE meetings to triangulate recurring communication and access themes, assign improvement actions and monitor delivery.



- Opportunity 2: Apply the “You Said, We Did, Difference Made” methodology through the Carers Passport, Patient Stories and Have Your Say programmes to link feedback to named actions, measures and evidenced outcomes.
- Opportunity 3: Strengthen standardised collection, prioritisation and reporting across PROMPTLY, PREMs and engagement intelligence to support earlier escalation, proportionate review and efficient monitoring of impact.

7. Compliance and Governance

The activity described in this report supports delivery of CTM 2030, the Integrated Medium-Term Plan, Annual Delivery Plan, Duty of Quality and the All-Wales People's Experience Framework. Intelligence from patient feedback, PREMs, PALS, engagement and partnership working informs service development, quality improvement and organisational decision-making.

Oversight is maintained through routine reporting to the Quality, Safety and Experience Committee and other relevant governance forums. Further development of the People's Experience Work Plan, aligned with the All-Wales Framework, will strengthen triangulation, monitoring and evidence of outcomes arising from patient experience activity.

8. Conclusion

The revised People's Experience model provides a stronger foundation for triangulating patient, carer and community intelligence, escalating recurring themes and linking feedback to service improvement. This provides moderate assurance that the necessary governance and reporting arrangements are developing. Evidence of consistent, measurable impact remains emerging and will be strengthened through implementation of the All-Wales People's Experience Framework, the People's Experience Work Plan, portfolio performance measures and the 'You Said, We Did, Difference Made' approach.

The Committee is asked to note the report, progress to date and the planned actions intended to strengthen the use of patient, carer and community intelligence in service improvement, organisational learning and quality assurance.

Appendices referred to within this report are available on request.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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 4 Community & Partner Engagement
	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	All Wellbeing Goals Apply
	If more than one applies please list below:



Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All Enablers of Quality Apply
	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): <u>None Undertaken</u> Summary of impact: The activity described within this report relates to the monitoring, analysis and use of patient, carer and community feedback to inform quality improvement, service development and organisational learning. The report highlights engagement activity with a range of communities and seeks to strengthen co-production and inclusion across CTMUHB. No adverse equality impacts have been identified through the activity outlined. Outcome for Welsh Language (delete as appropriate): NEUTRAL Summary of impact: The activity described within this report supports the Health Board's commitment to bilingual service provision and engagement. Feedback and engagement mechanisms continue to be available through Welsh and English language routes, with no adverse impact on Welsh language provision identified.	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



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)	This report provides an overview of the work the patient experience team are supporting, any change to services and quality impact assessment would be undertaken by the Care Group.
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
	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advisory Liaison Team
MDT	Multi-Disciplinary Team
CNS	Clinical Nurse Specialist
TVS	Trans Vaginal scan
QSRE	Quality, Safety, Risk and Experience



Quality, Safety & Experience Committee

Clinical Executive Directors Report

Eitem yr Agenda / Agenda Item	4.3
Dyddiad y Cyfarfod / Date of Meeting:	22/09/26
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	• Richard Hughes- Executive Director Nursing, Midwifery and Patient Care • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science
Cyflwynydd yr Adroddiad / Report Presenter:	• Richard Hughes- Executive Director Nursing, Midwifery and Patient Care • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting

Argymhelliad (Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).	Note the bi-monthly oversight and assurance report prepared by the three Clinical Executive Directors.
Recommendation (Linked to the "What Next" section above).	

1. Situation / Background

- 1.1 The Quality, Safety & Experience Committee receives regular reports from the Clinical Executive Directors to provide oversight and assurance regarding quality, safety and patient experience across Cwm Taf Morgannwg University Health Board. These reports highlight key

achievements, challenges, risks, emerging issues and areas of improvement within their respective portfolios.

1.2 This report provides a summary of matters identified by the:

- Executive Director of Nursing, Midwifery and Patient Care
- Executive Medical Director
- Executive Director of Allied Health Professionals and Health Science
- Executive Director of Public Health.

1.3 Additional assurance relating to quality performance, patient safety and patient experience continues to be provided through the Quality, Safety & Patient Experience Dashboard, which is presented separately to each meeting of the Committee.

2. Strategic Insights

2.1 This report provides strategic oversight of quality, safety and patient experience across the portfolios of the Clinical Executive Directors.

It highlights key achievements, significant risks and challenges, emerging themes, and areas of ongoing improvement, enabling the Committee to gain assurance regarding the effectiveness of governance arrangements, progress against organisational priorities and the quality of services provided across CTM UHB.

3. Specific Matters for Consideration

3.1 Executive Director of Nursing, Midwifery & Patient Care Update:

- Health Visitor

The Quality Safety & Experience Committee is asked to note that the Health Board continues to manage a significant operational and safeguarding challenge arising from the ongoing Health Visiting industrial dispute.

A structured recovery and assurance programme is in place, focused on maintaining the safety and wellbeing of children and families, particularly those subject to Child Protection Register and Care and Support Plan arrangements.

Central to the response is a detailed child-by-child review process, supported by enhanced professional risk assessment, multi-agency information sharing and Local Authority validation to ensure that vulnerable children are appropriately identified and safeguarded.

Progress has continued against the Ministerial requirements.

Reviews are underway for approximately 303 families within the highest-risk safeguarding cohort and a further 701 vulnerable families identified through risk stratification.

Other elements of the Ministerial response remain on track for completion within the original timeframe, with a requested extension to 08 October 2026 applying only to the detailed child-by-child review and assurance exercise in recognition of the complexity of the work and the need for robust professional judgement.

The revised risk assessment framework, including the new Home Visit Risk Assessment Checklist, strengthens consideration of safeguarding risks, protective factors, immediate actions and professional decision-making.

Governance and assurance arrangements have been strengthened through the development of a Gold-level action tracker and RAID log, daily oversight arrangements, regular assurance meetings and enhanced multi-agency engagement.

Discussions continue with Local Authority partners, and preparations are underway for a dedicated multi-agency safeguarding meeting later in September.

Consideration is also being given to additional safeguarding capacity, mutual aid arrangements and supplementary clinics, all subject to appropriate legal, workforce, governance and industrial relations advice.

Whilst progress is being made and oversight has become increasingly structured, key risks remain.

These include the scale and complexity of the review relative to available specialist capacity, the ongoing impact of industrial action on service delivery, dependence on partner information, workforce resilience, and the potential emergence of previously unidentified safeguarding needs requiring follow-up intervention.

The immediate priority remains safeguarding children and providing assurance to the Board and Welsh Government, whilst concurrently preparing for the wider recovery and restoration of Health Visiting services.

- Winter Planning and Learning

The Quality Safety & Experience Committee is asked to note the successful conclusion of the 2025/26 winter period and the significant organisational effort undertaken across operational, clinical and corporate teams to maintain patient safety, flow and service resilience during a period of sustained system pressure. While considerable work was undertaken to manage demand and mitigate risk, winter planning is a continuous cycle of improvement rather than a discrete seasonal exercise.

A detailed review of performance, operational pressures, workforce impacts, escalation activity and the effectiveness of mitigation measures is therefore underway to ensure learning is fully captured and embedded.

A comprehensive lessons-learned approach will be taken, incorporating feedback from clinical services, operational teams, partner organisations and patient experience where appropriate.

This will enable the Health Board to identify what worked well, areas requiring further development, and opportunities to strengthen system resilience ahead of future periods of increased demand.

In recognition of the importance of proactive preparation, the Committee is proposed to receive a substantive agenda item in November 2026 meeting to review the organisational learning from winter 2025/26 and consider the strategic approach to winter preparedness for 2026/27.

This will provide an opportunity to assess lessons learned, review emerging risks and agree priorities for strengthening quality, safety, capacity and system resilience ahead of the forthcoming winter period.

- Patient Boarding

The Quality Safety & Experience Committee is asked to note that patient boarding remains a significant quality and safety concern. Despite considerable operational focus and mitigation, boarding remains a consequence of wider system pressures and creates risks relating to patient experience, continuity of care, clinical oversight and flow.

Whilst there is evidence of active management and executive oversight, I remain concerned that boarding has become too familiar a feature of day-to-day operations and risks normalisation.

Continued attention is required to strengthen assurance, reduce reliance on boarding and ensure that quality and safety considerations remain at the forefront of operational decision-making.

A more detailed review is proposed for the November 2026 meeting of the Quality, Safety & Experience Committee, enabling the Committee to consider the scale of the issue, quality and safety implications, emerging themes and the actions required to achieve sustained improvement.

- Maternity Services

The Quality Safety & Experience Committee is asked to note that Maternity Services continue to face significant challenges related to workforce availability, service sustainability, and the delivery of care across both acute and community settings.

Whilst the service continues to demonstrate a strong commitment to maintaining safe and compassionate care, there remain areas where assurance is not yet where I would wish it to be, particularly in relation to capacity, resilience and the pace at which some longstanding issues can be addressed.

The position regarding Tirion Birth Centre and the wider community midwifery model has highlighted complex operational, workforce, and quality considerations.

While work is progressing to identify sustainable solutions, these arrangements have reinforced the importance of ensuring service changes are clinically sustainable, supported by robust governance and aligned to the needs of women, families and staff. We still need to balance immediate operational pressures with longer-term service quality and workforce sustainability.

I am encouraged by the commitment and professionalism being demonstrated by maternity and community midwifery teams during a challenging period.

However, I remain concerned about the cumulative impact of current pressures and the risk that continued workforce and service constraints could affect our ability to deliver the level of improvement and assurance that women and families rightly expect.

Continued Executive oversight, clear recovery planning and sustained organisational focus will therefore be required over the coming months.

- Bare Below the Elbows (BBE) / Personal Protective Equipment (PPE) Behavioural Change Programme

The Quality Safety & Experience Committee is asked to note that ongoing Infection Prevention and Control assurance work demonstrates generally strong compliance with Bare Below the Elbows standards across most clinical areas; however, point prevalence studies have identified greater variation in hand hygiene and PPE practices.

In response, we are implementing targeted education, observational auditing, real-time coaching, and strengthened leadership oversight, alongside behaviour-change work with Quality Improvement colleagues.

Whilst assurance regarding BBE compliance is positive, I remain concerned about the variability in PPE behaviours and will continue to monitor progress through regular audit and assurance arrangements.

3.2 Executive Medical Director Update:

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

Achievements

This section covers the following achievements:

1. Deputy Medical Director Appointment
 2. Appointment of Guardian of Safe and Flexible Working
 3. Call for Concern
- Deputy Medical Director Appointment

Following a competitive recruitment process, we are pleased to confirm the appointment of Dr Kevin Conway as the new Deputy Medical Director, who commenced in July 2026. Kevin brings a wealth of clinical leadership experience and a strong track record of supporting service improvement, workforce development, and clinical transformation across CTM UHB. His appointment further strengthens the Health Board's senior medical leadership team and will provide valuable support in delivering our strategic priorities.

We extend our sincere thanks to Dr Anthony Gibson for his contribution and leadership during his time as Deputy Medical Director.

- Appointment of Guardian of Safe and Flexible Working

We are pleased to confirm the appointment of Dr Rainer Fortner as CTMUHB's Guardian of Safe and Flexible Working.

This important role will provide independent oversight and assurance in relation to safe working hours, rota compliance, exception reporting, and trainee wellbeing.

Dr Rainer Fortner will work closely with Medical Workforce, Medical Education and clinical teams to support the delivery of safe, sustainable training environments and ensure the Health Board meets its obligations under the new contractual framework.

This appointment, funded by NWSSP, represents a significant step in strengthening governance arrangements and supporting the successful implementation of resident doctor contract reform across CTMUHB.

- Call for Concern

We are delighted to let you know that Call for Concern has now launched across Cwm Taf Morgannwg, with implementation beginning on adult inpatient wards across Princess of Wales Hospital, Prince Charles Hospital and Royal Glamorgan Hospital.

Call for Concern is a service that supports patients, their families and carers to call for urgent help if they feel their concerns haven't been addressed by staff on the ward.

From planning the operational delivery across our acute sites, developing processes and pathways, producing communication materials, engaging with ward teams, and testing the service with patients and families, every contribution has played an important part in getting us to this point.

The initial phase will focus on helping staff become familiar with the service before wider engagement takes place.

Call for Concern is another important step in strengthening our culture of openness, partnership, and patient safety, ensuring that patients and families feel heard, involved and empowered to speak up when they are worried about acute deterioration.

Areas of Focus

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

1. Resident Doctor Contract
2. Physician Associates GMC Registration

- Resident Doctor Contract

Implementation of the Resident Doctor Contract has now moved into the delivery phase, with all 83 resident doctor rotas reviewed and reported as compliant.

Financial implications have been identified and escalated to the Executive Team, while recruitment activity is underway to support sustainable rota delivery. Work continues nationally to clarify transition arrangements for existing locally employed doctors and a number of specialties, including Radiology, Ophthalmology and Urology, who have highlighted potential service impacts associated with compensatory rest requirements.

Care Groups are developing mitigation plans and quantifying associated risks, while recruitment progress, vacancy risks and financial impacts continue to be monitored.

In addition, recruitment to the Guardian of Safe and Flexible Working post is progressing to strengthen oversight and assurance under the new contractual framework.

- Physician Associate GMC Registration

Welsh Government has requested that Health Boards ensure all employed Physician Associates (PAs) are aware of the requirement to register with the General Medical Council (GMC), with applications submitted by 14 September 2026 to support processing ahead of the statutory deadline of 13 December 2026, when the title *Physician Associate* becomes legally protected and GMC registration mandatory.

Within CTMUHB, Medical Workforce and Medical Education leads have been tasked with communicating the requirements to all affected staff, seeking assurance that eligible colleagues are progressing their registration applications and monitoring compliance ahead of the implementation deadline.

3.3 Executive Director Allied Health Professionals and Health Science Director Update:

Recognition

- UKAS Accreditation

CTM Pathology Department has successfully maintained its UKAS accreditation to ISO 15189:2022 - the internationally recognised standard for medical laboratories.

UKAS accreditation is an independent check that pathology services are providing safe, effective and high-quality care. It shows that laboratories meet internationally recognised standards and have the right systems in place to ensure reliable results, well-trained staff, and continuous improvement.

The 2026 UKAS assessment took place over six days in June, covering a wide range of pathology services, including Biochemistry, Haematology, Blood Transfusion, Microbiology, Cellular Pathology and Mortuary Services. Specialist assessors reviewed each pathology discipline, while a lead assessor examined the department's overall quality management system.

Across all pathology services, only 18 minor non-conformities were identified. This is an excellent result for such a large and complex service and reflects the hard work, professionalism and commitment of staff to delivering high-quality patient care every day.

- Cwm Taf Morgannwg hosts first Prosthetics & Orthotics student

CTM Orthotics department is hosting its first student placement, a consequence of moving Orthotic services in-house in 2025.

An orthotist is an allied health professional who designs, fits and manages orthotic devices to support or correct the function of the body.

Orthotists are recognised as a shortage profession nationally but are an essential part of pathways across multiple disciplines.

The placement plays an important part in supporting the next cohort of clinicians as well as showing what the health board and local area have to offer.

The first-year student is from Keele University and is entering the profession through the post graduate route. The student says:

"I previously completed a Bachelor of Engineering in Biomedical Engineering and was determined to pursue a career that would allow me to continue applying my engineering knowledge while also working directly with patients. This led me to discover the field Prosthetics and Orthotics (P&O), which I quickly realised was the perfect combination of my interests in engineering, healthcare and patient-centred care. I strongly believe that P&O should be promoted more widely, as many people are unaware of the profession and the significant impact it can have on patients' quality of life.

I have thoroughly enjoyed my first two weeks of placement here in South Wales. I have been extremely fortunate to be welcomed into such a supportive and friendly team of professionals. During this initial period of observation, I have gained valuable insight into the field of Orthotics and how orthotic interventions support people to live independently by offering innovative and patient-centred solutions to complex physical challenges. My educators have been particularly supportive and welcoming throughout my placement. They have provided me with every opportunity to learn, observe and ask questions, which has been invaluable to my development, particularly as this is my first clinical placement. I am very grateful for the time and guidance they have given me so far. I am looking forward to my next four weeks of clinical placement with the team and to continuing to develop my knowledge, confidence and practical skills within the field of Prosthetics and Orthotics.

- PIPYN

The PIPYN programme is a targeted population health initiative delivered by Public Health Dietetics to support children aged 3–7 years and their families to achieve and maintain a healthy weight and develop sustainable healthy lifestyle habits.

The family-focused programme promotes healthier eating, increased physical activity and improved wellbeing, and has demonstrated strong engagement and positive impact within local communities.

As a result, PIPYN has received external recognition through partner nominations for three awards reflecting wider recognition of the impact and innovation of the service.

- 1) Nominated for AHA Cymru in the New Ways of Working category
- 2) Shortlisted for an HSJ Award
- 3) Finalist in the CTM Seren awards.

- Seren Award-The Head of Audiology June Winner of Seren of the Month 2026.

The Seren Winner for the month of June was nominated by her colleague in recognition of her outstanding leadership, unwavering support, and commitment to developing the Audiology team.

Her colleagues describe her as an approachable, inspirational and compassionate leader who consistently encourages staff to pursue further education, builds confidence, creates opportunities for development and makes people feel valued as well as being praised for her open-door approach, willingness to provide support whenever needed and dedication to both staff wellbeing and patient care.

The overwhelming feedback highlights the significant and lasting positive impact she has had on individuals, the department and the service.

For information

- Chief Allied Health Professional Officer

Gareth Evans has been announced as the new Chief Allied Health Professional Officer for Wales.

A podiatrist by background, Gareth brings a wealth of experience to this role and will work closely with Executive Directors of AHP and Health Sciences to deliver high quality and sustainable AHP services.

This important role has been vacant for over 12 months and the AHP leaders across Wales, including in CTMUHB, have been strongly advocating for AHPs in the interim.

- Advancing Healthcare Awards Cymru 2026

The Advancing Healthcare Awards Cymru 2026 will take place on Thursday 15th October and is an opportunity to celebrate the important and innovative work undertaken by both Allied Health Professions and Healthcare Scientists. CTM UHB colleagues have been shortlisted in both the Outstanding Leadership and Rising Star categories.

- Audiology Cymru Conference 2026

The Audiology Cymru Conference 2026 will be held in Cardiff City Stadium on the 17th of September. The conference has been jointly organised by Audiologists from Cwm Taf Morgannwg UHB and Cardiff and Vale University Health Board.



- Focus on Physiotherapy

FOCUS ON PHYSIOTHERAPY

CTMUHB
PHYSIOTHERAPY

Power of Compassion

We work together with compassion, honesty and respect to help people lead healthy and happy lives

✓ Digital access and safer systems

The modernised Microsoft Forms self-referral route is now established. The associated legacy-system risk has been removed from the risk register. Thanks to the clinical team for design and for digital team and Exec support with implementation, an example of a Clinically led change leading to improved patient safety

★ National recognition for pulmonary rehab

The physiotherapy-led MDT pulmonary rehabilitation service was identified by Asthma + Lung UK as the most accessible service, with the lowest waits in Wales and the second-highest referral level. A PR video has just been launched to increase awareness <https://www.facebook.com/watch/?v=27552632351095798>

😊 A strong early-career experience

Annual review of Graduate rotation feedback has shown from 86 rotations - 98% felt welcomed, 95.6% felt confident by the end of their rotation and 95% would recommend their rotation, 98% felt part of the team, 99% felt they could approach their seniors.

★ Compassionate Leadership

Physiotherapy Clinical Leads Nia Giles and Jess Thomas have teamed up with HEIW's AHP workforce transformation lead Lucy Smothers to roll out Compassionate Leadership training across Therapy Services

Compassionate leadership in action – Margery Costa – Clinical Lead Physiotherapist has been nominated by one of her team for an Inclusion & Respect Seren Award.

➤ Care closer to home

Recurrent funding is confirmed for First Contact Physiotherapy, supporting Community by Design and a "shift left" approach through earlier expert assessment (>5,000 appointments in Q1 26/27) delivered in Primary Care.

♥ Prevention in action

The "Don't Fall for It" team is demonstrating a strong public-health and prevention focus, helping people maintain confidence, mobility and independence.



◆ Quality improvement and shared learning

A new service-wide Physiotherapy SharePoint portal brings together team PDRs, recorded presentations and QI Projects. Some highlights to share: [Poster - Community physio reablement pilot.pdf](#) 86% reduction in waiting time. £25k saving from clinically led training redesign [Respiratory Physiotherapy On Call Training Redesign 2025.pdf](#)



➤ Growing Demand

Physiotherapy have growing demand in almost all our services; Inpatient Activity is growing year on year, with unmet need at 11.5%, 165% increase in MSK Primary care referrals and 36-37% increase in Paeds MSK, Pelvic health and Neuro OP services. With no increase in workforce this is resulting in pressure across multiple staff groups

- Awareness

Health Education and Improvement Wales have developed a dashboard that provides a comprehensive overview of current and projected workforce vacancies across healthcare professions in Wales. It is designed to support strategic workforce planning, IMTP request validation, and recruitment advertising efforts.

The table below highlights numbers of advertised roles against commissioned places for CTM UHB for July 2026.

Commissioned places are estimated using information available at the time including workforce planning, skill mix, retirement ages, new service provision, service transformation, regional working and technological advancement.

Service	Commissioned Numbers	WTE advertised	WTE appointed	Current Position	Mitigations
Audiology	3	0	0	-3	Three posts to be advertised in September 2026. 2 x B6, 1 x B5
Biomedical Science	4	1	1	-3	Two haematology posts to be advertised imminently.
Cardiac Physiology	3	0	0	-3	No posts to recruit into at present as establishment complete, this is under regular review.
Diagnostic Radiology	30	8	8	-22	Three posts to be advertised in September.
Dietetics	9	5	3	-6	Two posts out to advert
Occupational Therapy	18	10	10	-8	Position under regular review. Anticipating further recruitment throughout the rest of the year.
Physiotherapy	12	12	12	0	Anticipating further recruitment in September/October.
Podiatry	2	0	0	-2	No posts to recruit into at present as establishment complete, this is under regular review.
Respiratory & Sleep Physiology	2	0	0	-2	No posts to recruit into at present as establishment complete, this is under regular review.
Speech and Language Therapy	3	0.9wte	0.9wte	-2.1	No posts to recruit into at present as establishment complete, this is under regular review.



4. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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)	All Strategic Risks Apply	
	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)	No - Not Applicable	
	If more than one applies please list below:	
Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhwch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i> Equality & Welsh Language Impact Assessment Outcome <i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE This is a bi-monthly oversight and assurance report. If service change arises the specific areas and activity impacted will be	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:



	subject to the appropriate impact assessment.	
	Summary of impact:	
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)	This is a bi-monthly oversight and assurance report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
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	
CTM UHB	Cwm Taf Morgannwg University Health Board
RAID	Risk, Assumptions, Issues and Decisions
AHP's	Allied Health Professionals
AHA	Allied Health Assistants
HSJ	Health Service Journal
NWSSP	NHS Wales Shared Services Partnership



Quality, Safety & Experience Committee

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

Eitem yr Agenda / Agenda Item	4.4.1
Dyddiad y Cyfarfod / Date of Meeting:	22 nd September 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter:	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action or decision required – report is for noting only
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context:</i> <i>This report aligns to the following Strategic Pillars</i>	All Strategic Pillars Apply If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Service Delivery within Planned Care and the impacts on Patient Quality and Safety of care.

1. Introduction

- 1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience meeting on 17th August 2026.

Key highlights from the meeting are reported in section 3.

2.0 Purpose of this Meeting

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

2.2 The Planned Care/Surgery QSRE Group will:

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

3.0 Highlight Report

Alert / Escalate

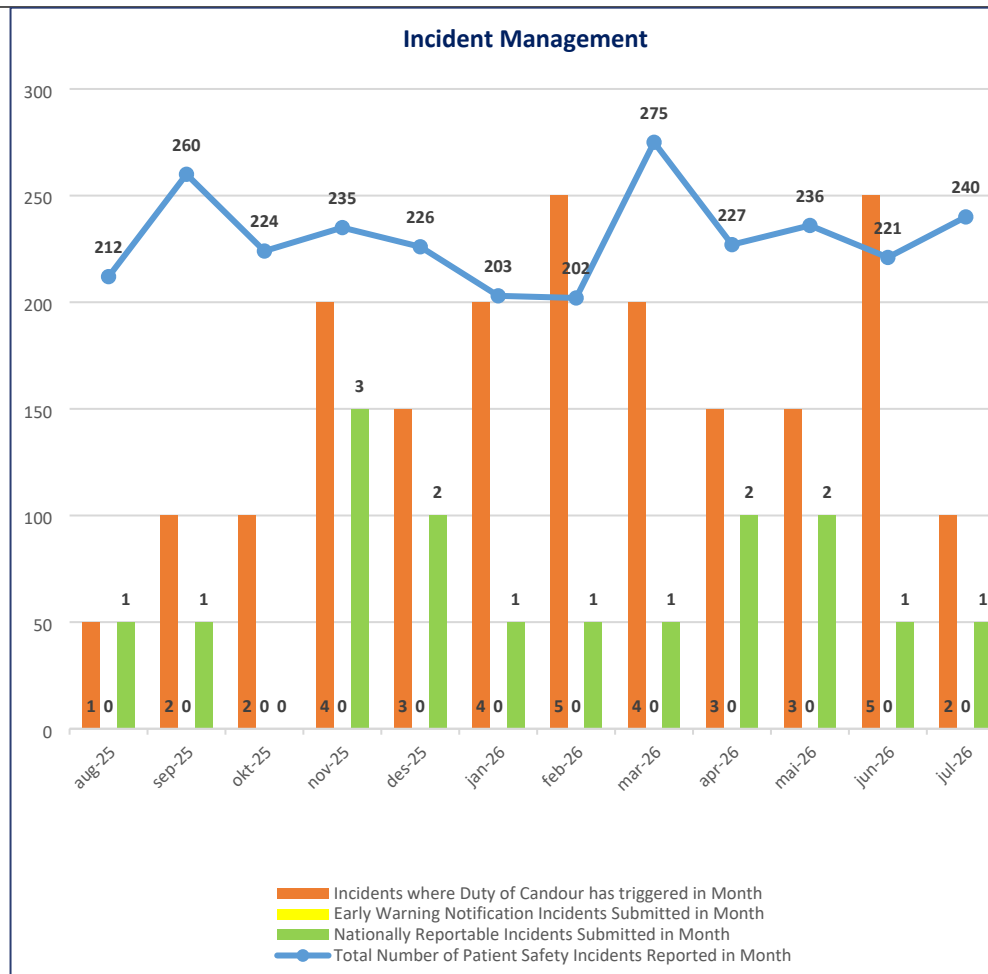
Gastrointestinal Services

Temporarily consolidated Princess of Wales Hospital (PoWH) inpatient Gastroenterology services at the Royal Glamorgan Hospital site, on an interim basis. This will allow Planned Care and Unscheduled Care to maintain safe emergency and inpatient care, including the management of gastrointestinal bleeds and other urgent conditions, while the Care Groups continue longer-term work to rebuild workforce resilience.

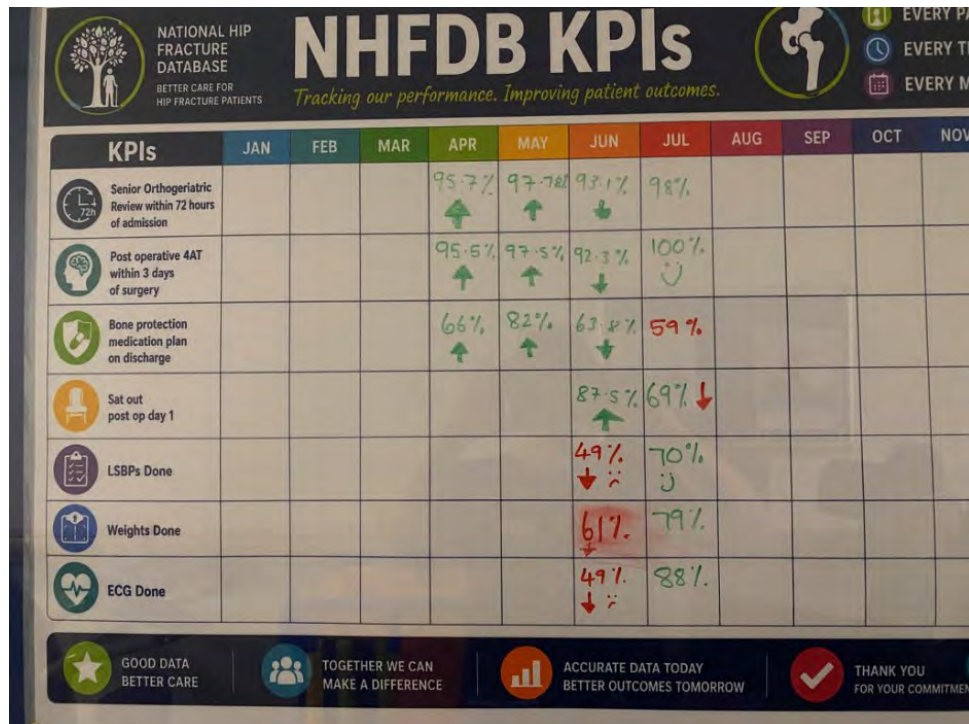
Ophthalmology HCQ pathway

Multiple patients prescribed long-term hydroxychloroquine (HCQ) have developed confirmed or suspected HCQ retinopathy. Since the *2018 Royal College of Ophthalmologists guidance*, patients on long-term HCQ (>5 years) should receive specialist ophthalmology screening.

	• Service has developed the Welsh General Ophthalmic Services (WGOS) pathway to ensure sustainable service but also proposed an immediate plan to review all patients. • Clinics have commenced to review the waiting list patients with a projection that within 2 months all the patients on a backlog list will be reviewed. Theatres Due to the high weather temperatures, at times some theatre humidity has exceeded recommended level of 65% humidity which has resulted in some arthroplasty and complex surgery being cancelled.																				
Advise	Concerns Management Early resolution (LtP) exceeded WG 40%performance, achieving 78% performance in July. Early Resolution Complaints (LtP) Received Managed as Early Resolution <table border="1"><thead><tr><th>Month</th><th>Early Resolution (LtP)</th><th>Early Resolution Converted to Formal (LtP)</th><th>Percentage</th></tr></thead><tbody><tr><td>Apr-26</td><td>7</td><td>2</td><td>78%</td></tr><tr><td>May-26</td><td>6</td><td>6</td><td>50%</td></tr><tr><td>Jun-26</td><td>16</td><td>9</td><td>64%</td></tr><tr><td>Jul-26</td><td>21</td><td>6</td><td>78%</td></tr></tbody></table> Top 5 themes • Over 50% received in July related to Clinical Treatment and Assessment. Other themes: • appointments (delay in receiving or Waiting lists) • Communication issues • Test & investigation • Relating to Patient Care Incident Management	Month	Early Resolution (LtP)	Early Resolution Converted to Formal (LtP)	Percentage	Apr-26	7	2	78%	May-26	6	6	50%	Jun-26	16	9	64%	Jul-26	21	6	78%
Month	Early Resolution (LtP)	Early Resolution Converted to Formal (LtP)	Percentage																		
Apr-26	7	2	78%																		
May-26	6	6	50%																		
Jun-26	16	9	64%																		
Jul-26	21	6	78%																		



National Hip Fracture Database (NHFD)
Specialist Orthogeriatric (OG) team in Trauma Unit (TU) in RGH have started to publish the NHFDB KPIs on the information Boards on the ward.



Designed and completed by OG Advanced Clinical Practitioner and Consultant. Demonstrates impact of dedicated OG team in RGH. Improved NJR (National Joint Registry) audit compliance, particularly delirium and A4T completion (72 hours post operatively) 100%, other upward trajectory in:

- Senior orthogeriatric review 72 hours post admission (98%)
- Lying & Standing BP being completed (70%)
- Accurate weights (79%)
- ECG being undertaken (88%)
- Need to roll out within PCH TU

Assure

Trauma & Orthopaedics (T&O)

- Standardisation of Trauma Units in RGH and PCH.
- Created a Trauma Unit in PCH to ensure standardisation of trauma services and clinical models pan CTM UHB
- Ward 8 (STAR ward) in POW will have an Activities Room for Patients by mid-September 2026, all the equipment and design is being provided by the Charity Dare2 Dream.

General Surgery & Gastroenterology

Opening of Surgical SDEC in Prince Charles Hospital

- 271 patients been via the Unit since opened on 24th June – end of July
- Includes GP admissions



	- Returning patients for reviews to reduce admissions/discharge faster. - Pull across suitable patients from ED supporting ED flow and pressures - Also increased the number of Monifer infusion clinics for surgical pre-operative patients. Endoscopy Short term insourcing commissioned to increase the position as 40 patients are waiting over 8 weeks for diagnostics. With the insourcing these patients will all have received their diagnostic procedure within a month.
Inform	PCH Ward 6 – IPC Summer Winners! - Bare Below the Elbow, Catheter and PVC bundles with audit scores on average 99% across all the 3 areas. T&O Appointment of 2 x 8a ACPs; 1 to PCH and 1 to Ward 7 POW Creation of Trauma Unit in PCH to standardise clinical model and practice across CTM UHB. Anaesthetics Critical Care Theatres One Stop Pre Assessment Clinics (PAC) are now available across all sites – reducing time to wait for PAC for USC patients Critical Care - Finalist in NHS Wales Awards From survival to Recovery : a Trauma-informed, Patient –Centred and co-Produced Critical Care Pathway
Appendices	No Appendices included in this highlight 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 1a Elective Capacity
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A Healthier Wales



Link to Wellbeing of Future Generations Act – Wellbeing Goals	If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All Enablers of Quality Apply	
	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.)	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact: No overall impact	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Equality & Welsh Language Impact Assessment Outcome (Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	Outcome for Welsh Language (delete as appropriate): /NEUTRAL/ Summary of impact:	
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)	QIA not undertaken as this is a report for Board encompassing a wider Planned Care Group matters to raise awareness for Committee	
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	
LtP	Listening to People
SDEC	Same Day Emergency Care
PVC	Peripheral Venous Catheter
KPIs	Key Performance Indicators
IPC	Infection Prevention Control



Unscheduled Care CSG Highlight Report from the Quality & Safety Committee.

Eitem yr Agenda / Agenda Item	4.4.2
Dyddiad y Cyfarfod / Date of Meeting:	22 nd September 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Deborah Matthews Nurse Director Unscheduled Care
Cyflwynydd yr Adroddiad / Report Presenter:	Deborah Matthews Nurse Director Unscheduled 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:	1. Note the key quality, safety and patient experience matters arising from the Unscheduled Care Quality and Safety arrangements. 2. Consider the areas highlighted for escalation, particularly the ongoing quality and safety concerns within Prince Charles Hospital Emergency Department. 3. Take limited assurance from the controls and improvement activity described within this report. 4. Note the requirement for continued executive oversight of Emergency Department safety, patient flow and delayed transfer risks.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol Strategic Context: This report aligns to the following Strategic Pillars</i>	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 Blynnyddol (Cyfeiriad blaenoriaeth berthnasol) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (Reference relevant priority)	This report supports delivery of Health Board priorities relating to: 1. Patient Safety and Harm Reduction 2. Timely Access to Urgent and Emergency Care 3. Improving Patient Flow and Reducing Delayed Transfers of Care

	4. Delivering Quality Care and Improved Patient Experience 5. Strengthening Quality Governance and Assurance Arrangements
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1. Introduction

1.1 This report has been prepared to provide the Quality, Safety and Experience (QSEC) with details of the key issues considered by the Unscheduled Care Group's Quality, Safety and Experience Group at its meeting on 22nd September 2026.

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

2. Purpose of this Meeting

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

2.2 The Committee is requested to note the report.

3. Highlight Report

Alert / Escalate	Emergency Department Prince Charles Hospital Prince Charles Hospital Emergency Department continues to manage significant operational pressures alongside a pattern of recurring patient safety and governance concerns. A review of incidents, complaints, GP concerns, rapid reviews and patient safety investigations has identified consistent themes relating to delays in assessment, escalation, treatment and overall clinical management of patients. Specific Patient Safety Concerns- • Delays in triage and initial nursing assessment. • Delays in clinician review following triage. • Delays in investigation and treatment. • Inconsistent recognition and escalation of patient deterioration. • Delays in ECG completion and review. • Risks relating to management and escalation of abnormal diagnostic results. • Inconsistent pain assessment, analgesia provision and reassessment. • Variable compliance with NEWS and MEWS monitoring, sepsis screening and escalation processes. These concerns have been triangulated through incident reviews, complaints, patient safety investigations, GP concerns and governance review processes. Whilst immediate mitigating actions have been implemented, the recurring nature of these themes indicates that risks have not yet been fully controlled or consistently mitigated.
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	A dedicated improvement plan has been established under executive oversight and a structured quality and safety assurance review is being implemented to provide additional scrutiny of operational delivery, governance arrangements, workforce factors and patient outcomes. The Committee should note that this remains an area requiring ongoing executive oversight and regular progress reporting until evidence demonstrates sustained improvement and reduction in risk.
Advise	Gastroenterology Services Reported in June 2026 and remains unchanged - the Gastroenterology Consultant rota has remained fragile following a critical incident at Princess of Wales Hospital (POWH), with further challenges arising from the unplanned loss of a locum consultant within Planned Care and additional workforce pressures. To maintain safe and sustainable service provision, a temporary transfer of the Gastroenterology service from POWH to Royal Glamorgan Hospital (RGH) was implemented from 5 May 2026 for six months. The temporary service reconfiguration continues to be monitored through established governance arrangements with ongoing review of workforce sustainability, patient outcomes, patient experience and service performance. Pathway of Care Delays PoCD is measured to understand how many patients remain in hospital despite being ready for the next stage of their discharge and to identify where flow is being delayed. PoCD remains a significant constraint to Patient Flow across CTM UB, and USC has the highest number of delayed patients. Assessment delays continue to contribute significantly to Pathway of Care Delays (PoCD), with 58 delays (validated) recorded across the three acute USC sites in July, an increase of 1 delay (+2%) from June. Including YGT, the total rises to 68 delays. Performance deterioration is primarily driven by Princess of Wales Hospital (POWH), where delays increased from 18 to 24 (+33%), accounting for the highest number of assessment delays across the Health Board. Improvement has been seen at both Prince Charles Hospital (15 to 11, -27%) and Ysbyty George Thomas (14 to 10, -29%), while Royal Glamorgan Hospital remained broadly stable at 23 delays (-4%). Local Authority assessment delays (24 cases, 35%) remain the largest contributor to delayed assessments, followed by Nursing assessments (17 cases, 25%). Together, these account for 60% of all assessment delays, indicating that delays at the health and social care interface remain the most significant constraint to timely discharge. Secondary delays include Joint Assessments (13%), Best Interest decisions (10%), and Mental Capacity assessments (7%), suggesting further opportunities to streamline complex discharge pathways.



	Assessment delays predominantly affect patients on Pathway 3 and complex care pathways, resulting in longer lengths of stay and reduced bed availability across the acute system. Although some hospital sites have improved, overall system performance remains constrained by assessment delays, particularly where discharge pathways require multi-agency decision-making and co-ordination. The principal residual risk remains prolonged length of stay for patients awaiting discharge assessment, with associated impact on patient experience, flow, capacity and timely access to care. Key improvement actions include: 1. Strengthening nursing capability in Discharge to Recover and Assess (D2RA) processes and effective use of electronic patient flow systems. 2. Clarification of accountability for discharge escalation through Ward Managers, Senior Nurses and Lead Nurses. 3. Establishment of Super Stranded Patient review processes. 4. Enhanced daily review and escalation of delays through multidisciplinary and multi-agency forums. 5. Standardisation of discharge improvement approaches across all acute sites. 6. Oversight through the System Flow Programme Board, working collaboratively with Health Board and external partners. Stroke A separate thematic review of Stroke Services is presented elsewhere on today's agenda. Key issues relating to quality, safety, workforce sustainability and service performance are therefore addressed within that report.
Assure	The Unscheduled Care Group provides assurance that CTMUHB continues to deliver safe and compassionate care across Unscheduled Care services, despite ongoing system pressures. Incident reporting increased from 670 in February 2026 to 804 in July 2026 (a 20% increase), which may be indicative of a positive reporting culture as well as increased patient acuity, with an identified trend in ED PCH as described under "alert" during the quarter. Please note the high number of patients attending ED with pressure damage below, hence the importance of robust assessment in line with the pressure ulcer policy and implementation of patient-centred management plans. For your information, the Pressure Ulcer Prevalence audit has been undertaken in ED for the 2nd year (June 2026), and the results show improvement. 77 patients were reviewed across all three ED sites, and no healthcare-acquired pressure ulcers were identified, with an overall pressure ulcer prevalence of 7.79% (6 patients, 9 ulcers-admitted with pressure damage). The assessment demonstrated improvements in risk assessment, preventative care planning, skin assessments and dietary requirements compared with 2025; however, variation remains in compliance with timely risk and skin assessments, repositioning plans, and appropriate equipment allocation. Key areas for improvement include ensuring all patients receive a PURPOSE T assessment and skin inspection within 6 hours, strengthening repositioning practices,



improving the accuracy of weight documentation, and ensuring appropriate mattresses, seating and moving and handling equipment are available to support effective pressure ulcer prevention.

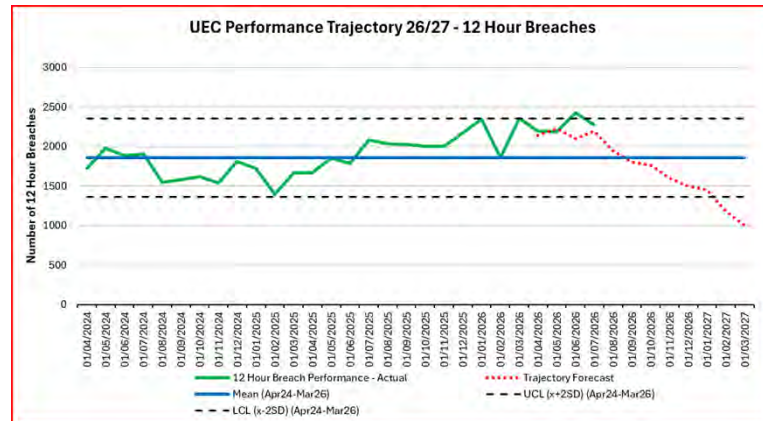
This improvement work is being progressed through the pan CTM ED weekly governance meetings.

Key areas requiring continued Executive oversight are the impact of prolonged Emergency Department waits and delayed transfers of care over 12 hours, which continue to affect patient flow and increase clinical risk exposure across the urgent and emergency care pathway. These challenges remain aligned with national and Ministerial priorities to improve timeliness of care and patient experience.

Action-ED 12-hour improvement programme (jointly owned operational plan for ED Teams, Flow Teams, Heads of Nursing, General Managers and all Care Groups) where a definitive improvement trajectory is being achieved to date:

UEC Performance Trajectory 26/27 - 12 Hour Breaches

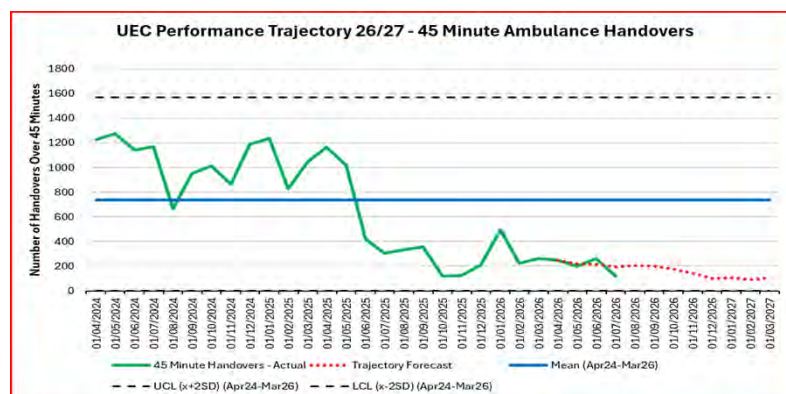
	Actual 24/25	Actual 25/26	Actual 26/27	Trajectory 26/27	Trajectory Status
April	1,724	1,664	2,197	2,139	Amber
May	1,980	1,850	2,190	2,227	Green
June	1,882	1,786	2,426	2,100	Red
July	1,904	2,082	2,274	2,196	Amber
August	1,544	2,036		1,945	-
September	1,578	2,028		1,800	-
October	1,616	2,004		1,764	-
November	1,540	2,000		1,605	-
December	1,811	2,172		1,500	-
January	1,719	2,348		1,453	-
February	1,393	1,860		1,180	-
March	1,667	2,354		1,000	-



Positively, ambulance handover performance remains strong, with CTMUHB reported via Welsh Government as the best performing Health Board in Wales across its three acute sites.

UEC Performance Trajectory 26/27 - 45 Minute Ambulance Handovers

	Actual 24/25	Actual 25/26	Actual 26/27	Trajectory 26/27	Trajectory Status
April	1,224	1,164	246	245	Amber
May	1,275	1,016	200	217	Green
June	1,138	416	262	214	Red
July	1,171	302	121	193	Green
August	667	334		206	-
September	948	356		200	-
October	1,011	119		176	-
November	866	123		141	-
December	1,186	211		101	-
January	1,237	496		106	-
February	829	225		93	-
March	1,046	261		103	-



The overall quality assurance position for Quarter 2 is:

- Safe: □ Substantial Assurance
- Effective: □ Moderate Assurance
- Patient Experience: □ Substantial Assurance
- Governance: □ Substantial Assurance

The Harm Free Agenda is a key priority; pressure ulcer prevention, falls reduction, and medicines management remain priority improvement areas, with performance being monitored across the 3 Acute Sites. Supporting trend data is continually reviewed for pressure damage, avoidable pressure ulcers, falls and medication incidents.

Regarding medication management, EPMA was rolled out in POWH and RGH on 22nd August 2026. PCH will follow; no firm date has been provided yet. Incidents have started to reduce in POWH, as demonstrated below.

Please see the trends across the 3 Acute Sites for pressure damage, falls and medication errors, noting the graphs now align with the newly implemented Integrated Performance Meetings.

Pressure Damage

Avoidable pressure ulcers between February and July 2026:

1. PCH reduced from 3 to 0, representing a 100% reduction. Developed or worsened pressure damage also reduced from 14 to 12, representing a 16.75% reduction.
2. RGH reduced avoidable pressure ulcers from 6 to 3, representing a 50% reduction. Developed or worsened pressure damage slightly increased from 14 to 18, representing a 28.6% increase.
3. POWH reduced avoidable pressure ulcers from 5 to 3, representing a 40% reduction. At the same time, developed or worsened pressure damage reduced from 29 to 21, representing a 27.6% reduction.
4. Collectively, the data demonstrates a positive reduction in avoidable pressure damage across the USC areas, suggesting that preventative initiatives, assurance processes and targeted improvement activity are beginning to have an impact. However, improvements remain inconsistent when considering all pressure damage developed or worsened during care, with an increase observed at PCH and RGH offsetting the gains seen at POWH.

Actions

- a) Targeted work continues in areas where trends are identified, including a quality improvement project in POWH, and learning is shared at the monthly Professional Focus Group.
- b) Pressure Ulcer Prevention training remains a focus
- c) PU collaborative/champions.
- d) Refocus and wards creating PU prevention information boards/updating with relevant detail to speciality.



	e) TVN's supporting with specific equipment reviews. Falls 1. Monthly reported falls continue to show variation across PCH, RGH and POWH, with no sustained reduction demonstrated across the 12-month period. 2. All three sites show fluctuating monthly falls volumes, with improvement in some months followed by rebound or deterioration. 3. PCH has shown the greatest month-to-month variation, with falls reducing to 26 in June 2026 before increasing again to 43 in July 2026. This suggests that improvements have not yet been reliably sustained. 4. RGH remains consistently high in reported falls activity, with the highest July 2026 position at 58 falls. This represents a deterioration from June and places RGH above the expected 30% improvement trajectory. 5. POWH showed an improvement in July 2026, reducing to 38 falls from 50 in June 2026. However, the 3-month average remains variable, and the site has not yet demonstrated a sustained downward trend. 6. Falls per 1,000 occupied bed days also demonstrate site-level variation. RGH increased to 2.14 in July 2026, which is the highest rate across the three sites and above the pooled mean. PCH increased to 2.18 in July 2026, also above its pooled mean. POWH fell to 1.08 in July 2026, improving from the previous two months. Actions a) MFRA completion and quality of assessment b) Lying and standing blood pressure compliance c) Clinical observations before falls d) Post-fall make-safe actions e) Consistent ward-level ownership of learning-includes purposeful staff rounding. Medication Errors 1. Incident rates remain within expected control limits across POWH, RGH and PCH, indicating common cause variation rather than special cause deterioration. The category breakdown: the greatest is administration errors following prescribing, storage/security/disposal issues and medication documentation errors. 2. RGH and PCH continue to show higher rates and greater variation than POWH (EPMA has been rolled out) with both sites recording notable increases in July 2026 3. RGH increased to 0.85 incidents per 1000 occupied bed days in July '26 following lower rates in May and June, indicating continued process reliability challenges. 4. PCH showed the highest single monthly rate across the period, peaking 1.14 incidents per 1000 occupied bed days in July '26, improvement, but not sustained
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5. POWH demonstrates comparatively lower and more stable rates reducing to 0.23 incidents per 1000 occupied bed days in July'26, previous monthly fluctuation remains evident.

Actions

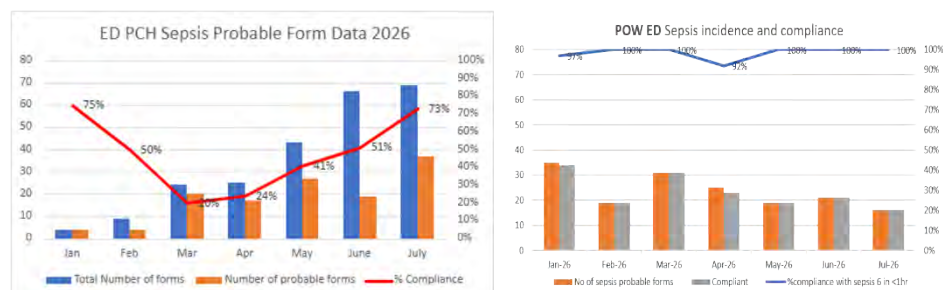
- Staff reminded of the importance of 5R's when administering medication.
- Reaching out to specialist teams for complex patients-Diabetes, Parkinson's.
- Endocrine Pharmacist supporting Stroke Unit.
- EPMA roll out-PCH to progress

Nutrition & Hydration

With support from the Head of Quality, the Stroke Variation Meeting has continued to be held monthly, with multidisciplinary representation from Nursing, Therapies, Medical, and Patient Safety teams. The meetings have been well established, supported by agreed Terms of Reference, and continue to provide a positive forum for reviewing patient safety incidents, sharing learning and identifying improvement opportunities. This review process has identified no moderate or severe harm incidents to date. The forum has also expanded to consider incidents occurring outside stroke-specific pathways, supporting broader organisational learning and assurance. Enhanced reporting of nutrition, hydration and swallowing incidents within the Stroke Unit reflects the presence of a dedicated unit-based Therapy Team and strengthened clinical oversight, rather than an increase in concerns, providing greater assurance regarding the identification, monitoring and management of risks.

Sepsis Compliance

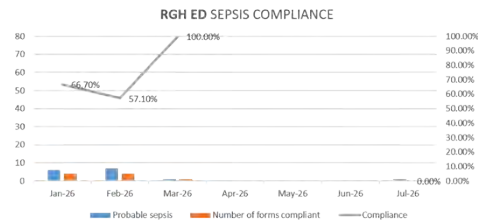
This is a priority for the Care Group, with targeted work across the Emergency Departments, particularly PCH, where the OUTREACH Team has been supporting. Key to the improvement work is ownership and accountability of the teams; the data below demonstrates improvements: -



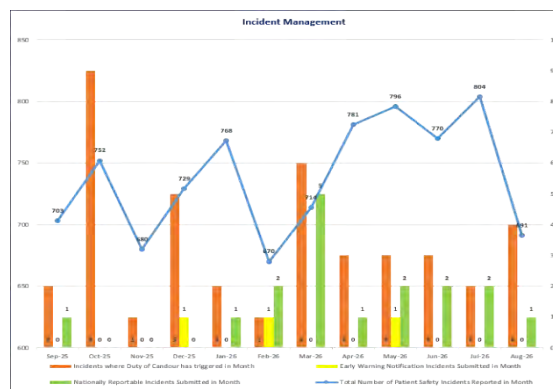


GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



Patient Experience



Sepsis Improvement plan

PCH

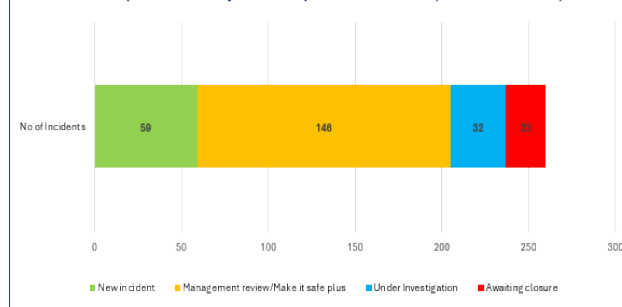
- Increase in sepsis forms
- Bleep for SCDM when sepsis probable at triage
- Improvement in Abs time

RGH

- Need to get more engagement and replicate process in PCH/POW



Total Open Incidents By Care Group – as at 01/09/2026 (260 total incidents)

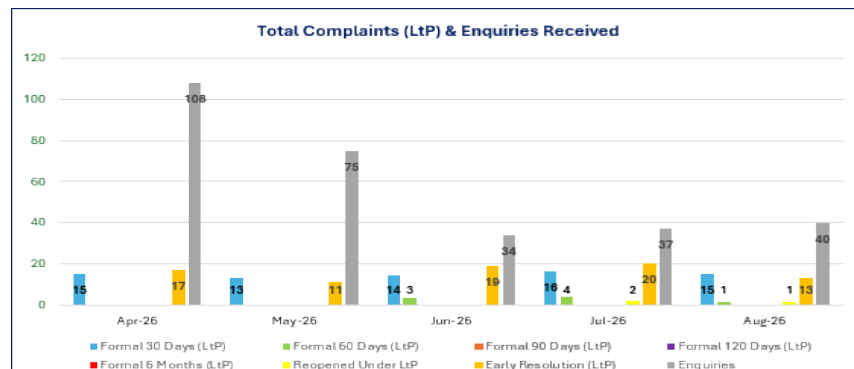


NRI status – as at 01/09/2026

Total Open NRIs	7
Total Open NRIs Overdue	5

Unscheduled Care Concerns

- PALS enquiries increased to 38 in July (16 in the previous reporting period).
- 20 Early Resolution concerns remain open.
- There are currently 26 formal concerns open, including 2 re-opened under the LTP process.
- No formal concerns are overdue, maintaining 100% compliance with statutory response times.
- Listening Discussions continue to be undertaken across the service.



Themes include communication, clinical diagnosis, delays in transfer out of ED impacting dignity, Infection Prevention & Control issues (primarily in ED), and discharge arrangements. Learning achieved through local performance & assurance meetings as well as site-based Professional Nurse Focus Group meetings.

Risk Register

The USC Directors undertook a comprehensive deep-dive review of the Care Group Risk Register to ensure risks remain current, accurately assessed, and supported by robust mitigation plans. The team then triangulated this review through structured discussions with Directorate Management Teams (DMTs), incorporating evidence from risk registers, risk mitigation plans, Datix incidents, and mortality reviews.

12 significant risks remain, mainly around capacity, waiting times, stroke care and ED safety.

External Stakeholder

There have been 2 HIW concerns; both have been managed under LTP. One in PCH in relation to environmental cleanliness and IPC compliance. One in the RGH related to environmental cleanliness, with a wait of over 12 hours to be transferred to the ward, limiting access to washing facilities and contributing to deconditioning.

There has been an immediate response around the Infection Prevention and Control concerns. The issues described are being addressed via the 12-hour Improvement Programme, a system-wide approach to facilitate timely transfer of patients out of ED to the speciality ward.

Inform

Achievements

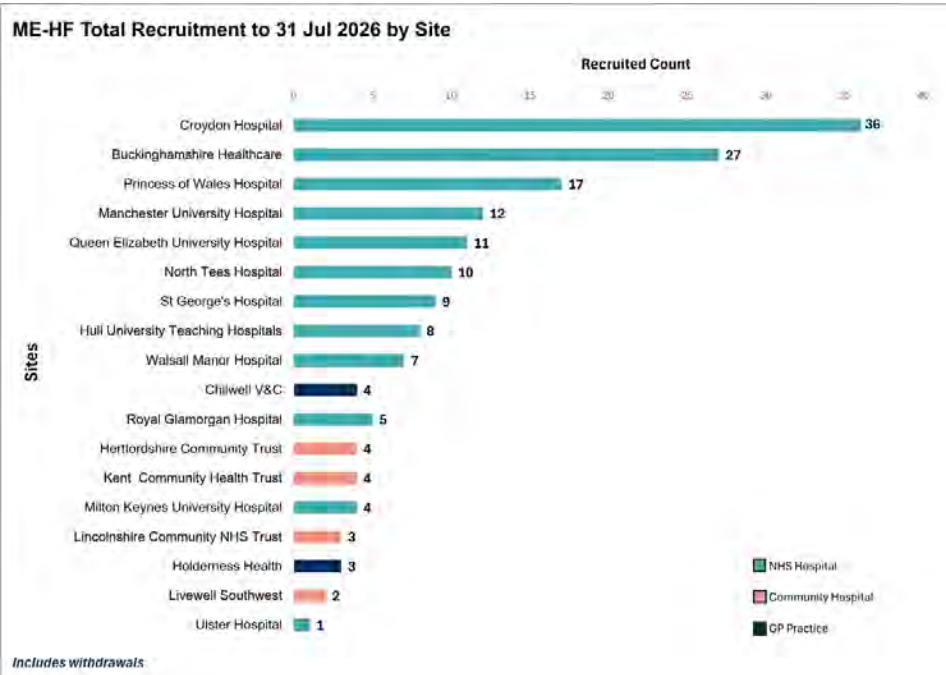
Unscheduled Care Newsletter 1st Edition July 2026. This month gives us a valuable opportunity to pause, recognise the progress being made across our services, and celebrate the dedication, professionalism and teamwork shown by colleagues every day.

Cardiology-We are proud to share that the Princess of Wales Hospital R&D team has been recognised as a top recruiting site in the UK in August for the ME-HF study. ME-HF is an innovative heart failure research study investigating whether early detection of fluid retention



through home-based monitoring technology can improve patients' quality of life and reduce hospital admissions.

This recognition reflects the outstanding collaborative effort of our patients, research teams, cardiology colleagues and wider CTM staff who have supported the study and championed research within everyday clinical practice. This highlights the important role that research plays in improving patient care.



Cardiology-Mandie Welsh, our Lead CNS for Heart Failure, has been appointed as an Honorary Senior Lecturer in Heart Failure at Swansea University.

Seren Award Nominations

- Congratulations to Dr Rahim Khan, who has received a nomination for a Seren Award in Bridgend, celebrating outstanding medical contributions.
- Ward 2 Manager Deborah Jones has been nominated for a Seren Award for all her hard work in coordinating and training staff in manual handling and improving training compliance from 0-15% to 85-95% in PCH USC.
- Seren nominations for the Stroke Nursing Team, Kelly Cleaver, PCH Ward 10 (frailty), has had a nomination from her team and from a member of the public.
- Congratulations to Alison Smith, ACP, Cote Team in RGH



	PREMS-Catering assistant Linda James, AMU in PCH, received a bouquet of flowers from the family of a patient. Linda worked closely with the family and patient to ensure they received the food and drink they enjoyed, which met their nutritional needs and, as a result, significantly impacted the patient's recovery. A great example of MDT work and going the extra mile.
Appendices	

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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 Emergency Capacity
	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	All Enablers of Quality Apply
	If more than one applies please list below:

Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	All Environmental Sustainability Impact (5Rs) Applies
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please select a reason below.



<i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i> Equality & Welsh Language Impact Assessment Outcome <i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	Policy/Plan/Proposal too broad Named Executive/Board member sign off for no EWLIA completion: Richard Hughes
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i> Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>	A Quality Impact Assessment has not been undertaken, as this report is presented for assurance and reporting purposes only and does not propose a service change, policy amendment, or new model of care requiring a formal Quality Impact Assessment.	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Effaith Adnoddau <i>(Pobl / Ariannol) / Resource Impact (People / Financial)</i>	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	
ACP	Advanced Clinical Practitioner
ADP	Annual Delivery Plan
BAF	Board Assurance Framework
CNS	Clinical Nurse Specialist
CSG	Care Group
CTMUHB	Cwm Taf Morgannwg University Health Board
D2RA	Discharge to Recover and Assess
DMT	Directorate Management Team

ECG	Electrocardiogram
ED	Emergency Department
EPMA	Electronic Prescribing and Medicines Administration
GMC	General Medical Council
HIW	Healthcare Inspectorate Wales
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention and Control
LTP	Listening and Taking Action Process
MDT	Multidisciplinary Team
MEWS	Modified Early Warning Score
MFRA	Multifactorial Falls Risk Assessment
NEWS	National Early Warning Score
PCH	Prince Charles Hospital
PoCD	Pathway of Care Delays
POWH	Princess of Wales Hospital
PREMs	Patient Reported Experience Measures
QSEC	Quality, Safety and Experience Committee (a formal committee of the Health Board)
QSRE	Quality, Safety, Risk and Experience Group (a subgroup meeting within the USC Care Group)
RGH	Royal Glamorgan Hospital
SALT	Speech and Language Therapy
TVN	Tissue Viability Nurse
USC	Unscheduled Care
YGT	Ysbyty George Thomas



Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Eitem yr Agenda / Agenda Item	4.4.3
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Gary Howell, Clinical Director of Therapies
Cyflwynydd yr Adroddiad / Report Presenter:	Gary Howell, Clinical Director of Therapies
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Sciences
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action/decision required – report is for noting only
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	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 (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable

1. Introduction

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

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

2. Purpose of this Meeting

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

2.2 The DTPS Care Group Quality, Safety, Risk and Experience meeting (QSRE) will:

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

3. Highlight Report

Alert / Escalate	<u>Pathology</u> LIMS 2.0: CTM status remains red due to low confidence in the national programme meeting Tranche 4 (Blood Sciences) and Tranche 5 (blood Transfusion) timelines. Significant quality, safety and operational risks remain for both tranches. Blood Transfusion remains a high-risk area, with further national delays in entering the User Acceptance Testing phase and low confidence in achieving deployment within the project timeframe. Disruption to Blood Transfusion services poses a significant clinical risk, and failure to meet Medicines and Healthcare Regulatory Agency (MHRA) legal requirements. The specific risk around Blood Transfusion has been escalated to be included in the next iteration of the organisational risk register (Risk 6633). National escalation calls are held weekly and the progress of the national programme and local impact is monitored via CTMUHB Executive Management Board. <u>Healthcare Science</u> Bed Management / Clinical Engineering There is currently a reduced number of dynamic mattresses available across the Health Board due to full hospital sites and a high number of mattresses / pumps being condemned as considered beyond repair, including dynamic mattresses used in the prevention and management of pressure ulcers. Current mitigation, where required, is for the clinical service to authorise and provide cost centre to rent equipment for highest risk patients. Risk ID: 6498 at level 16. There are many bed systems that will come out of support and require replacing over the next few years. Work is underway to identify a replacement solution. <u>Audiology</u> <i>Waiting Lists</i> There continue to be breaches for adult hearing aid pathways, paediatric assessment pathways, and diagnostic waits in audiology services, however considerable progress has been made to reduce the long waits and improve patient experience. At present, just over 3,300 adult patients are waiting, with 1700 breaches (previously >2800). Adult longest wait for hearing aids is now just under 25 weeks (previously over 40 weeks). Paediatric Audiology is prioritised, however loss of
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	staffing there has resulted in 257 breaches waiting for new paediatric assessments (6-week target). The service has a number of mitigations in place to reduce the waiting lists, including the work of the PIT board, change in ENT clinic cover with a 50% reduction in cover to utilise unused capacity and a whole-service waiting list focus with all non-patient facing work being cancelled until the end of August (e.g., staff meetings, PPI, Research & Development (R&D), Service development activities). Performance & Improvement (P&I) have developed an Audiology dashboard, so demand, capacity and all activity can be viewed easily. This is currently a test version, should be ready to report from by the end of October which will enable greater scrutiny of data to inform ongoing waiting list reduction planning. <i>School Entry Hearing Screening</i> The School Entry Hearing Screening Programme transferred from School Nursing to Audiology in September 2025 in line with the national pathway. Implementation has been significantly delayed due to workforce onboarding, delayed release of equipment and periods of staff absence, resulting in the programme being approximately 5.5 months behind schedule. As of June 2026, 43 of 168 schools (25.6%) had been fully completed, with 1,444 of 4,005 children (36.1%) completing the pathway and 2,961 children (51.6%) yet to receive any contact. The principal risk is that up to 40% of children may not complete the screening pathway within the current reporting window. This could lead to delayed identification of hearing loss and subsequent delays in assessment and intervention, potentially impacting speech, language development and educational outcomes for affected children. Mitigating actions include extending screening into Year 1 alongside the new Reception cohort, prioritising larger schools to maximise coverage, strengthening parental information to encourage early help-seeking, and providing additional catch-up clinics during school holidays to support pathway completion and reduce the number of children remaining outstanding.
Advise	<u>Pathology</u> Cellular Pathology Service Capacity Concerns: There are currently risks recorded on the risk register relating to both Cellular Pathology laboratory space and staff resource. The department does not have sufficient physical capacity to

safely support its existing outsourcing activity and consequently has no additional space to accommodate further workload.

This presents a significant risk in light of ongoing discussions regarding the repatriation of the POW Cellular Pathology workload, which is currently being processed by Swansea Bay. A Cellular Pathology Multi-Disciplinary Team (MDT) Repatriation Working Group has been established to develop a structured plan for the repatriation of this workload.

Patient Mis-identification Incidents:

Pathology incident data for the previous 12 months has identified 31 patient mis-identification incidents. This figure relates solely to incidents reported within Pathology and does not include incidents occurring in other areas of the Health Board, or those that may have gone unreported or undetected. Pathology incidents include:

- Incorrect patient blood incidents, often detected through the vigilance of the laboratories.
- Instances of incorrect patient details entered into Point of Care Devices.
- Two incidents where incorrect patients' blood has been transfused in the last 6 months (one was a Never event). The occurrence of two incidents within a six-month period is significant concern and highlights the importance of strengthening identification and verification processes across the Health Board

Patient misidentification represents a significant organisational risk, discussions are underway regarding escalation of this risk to the Organisational Risk Register to ensure appropriate oversight, controls, and mitigating actions are applied. In the interim, a Patient Safety Briefing has been issued for dissemination across CTM to reinforce good practice and raise awareness of the risks associated with patient identification errors.

BadgerNet Transcription Error Risk:

An SBAR has been drafted by the WBS Blood Health Team regarding an emerging patient safety risk associated with transcription errors within the Maternity BadgerNet system. Transcription errors have been identified across three Welsh Health Boards. These errors arise from the manual transfer of pathology and transfusion-related information into the Badgernet system, increasing the risk of incorrect, omitted or delayed clinical decisions.



The lack of interoperability between maternity and laboratory systems creates a significant transfusion safety and patient safety risk. Accurate recording of transfusion information and laboratory results is essential to ensure appropriate patient management.

The risk has been recognised by the All-Wales Transfusion Practitioners Group (AWTPG), Blood Health National Oversight Group (BHNOG) and the Welsh Blood Service (WBS) Transfusion Risk Group (TRG), with consideration being given to further national escalation.

Untracked Whistl-Royal Mail Service Impacting the CTM FIT Service:

Since December 2025, 237 Faecal Immunochemical Test (FIT) kits have been reported as lost in transit through the Whistl-Royal Mail service, with no available tracking or audit trail to determine their location or point of loss. This has resulted in delays to patient testing and diagnosis, particularly where FIT results are used to support colorectal cancer pathway decision-making.

The absence of a traceable postal pathway creates significant operational challenges, including the need for repeat requests, replacement FIT kits, additional administrative and laboratory workload, and difficulties providing assurance regarding the timely handling of patient samples. The issue also impacts patient experience, with patients required to repeat testing and potentially experiencing delays in receiving results and onward clinical management.

The care group is working with facilities to identify a solution. The current untracked postal process presents an operational and quality risk to the FIT service. Further work is required to establish a more robust and auditable system that provides assurance regarding the safe and timely transportation of patient samples.

Radiology

Radiology Alerts: Semi-automation is strengthening oversight of Significant Finding Alerts. However, increasing reliance on alerts rather than timely review of radiology reports by referring teams creates a risk that positive findings may not be acted upon promptly where an alert threshold has not been met. Radiology Alert worklists within WCP are currently being piloted by ED at POW. If successful, wider adoption across specialties could improve access to radiology findings and reduce delays in the review and action of imaging results.



Report Turnaround Times: Increased imaging capacity has not been matched by reporting capacity, resulting in growing CT and MRI reporting backlogs that may delay clinical decision-making and treatment. Mitigations remain in place, including outsourced reporting, locum support and the return of staff following summer leave, which are expected to improve reporting capacity and reduce the backlog.

CT Dose Reference Level Audit: Several examinations require further optimisation. An action plan is in place, supported by Medical Physics and manufacturer applications teams, to review doses and optimise protocols, reducing the risk of pathway changes being required to maintain compliance and patient safety.

Patient Experience Feedback: Survey engagement remains high, but limitations within the Promptly platform continue to restrict access to qualitative feedback. This limits learning from patient experience and may impact the service's ability to evidence improvement and support accreditation requirements.

IT Business Continuity Planning: The Radiology IT downtime plan is nearing completion, with remaining actions focused on referral processes, reporting arrangements and service configuration during periods of downtime.

Nuclear Medicine MPE Audit: This compliance audit identified a small number of recommendations relating to document control, employer procedures and local governance arrangements. Minor amendments are required, together with completion of the SLA for Medical Physics support with Swansea Bay. An action plan is in place to address these areas and provide assurance of ongoing regulatory compliance.

Ultrasound Governance Review: The review provided positive assurance against the national US governance framework. Ongoing work is focused on peer review, Quality Assurance (QA) and workforce capacity.

Health Sciences

Audiology

Health Visitor industrial action is expected to reduce referrals into paediatric audiology services, potentially delaying diagnosis and intervention for hearing loss. Potential consequences include impacts on speech, language and communication development, and poorer developmental and educational outcomes due to later identification of hearing loss. Potential influx of referrals when strike concludes.



Mitigating actions include additional 0 to 3-year-old clinics, development of Band 6 staff, upskilling adult audiology staff in paediatric assessment, and exploration of alternative referral routes, including self-referral.

Medicines management

Medication Administration Record (MAR) Chart service: Community Pharmacy Wales has advised CTMUHB contractors to consult their indemnity providers. Withdrawal could put medication-administration support at risk as care providers increasingly transcribe pharmacy paper MAR charts into eMARs. National specification changes may partly mitigate the impact.

Parc Prison — mirtazapine misuse: G4S reports tablets are being crushed and smoked; no similar intelligence has been reported from other Welsh prisons. In-cell checks will increase, non-compliant prescriptions will be reviewed with prescribers, and the Task and Finish Group remit will expand to all strengths. Consider escalation via LIN. A Home Office compliance visit is scheduled for 13 October, with documentation due on 10 August.

Assure

Allied Health Professionals

The new MS Forms physiotherapy self-referral pathway has now been fully implemented, replacing the legacy referral system and addressing the associated patient safety concerns. The enhanced form incorporates improved clinical screening and pathway navigation functionality, ensuring patients are directed to the most appropriate service. As a result, the associated high-risk (Risk ID 6429) has been successfully mitigated and closed.

This improvement demonstrates successful clinically led service redesign, delivered through effective collaboration between Physiotherapy, Digital Services and Executive colleagues. The new process provides a safer, more robust self-referral route for patients and strengthens governance around the identification and management of urgent clinical presentations.

Medicines Management

CD audits June and July 2026: Target= 100%. Current figures for completion of CD audits are:

	RGH/YCR	PCH/YCC	POW/YGT
Current compliance	81.5 %	100 %	100 %



with CD ward Audits %			
Previous months compliance %	86.9%	100%	75%

In mitigation:

- The only outstanding audit is for theatres in RGH. The team are awaiting confirmation of an audit day to facilitate access to complete the audit.
- Penicillamine Allergy National Patient Safety Alert: action is due November 2026. Returns have been received from 20/44 practices, identifying 54 patients. Outstanding practices will be chased; records will be reviewed and shared with secondary care for amendment where needed.

Pathology

Pathology HCID (High Consequence Infectious Disease) Task & Finish Group:

The Group has been established to support the development of the CTMUHB HCID Guideline and ensure Pathology procedures align with this guideline. An area of risk identified was the transport of Pathology samples from wards to Pathology and between hospital sites. To support, key members of staff in Pathology have received training in Category A Dangerous Goods Packaging and Transport, training will then be cascaded to Pathology staff. Some risks remain in relation to Category a packaging in the clinical area and Personal Protective Equipment (PPE) guidance, these risks will be actioned as meetings progress.

LIMS 2.0

Tranche 3 (Microbiology) successfully went live on 24th August 2026 and is operational and stable. Go-live proceeded with some defects remaining, however these were mitigated by operational work arounds which will remain in place until resolution of the defect. Successful delivery of Tranche 3 within CTM has been achieved due to the commitment and expertise of the colleagues involved.

Evidential compliance Audit for HTARI Reporting:

The Human Tissue Authority (HTA) has requested that all licensed establishments undertake a sector-wide Evidential Compliance Audit focusing on Human Tissue Authority Reportable Incidents (HTARIs). Organisations are required to submit a declaration of compliance by 18 September 2026, with



any retrospectively identified HTARIs to be formally reported to the HTA by 30 September 2026.

To support this requirement, CTMUHB has completed a comprehensive retrospective review of HTA-related incidents dating back to April 2015. This review involved detailed examination of 198 cases to determine whether incidents met the HTA reporting threshold.

As a result of the review, four probable HTARIs and three potential HTARIs have been identified and are being progressed for retrospective reporting to the HTA. A further assessment of these cases is underway to ensure appropriate classification, reporting, and learning is captured in line with regulatory requirements.

Radiology

Nuclear Medicine Attendance: Work with the Behavioural Science Team is underway to improve attendance at Nuclear Medicine appointments, with the aim of reducing non-attendance and making better use of existing capacity. If successful, the approach could be adopted across other imaging pathways.

Inform

SimplyDo Idea of the Month:

The Biochemistry manager was awarded ‘Simply Do Idea of the Month’ for the proposed standardisation of urine collection bottles across Primary and Secondary Care, with significant laboratory efficiencies identified.

The physiotherapy falls service was awarded ‘Simply Do Idea of the Month’ for August 26 for the proposal on evaluating the long-term effects of falls prevention programme.

Allied Health Professionals

Physiotherapy: The physiotherapy-led MDT pulmonary rehabilitation service was identified by Asthma and Lung UK as the most accessible service, with the lowest waits in Wales and the second-highest referral level. A Pulmonary Rehab video has just been launched to increase awareness.

DTPS Complaints Received and Compliance

Total Complaints (LtP) & Enquiries Received

Month	Formal 30 Days (LtP)	Formal 60 Days (LtP)	Formal 90 Days (LtP)	Formal 120 Days (LtP)	Formal 6 Months (LtP)	Early Resolution (LtP)	Reopened Under LtP	Enquiries
Apr-26	2	0	0	0	0	0	0	59
May-26	2	0	0	0	0	0	0	32
Jun-26	1	8	0	0	0	1	0	22
Jul-26	1	0	0	0	0	0	0	24

Closed Early Resolution (LtP) Complaints Compliance

Month	Early Resolution Complaints Closed	Number Closed within Due Date	Compliance %
Apr-26	2	1	50%
May-26	1	1	100%
Jun-26	5	3	60%
Jul-26	4	4	100%

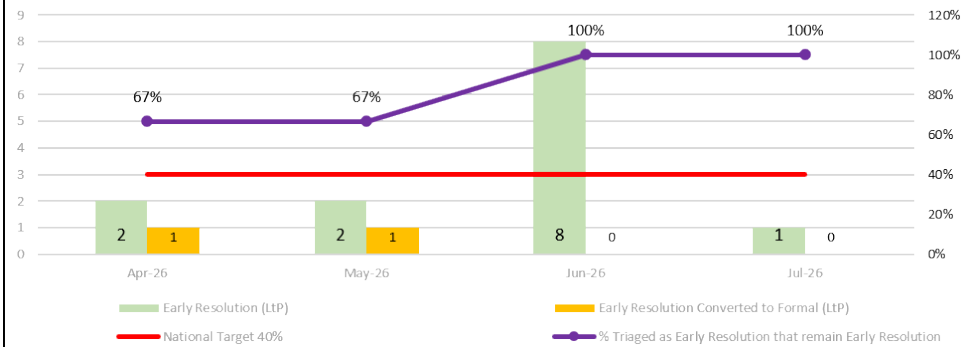
CTM Internal Target 75%



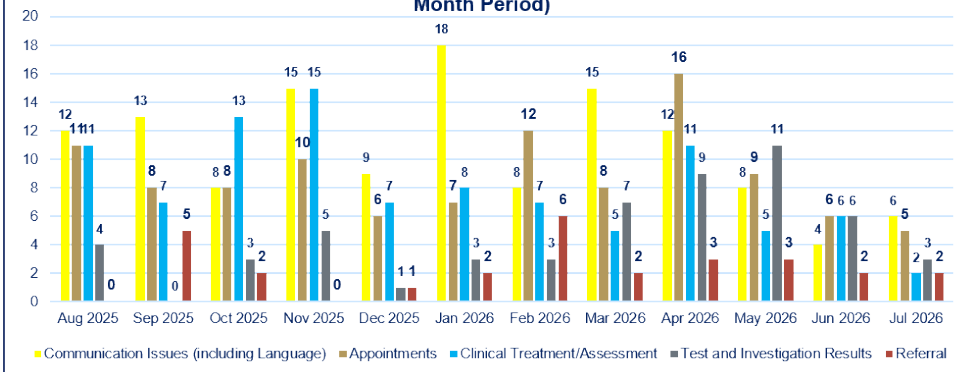
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

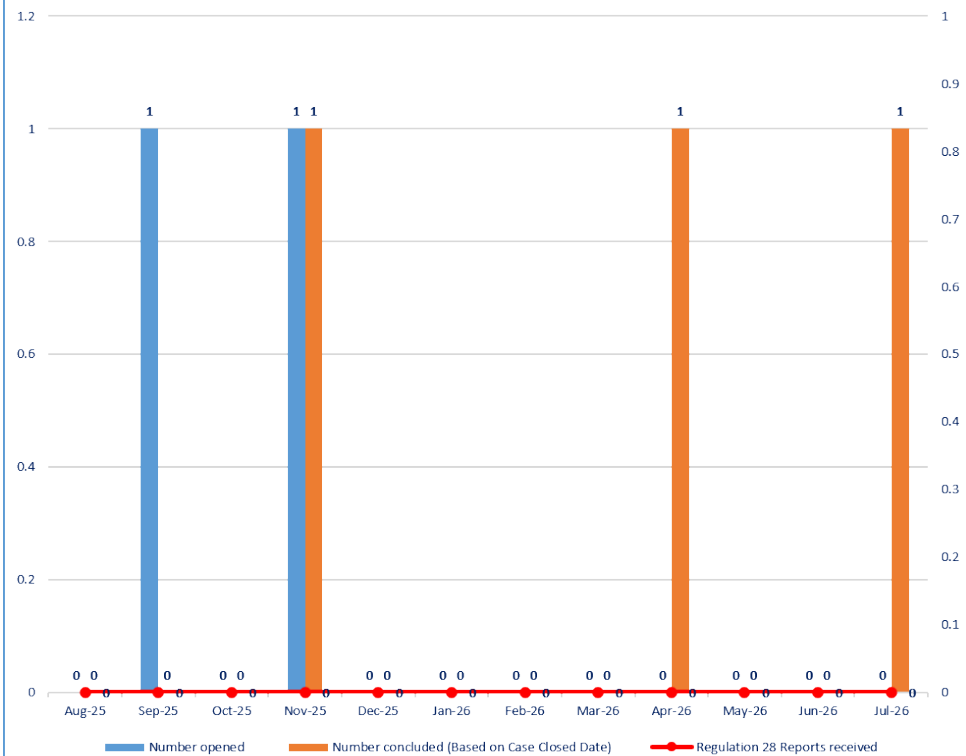
Early Resolution Complaints (LtP) Received Managed as Early Resolution



Top 5 Subjects of Complaints (PTR & LtP) & Enquiries Received (Over 12 Month Period)



Inquest Activity





Appendices	
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4. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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 8 Prevention & Early Intervention
	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	Data to Knowledge
	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 (<i>Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhwch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.</i>) Equality & Welsh Language Impact Assessment Outcome	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please select a reason below. Choose an item. Named Executive/Board member sign off
	Not a requirement at this point Summary of impact: Outcome for Welsh Language (delete as appropriate):	



<i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	POSITIVE/NEUTRAL/NEGATIVE Not a requirement at this point Summary of impact:	for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i> Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>	Not a requirement at this point	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau <i>(Pobl / Ariannol) / Resource Impact (People / Financial)</i>	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
N/A		

Acronyms / Glossary of Terms	
AHP	Allied Health Professionals
CDs	Controlled Drugs
CT	Computed Tomography
DHCW	Digital Health and Care Wales
DI	Designated Individual
DRL	Diagnostic Reference levels
DTPS	Diagnostics, Therapies, Pharmacy and Sciences
FUNB	Follow Up Not Booked
HB	Health Board
HMPPS	His Majesty's Prison and Probation Service
HO	Home Office



HTA	Human Tissue Authority
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
ISO	International Organisation for Standardisation
LIMS	Laboratory Information Management System
LIN	Local Intelligence Network
NOUS	Non-Obstetric Ultrasound Scan
MRI	Magnetic Resonance Imaging
MH&LD	Mental Health & Learning Disabilities
MHRA	Medicines and Healthcare Products Regulatory Agency
MPE	Medical Physical Expert
OOH	Out Of Hours
PACS	Picture Archiving and Communication System
PCH	Prince Charles Hospital
PIT	Productivity, Innovation and Transformation
POW	Princess of Wales Hospital
PPI	Patient and public involvement
QSRE	Quality, Safety, Risk & Experience
RISP	Radiology System Information Project
RGH	Royal Glamorgan Hospital
SDEC	Same Day Emergency Care
SLT	Speech and Language Therapist
SLA	Service Level Agreement
TCLe	Trakcare Lab Enterprise
UAT	User Acceptance Testing
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
WCP	Welsh Clinical Portal



Quality, Safety & Experience Committee

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

Eitem yr Agenda / Agenda Item	4.4.4
Dyddiad y Cyfarfod / Date of Meeting:	22 nd September 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Suzanne Hardacre, Director of Nursing & Midwifery Mohamed Elnasharty, Medical Director
Cyflwynydd yr Adroddiad / Report Presenter:	Suzanne Hardacre
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:	No action or decision required – report is for noting only
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	All Strategic Pillars Apply
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable for this report



1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Children and Families Care Group at its meeting on 13th August 2026.

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

2. Purpose of this Meeting

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

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

2.3 Provide evidence based and timely advice based on local need, to assist in discharging its functions and meeting its responsibilities.

2.4 Provide assurance to the Children and Families Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide. Ensure that care is delivered in accordance with the Duty of Quality and Health & Care Standards for Health Services in Wales.

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

3.0 Highlight Report

Alert / Escalate

- Health Visitor discontinuous industrial action continues and is expected to remain in place until the end of October 2026. Essential contacts and safeguarding priorities maintained. Wellbeing support has been actively sought and made available for staff who continue to work during this period. Meetings have been held with the Nursing and Midwifery Council (NMC) to clarify regulatory requirements and professional accountability arrangements throughout the delivery of essential services. Daily Care Group and Workforce Strike Cell meetings continue to provide oversight of operational activity, workforce deployment, service flow, and risk management. Care Group visits to Hubs for support in place, Chair, Chief Executive and Executive Director of Nursing and Patient Care have visited staff at Keir Hardie Health Park.
- Due to exceptionally high sickness absence rates within the community midwifery workforce, the Tirion Freestanding Midwifery Unit (FMU) and home birth service were



	temporarily suspended for a six-week period to maintain the safety and sustainability of core services. Daily situational reporting (SITREP) meetings have remained in place to provide assurance regarding safety, staffing, and operational pressures across all maternity service areas. As workforce pressures have begun to ease, the Tirion Birth Centre will resume operationally from 7 September 2026, with the home birth service situation review scheduled for 17 September 2026. Quality Impact Assessment (QIA) and Risk Assessments in place.
Advise	• Concerns raised by community midwives and Trade Union representatives relate to psychological safety and speaking up, workforce and workload pressures, leadership visibility, communication, on-call arrangements, clinical safety and governance. A confidential listening exercise has identified consistent themes and recommendations. Immediate safety concerns are being assessed separately from the longer-term cultural and leadership actions. A consolidated action plan, with named executive and operational ownership, milestones, staff engagement arrangements and measures of improvement, is being developed and will be overseen through the agreed governance route. • Care Group Directors attending Executive Management Board on 1st September to discuss workforce, whole system pressures, outcome measures and opportunities for improvement. • Regional Integrated Fund (RIF) funding for the CHOICE Programme within Sexual Health is due to end on 31 March 2027. The programme has been operating since 2020 and has made a significant contribution to improving prevention and early intervention, enhancing privacy and confidentiality, and reducing the stigma associated with accessing sexual health services, helping to reduce health inequalities and improve outcomes, including increased uptake of cervical screening. Service leads are developing an options appraisal, exploring opportunities for the programme's long-term sustainability. • Pregnancy Advisory Service (PAS) service level agreement (SLA) with Swansea Bay University Health Board (SBUHB) has begun. Nursing posts awaiting approval on TRAC system for recruitment. • An issue relating to the accuracy of growth charts within the BadgerNet system has been identified by the service. This has been confirmed as a national issue, and all Welsh Health Boards and the Welsh Government have been briefed accordingly.



Assure	• Changes to the Vaccine Group Directive (VGD) for immunisations have had a significant impact on staffing requirements and are expected to slow the delivery of the immunisation schedule. Under revised arrangements, all consent and clinical assessments must now be undertaken by a registered practitioner, supported by a staffing ratio of one registrant to three unregistered staff. Ten week delivery plan in place with two further weeks to target areas of low uptake. • Opportunities to streamline Band 5 Children's Registered Nurse (RN) posts are being explored. The Practice Development Team is actively working to upskill the existing workforce to meet increasing service demands and required competency standards. • Single point of access (SPOA) weekly dashboard analysis of contacts, including themes and trends monitored via daily strike cell meeting. • Care Group Safeguarding Forums introduced to share learning, updates and improve communication by service area. Chaired by Lead Nurse for Safeguarding. • Care Group pressure ulcer forum introduced to align with Health Board Harm Free Care, ensure appropriate level of scrutiny and improvement actions in place. • Maternity service working with planned care colleagues to improve standards and environmental challenges within obstetric theatres and ensure alignment with planned care. • Maternity 'Call for Concern' programme commencing 14th September 2026. • Infant security system progressing within Princess of Wales (PoW) maternity Unit. The 'XTAG' system standardises systems across postnatal wards and improves security standards at PoW.
Inform	• Nursery Fluenz – thanks to primary care and public protection team for supporting the Care Group to ensure timely delivery of the vaccination programme during industrial action (IA). • The care group has provided comments in response to all Wales job descriptions (health visitor) • Paediatric diabetes team have been awarded a co-production grant to support children with type 1 diabetes and their families through three co-produced events (under 7s, 8-12 and 12-18yrs). Exploring early post diagnosis experience and how young people prefer to access structured diabetes education. • Trial of QR code as part of handover within paediatrics to capture informal feedback from families. Work underway with the patient experience team to explore different ways of capturing feedback for children, young people and their families.



	• Estates work to enhance the gynaecology hub at Royal Glamorgan now underway. Re-opening plan being prepared. • Outdoor space for special care baby unit (SCBU) at PoW secured, this will enhance family integrated care and family experience • Endometriosis specialist nurse interviews arranged. • Electronic birth outside of guidance referrals has been implemented. This has ensured more timely access with clinics extended across sites. • Consultant midwives presenting at the national midwifery and maternity festival on 23rd September • Multi professional team supported to attend latest MBRRACE Study Day 17th September • Three midwives will begin enhanced recovery care module via HEIW at Cardiff University in January 2027 • Two midwives and two specialist community health practitioners (SCPHN) have been supported to undertake 'remote decision-making workshops'.
Appendices	

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)	All Strategic Risks Apply
	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	All Enablers of Quality Apply
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	If more than one applies please list below:
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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 <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	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:
Equality & Welsh Language Impact Assessment Outcome <i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>		
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i>	Not applicable for this report	
Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>		
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau <i>(Pobl /Ariannol) / Resource Impact (People / Financial)</i>	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	
HEIW	Health Education & Improvement Wales
HV	Health Visitor
IA	Industrial Action
MBRRACE	Mothers & Babies, Reducing Risk through Audit & Confidential Enquiries
NMC	Nursing & Midwifery Council
PAS	Pregnancy Advisory Service
PCH	Prince Charles Hospital
PoW	Princess of Wales Hospital
QIA	Quality Impact Assessment
QR	Quick Response
RGH	Royal Glamorgan Hospital
RIF	Regional Integrated Fund
RN	Registered Nurse
SBUHB	Swansea Bay University Health Board
SCBU	Special Care Baby Unit
SCPHN	Specialist Community Public Health Nurse
SITREP	Situation Report
SLA	Service Level Agreement
TRAC	NHS recruitment applicant tracking system
VGD	Vaccine Group Directive



Quality, Safety & Experience Committee

Highlight Report

Primary Care and Communities Care Group

Eitem yr Agenda / Agenda Item	4.4.5
Dyddiad y Cyfarfod / Date of Meeting:	22 nd September 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Nurse Director, Primary Care & Communities
Cyflwynydd yr Adroddiad / Report Presenter:	Nurse Director, Primary Care & Communities
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:	No action or decision required. Report is for noting only
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	All Strategic Pillars Apply
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable

1. Introduction

- 1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience Primary Care and Communities Care Group at its meeting on the 20th August 2026.
- 1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

- 2.1 The purpose of the Care Group is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.
- 2.2 The Primary Care and Community Care Group QSRE Board will:
- Put the needs of patients, carers and the public at the centre of all its business.
 - Provide evidence based and timely advice to the Primary Care and Community Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
 - Provide assurance to the Primary Care and Community Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
 - Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
 - Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

Alert / Escalate

Paediatric Dentistry GA List

A significant delay with a small number of children requiring GA. The teams have worked alongside secondary care colleagues to plan reductions in waiting times for the children on the list. Please see appendices for a detailed breakdown and trajectory of the service.

Since October 2025, the longest wait has reduced from 106 to 75 weeks to July 2026 - children receive GA within 8-10 weeks of assessment. There was a spike in June as all Paeds assessment clinics were merged into one Paeds assessment



	clinic, where all outcomes for treatment could be assessed in 1 assessment i.e. GA and sedation. This is positive for both patients and the service. The trajectory shows that there is a significant decline in those needing a GA for treatment, which is estimated to go down to 240 by December 2026. The service is now allocated sufficient theatre lists to meet capacity. In addition, the conversion rate is reducing due to children being assessed and treated sooner than in previous years.
Advise	<u>Lymphoedema Service</u> There is currently a waiting list of approximately 1,700 patients, with the service receiving around 130 referrals each month. Following an initial review with the team, it has been identified that a significant proportion of referrals may not be appropriate for the service. Consequently, patients can remain on the waiting list awaiting an initial assessment, following which they are either discharged or retained within the service due to the limited availability of alternative pathways to meet their needs. As an immediate mitigation, referral processes and criteria are being reviewed with the service and key stakeholders to improve the appropriateness of referrals and reduce avoidable waiting times. This will be supported by strengthened clinical oversight and engagement with referring teams to ensure patients are managed through the most suitable pathways. Early findings provide assurance that there are opportunities to improve service efficiency and flow through reconfiguration of the current model. It is anticipated that implementation of a revised operating model will result in a significant reduction in the waiting list and an improvement in patient access. The review will also establish a clear understanding of demand, capacity, and productivity to support sustainable service delivery. A programme of work will commence in September 2026 to undertake a comprehensive review of the service, including referral appropriateness, demand and capacity and opportunities for service redesign. This work will also explore alternative models of care and support, ensuring patients are directed to the most appropriate services at the earliest opportunity. The programme of work is expected to conclude by December 2026, with recommendations for service redesign and implementation plans developed thereafter. Detailed activity modelling, trajectory projections, and key performance milestones will form part of the review, providing assurance on



the anticipated timescales for waiting list reduction and ongoing performance monitoring.

Navigation Hub

Due to a system change within WAST, Navigation Hub clinicians are now unable to enter the ambulance stack for patients who are undergoing screening by WAST. This screening can take up to 55 minutes for WAST to complete. This means that there is now a delay in Navigation Hub clinicians being able to manage cases and subsequently a delay to patient care and treatment. Work is ongoing with WAST leaders to explore alternative ways of working.

Specialist Palliative Care Ward (Ward 6, YCC)

The inpatient ward is currently planned to close during September/October 2026. The final closure date will be determined following a comprehensive review of the needs of the patients currently receiving care on the ward, ensuring that appropriate arrangements and continuity of care are in place prior to implementation.

Detailed transition planning is underway to ensure continuity of care for existing patients, support for staff, and management of operational risks associated with the ward closure. Referral pathways, workforce requirements, and community service capacity will be closely monitored throughout the implementation period. The programme is being overseen through established governance arrangements, with regular review of patient outcomes, workforce preparedness, pathway effectiveness, and service performance.

As part of the transition, a new direct admission pathway from the Emergency Department to Community Hospital beds for patients requiring end-of-life care will be formally implemented. This pathway is currently being piloted on Ward 6 and is providing valuable assurance regarding patient flow, operational processes, and the suitability of the model prior to full rollout. Learning from the Ward 6 pilot will inform the final implementation of both the Hospice at Home service and the direct admission pathway.

Following ward closure, the new Hospice at Home model will be introduced. The service has been designed in response to identified patient needs and will provide a more flexible and responsive approach to delivering palliative and end-of-life care within community settings. A structured implementation and induction programme will be undertaken to support staff transitioning to the new model, including the provision of any



	additional training, skills development, and competency assessments required to ensure safe and effective service delivery. <u>Operational Issue with Civica Scheduling within District Nursing</u> The District Nursing Service currently utilises the Civica scheduling system to support the allocation and management of patient visits. Ongoing system issues, which are being experienced across Health Boards in Wales, continue to impact scheduling reliability, data quality, and visibility of demand and capacity. The primary risk relates to patient safety, with the potential for visits to be delayed, missed, duplicated, or allocated inappropriately. There is also a risk to operational efficiency, workforce productivity, and the accuracy of performance reporting. Enhanced clinical and managerial oversight, daily validation of scheduling activity, and manual contingency processes have been implemented to minimise risk. Issues continue to be escalated through local and national governance arrangements with DHCW and Civica. A new version has been implemented which has delivered improvements in system performance and functionality. Remaining issues are subject to ongoing monitoring through established governance and risk management processes to ensure patient safety is maintained. A further updated version is scheduled for implementation and is expected to address the majority of outstanding issues. Existing mitigations will remain in place until the upgrade has been implemented and evaluated, with progress and residual risks reported through the appropriate governance structures.
Assure	<u>Woundcare Project</u> Following non-recurrent funding received the team have developed a Wound Care pilot. This team will support patients with complex wounds and/or lymphoedema. The aim of the service is to Provide a more focused and streamlined approach with earlier interventions that support people to become more independent with their Woundcare at home for longer. Have a stronger focus on prevention as well as treatment and improve health and wellbeing outcomes. Easier to access to specialist advice compared to the current fragmented and numerous systems of care. There are national measures and outcomes in place to provide an ongoing and final evaluation of the project.



	<u>Drug Storage</u> An issue has been identified during the heatwave with the storing of drugs in the home visiting cars. The temperature has exceeded that recommended by the manufacturer for safe storage. There is a risk that this may cause some medications to have a reduced efficacy or earlier expiry date. We have explored this issue with pharmacy colleagues and have agreed actions to ensure the medication is safe to use.
Inform	<u>Staff Achievements</u> 4 staff members of District Nursing staff nominated for Nurse of the Year awards, 2 have been shortlisted. Y Bwthyn Newydd inpatient unit, recently won the best student placement 2026 from the interprofessional team @ USW across CTMUHB. <u>Direct payments for CHC.</u> Direct Payments are cash allowances provided to patients requiring care and allowing them to purchase services themselves. Recent legislation has been introduced in Wales to enable DPs for CHC; further legislative steps are required to develop regulations which will pass these Directed Functions onto HB's. From 1st of April there is a requirement that HBs develop operational structures to meet this function, ensuring HB's are in a position to develop full local protocols. An implementation group has been set up looking at the operational requirements including a Standard operating policy and joint working with partner agencies. <u>District Nursing</u> New medication panels within District Nursing commenced June 2026 with good effect and scheduled monthly chaired by Lead Nurse. Good learning opportunities across the service. <u>Junior Volunteer Pilot</u> Commenced in YCR hospital throughout June and July. Children aged 15 volunteering with patients and therapy nurses on the Stroke Ward, supporting patients with companionship, games etc. The plan is to roll out the programme into schools to continue in the Summer next year, also including YCC Hospital. <u>Pathways Navigation Hub.</u> There is a number of new pathways introduced within the Nav Hub. • Prescribing pathway for wound clinic work is ongoing. The team are currently scoping a prescribing pathway to support Lymphoedema services.



- The prescribing pathway for high-risk podiatry patients has now gone live. This supports the podiatry service in order to reduce delays to treatment commencing.
- Rabies pathway with HPOT- we have now had over 30 cases via the CNH.
- Post Exposure Prophylaxis pathway in conjunction with HPOT and PHW for Measles and Hepatitis A is almost complete. This is the first pathway of this type in Wales. This pathway encompasses vaccination and administration of HNIG to those patients in a high-risk group.

Rabies Pathway – Navigation Hub

The post-exposure Rabies pathway has recently been reviewed and adjusted to reflect growing experience of working within the process. The amended document was presented to the Post-Exposure Prophylaxis Working Group in July 2026. The team have administered circa 30 vaccinations (since March 2026) which is significantly higher than anticipated.

2026/27 Seasonal Flu Planning

The detailed planning required for the upcoming Autumn/Winter Seasonal Flu Programme 2026/27 is underway. This year's WHC directs Health Boards to the co-administration of both Covid and Flu vaccinations (where operationally possible). This is to be an offer that is a patient-centred approach reducing the need for the public to have each vaccine given in different venues and by different providers. The direction has a particular significance for our Primary Care colleagues and the implications (both financial and logistically) are currently being worked through.

A working group looking at the model for the staff flu vaccination campaign has been established to build upon the work and outcomes achieved last year. The working group is being led by colleagues in Occupational Health.

In-Patient/Staff vaccinations:

The Health Protection team is providing training for all hospital sites to ensure there is a peer vaccinator programme in place. This will allow hospital-based staff to vaccinate their own staff and in-patients this coming Autumn/Winter Flu season.

MeningitisB one-off Student Campaign

We are currently working through the Meningococcal B programme for students who will newly attend Universities/residential Higher Education this year. The campaign began on 21st July and has been very well received. By the 24th August, the team has administered circa 1,500 MenB vaccinations averaging 240 per day across the sites.



	<u>Big Welsh Bite 2026</u> The Health Protection Team had secured a pitch for a Mobile Vaccination Unit to be sited at the Big Welsh Bite food festival on Saturday 1st August. This gave them the opportunity to have staff on site for the day to meet and greet the public and to have vaccine conversations. The team also took the opportunity to raise awareness of the service; to have some myth busting discussions and where eligible they vaccinated on site. An evaluation of the success of the day will follow. <u>Parc Prison</u> A Tuberculosis exercise was undertaken on 30/6/26 by PHW across Wales Prisons to evidence and assure the ability of an outbreak, the team are awaiting feedback. Meningitis Vaccinations – a group of Young Persons and Main Prisoner/Patient have completed a programme of meningitis vaccinations. This focusses on those between born between 1/9/2007 to 31/8/2008.
Appendices	

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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 Service Transformation & Outcomes
	If more than one applies, please list below: Strategic risk 3, 4, 5, 8, 9
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: Ageing well Dying Well Growing Well



Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All Enablers of Quality Apply	
	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.)	Outcome for Equality (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:
Equality & Welsh Language Impact Assessment Outcome (Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	
Canlyniad Asesiad Effaith Ansawdd (Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)	QIA's are undertaken for reports that require a formal decision. As part of the governance process, all decision-making reports are discussed with the Care Group.	
Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	QIAs are not required for reports that are presented for noting rather than decision.	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	

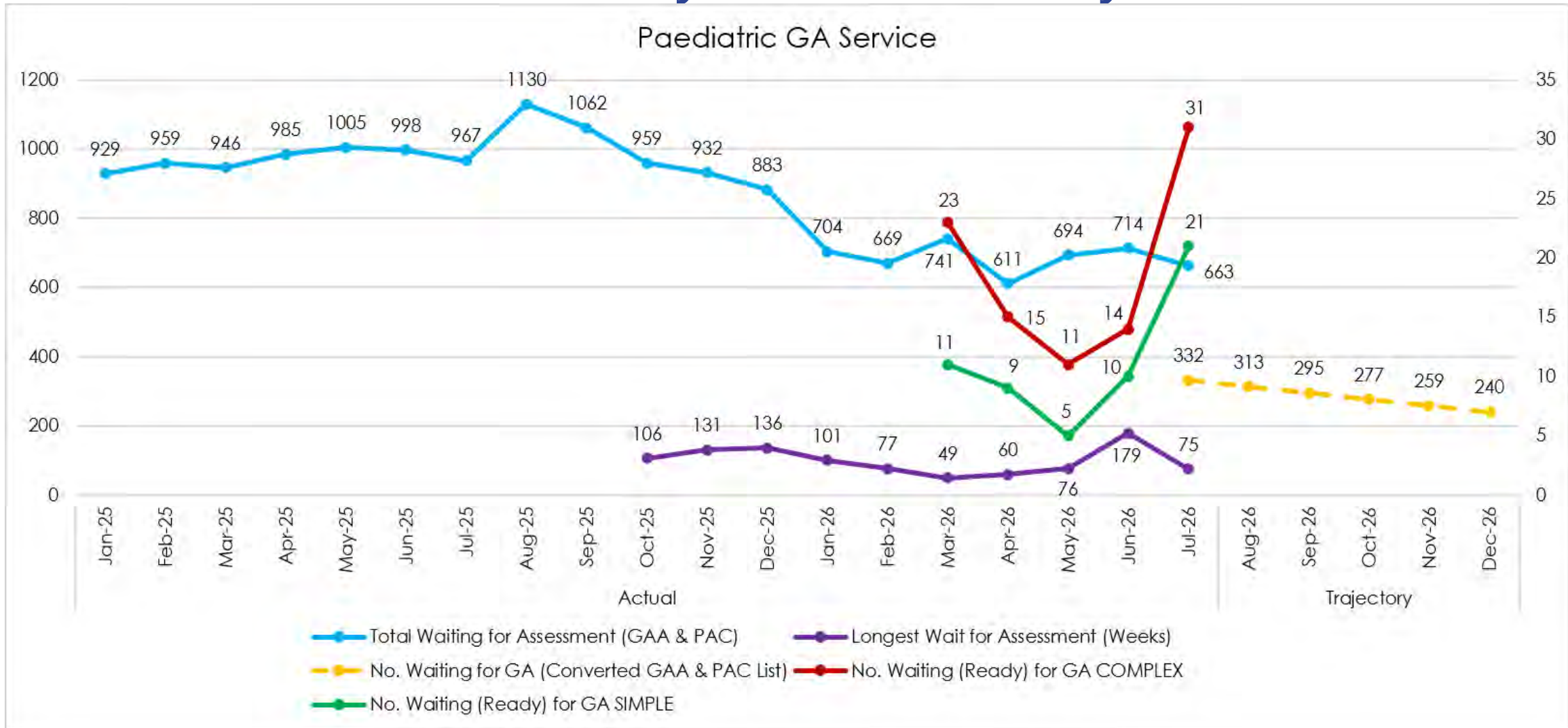


Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report

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	
CHC	Continuing Health Care
CNH	Clinical Navigation Hub
CTM	Cwm Taf Morgannwg
DN	District Nurse
DP	Direct Payments
ED	Emergency Department
GA	General Anaesthetic
GDP	General Dental Practice
GP	General Practitioner
HB	Health Board
HNIG	Human Normal Immunoglobulin
HPOT	Health Protection Outreach Team
LA	Local Anaesthetic
PHW	Public Health Wales
USW	University of South Wales
WAST	Welsh Ambulance Service Trust
WHC	Welsh Health Circular
YCC	Ysbyty Cwm Cynon Hospital
YCR	Ysbyty Cwm Rhondda Hospital

Paediatric Dentistry - Community Dental



Updated Trajectory for Paediatric GA Dentistry.

- This graph shows the **COMPLEX CARE** patients represented by the **RED LINE** and **SIMPLE** cases by the **Green line**
- The **BLUE LINE** represents **ALL CHILDREN** in the system needing an assessment- outcomes can be treatment under GA/Sedation/LA/return to GDP.
- The spike in July **COMPLEX** and **SIMPLE** ready for GA is due to increased assessment clinics being run in readiness to fill the GA lists, however the delay in these patients being treated was due to 6 weeks of GA lists being cancelled at RGH due to anaesthetic cover.
- The **YELLOW LINE** shows how many children will convert into GA from the **BLUE LINE**- showing a significant decline in those needing a GA for treatment, which is estimated to go down to 240 by December 26. The conversion rate has reduced from over 78% to below 50%.
- **PURPLE LINE**: Since Oct 25, the longest wait has reduced from 106 to 75 weeks in July'26- children receive GA within 8-10 weeks of assessment. There is a spike in June as all Paeds assessment clinics were merged into one Paeds assessment clinic [PAC], where all outcomes for treatment can be assessed in 1 assessment i.e. GA and sedation. This is positive for both patients and the service.



Quality, Safety & Experience Committee

MHLD Highlight Report

Eitem yr Agenda / Agenda Item	4.4.6
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Jacky Francis Care Group Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter:	Lloyd Griffiths Head of Nursing
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:	For QSEC members to note the content and take assurance from the report.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	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 Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable

1. Situation / Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the MHL D Care Group at its QSE meeting on 12/08/2026.

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

2. Specific Matters for Consideration

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

2.2 The MHL D Care Group QSE Board will:

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

3. Key Risks / Matters for Escalation

Alert / Escalate

- The use of surge beds on Ward 14 has increased in frequency. Over the past three months, the ward has regularly exceeded its capacity. The patient flow coordinator role and daily huddles ensure that patient flow is managed and there is a clear escalation and de-escalation process in place for use of additional beds. This includes a process for escalation to senior managers/clinicians to ensure good governance and oversight. There is robust operational and clinical oversight of the use of surge capacity.

Where required additional staffing is sourced to manage the increased clinical dependency. However, due to the unplanned nature of some admissions, securing staff at short notice remains challenging which can place additional pressures on the ward clinical team. There is work planned to review the staffing position for inpatient wards which will be led by the Nurse Director MHL D.

	- The anti-ligature risk assessment process has identified additional works required to further reduce ligature risk within the inpatient environment. These have been escalated to estates and have commenced. The adult directorate are managing this, and the risk is known at ward level and identified on ward risk assessments. - Staffing in the Rhondda CMHT is pressured due to high levels of sickness and vacancies resulting in higher caseload numbers for remaining staff. To mitigate this demand other Community MH services are providing temporary cover and 2 Community Mental Health Nurses (CMHN's) have been appointed and commenced in role. A substantive Consultant Psychiatrist is due to commence in post September 2026 and in the interim a Locum Consultant Psychiatrist is providing dedicated caseload review sessions. Local Authority (LA) colleagues are supporting with duty cover.
Advise	- EPMA was successfully implemented across Ward 14 and PICU at POW. The Crisis Resolution Home Treatment Team (CRHTT) team at POWH has completed training and is operating in line with the agreed Standard Operating Procedure (SOP). Training for the teams at Prince Charles Hospital (PCH) and RGH is currently underway. - All MHLd now have Anti-ligature risk assessment using the new all Wales workbooks. The risk assessments are completed by ward teams alongside Health and Safety and Estates colleagues and approved at the Care Groups bi-monthly Anti-Ligature Escalation Panel. - Phase 2 of the Capital Improvement scheme in Ty Llidiard which will create a purpose-built Extra Care Area is well under way with completion estimated for October 2026. - On 13/04/2026 CTMUHB was notified that a private provider awarded a contract (to provide Opioid Replacement Therapy (ORT), such as Methadone and Buprenorphine, to those CTM residents leaving prison custody) could not meet the requirements of the contract due to registration issues with HIW. To maintain the prescribing for these individuals the only viable option was for the CDAT service to temporarily take over the prescribing and administration of the ORT until the

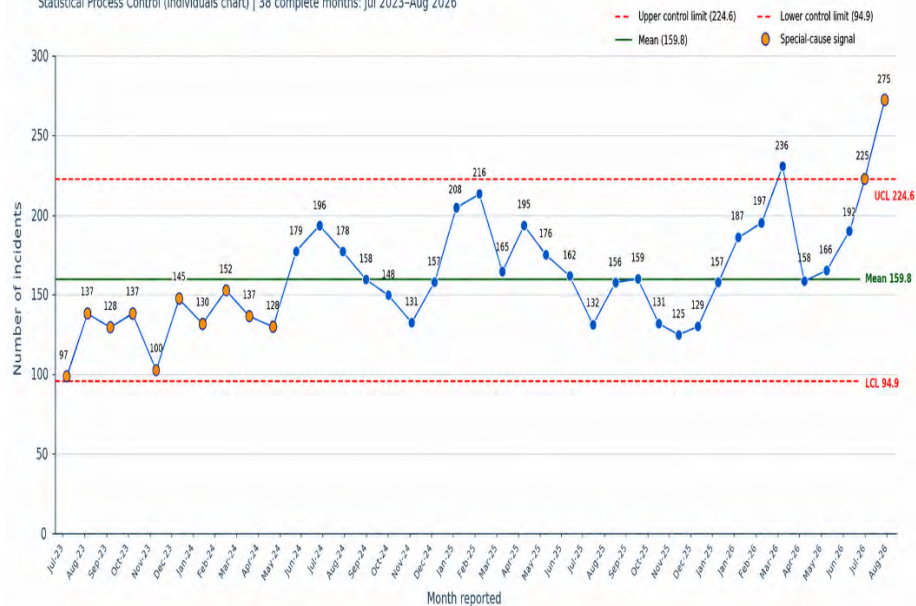


	provider received its HIW registration. There are around 150 CTM residents affected. The CAMHS and SS directorate continue to hold regular meetings with partner agencies to provide updates, and a further daily meeting is held with clinical staff to resolve any operational issues.
Assure	• The total number of concerns received by the Care Group during this reporting period (8 in July and 7 in August) was below with the yearly monthly mean of 13. The top 3 subject areas for concerns and enquiries have remained consistent over the past 12 months; 1. Clinical Treatment/Assessment (Highest last report) 2. Appointments (Third highest last report) 3. Communication Issues (Second highest last report) The Adult Community Directorate has the highest number of concerns; however, this is not unexpected as it is the directorate with the largest number of service users in areas such as Outpatients and LPMHSS. The themes of concerns and enquiries are monitored in the individual directorate QSE meetings using the Datix dashboards. At the time of this report there are 11 open complaints in the MHL D Care Group, all of which were received during this reporting period and are in date. • The number of patient safety incidents reported on Datix in recent months is more than the 3-year mean of 160 per month. There were 225 reported in July and 275 in August.



Mental Health Care Group - Patient Safety Incidents

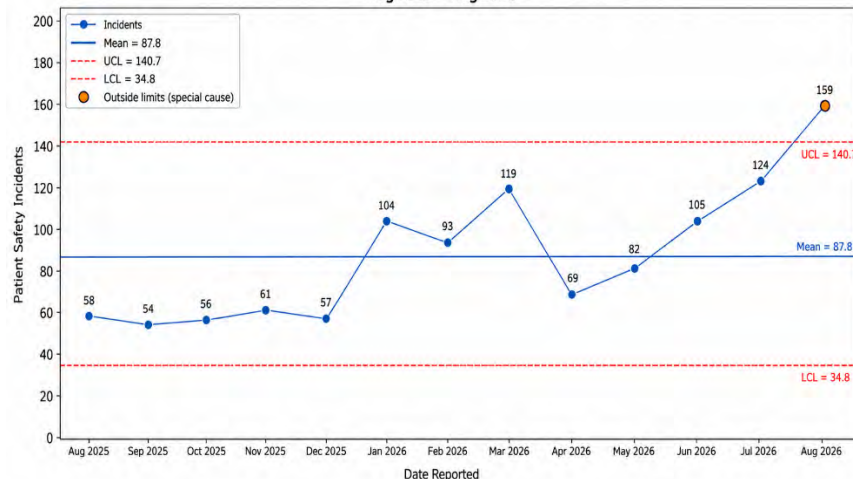
Statistical Process Control (Individuals chart) | 38 complete months: Jul 2023-Aug 2026



Limits calculated from the average moving range (3-sigma). Orange points indicate an SPC signal, not necessarily good or bad performance.

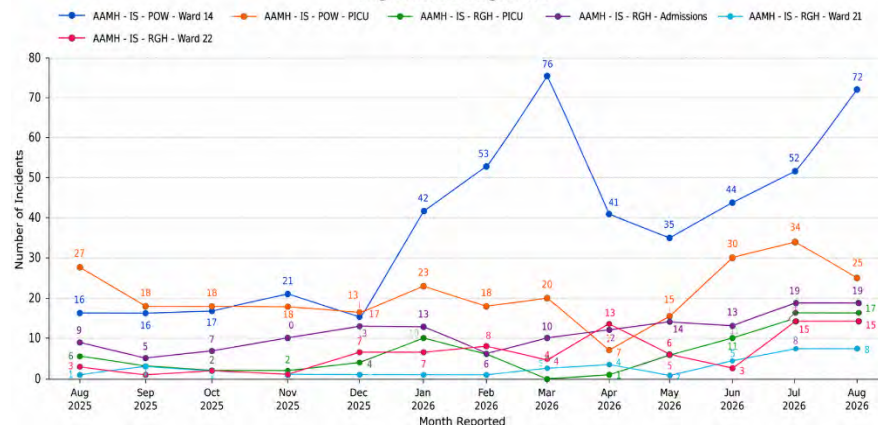
These above average figures are being driven by high levels of reported patient safety incidents in the Adult Acute directorate (inpatient wards); however, it is above the 1 year mean of 88 and above the upper control limit.

Mental Health & Learning Disabilities (Adult Acute) - SPC Chart Aug 2025 - Aug 2026





AAMH Patient Safety Incidents – Run Chart (AAMH Areas Only)
August 2025 to August 2026



Of the 6 Adult Wards, Ward 14 POW has seen a noticeable and sustained increase in incidents (72 in August). The Adult Acute Directorate were asked to present a deep dive into this increase at the MHLDCare Group QSE.

Of the 72 incidents reported in August, 46 involved self-harm, no other category had more than 3 reported incidents. The 1 year mean for the self-harm category is 15.

Of these 46 self-harm incidents all 46 were reported and assessed as being no or low harm. 44 of the 46 incidents involved 2 patients (32 +12 incidents). Both patients have a history of high volume, low harm incidents as inpatients and both have robust care plans including discharge plans to mitigate and manage their individual clinical risk profiles.

The Adult Acute Directorate will continue to monitor incident rates, themes and trends and will further report to the October MHLDCare Group QSE. This will enable us to consider any actions required as a result where trends or themes are identified.

- There are 3 open NRIs which is below with the 2-year mean.

There were 2 new NRIs reported during this period (1 July, 1 August).

- The use of AMAT is firmly embedded in the Care Group. Compliance with ward audits as of the end of August is shown below.



	Project	Number of audits	Current compliance
	Health & Safety	1	
	Health and Care Standards	2	
	Infection Control	16	 85.0%
	Medicines Management	2	 94.7%
	Patient Safety	28	 92.2%
	In the Patient Safety category, the overdue actions have increased from 51 to 72 as further audits have been added. Of the 72, 38 are RAG rated green with 4 RAG rated as amber and 0 as red (down from 2). The 4 Amber areas relate to Senior Nurse Spot checks on the Older Adults (OA) wards and will be rectified this month. Performance against these audits is monitored in individual directorate's QSE meetings. Mental Health In-Reach Team (MHIRT) has established a regular depot clinic at HMP Parc within a dedicated clinical area. This is having a positive impact on patient care and healthcare service delivery within the prison.		
Inform	- The Older Adult Memory Service team completed the 13-mile Brecon Trek to raise money for the Alzheimer's Society. - The MHLDC team have been working with the VBHC team to develop a suite of questions to collect feedback from patients in CHC funded placements. The VBHC will also support in developing easy read versions for implementation in Learning Disabilities (LD) and Dementia Care settings. Results will be reported to the MHLDC QSE. - The Team Leader from Older Adults Mental Health Services (OAMHS) Memory Service in Bridgend met with South Wales Police (SWP) to give an overview of the Memory services and the support provided for people living with dementia both in the community and Prison. The feedback from SWP was very positive and further presentations for newly recruited police officers have been arranged.		
Appendices	None		



Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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 Service Transformation & Outcomes	
	If more than one applies please list below: Risk 6 Safe Estate Infrastructure Risk 3 Workforce Capacity and Culture Risk 8 Prevention and Early Intervention	
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: A Resilient Wales	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research	
	If more than one applies please list below: Culture and Valuing People Data to Knowledge Whole systems perspectives	
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 (<i>Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.</i>) Equality & Welsh Language Impact Assessment Outcome (<i>Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.</i>)	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: No impact identified. Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: No impact identified.	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)	This is a quality, safety, experience committee report which updates and assures a wide range of clinical and operational matters. No decisions taken within the report which would impact on service provision, people using our services or staff to necessitate a QIA.
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	
AMAT	Audit Management and Tracking system
CAMHS	Child and Adolescent Mental Health Services
CDAT	Community Drug and Alcohol Team
CHC	Continuing Health Care
CMHT	Community Mental Health Team
CTM	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
DSH	Deliberate Self Harm
EPMA	Electronic Prescribing & Medication Administration
FACS	Forensic Adolescent Consultation Service
HB	Health Board
HCSW	Health Care Support Worker
HIW	Healthcare Inspectorate Wales
JCC	Joint Commissioning Committee
KPI	Key Performance Indicator



GIG
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Cwm Taf Morgannwg
University Health Board

LPMHSS	Local Primary Mental Health Support Service
LtP	Listening to People
MDT	Multi-Disciplinary Team
MH	Mental Health
MHLD	Mental Health and Learning Disability
NG	Naso-Gastric
NHSPI	National Health Service Performance and Improvement
NRI	Nationally Reportable Incident
ORT	Opioid Replacement Therapy
OPMHS	Older Peoples Mental Health Services
PICU	Psychiatric Intensive Care Unit
PMVA	Prevention and Management of Violence and Aggression
POW	Princess of Wales Hospital
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
RGH	Royal Glamorgan Hospital
RN	Registered Nurse
SLT	Senior Leadership Team
SON	Statement of need
SS	Specialised Services
VBHC	Values Based Health Care



Meeting Name:	Quality, Safety and Experience Committee
Report Title:	Stroke Service update
Agenda Item:	22/09/2026
Date of Meeting:	4.5
Publication Status:	Public
Report Prepared by:	Sarah Follows, Service Director, USC Gary Howell, Clinical Director of AHPs
Report Presenter:	Sarah Follows, Service Director, USC
Report Executive Sponsor	Lauren Edwards, Exec Director AHP and HS
Report Purpose:	For Noting
Action / Decision Required:	The Committee is asked to note the progress achieved, recognise the residual variation and flow-related risks, and support continued oversight until improvements are consistently embedded.
Strategic Context: This report aligns to the following Strategic Pillars	Improving Care
Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (Reference relevant priority)	Strategic Clinical Services Plan

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:

What (summary of current position / issue & why it matters and evidence to support that position etc)	The 40-day review demonstrates broad improvement across the major stroke pathway measures. In the latest reported week, CT within 60 minutes increased from 44% to 75%, CT within 45 minutes from 28% to 70%, ASU admission within four hours from 14% to 35%, and swallow screening within four hours from 37% to 65%. AHP and Early Supported Discharge performance have also strengthened.
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 programme is improving the timeliness and reliability of stroke care and supports the Strategic Clinical Services Plan. However, assurance remains partial because CT within 20 minutes is below the national standard, performance varies by week and site, and ASU transfer remains vulnerable to patient flow, bed availability and workforce capacity.
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)	Over the next 30 days, maintain daily oversight; standardise RGH and golden-pathway practice across sites; undertake case-level delay reviews; escalate capacity and flow constraints; and strengthen patient and family experience evidence. These actions aim to consolidate gains, reduce variation and support sustainable delivery.



Recommendation (Linked to the “What Next” section above).	NOTE the improvement across the major pathway and AHP measures; RECOGNISE the residual variation, flow and workforce risks; and SUPPORT continued oversight and delivery of the next 30-day actions. Recommended assurance: PARTIAL.
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 patient safety Impact: delayed imaging, inconsistent access to the Acute Stroke Unit, site variation and insufficient workforce capacity may affect timely, safe and equitable stroke care. The improvement programme mitigates this through daily oversight, standardisation and escalation.
Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales Also supports A More Equal Wales through consistent access to evidence-based stroke care, and A Resilient Wales through development of a sustainable specialist workforce and pathway.
Environmental Sustainability Impact (5Rs)	Reduce, Reuse and Rethink Pathway redesign and Early Supported Discharge support care closer to home and may reduce avoidable inpatient delay and travel. Environmental impact has not been separately quantified within this update.
Link to Enablers of Quality	Leadership, workforce and whole-system approach Enabled by multidisciplinary clinical leadership, data-led improvement, patient-focused care, learning across sites and clear accountability through operational and quality governance.
Impact Assessment	
Equality & Welsh Language Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	No separate assessment has been completed for this progress update. The pathway focus is intended to improve equitable access; Welsh-language needs will continue to be met in line with organisational standards.
Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	The review identifies a positive quality impact through improved imaging, swallow screening and thrombolysis reliability. Residual risks remain from pathway variation, flow, bed availability and workforce capacity, requiring continued oversight.
Cyfreithiol / Legal	No specific legal issues are identified within this update. Delivery must continue to meet applicable clinical, workforce, equality and Welsh-language duties.
Enw da / Reputational	Improved performance supports public confidence. Continued variation or inability to sustain timely access may create reputational risk; transparent monitoring and escalation remain important.
Resource Impact (People / Financial)	Delivery requires sustained multidisciplinary capacity and management oversight. Current AHP workforce is insufficient for a seven-day service; any further financial or workforce implications will require assessment through the developing service options.

40-Day Stroke Pathway Improvement Review

Quality, Safety and Experience Committee update | Review period: 22 June to 15 August 2026

Executive position

The improvement programme is delivering measurable gains across every major stroke pathway KPI. Imaging reliability has strengthened, swallow screening has become more consistent, and more patients are experiencing the full “golden” pathway.

POSITIVE TRAJECTORY

CT ≤60 mins

44% → 75%

+31pp

CT ≤45 mins

28% → 70%

+42pp

ASU ≤4 hrs

14% → 35%

+21pp

Swallow ≤4 hrs

37% → 65%

+28pp

Latest position: week commencing 9 August 2026
NB: National Issues with SSNAP now resolved awaiting validated position

Performance Scorecard

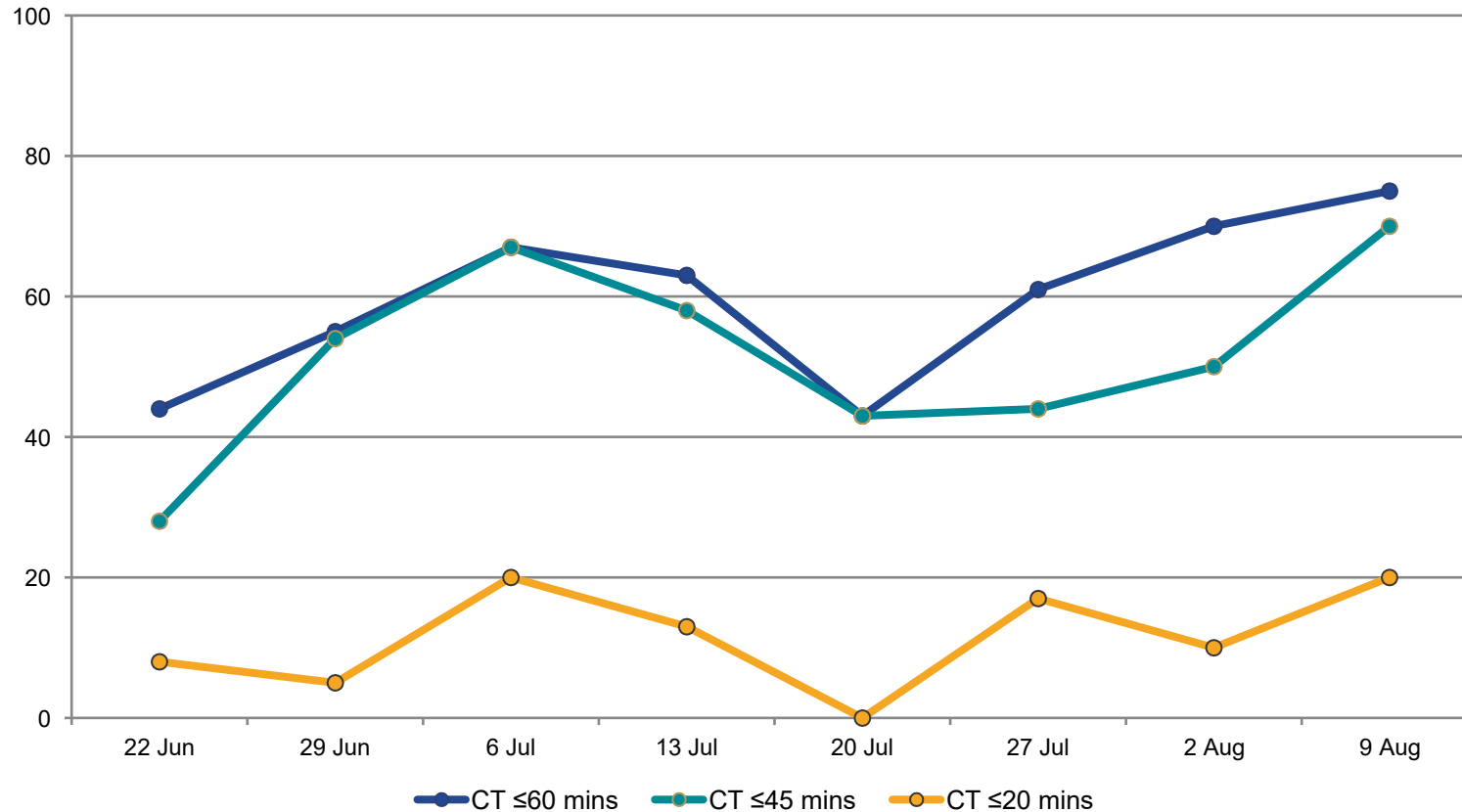
Baseline compared with the latest reported week commencing 9 August 2026

Measure	Baseline	Latest	Change	Assurance position	
CT within 20 minutes	8%	20%	+12pp	Internal 7%	Above internal, below national 40%
CT within 45 minutes	28%	70%	+42pp	Internal 70%	Internal target achieved
CT within 60 minutes	44%	75%	+31pp	Internal 70%	Internal target exceeded
Admission to ASU within 4 hours	14%	35%	+21pp	Internal 30%	Above internal target
Swallow screen within 4 hours	37%	65%	+28pp	Internal 60%	Above internal target

Key message: improvement is broad-based, but national standards remain the longer-term ambition.

Imaging Performance Has Strengthened

CTM weekly actual performance across the 40-day review



Strongest latest position
75% within 60 mins
70% within 45 mins

Quality signal

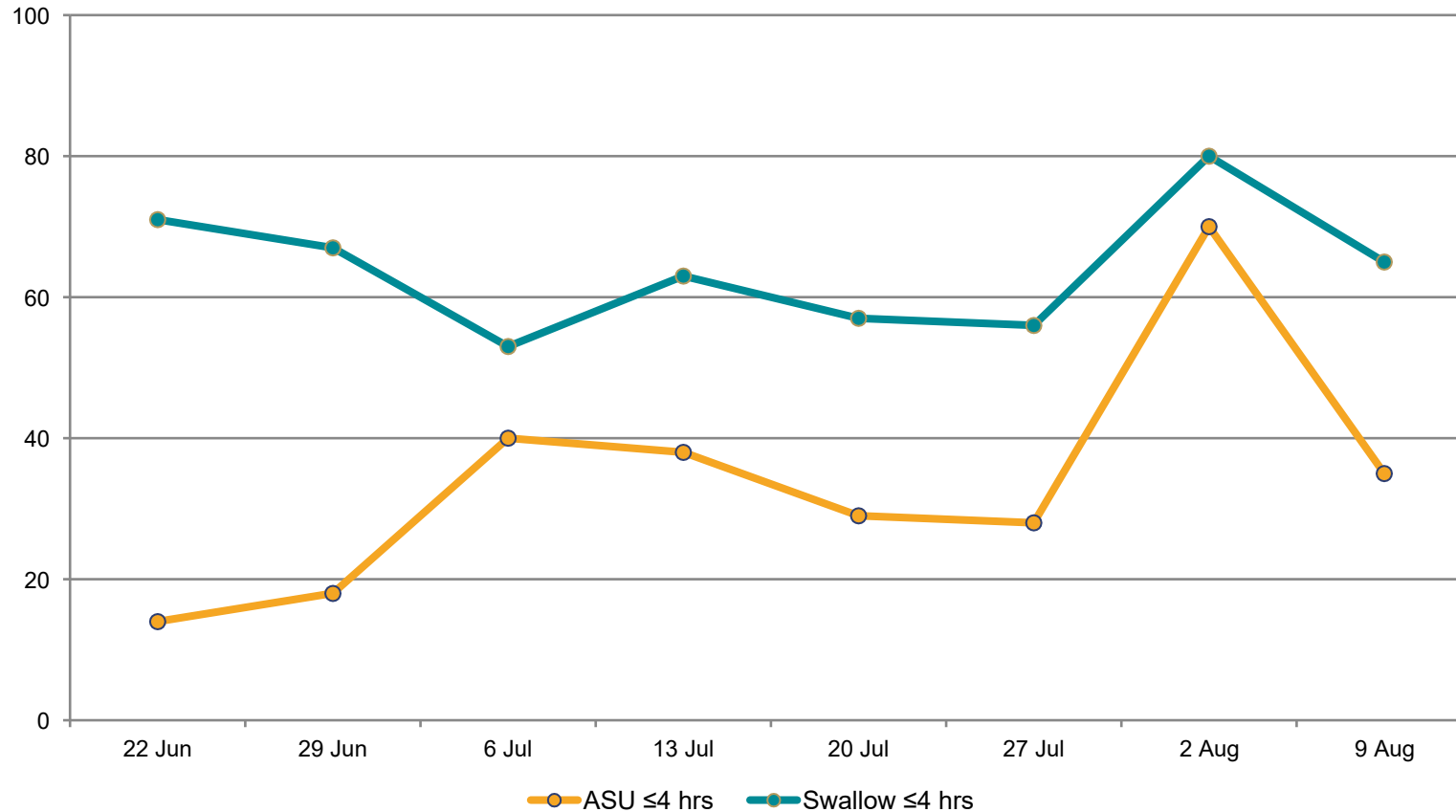
Four golden pathway patients were reported in the latest week. Golden patients achieved last 7/52.

Remaining gap

CT within 20 minutes improved to 20%, this remains variable and below the 40% national standard.

Early Care Delivery: Improvement With Ongoing Variation

Admission to ASU and swallow screening within four hours



Swallow screening

65% latest
+28pp from stated baseline

ASU admission

35% latest
+21pp from baseline

Control required

The fall from 70% to 35% in ASU transfer demonstrates continued sensitivity to flow, bed pressures, as well as doubling of new confirmed strokes in last 7 days.

Evidence of Pathway Maturity

What is working, where reliability is strongest, and what needs to spread

Reliable practice

- 1 100% of eligible patients received thrombolysis
- 2 Near-platinum thrombolysis pathway achieved with a 49-minute door-to-needle time
- 3 Increasing golden pathway delivery

Site learning

- 1 RGH remained the strongest-performing site
- 2 RGH achieved 100% CT within 60 minutes and 100% swallow screening w/c 2 August
- 3 Pre-alerted and WAST-conveyed pathways supported rapid imaging

Spread priority

- 1 Standardise rapid recognition and direct-to-imaging behaviours
- 2 Strengthen cross-site consistency
- 3 Protect pathway escalation during flow and bed pressure

Quality, Safety and Experience Assurance

Assurance is improving, with targeted risks still requiring active oversight

QUALITY

More timely assessment and treatment

Improved access to CT, stronger swallow-screen performance and reliable thrombolysis indicate safer, more effective hyperacute care.

SAFETY

Golden pathway delivery is increasing

Four golden patients in the latest reporting week demonstrate that rapid recognition, immediate stroke-team involvement and expedited imaging can be achieved.

EXPERIENCE

Quicker progression through the pathway

Faster diagnosis and earlier specialist care should improve pathway timeliness. The review does not include direct patient-reported experience measures. PREM's and PROM's being developed.

Residual risks

- Patient flow and bed availability continue to affect ASU transfer reliability.
- Week-to-week variation remains across sites and measures.
- CT within 20 minutes remains below the national standard.
- Sustainability depends on continued pathway grip during operational pressure.

PARTIAL ASSURANCE

Next 30 Days: Consolidate, Standardise and Sustain

Proposed focus following the 40-day review

1

CONSOLIDATE

Maintain daily oversight of imaging, swallow screening and ASU transfer performance.

2

STANDARDISE

Spread RGH pathway learning and golden-patient behaviours across all acute sites.

3

REMOVE DELAY

Use case-level review to identify avoidable delay in recognition, imaging and ASU transfer.

4

STRENGTHEN FLOW

Escalate stroke capacity and flow constraints through operational governance routes.

5

EVIDENCE EXPERIENCE

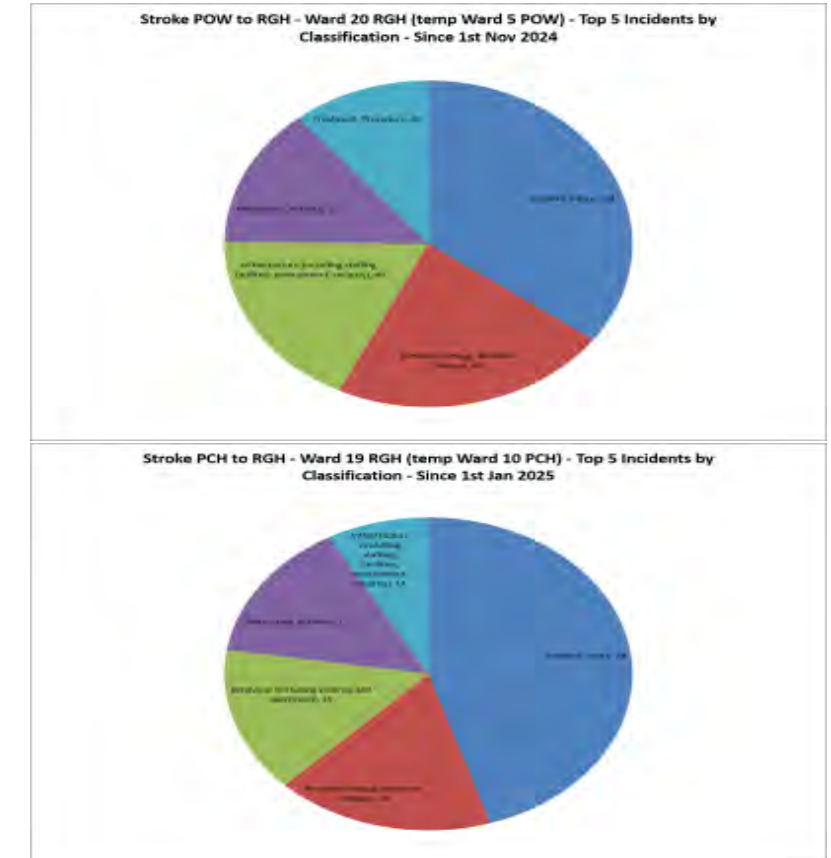
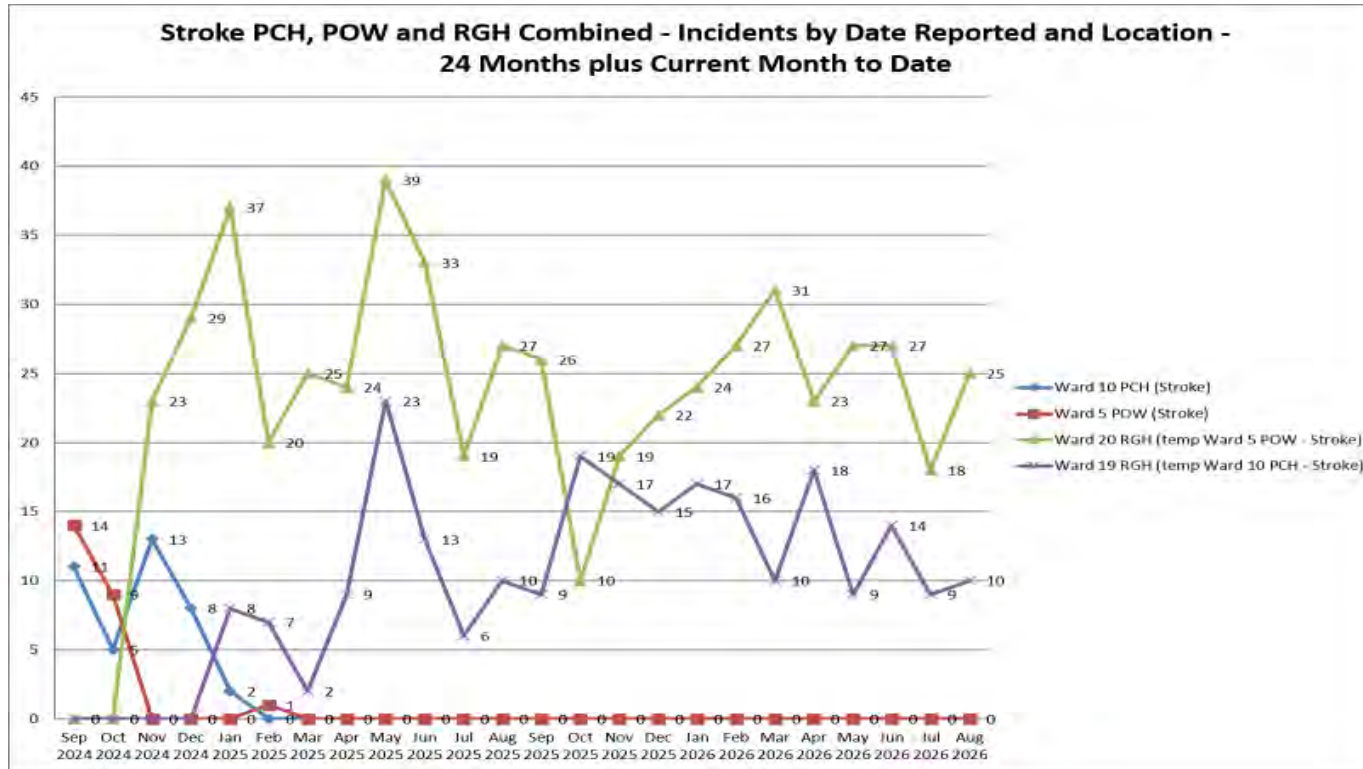
Add patient and family experience intelligence to the next review.

Committee is asked to:

- NOTE the sustained improvement across all major KPIs.
- RECOGNISE the residual variation and flow-related risk.
- SUPPORT continued oversight until improvements are consistently embedded.

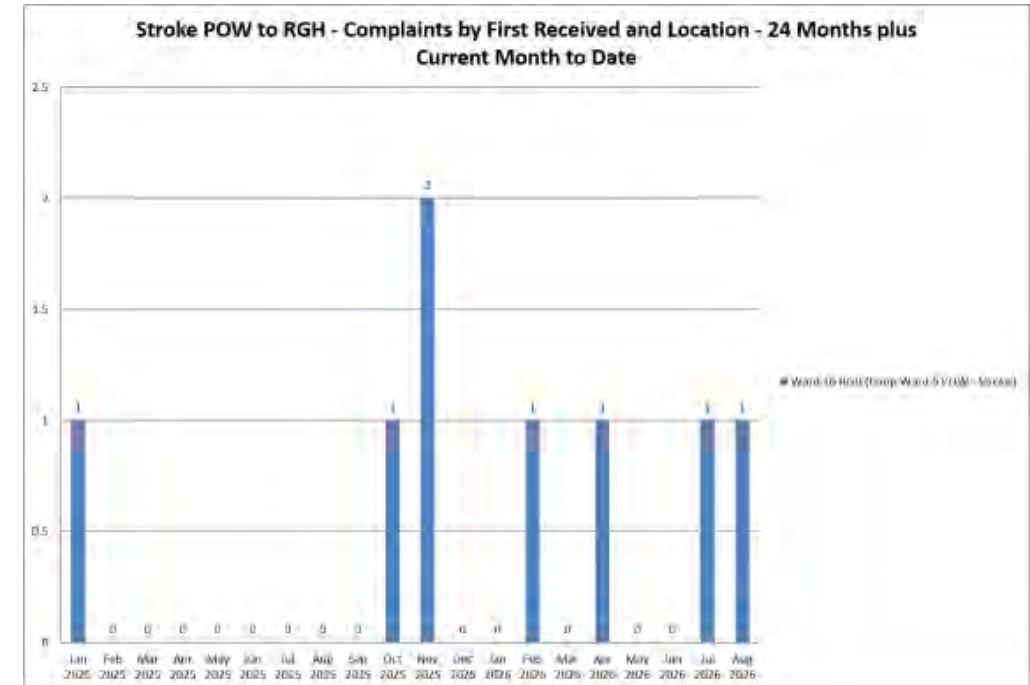
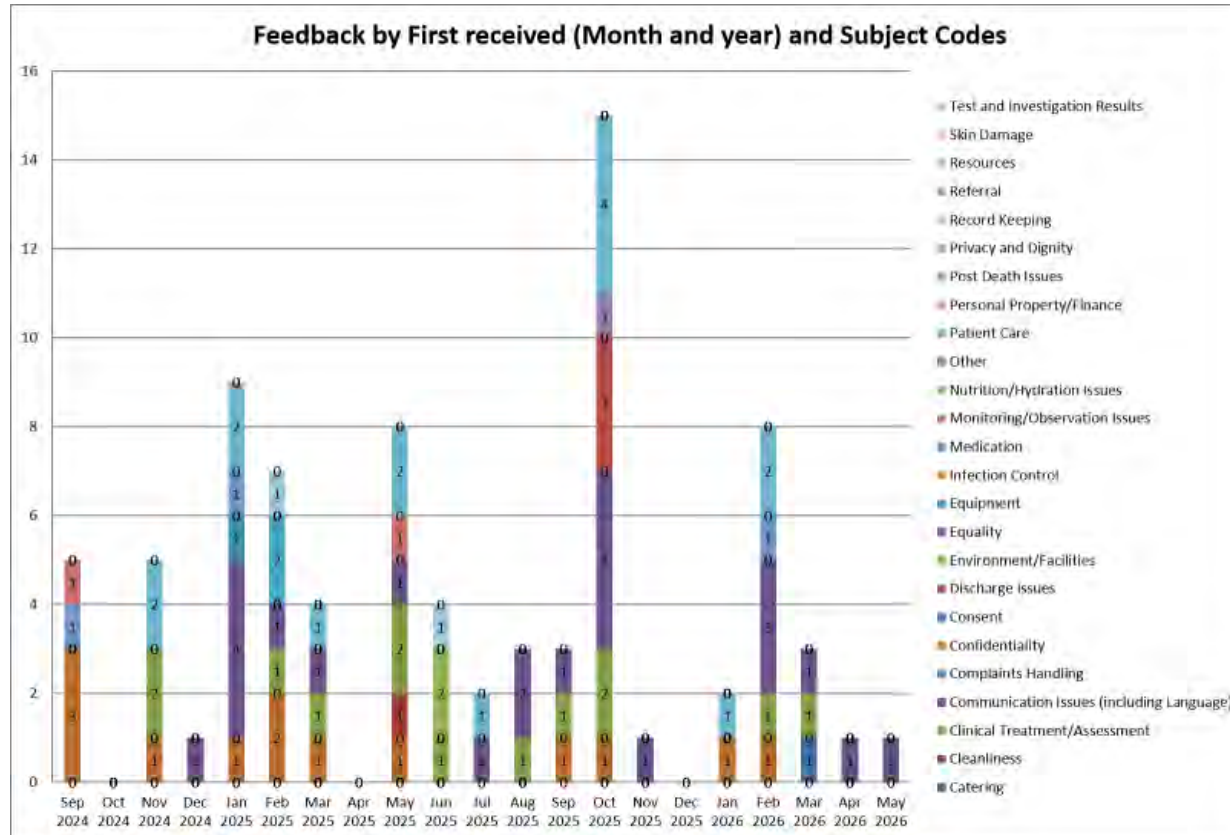
Recommended assurance: **PARTIAL**

CTM Stroke Service Transformation Programme- Incident Management



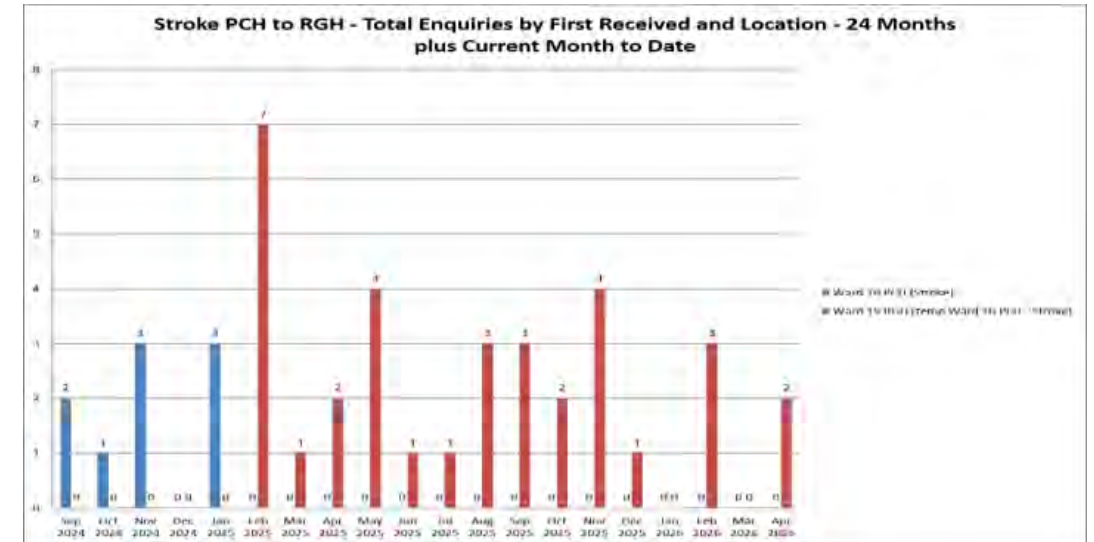
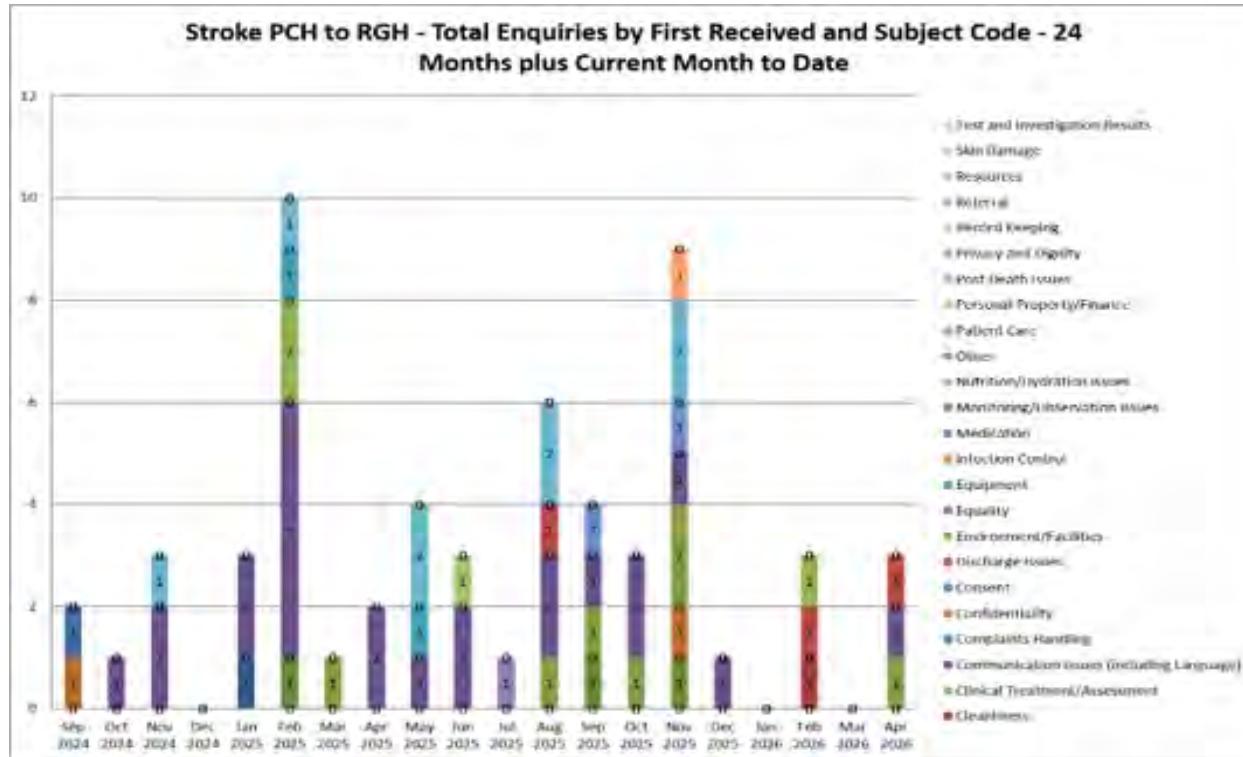
- Incident reporting remains concentrated within the RGH stroke wards, with Ward 19 RGH reporting between 9 and 18 incidents per month.
- Continued identification and reporting of patient safety events following service reconfiguration.
- Identified trends included, avoidable pressure damage, medication errors, nutrition and hydration and environmental issues and resources.

CTM Stroke Service Transformation Programme- Patient experience



- Formal complaints relating to Ward 20 RGH have remained low throughout the reporting period, with only isolated complaints received and no sustained increase in complaint activity identified.
- Top 3 issues, patient care, equity and discharge planning.
- Stroke transformation programme has resulted in sustained improvement.

CTM Stroke Service Transformation Programme- Patient experience



- Top 3 reasons, patient care, equity and environmental issues.
- Stroke transformation programme has resulted in sustained improvement evident across the Acute Stroke Unit.
- Enquiry volumes remain low overall, with occasional peaks within Ward 19 RGH but no emerging trends of concern identified.

Allied Health Professions (AHP) Provision

AHP Service Provision

- Ward 19 / 20 RGH: acute stroke unit and specialist stroke rehabilitation
- Inpatient Stroke Ward D4 YCR: Specialist stroke rehabilitation
- Early Supported Discharge Service provides specialist community stroke rehabilitation
- Neuro/stroke psychologist in post p/t since July 2026
- 5-day, 08:00-16:00 service across stroke pathway; RGH and YCR and Early Supported Discharge (ESD) service.
- Current workforce numbers are insufficient to provide 7-day service and impact on ability to meet national standards.

AHP inpatient registered workforce provision

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

Early Supportive Discharge AHP registered workforce

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

AHP Performance Scorecard

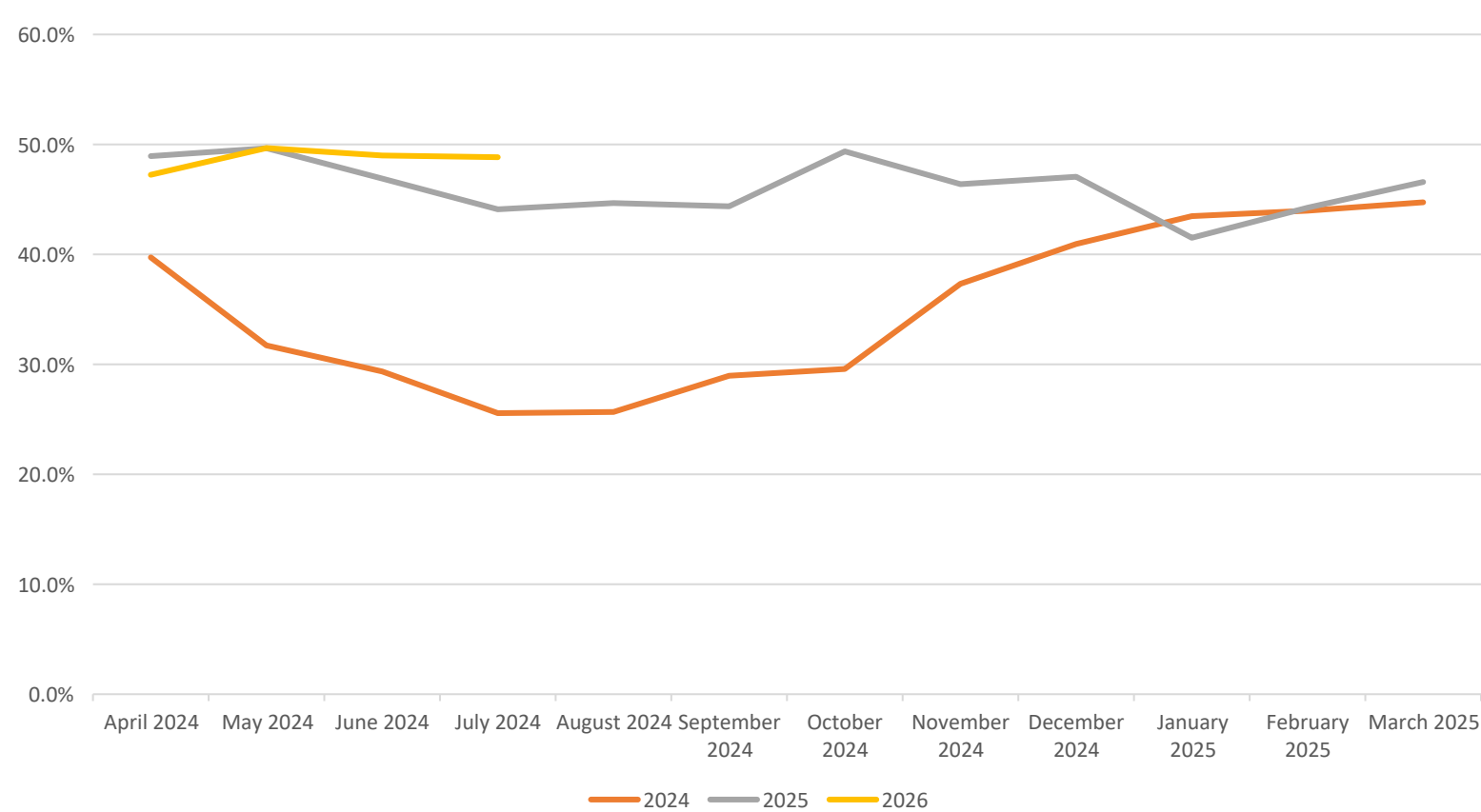
Baseline (9 months prior to CI) compared with the latest reported period of July 2026

Measure	Baseline	Latest	Change	Assurance position
Assessed by 1 therapy in 24 hours	68%	80%	+12pp	Improved from baseline to achieve current national average 80%
Physio within 24 hours	36%	44%	+8pp	Improved position, but remains below national average of 58%
Physio within 72 hours	80%	97%	+17pp	Improved position, aim to maintain above 95%
OT within 24 hours	32%	44%	+12pp	Improved position, but remains below national average of 55%
OT within 72 hours	77%	94%	+17pp	Improved position, aim to maintain above 95%

Key message: improvement is broad-based, but national standards remain the longer-term ambition.

Early Supported Discharge Has Strengthened

CTM monthly actual performance



Latest position:
ESD achieved 49% in July 2026
Baseline position 31%

National Average 30% (July 2026)

ESD patient feedback 2026

“Extremely happy with the ESD support have given me, the goal I wanted, and encouraged me to become more self sufficient. They have given me the self confidence to strive to be as mobile as before my stroke.”

“Very helpful in rebuilding my confidence and helping to understand my limitations regarding the effects of the stroke, all delivered in a friendly manner. “

“All of you have boosted my confidence & you're all bloody marvellous”

“The input from this wonderful service has been invaluable. The progress made has enabled us all to have a more normal future and look forward. Thank you for your support.”

“Dedicated to my wellbeing , they were very professional they made me feel positive about my process. They were interested in what I said and guided me.”

“Very helpful and supportive at a very difficult time”

“Feel that I benefited more from ESD at home rather than the rehab I had at hospital setting”

“Support from team has been fabulous, don't know how I would have managed or improved without the input from them. Many tips taken on board.”

Stroke Service Update

- The continuation of the temporary service change has been extended to support the continued stabilisation of the specialist medical workforce in line with the local and regional stroke plan and allow for monitoring and evaluation of the current change to take place.
- By extending the temporary change we aim to secure a safe and resilient workforce across our Acute Stroke Unit at RGH to ensure we are providing the best possible care to our patients and additionally to support this valuable multidisciplinary team
- The next 12 months will allow time to develop the options for the optimal stroke pathway for CTM and its residents.



Quality, Safety & Experience Committee

Annual Duty of Quality Report 2025/26

Eitem yr Agenda / Agenda Item	4.6
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Nigel Downes, Assistant Director of Quality & Safety
Cyflwynydd yr Adroddiad / Report Presenter:	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	Endorse for Board Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee are being asked to ENDORSE for Board Approval
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	All Strategic Pillars Apply
	If more than one applies please list below: Creating Health; Improving Care; Living Well; Sustaining our Future; Inspiring People
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	The report supports the Health Board's strategic focus on improving care and provides a public account of activity, improvement, learning and assurance across the six domains of quality during 2025/26.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhai'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 Annual Duty of Quality Report covers the financial year 2025/26 and is the third report produced by the Health Board under the Duty of Quality reporting arrangements. It has been developed, in line with last year's approach, as an interactive public-facing resource to help patients and communities understand the work undertaken across CTMUHB in accordance with its legislative duties. The report brings together activity from clinical services and corporate functions across the six domains of quality: Safe, Timely, Effective, Efficient, Equitable and Person-Centred.

Felly, beth (darparu dadansoddiad ystyrion 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 captures key initiatives and work undertaken across CTMUHB during 2025/26 and provides an overview of activity across the clinical and corporate service portfolio. It also identifies future and ongoing work for 2026/27 aligned with national, regional and local priorities. The format continues to be developed to make the report inclusive and accessible to a wide range of readers, while providing a balanced account of progress, learning and continuing challenges.

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 approval, the report will be submitted for Welsh translation and publication. Feedback will be sought from key stakeholders to inform future approaches to Duty of Quality reporting. The Health Board will also develop its next strategic approach to the Duty of Quality for 2026-2029, aligned with the annual reporting cycle, the three-year Strategic Plan delivery framework, CTM 2030 and statutory requirements.

Argymhelliad (Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).

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

Quality Safety & Experience Committee members are asked to formally ENDORSE the Annual duty of Quality Report 2025/26 for Board Approval

1. Background / Context

1.1 The report is the third of its kind, following the first report issued in 2024 in accordance with guidance established by NHS Performance and Improvement. The Health Board continues to build on its approach to understanding how the report can best meet the needs of patients and communities.

1.2 The 2025/26 report has been developed in line with last year's report as an interactive resource for patients and community members. It is intended to provide an accessible account of work undertaken by CTMUHB in accordance with its legislative duties.

2. Strategic Insights

2.1 The report provides an overview of key initiatives and work undertaken across CTMUHB during 2025/26, covering the clinical and corporate service portfolio. The content is organised around the six domains of quality and includes areas of future and ongoing work for 2026/27 aligned with national, regional and local priorities.

2.2 The report is intended to support public understanding of the Health Board's work and to present activity, progress, learning and areas where further work remains necessary.

3. Risks and Opportunities

3.1 The principal risk is that the report does not meet the needs of all readers if its content or presentation is not sufficiently clear and accessible. The interactive format continues to be developed with inclusivity and accessibility in mind.

3.2 There is an opportunity to seek feedback from key stakeholders following publication and use this to inform future Duty of Quality reporting. The next strategic approach to the Duty of Quality for 2026-2029 will provide a further opportunity to align annual reporting with CTM 2030 and the three-year Strategic Plan delivery framework.

4. Compliance and Governance

4.1 The report has been prepared to support the Health Board in meeting its annual reporting responsibilities under the Duty of Quality. It covers the financial year 2025/26 and reports activity across CTMUHB's clinical and corporate services.

4.2 Subject to approval, the report will be submitted for Welsh translation and publication. The published version will be made available in English and Welsh.

5. Benchmarks

5.1 No specific benchmarking assessment is presented within this cover paper. Where comparative or national information is included within the Annual Duty of Quality Report, it is presented within the relevant quality-domain narrative.

6. Conclusion

6.1 The Annual Duty of Quality Report 2025/26 brings together the Health Board's account of key activity, progress, learning and future priorities across the six domains of quality.

Approval will enable the report to proceed to Welsh translation and publication.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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 Service Transformation & Outcomes
	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	All Enablers of Quality Apply
	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: The report includes content on equitable and person-centred care. Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Parts of the approved report will be made available in English and Welsh.	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)	A separate Quality Impact Assessment has not been undertaken because the paper reports existing activity, improvement, learning and assurance through the Annual Duty of Quality Report.	
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
EMB	01/09/2026	Noted

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Version 2 August 2026

STEEEP

Safe, Timely, Effective, Efficient, Equitable
and Person-Centred



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

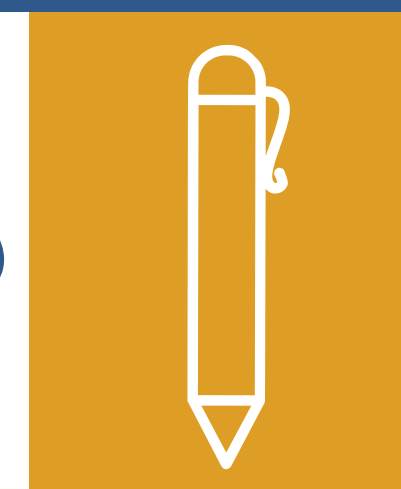


DUTY OF QUALITY

ANNUAL REPORT



2025 - 2026





Safe

Timely

Effective

Efficient

Equality

Patient
Centred

All Domain
Sections

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Safe

Timely

Effective

Efficient

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Appendix

Glossary

AT A GLANCE 2025/26

Safe

- 40 HIW recommendations completed
- 100% safe sleep compliance at discharge
- SafeCare expanded

Timely

- No children waiting over 104 weeks
- Improved ambulance handovers

Effective

- 72/75 Baby Friendly Standards achieved
- New clinical pathways implemented

Efficient

- Reduced glove spend by £25k+
- New digital systems introduced

Equitable

- BLOOM pilot introduced
- Welsh language offer strengthened

Person Centred

- Carers Passport launched
- Veterans Engagement Day delivered



[Safe](#)[Timely](#)[Effective](#)[Efficient](#)[Equality](#)[Patient
Centred](#)[All Domain
Sections](#)[Appendix](#)[Glossary](#)

INTRODUCTION

This Annual Quality Report outlines the work undertaken by Cwm Taf Morgannwg University Health Board to improve the quality, safety & experience of care during 2025/26.

The report brings together evidence from across the Care Groups & corporate services, highlighting improvements, learning & quality assurance activity that have contributed to better outcomes & experiences for patients, families & communities throughout the year.

The Health & Social Care (Quality & Engagement) (Wales) Act 2020 places a Duty of Quality on NHS organisations to continuously improve services & outcomes. This responsibility is shared by all members of staff & is reflected in the delivery of care, the application of learning from experience & the pursuit of continuous improvement.

The report is structured around the six recognised domains of quality: Safe, Timely, Effective, Efficient, Equitable & Person-Centred.

Together, these domains provide a framework for assessing the quality of healthcare & demonstrating how services continue to evolve in response to the needs of the population served.

While the report highlights areas of progress, it also recognises continuing challenges & opportunities for further improvement. Quality improvement remains an ongoing process, supported by continued learning, listening & collaboration with patients, carers, staff & partners to improve care & outcomes across Health Board services.





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QUALITY STANDARDS

The following sections present the evidence of progress under each of the STEEEP domains. A framework developed to define the core dimensions of high-quality healthcare. It helps healthcare organisations structure their improvement work & monitor progress. Each letter stands for a key domain:

S

Safe: Care should avoid causing harm to patients.
This means reducing infections, falls, medication errors, & improving learning from incidents.

T

Timely: Care should be delivered without unnecessary delay.
Focuses on quick access to treatment, avoiding waiting list backlogs, & supporting prompt discharge.

E

Effective: Care should be based on scientific knowledge & evidence-based practice.
Ensures patients get the right treatment, audits are used to monitor quality, & outcomes improve.

E

Efficient: Resources should be used wisely to avoid waste.
Prioritises value workforce planning, & streamlined care delivery using technology & automation.

E

Equitable: Everyone should have fair access to care regardless of background.
Addresses health inequalities, supports marginalised groups, & ensures accessibility & inclusion.

P

Person-Centred: Care should respect & respond to individual preferences, needs, & values.
Involves patients & carers in decisions, builds relationships, & delivers compassionate care.





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FOREWORD

I am pleased to present Cwm Taf Morgannwg University Health Board's Annual Quality Report for 2025/26.

Quality is at the heart of everything we do. Every day, our staff work alongside patients, families, carers & partners to provide safe, compassionate & effective care across a wide range of services & settings. The Duty of Quality challenges us not only to deliver good care, but to continuously seek opportunities to learn, improve & provide the best possible outcomes for our communities.

This report brings together evidence from across our services to demonstrate where improvements have been achieved, where learning has been embedded & where further work remains necessary.

Importantly, this report is not simply a reflection on what has been achieved. It is also an opportunity to consider what we have learned. Throughout the year, we have continued to listen to patients, families, carers & staff, using their experiences to inform service development & support ongoing improvement.

Whilst there have been many positive developments during 2025/26, we recognise that challenges remain. Continuous improvement requires openness, honesty & a willingness to learn from both success & adversity. The Health Board remains committed to strengthening quality, safety & experience across all services, while ensuring that the voices of the people we serve continue to shape our priorities for the future.

I would like to thank our staff for their commitment, professionalism & compassion, & to thank our patients, families, carers, volunteers & partners for their continued support & contribution throughout the year. Together, we will continue to build on the progress described in this report & work towards our shared ambition of delivering high-quality, person-centred care for all.

Richard Hughes
Executive Director
of Nursing





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WELSH LANGUAGE



CTMUHB is fully committed to the Welsh Government's vision for a truly bilingual health & social care system, ensuring that individuals can receive services in their language of choice, without having to ask.

As part of our obligations under the Welsh Language Standards (Health Sector), we have taken significant steps to embed the “Active Offer” principle across our services, proactively offering Welsh language services without placing the burden on the individual to request them.

Progress in 2025–2026:

Continued implementation of the Welsh Language Action Plan across care groups & corporate functions.

Increased availability of bilingual documentation & signage across all hospital sites.

Integration of Welsh language awareness into staff induction & mandatory training programmes.

Strengthened links with the Welsh Language Officer to support frontline services in delivering Active Offers confidently & consistently.

Patient Experience:

Welsh-speaking patients report feeling more understood, respected, & at ease when receiving care in their first language. This is particularly important in services supporting vulnerable groups such as older people, children, mental health service users, & individuals with dementia.

Looking Ahead:

Expanding bilingual digital communications & patient feedback mechanisms.

Strengthening monitoring & reporting of compliance with the Welsh Language Standards.

Ongoing workforce development to grow Welsh language capacity across clinical & non-clinical roles.

This work forms a vital part of delivering equitable, person-centred care that reflects & respects the cultural identity of our communities.



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DUTY OF CANDOUR

CTMUHB remains committed to openness, transparency, & learning through the statutory Duty of Candour, introduced in Wales from 1st April 2023 under the Health & Social Care (Quality & Engagement) (Wales) Act 2020.

The Duty of Candour requires that when a service provided by the Health Board has, or may have, caused unintended or unexpected harm that is more than minimal, we must:

Notify the person affected;

Apologise to them;

Offer an appropriate level of support;

Undertake a review to learn & improve.

Implementation Progress:

Governance arrangements & processes have been aligned with national guidance;

Training has been rolled out to clinical teams & senior leaders;

A reporting & monitoring framework is in development to support compliance & transparency.

Looking Ahead:

Ongoing review of systems to ensure early identification of harm;

Embedding the principles of candour within all levels of service delivery & staff culture;

Sharing learning through incident reviews, quality reports, & improvement networks.





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Creating safe environments for patients, carers, & staff is fundamental to high-quality care. CTMUHB's efforts focus on reducing harm, enhancing infection control, & using audit-driven learning to identify & address risks early.

SAFE OVERVIEW

Cwm Taf Morgannwg University Health Board has prioritised safety across patient care, safeguarding, & staffing throughout 2024-2025. Key initiatives included strengthening safeguarding education, enhancing workforce responses to harm, & embedding SafeCare to support staffing levels. Ongoing statutory compliance & improvement plans have reinforced CTMUHB's commitment to safety.

Key Areas of Focus:

- Safeguarding policy development & awareness campaigns
- Establishment of a dedicated Safeguarding Practice Educator
- Safe sleep & domestic abuse prevention initiatives
- Embedding SafeCare in section 25B wards & beyond
- Statutory compliance with Nurse Staffing Levels (Wales) Act





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CHILDREN & FAMILIES IMPROVING SAFETY FOR WOMEN, BABIES & CHILDREN

Children & Families continued to strengthen patient safety through implementation of recognised safety standards, enhanced assurance arrangements & targeted improvement programmes across maternity, neonatal & children's services. During 2025/26, new early warning score systems were introduced, maternity safety training remained a key focus, safeguarding training compliance improved, supported by positive audit findings relating to safe sleep advice. Learning from incidents was reviewed through internal & external assurance processes to support safer care for women, babies, children & young people.

WHAT IMPROVED

Early Warning Score systems were implemented across the Care Group to support the early identification & management of patient deterioration.

PROMPT Wales maternity safety training remained a key focus throughout the year, supported by ongoing improvement activity to maintain compliance & strengthen maternity safety.

Midwifery safeguarding performance improved, with audit evidence demonstrating 100% compliance with safe sleep advice on discharge from hospital & 88% compliance at first postnatal visit.

External reviews of nationally reportable maternity incidents identified no additional issues beyond those already recognised through internal governance & learning processes.

Multi-professional baby abduction exercises led to plans to standardise infant security arrangements across maternity services, including approval to introduce security systems at Princess of Wales Hospital.





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CHILDREN & FAMILIES IMPROVING SAFETY FOR WOMEN, BABIES & CHILDREN

IMPACT

Early Warning Score systems were implemented to support the identification & management of patient deterioration. The safe sleep audit demonstrated 100% compliance on discharge from hospital & 88% compliance at the first postnatal visit. External reviews of nationally reportable maternity incidents identified no additional issues beyond those already recognised internally.

LOOKING AHEAD

- Continue PROMPT Wales improvement activity.
- Progress plans to standardise infant security arrangements across maternity services, including introduction of the approved XTAG security system, already used in Prince Charles Hospital, rolled out to Princess of Wales Hospital.



Xtag Medical Customer Stories: Cwm Taf Morgannwg University Health Board

Cwm Taf Morgannwg University Health Board selected Xtag Medical to design and install Baby Tagging in the Prince Charles Hospital.

xtag.co.uk





DIAGNOSTICS, THERAPIES, PHARMACY & SCIENCES STRENGTHENING SAFETY & ASSURANCE

DTPS strengthened safety & assurance during 2025/26 through external inspection, accreditation activity, improved medicines governance & service developments designed to reduce risk & support safe care. Significant risks continued to be monitored through established governance arrangements.

WHAT IMPROVED

A new urine analyser was implemented in Microbiology in June 2025, replacing ageing equipment associated with a high-rated service risk.

The unannounced Human Tissue Authority (HTA) inspection found no significant findings across CTM mortuary services.

All findings from the July 2025 UKAS inspection were cleared.

Controlled drug governance arrangements were strengthened following incidents, including revised storage arrangements, registers & auditable processes.

IMPACT

- The new Microbiology analyser significantly reduced the number of urine specimens requiring culture & supported appropriate antibiotic prescribing.
- The HTA inspection identified no significant findings & no concerns with the operation of CTM mortuary services.
- All UKAS inspection findings were cleared, providing assurance regarding compliance with required standards

LOOKING AHEAD

Continue delivery of the Blood Transfusion Safety Standards action plan & ongoing management of significant risks including Laboratory Information Management System (LIMS) 2.0, Blood Transfusion & Microbiology infrastructure.



MENTAL HEALTH & LEARNING DISABILITY

EMBEDDING SAFER CARE ACROSS MHLD SERVICES

Mental Health & Learning Disabilities completed a major programme of improvement in response to Healthcare Inspectorate Wales (HIW) recommendations relating to adult inpatient mental health services. Improvement activity focused on leadership, safe & effective care, & patient experience. All actions were completed during 2025/26, with ongoing oversight transferred into routine Quality, Safety, Risk & Experience governance arrangements.

WHAT IMPROVED

The Adult Mental Health Inpatient Improvement Programme completed all 40 actions arising from the HIW review of inpatient discharge arrangements. with the final two outstanding actions were completed during October 2025. The completed action plan was agreed by Healthcare Inspectorate Wales. Improvement work was incorporated into ongoing Quality, Safety, Risk & Experience governance arrangements. Mental Health services continued participation in national patient safety improvement programmes, including Safewards.



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MENTAL HEALTH & LEARNING DISABILITY

EMBEDDING SAFER CARE ACROSS MHLD SERVICES

IMPACT

Completion of the HIW action plan provided external assurance that all 40 identified actions had been delivered.

Ongoing improvement actions are reviewed monthly, with progress reported through the MHLD Quality, Safety & Experience Committee.

The first two Safewards interventions on Ward 14 were positively received by staff & patients, with positive feedback also provided by the NHS Wales Improvement Team.

LOOKING AHEAD

Continue aligning inpatient improvement work with the National Patient Safety Programme, including Safewards, patient-centred safety planning, risk formulation, relational & procedural safety, & outcome measures.





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PLANNED CARE

STRENGTHENING PATIENT SAFETY THROUGH LEARNING & IMPROVEMENT

Planned Care strengthened its patient safety systems during 2025/26 through scrutiny panels, multidisciplinary learning, targeted improvement work, governance review & shared learning. Improvement activity focused on falls prevention, pressure damage, incident management & the use of Professional Focus Groups to share learning across clinical teams.

WHAT IMPROVED

Falls, pressure damage & medication assurance panels feed into newly established steering groups to drive service-wide learning & identify recurring/ emerging themes.

Targeted pressure ulcer improvement work was introduced, including revised documentation, specialist teaching & enhanced audits.

Strengthened governance arrangements within Anaesthetics, Critical Care, Theatres, Trauma & Orthopaedics (ACCTTO).

Directorate governance reporting was strengthened through a revised QSRE reporting structure & quality KPI oversight.

Enhanced support from patient safety teams provided to services for Learning From Events Reports.

Strengthened monitoring of patient safety improvement action plans.

IMPACT

- Ward audit activity identified improved compliance with fluid balance recording following focused education, audit & feedback.
- The final COVID deaths review panel identified no harm for patients receiving care within Planned Care services.
- No avoidable falls were reported across Planned Care between January & March 2026.

LOOKING AHEAD

Continue the focus on falls prevention, pressure damage reduction, staff education & monitoring of patient safety improvement actions across Planned Care





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PRIMARY CARE & COMMUNITY STRENGTHENING SAFETY THROUGH GOVERNANCE, ASSURANCE & CLINICAL PRACTICE

Primary Care & Community services strengthened safety through professional development, safeguarding training, practice assurance arrangements & service improvement activity. Workforce development programmes, multidisciplinary GP practice assurance visits & targeted quality improvement initiatives were progressed across primary care & community services during 2025/26.

WHAT IMPROVED

Professional Nurse Advocacy & Practice Development arrangements were introduced, supporting workforce development & clinical practice improvement.

Best practice guidance was developed & implemented for pressure ulcer incident reporting using the SBAR methodology.

District Nursing services implemented bespoke safeguarding training, with further safeguarding training development across GP practices.

GP practice assurance visits commenced under the Unified Contract Assurance Framework, reviewing compliance against all 12 quality standards.

IMPACT

District Nursing manual handling compliance improved to 91%, allowing the associated risk to be removed from the risk register.

GP practice assurance visits commenced, with multidisciplinary reviews undertaken against all 12 Quality Standards.

Professional Nurse Advocacy & Practice Development arrangements supported delivery of workforce development & clinical practice initiatives across community services.

LOOKING AHEAD

Continue GP practice assurance visits & follow-up action plans through the Unified Contract Assurance Framework.

Continue workforce development & safeguarding programmes across Primary Care & Community services.





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UNSCHEDULED CARE

STRENGTHENING OVERSIGHT OF AVOIDABLE HARM

Unscheduled Care continued to strengthen its approach to patient safety through enhanced monitoring, assurance & learning processes. Pressure damage, falls, medication incidents & sepsis compliance remained key areas of focus. Weekly assurance panels, multidisciplinary reviews & targeted improvement actions were used to monitor themes, identify learning & support safer care across acute hospital services.

WHAT IMPROVED

Pressure damage, falls & medication incidents were reviewed through regular assurance & governance processes, with themes & actions identified.

Weekly assurance panels were used to review incidents, identify themes & support learning across services.

Medication incidents were reviewed through Medicines Management Committee arrangements, with recurring themes identified across medicines documentation, prescribing & administration.

Sepsis compliance was identified as an area requiring refocus, with targeted support for Emergency Department teams.

IMPACT

Recurring themes relating to pressure damage, falls & medication incidents were identified through assurance & governance processes, enabling targeted actions & learning to be implemented.

Weekly assurance panels provided structured review of incidents, trends & areas requiring improvement across services.

Medicines Management Committee oversight enabled wider learning from medication incidents relating to documentation, prescribing & administration.

LOOKING AHEAD

Continue targeted improvement work on pressure damage, falls, medication safety & sepsis compliance.





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CONCERNS

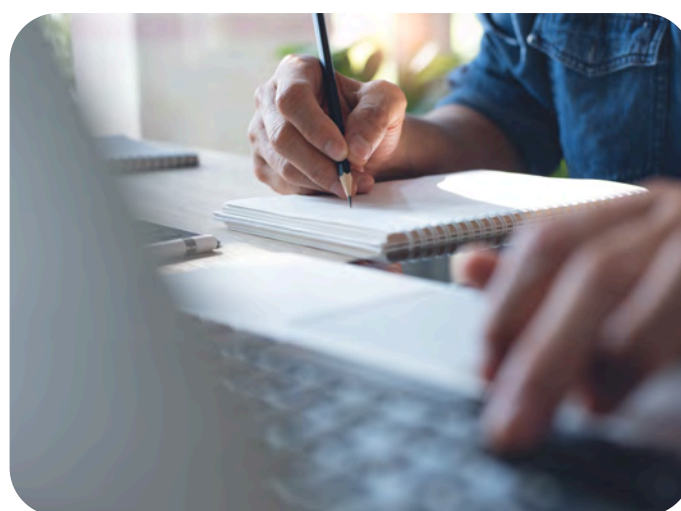
LEARNING FROM CONCERNS TO IMPROVE CARE



Concerns & patient feedback were used alongside Datix information & quality governance processes to support learning, identify recurring themes & strengthen assurance. The extract shows that learning from concerns is being more systematically captured & shared, but it does not provide specific patient safety themes, examples of service change or harm reduction data.

WHAT IMPROVED

- Concerns & patient feedback were increasingly used alongside Datix & governance information to identify themes & risks.
- Learning identified through concerns was reviewed & shared with services.
- Stronger links were developed between concerns management, patient experience & quality governance processes.
- Learning from concerns was more systematically captured & shared across the Health Board.
- Head of Concerns attends Care Group Quality, Safety, Risk & Experience monthly meetings to ensure more joined up working between the Care Group & Central Concerns Team.



IMPACT

Learning identified through concerns was captured & shared with services more systematically.

The Head of Concerns' attendance at monthly Care Group Quality, Safety, Risk & Experience meetings supported more joined-up working between Care Groups & the Central Concerns Team.

LOOKING AHEAD

Strengthen the evidence showing how learning from concerns results in service changes, improved care & reduced risk, including identifiable examples & measurable outcomes.





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LEGAL SERVICES

LEARNING FROM CLAIMS, INQUESTS & LITIGATION

During 2025/26, Legal Services strengthened arrangements to identify, capture & disseminate learning arising from claims, redress, inquests, Ombudsman scrutiny & litigation themes. Legal learning was more clearly connected to corrective action & assurance, with structured review & escalation strengthening oversight of legal & patient safety risk.

WHAT IMPROVED

- Worked collaboratively with the Welsh Risk Pool to review & strengthen Learning from Events systems & processes.
- Established the Learning from Events Report Panel.
- Delivered Learning from Events training across the Health Board.
- Strengthened Learning from Event Reports & Case Management Reports to separate factual findings, causal learning, remedial action & evidence of implementation.
- Reviewed & escalated open inquests & risks relating to Prevention of Future Deaths.
- Identified recurring themes to inform audits, training & wider improvement activity.

IMPACT

- First-time approval of Learning from Events Reports by the National Learning Advisory Panel increased from 16% in 2024/25 to 31% in 2025/26.
- Legal findings were linked more explicitly to identified owners, actions, supporting evidence & governance routes.
- Coronial learning informed improvement activity.

LOOKING AHEAD

- Continue to strengthen collaborative working with the Welsh Risk Pool, Legal Services & the Coroner's Office to support learning, assurance & continuous improvement.





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INFECTION PREVENTION & CONTROL STRENGTHENING SAFETY & ASSURANCE

IPC supports safer care by reducing avoidable infection, limiting transmission & ensuring infection risks are visible from ward to Board. In 2025/26 the service strengthened surveillance, outbreak response, decontamination oversight & specialist advice while identifying areas requiring further improvement.

Healthcare-associated infections can cause avoidable harm, prolong stays & increase pressure on patient flow. CTMUHB compared favourably with Wales for *C. difficile*, *Pseudomonas aeruginosa*, MSSA & MRSA, while *E. coli* & *Klebsiella* bacteraemia remained above the Wales benchmark.

WHAT WE DID

- Surveillance & infection review: The IPC team used ICNet, HARP data, microbiology advice & post-infection review to monitor infection risks & support learning.
- Outbreak response: IPC worked with clinical teams, site management, microbiology, facilities, estates, occupational health & Public Health Wales to manage outbreaks & periods of increased incidence & is currently developing a new outbreak response framework to give faster, more effective response with improved governance.
- Specialist risk controls: Isolation, decontamination, water, ventilation & high consequence infectious disease preparedness risks remained visible through governance & risk routes.

IMPACT

- 86 outbreaks or periods of increased incidence were recorded, affecting 729 patients & 140 staff, with 652 bed days lost.
- Hospital-onset *E. coli* & hospital-onset *Pseudomonas aeruginosa* reduced, showing that focused prevention can support improvement.
- Key residual risks were identified & transferred into the 2026/27 improvement programme.

LOOKING AHEAD

- Reduce *C. difficile* by at least 25% against the 2024/25 count, subject to final baseline confirmation.
- Deliver Gram-negative bloodstream infection reduction work focused on catheter-associated urinary tract infection prevention, urinary catheter passports, hydration & device care.
- Progress funded negative-pressure rooms at Royal Glamorgan Hospital & Princess of Wales Hospital.





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NURSE STAFFING LEVELS

CTMUHB has continued to strengthen nurse staffing governance through implementation of the Nurse Staffing Levels (Wales) Act 2016. Supported by SafeCare, patient acuity data & professional judgement, this approach provides assurance that nursing resource is deployed safely, effectively & in response to patient need.

WHAT IMPROVED

- Maintained biannual acuity audits & reviews following service changes.
- Delivered monthly SafeCare & Welsh Levels of Care training.
- Enhanced visibility of patient acuity, professional judgement & escalation indicators.
- Improved use of staffing intelligence within operational decision making.

Looking Ahead

- Support implementation of All-Wales Section 25A guidance.
- Continue SafeCare expansion across community & mental health services.
- Strengthen local ownership of staffing governance & assurance processes.
- Enhance use of workforce intelligence to inform workforce planning & quality outcomes.



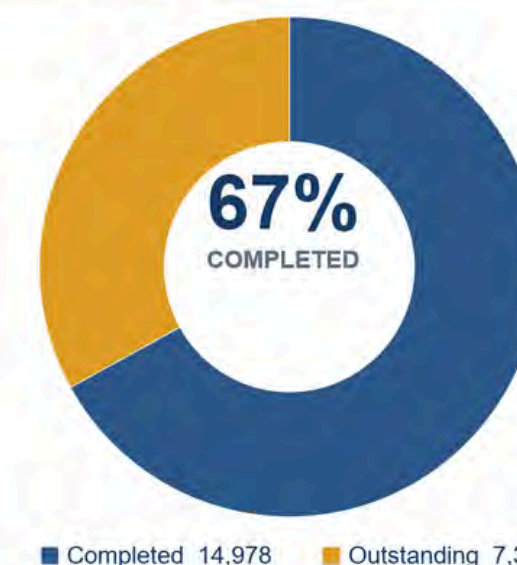
IMPACT

- Strengthened organisational oversight of nurse staffing.
- Enabled more consistent review & response to staffing variation.
- Improved assurance regarding safe deployment of nursing resource.
- Supported responsive staffing decisions aligned to patient acuity & service demand.

SafeCare completion reached 67%

14,978 of 22,359 expected assessments across 75 wards | January–June 2026

ASSESSMENT COMPLETION



EXPECTED ASSESSMENTS

22,359

14,978 completed · 7,381 outstanding

WARDS IN SCOPE

75

PATIENT TOTAL CAPTURED

327,792

One in three expected assessments remained incomplete.

Coverage spans 75 wards and 327,792 recorded patient assessments.





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HARM FREE CARE

Harm Free Care brings together CTMUHB's approach to preventing avoidable harm through falls & deconditioning, pressure damage, nutrition & hydration, & shared learning. During 2025/26, governance, prevention & improvement activity were strengthened to support safer, more consistent care for patients.



WHAT WE DELIVERED

- Strengthened governance & reporting across Harm Free Care workstreams.
- Improved consistency of risk assessment & preventative care processes.
- Established the Harm Free Care Collaborative to drive improvement & share learning.
- Expanded the Falls programme to include deconditioning, supporting mobility & independence.
- Developed co-produced falls & pressure damage resources for patients, families & staff.
- Embedded Harm Free Care principles within clinical education programmes.



WHAT DIFFERENCE DID THIS MAKE

- Falls audit findings provided reasonable assurance across all quality domains.
- Improved organisational oversight of avoidable harm risks.
- Stronger alignment between frontline improvement, committee scrutiny & Board assurance.
- Increased sharing of learning & reduction of unwarranted variation across services.
- More systematic monitoring of improvement activity & harm prevention initiatives.

2026/27 PRIORITIES

- Standardise Harm Free Care practices across services.
- Develop a Harm Free Care dataset to support a single source of quality intelligence.
- Further embed prevention, education & local ownership of improvement.





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WARD ASSURANCE & ACCREDITATION

Strengthening quality oversight, continuous improvement & accountability across inpatient wards
Ward Assurance & Accreditation remains a key component of CTMUHB's approach to delivering safe, high-quality care. During 2025/26, work focused on strengthening the use of quality intelligence, improving assurance processes & preparing for alignment with national quality frameworks to support sustainable improvement across ward services.

WHAT IMPROVED

Strengthened the use of quality & safety intelligence to identify risks & improvement opportunities.
Expanded the use of assurance information to support ward-level quality monitoring & prioritisation.
Began redesign of Bronze Accreditation to reduce duplication & strengthen local ownership.
Aligned local developments with the emerging NHS Wales National Clinical Excellence Framework.
Enhanced organisational oversight through more structured assurance & improvement planning.

WHAT DIFFERENCE DID THIS MAKE

- Improved strategic clarity regarding the purpose & role of Ward Assurance & Accreditation.
- Increased understanding of assurance requirements in wards not yet accredited.
- Clearer expectations for Care Group ownership of quality improvement.
- Stronger foundations for escalation, reporting & organisational learning.
- More consistent, intelligence-led oversight of Quality & Safety across wards.

2026/27 PRIORITIES

- Complete implementation of the revised Ward Assurance & Accreditation approach.
- Further strengthen the use of quality intelligence to identify risk earlier.
- Align accreditation arrangements with national quality & clinical excellence frameworks.
- Support wards to achieve sustained improvement through local ownership & improvement planning.
- Strengthen measurement of quality outcomes & assurance across all ward areas.



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University Health Board

WARD ASSURANCE VISIT REPORT





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SAFEGUARDING

WHAT IMPROVED

Strengthened safeguarding governance through enhanced reporting to Quality, Safety & Patient Experience structures across Care Groups, with escalation of training-compliance risks and referral themes & trends.

Continued development & implementation of the Once for Wales Safeguarding Module, improving recording, oversight & audit, including Section 5 persons in a position of trust concerns.

Strengthened processes for complex safeguarding concerns, including cross-boundary & multi-agency escalation.

Enhanced safeguarding supervision & reflective practice, with mechanisms to assess supervision quality and extend supervision across health services.

Developed & implemented safeguarding policies & Standard Operating Procedures (SOPs), including the safeguarding supervision policy & Multi Agency Risk Assessment Conference (MARAC).

Established a health Independent Domestic Violence Advocate (IDVA) team, dual trained as Independent Sexual Violence Advocates (ISVA), to provide advice & support to patients & staff within CTMUHB.

IMPACT

- Improved consistency, quality & timeliness of safeguarding referrals & documentation.
- Strengthened assurance to the Board regarding statutory compliance & risk management.
- Increased practitioner confidence in managing complex safeguarding cases.
- Positive staff feedback on access to safeguarding advice & supervision.
- The IDAV service will strengthen the health boards application of VAWDASV legislation, strategy & training framework. The service will also support sexual safety priorities.

LOOKING AHEAD

- Further embed digital systems for real-time safeguarding data & performance dashboards.
- Strengthen quality assurance processes through thematic audits & deep dives.
- Continue to develop organisational learning from incidents & reviews (including Single Unified safeguarding reviews).





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Ensuring timely interventions improves patient outcomes, optimises flow, & reduces avoidable delays in care & discharge planning.

TIMELY OVERVIEW

The Health Board has made demonstrable progress in reducing delays & promoting access to care. Enhanced safeguarding pathways, targeted education, & de-escalation of CAMHS services reflect ongoing improvement in timely response & intervention.

Key Areas of Focus:

- CAMHS de-escalation to routine monitoring
- Creation of bespoke safeguarding training programmes
- Multidisciplinary partnership training days
- Policy revision for management of concerns & neglect
- 'Was Not Brought' policy review underway





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CHILDREN & FAMILIES REDUCING WAITS & IMPROVING ACCESS FOR CHILDREN & FAMILIES

Children & Families progressed work during 2025/26 to reduce long waits & develop pathways for assessment, diagnosis & treatment. Evidence from the Care Group demonstrates sustained improvement in Neurodevelopment waiting times, achievement of Gynaecology RTT targets, development of a diagnosis-at-triage pathway for selected autism referrals, commencement of the Women's Health Hub Pathfinder Service & transfer of the School Entry Hearing Screening Service to Audiology.

WHAT IMPROVED

- Sustained improvement in neurodevelopment waiting times resulted in no children waiting more than 104 weeks by May 2025, with further progress maintained throughout the year.
- A diagnosis-at-triage pathway was piloted for selected autism referrals, enabling assessment decisions to be reached earlier where sufficient information was available from families & schools.
- Gynaecology pathways achieved the target of no patients waiting more than 104 weeks, supported by ongoing pathway improvement work.
- The Women's Health Hub Pathfinder Service was developed & commenced in February 2026, supported by additional medical sessions & joint working with Primary Care colleagues.
- Responsibility for the School Entry Hearing Screening Service transferred to Audiology, supporting delivery of a new service model.

IMPACT

- By May 2025, no children were waiting more than 104 weeks for a neurodevelopment assessment.
- Gynaecology achieved the target of no patients waiting more than 104 weeks.
- The Women's Health Hub Pathfinder Service commenced in February 2026.

LOOKING AHEAD

- Maintain the progress reported in neurodevelopment waiting times.
- Continue the phased development of the Women's Health Hub Pathfinder Service with Primary Care colleagues.
- Continue delivery of the new School Entry Hearing Screening Service model following its transfer to Audiology.





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DIAGNOSTICS, THERAPIES, PHARMACY & SCIENCES

IMPROVING TIMELY ACCESS

DTPS introduced targeted measures during 2025/26 to address delays in Echocardiography, Neurophysiology & death certification. Additional clinical sessions & a new Medical Examiner Service QR code increased capacity & supported better monitoring. The papers report progress in Echocardiography & death-certification turnaround, while continuing to identify demand & capacity pressures across several services.

WHAT IMPROVED

- Additional weekend Echocardiography appointments were funded to reduce the waiting list.
- Planned Care Recovery funding supported additional weekday Neurophysiology sessions.
- Procurement progressed for additional Neurophysiology weekend sessions during quarter four.
- The CTM Medical Examiner Service QR code was launched in October 2025 to support the death-certification process & improve data capture. This has improved the timeliness of certification & helped improve flow by releasing bed time.

IMPACT

- Additional weekend Echocardiography clinics helped reduce the demand-capacity gap during 2025/26, & by March 2026 the recovery programme remained on target to bring waiting times below the eight-week diagnostic target.
- The Medical Examiner Service QR code was reported to have had a positive impact in some areas & improved data capture to identify where delays occurred.

LOOKING AHEAD

Continue work to address the demand-capacity gaps and waiting-list pressures identified in Neurophysiology, Audiology, Radiology reporting and Echocardiography through 2026/27. Proposals have been submitted to Performance and Improvement teams in Welsh Government.





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MENTAL HEALTH & LEARNING DISABILITY

IMPROVING ACCESS & CONTINUITY OF CARE

Mental Health & Learning Disabilities implemented changes to the adult inpatient model at Royal Glamorgan Hospital during October 2025. The changes were designed to improve continuity of care, reduce unnecessary transfers between wards & enhance patient flow, while maintaining overall bed capacity. The Care Group continues to monitor the impact of these changes through its governance arrangements.

WHAT IMPROVED

- The adult inpatient model at Royal Glamorgan Hospital was redesigned, moving from one admissions ward to two admissions wards & one pre-discharge ward to support continuity of care, reduce unnecessary transfers & enhance patient flow.
- Patients with learning disabilities assessed as ready for discharge continued to be supported by the MHLD Commissioning Team & local authority partners to secure appropriate community placements & ongoing support.
- The Preparing for Discharge (P4D) programme was introduced to support patients preparing for discharge from inpatient services.
- Additional support was introduced for young people waiting for specialist substance misuse services, including the appointment of an additional registered nurse, weekly waiting list reviews & regular communication with young people & families.

IMPACT

- The revised inpatient model maintained existing bed capacity, with initial feedback reported as positive & ongoing monitoring through Adult Directorate governance arrangements.
- The Preparing for Discharge programme comprised five consecutive sessions & three community drop-in sessions to support transition from hospital to home.
- Young people waiting for specialist substance misuse services received additional oversight through an appointed Registered Nurse, weekly multidisciplinary discussions & updates to young people & families every four weeks.

LOOKING AHEAD

- Continue monitoring the revised inpatient model & the support provided to young people waiting for specialist substance misuse services through the relevant directorate governance arrangements.





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PLANNED CARE

IMPROVING ACCESS & REDUCING DELAYS

Throughout 2025/26, Planned Care redesigned pathways & introduced additional assessment & review capacity. Developments included weekend outpatient activity, one-stop pre-assessment clinics, trauma pathway redesign & new models to support assessment, discharge & patient flow.

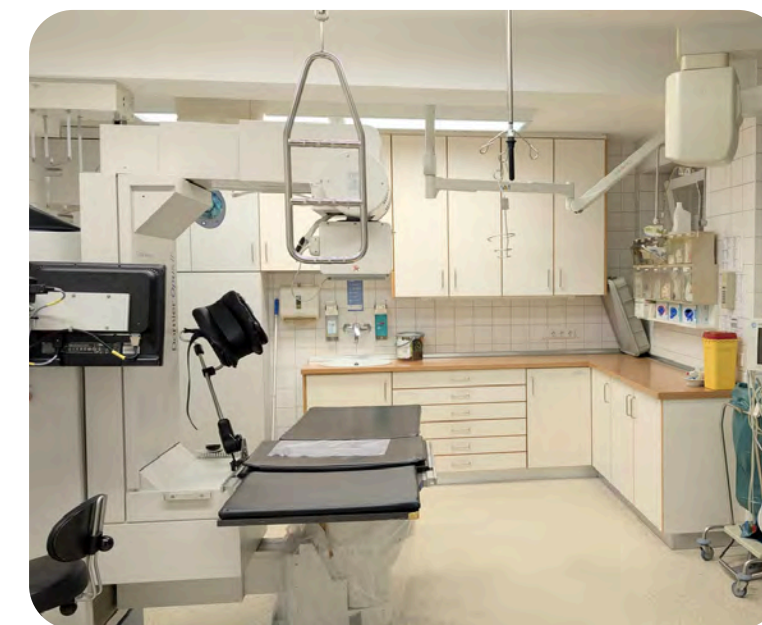
WHAT IMPROVED

- Weekend outpatient clinics were delivered across multiple specialties to support assessment & treatment activity.
- A new Trauma Assessment Unit was opened at RGH to support rapid assessment & treatment.
- One-stop pre-assessment clinics were introduced at RGH alongside a standardised pan-CTM pre-assessment pathway.
- The Optimal Trauma Reset Fortnight reviewed delays within the trauma pathway & introduced targeted improvement actions.
- Work commenced to develop Trauma Same Day Emergency Care pathways to support assessment & treatment outside an inpatient ward setting for selected patients.



IMPACT

- 4,149 patients had been discharged from further outpatient clinics following weekend appointments.
- During the Optimal Trauma Fortnight, the time to first Occupational Therapy review on the Trauma Unit reduced from 12 days to one day
- The Health Board was de-escalated to Level 1 for cancer performance, with Single Cancer Pathway compliance of 65% in November & 64.1% in December.



LOOKING AHEAD

Complete the clinical pathways & standard operating procedures required to support Trauma Same Day Emergency Care, initially through the Royal Glamorgan Hospital Fracture Clinic & subsequently through the Prince Charles Hospital Fracture Clinic





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PRIMARY CARE & COMMUNITY IMPROVING ACCESS & COORDINATION OF SERVICES

Primary Care & Community services progressed a number of service developments during 2025/26, including the introduction of the Enhanced Community Care team, development of a District Nursing Single Point of Access model, expansion of the Respiratory Virtual Ward & implementation of WGOS 4 filtering services within primary care.

WHAT IMPROVED

- The Enhanced Community Care (ECC) team was introduced to enable more patients to be cared for at home rather than in hospital, with services reconfigured to increase the range of support available.
- A new District Nursing Single Point of Access model was progressed in Bridgend to provide a single contact number for District Nursing services, supporting implementation of the Community Nursing Specification.
- The Respiratory Virtual Ward supports 20 patients across Rhondda Taf Ely & Merthyr, with referrals from the Bridgend COPD team commencing during 2025.
- Primary Care implemented “Welsh General Ophthalmic Services (WGOS) 4 filtering services” to reduce referrals into hospital eye care services.

IMPACT

- The District Nursing Single Point of Access was implemented across the Health Board, providing a single contact number for patients & referrers.
- The Respiratory Virtual Ward increased from 20 to 35 patients across Rhondda Cynon Taf & Merthyr.
- Diabetes 8 Care Process compliance improved from 32% to 46.61% through targeted work with GP practices.

LOOKING AHEAD

- Continue development of Respiratory Virtual Ward capacity & supporting pathways.





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UNSCHEDULED CARE

STRONG AMBULANCE HANDOVER PERFORMANCE WITH CONTINUED FOCUS ON PATIENT FLOW

Strong ambulance handover performance, with ambulance handover performance & lost ambulance hours compared with other Welsh Health Boards.

Challenges continue in patient flow within hospitals, reflected in increasing numbers of patients waiting over 12 hours in Emergency Departments.

WHAT IMPROVED

- The 45-minute ambulance handover model was implemented from October 2025 as part of wider urgent & emergency care improvement work.
- Relatively low lost ambulance hours compared with many other Welsh Health Boards.

IMPACT

- CTMUHB reported relatively low lost ambulance hours compared with other Welsh Health Boards during the year.
- Ambulance handover performance compared favourably with other Welsh Health Boards.
- Reports identified increasing numbers of patients waiting over 12 hours in Emergency Departments, highlighting continuing internal flow pressures.

LOOKING AHEAD

Continue to improve patient flow, discharge processes & operational performance across urgent & emergency care pathways.





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CONCERNS

ADDRESSING HISTORIC CONCERNS & IMPROVING EARLY RESOLUTION

During 2025/26, the service focused on improving the timeliness of concerns management by addressing historic Putting Things Right responses & Early Resolution cases, while strengthening opportunities for earlier engagement through Listening Discussions. The available evidence shows improvement activity, but further data is needed to quantify the scale & impact of the reduction.

WHAT IMPROVED

- Significant progress was made in reducing historical Putting Things Right (PTR) responses. With plan to close all PTR responses by 30 June 2026.
- Historic Early Resolution backlogs were reduced. Again with planned target to close all Early Resolution cases by 30 June 2026.
- As part of the Quality & Safety team Organisational Change Process, part of the PALS team were transferred to the Concerns Team to undertake more active Listening Discussions supported earlier engagement with patients & families.
- Closer working with clinicians, particularly through Early Resolution processes, has enabled concerns to be addressed earlier, supporting more timely feedback, earlier communication with patients & families, & opportunities to resolve issues in real-time & closer to the point of care.

IMPACT

- Progress was made in addressing historic Putting Things Right responses & Early Resolution cases, although the available slide does not quantify the reduction.
- The transfer of part of the PALS team into the Concerns Team increased capacity for active Listening Discussions & earlier engagement with patients & families.
- Closer working with clinicians through Early Resolution supported earlier communication, more timely feedback & opportunities to resolve concerns closer to the point of care.

LOOKING AHEAD

- Complete the planned closure of outstanding historic Putting Things Right responses & Early Resolution cases by 30 June 2026.
- Monitoring whether earlier engagement improves the timeliness of concerns management.





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LEGAL SERVICES

IMPROVING OVERSIGHT OF LEGAL & REDRESS DEADLINES

Structured review & escalation improved visibility of court, coroner, limitation, disclosure, statement & reimbursement deadlines. Review meetings, trackers & risk-based prioritisation supported earlier identification of delays, dependencies & matters requiring escalation.

WHAT IMPROVED

- Strengthened deadline oversight through review meetings & trackers.
- Prioritised high-risk cases according to risk.
- Reviewed older cases to support progression & identify blockages.
- Used weekly reviews & enhanced monitoring to support Redress recovery.
- Escalated overdue statements, incomplete disclosure & missing learning.
- Submitted learning statements to the Coroner.

IMPACT

- Historic Redress cases awaiting the outcome of investigation reduced from 55 to 21.
- Learning statements were submitted to the Coroner, avoiding the issuing of Prevention of Future Deaths Reports.

LOOKING AHEAD

- Implement the Organisational Change Programme to strengthen capacity & resilience across the Claims, Redress & Inquest teams.





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INFECTION PREVENTION & CONTROL

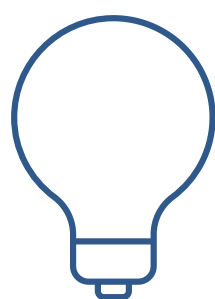
TIMELY ADVICE IS ESSENTIAL

Timely IPC advice is essential when infection risk affects isolation, patient placement, outbreak control, staff safety or service continuity. CTMUHB strengthened access to IPC support through 12-hour acute-site cover, weekend & bank holiday on-call arrangements & the IPC Hub model.

Delays in isolation, testing, escalation, cleaning, outbreak control or specialist advice can increase transmission risk & disrupt services. Winter viral activity, high occupancy & limited side-room availability made timely decision-making particularly important.

WHAT IMPROVED

- 12-hour acute-site IPC support: Support was strengthened across Prince Charles, Royal Glamorgan & Princess of Wales Hospitals during key operational hours.
- Weekend & bank holiday on-call: Urgent IPC issues could be reviewed outside standard working patterns.
- IPC Hub coordination: The Hub helped triage requests, allocate IPC resource according to risk & support consistent advice across sites.



IMPACT

- Clinical areas had improved access to IPC advice for patient placement, outbreak management, environmental concerns & urgent infection risks.
- The service became more resilient, with stronger continuity of advice at weekends & bank holidays.
- Hub working improved situational awareness & supported consistent prioritisation during pressure.

LOOKING AHEAD

- Evaluate the 12-hour acute-site model & weekend/bank holiday on-call service through quarterly reporting.
- Map IPC workflows to improve standardisation, documentation, efficiency & resilience.
- Aim for post-infection reviews to be completed within three weeks of the positive result, except where typing or cluster investigation requires longer.





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SAFEGUARDING

WHAT IMPROVED

- Improved access to safeguarding advice through clear referral pathways & escalation processes. The implementation of the safeguarding duty desk has increased accessibility to timely advice.
- Strengthened engagement within MASH to support timely multi-agency decision-making. The use of a shared information sharing platform & regular operational meetings allows for any issues or concerns to be resolved timely.
- Ongoing monitoring of referral quality & prioritisation of high-risk cases, through screening within MASH & the duty desk.
- Improved processes for timely statutory health assessment for care experienced children.
- Reduction in historical backlogs for Deprivation of Liberty Safeguards, through targeted interventions.
- Increased compliance with Mental capacity act training, ensuring care is provided in line with legislative practice.

IMPACT

- Reduction in delays in safeguarding decision-making & improved responsiveness to risk.
- Enhanced coordination with partner agencies to support information sharing & early intervention.
- Improved compliance with statutory timescales.

LOOKING AHEAD

- Further streamline referral processes through digital integration.
- Improve performance reporting on response times & outcomes.
- Continue to align with national safeguarding metrics.





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Effective care is underpinned by evidence-based practice, robust clinical audit, & workforce development.

EFFECTIVE OVERVIEW

CTMUHB has promoted effectiveness through data-driven improvement, feedback integration, & cross-sector partnerships. Clinical teams have embedded audit learning & service user voice to inform decision-making & service development.

Key Areas of Focus:

- Use of outcome measures in Occupational Therapy
- Inclusion of child voice in safeguarding processes
- Improved sharing of review learning through new intranet & link sessions
- Animal-assisted therapy & palliative interventions
- Collaborative audit & review action planning





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CHILDREN & FAMILIES STRENGTHENING CARE THROUGH EVIDENCE-BASED SERVICES & PATHWAYS

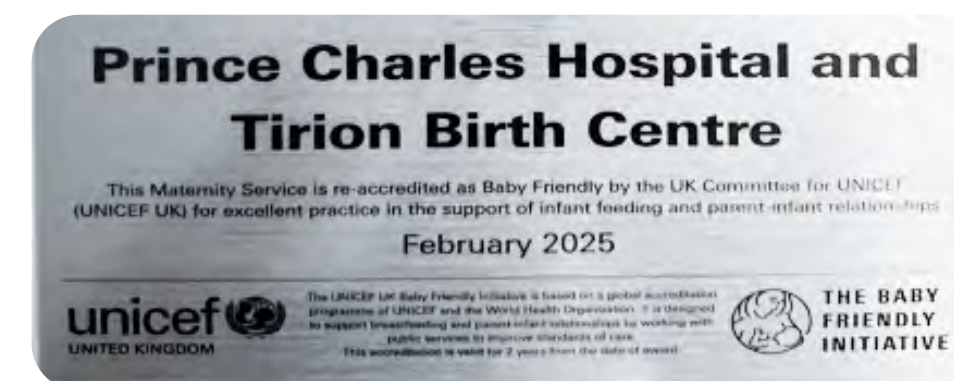
Children & Families continued to strengthen care during 2025/26 through delivery of national programmes, development of specialist services & implementation of recognised clinical approaches for children, young people & families. Work during the year included improvements in Healthy Child Wales Programme delivery, implementation of Hybrid Closed Loop technology for children with Type 1 diabetes, Baby Friendly Initiative assessment activity & development of services to support vulnerable families.

WHAT IMPROVED

- Improvements in delivery of the Healthy Child Wales Programme & Health Visiting services were reported through Care Group oversight arrangements following recovery from previous industrial action.
- Phased implementation of Hybrid Closed Loop insulin pump technology commenced for children with Type 1 diabetes in line with NICE recommendations.
- A positive Baby Friendly Initiative assessment was achieved across community midwifery, Princess of Wales Maternity Unit & Tirion Birth Centre, with 72 of 75 standards passed.
- A review of the Midwifery Sonography Service identified the need for additional sonography capacity & included plans for electronic referrals, specialist clinics & strengthened governance arrangements.
- The BLOOM pilot service was established to provide continuity-based midwifery care for families experiencing complex challenges, including mental health issues, domestic abuse, substance misuse & late engagement with maternity services.

IMPACT

- The Baby Friendly Initiative assessment passed 72 of 75 standards across community midwifery, Princess of Wales Maternity Unit & Tirion Birth Centre.
- Phased implementation of Hybrid Closed Loop insulin pump technology commenced for children with Type 1 diabetes.
- The BLOOM pilot established a continuity-based midwifery service for families experiencing complex challenges.



LOOKING AHEAD

- Continue the phased implementation of Hybrid Closed Loop insulin pump technology.
- Progress the plans identified through the Midwifery Sonography Service review, including additional capacity, electronic referrals, specialist clinics & strengthened governance arrangements.





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DIAGNOSTICS, THERAPIES, PHARMACY & SCIENCES

DELIVERING HIGH QUALITY CARE

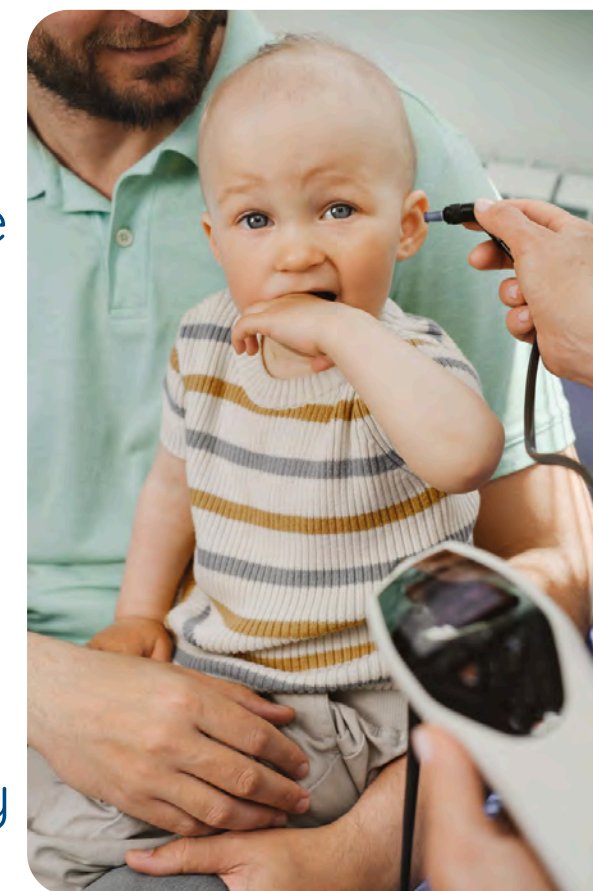
During 2025/26, DTPS demonstrated high levels of compliance with professional standards, external quality assurance requirements & evidence-based practice. Positive audit outcomes, quality assessments & implementation of new clinical processes provided assurance regarding the effectiveness of services across Audiology, Pathology & Allied Health Professional services.

WHAT IMPROVED

- Newborn Hearing Screening Wales met its overall compliance target & all individual quality standards.
- Adult Audiology achieved an overall quality standard compliance score of 91.8%, exceeding the required target of 85%.
- Three Speech & Language Therapy procedures were approved covering Mouth Care, Acute Dysphagia Referrals, & Eating & Drinking at Acknowledged Risk, with awareness training rolled out to staff.
- A two-year Point of Care CRP Testing pilot was implemented in Primary Care, with all 27 participating sites live by February 2026.

IMPACT

- The Newborn Hearing Screening Wales Quality Assurance Audit confirmed CTMUHB achieved 95% overall compliance across targets 1-8 & 90% compliance for each individual standard.
- The audit identified areas of good practice including flexible appointment arrangements, comprehensive hearing assessments & timely reporting to families & healthcare professionals.
- Adult Audiology achieved an overall compliance score of 91.8%, exceeding the required standard of 85%.
- All 27 primary care sites that expressed an interest in the Point of Care CRP Testing pilot were live by February 2026.



LOOKING AHEAD

- Continue the two-year Point of Care CRP testing pilot, which aims to support access to healthcare closer to home & more targeted antibiotic prescribing.





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MENTAL HEALTH & LEARNING DISABILITY

STRENGTHENING EFFECTIVENESS THROUGH QUALITY IMPROVEMENT

Mental Health & Learning Disabilities continued to strengthen the effectiveness of services through delivery of a major improvement programme, development of outcome measurement approaches, participation in national improvement initiatives & ongoing quality assurance activity. Inspection findings & internal quality assurance reviews identified positive findings across inpatient & community services.

WHAT IMPROVED

- The Adult Mental Health Inpatient Improvement Programme completed all 40 actions arising from Healthcare Inspectorate Wales recommendations.
- The Older People's Mental Health Services Falls Collaborative had its improvement work published in the British Medical Journal.
- Internal quality assurance reviews continued across community & inpatient services, supporting teams to identify improvement opportunities & prepare for inspection activity.
- Healthcare Inspectorate Wales feedback was positive following reviews of Taf Ely Community Mental Health Team & Ty Llidiard.
- ReQoL outcome measures were introduced to support consistent measurement of patient outcomes across mental health services.

IMPACT

- HIW's unannounced inspection of Ty Llidiard reported excellent overall feedback, positive & sustained improvements, & no requirement for immediate assurance.
- HIW's review of Taf Ely Community Mental Health Team reported largely positive feedback on care planning, governance & leadership, while also identifying medication management & prescribing actions requiring attention.
- Staff at Taf Ely Community Mental Health Team reported that the Care Group's internal quality assurance review provided valuable preparation for the subsequent HIW review.

LOOKING AHEAD

- Continue the programme of internal quality assurance reviews & progress the remaining actions arising from the Taf Ely Community Mental Health Team inspection.





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PLANNED CARE

DEVELOPING CONSISTENT CLINICAL PATHWAYS

During 2025/26, Planned Care introduced a range of service & pathway developments aimed at improving the delivery of care. This included implementation of a GIRFT-aligned arthroplasty pathway, development of virtual review services through Surgical Assessment Unit & Surgical Same Day Emergency Care, & multidisciplinary approaches to support patients across planned care services.

WHAT IMPROVED

- An inpatient arthroplasty pathway aligned to GIRFT principles was introduced as part of orthopaedic service transformation.
- Orthogeriatric in-reach was introduced to support trauma patients within the Royal Glamorgan Hospital.
- A standardised pan-CTM pre-assessment pathway was developed across acute sites.
- Virtual ward & follow-up pathways were developed through the Surgical Assessment Unit & Surgical Same Day Emergency Care services.

IMPACT

- Between 13/12/2025 & 16/02/2026: 1,000 patients had received arthroplasty surgery since the seven-day working model.
- Reported average length of stay for hip & knee arthroplasty patients was 2.5 days.

LOOKING AHEAD

- Progress the planned enhanced care bay for elective arthroplasty patients at Princess of Wales Hospital & continue the use of virtual review & follow-up through surgical assessment services.





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PRIMARY CARE & COMMUNITY STRENGTHENING CLINICAL PRACTICE & PROFESSIONAL DEVELOPMENT

Primary Care & Community services progressed a range of clinical practice, education & professional development initiatives during 2025/26. This included implementation of clinical guidance, delivery of training programmes & development of professional support resources for nursing staff, assistant practitioners & community services.

IMPACT

Ten staff were identified to undertake the District Nursing Specialist Practitioner Qualification. Training programmes were implemented for registered nurses, assistant practitioners & Band 6/7 staff.



WHAT IMPROVED

- Best practice guidance for the completion & submission of pressure ulcer incident reports was developed & implemented using the SBAR format.
- Training programmes were developed & implemented for registered nursing staff, including interview skills, CPR, manual handling, venepuncture & TRAC training.
- Training events were delivered for Level 4 Assistant Practitioners in relation to the core skills training framework.
- A Band 6/7 development programme was developed & implemented through the Professional Nurse Advocacy & Practice Development Service.

LOOKING AHEAD

- Continue delivery of professional development & specialist training programmes.





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UNSCHEDULED CARE

STRENGTHENING CLINICAL EFFECTIVENESS THROUGH SERVICE IMPROVEMENT

Focus on strengthening clinical effectiveness through service redesign, workforce investment, strengthened governance arrangements & targeted quality improvement activity.

Improvement programmes were established to support clinical quality, patient safety & sustainable service delivery.

WHAT IMPROVED

- Stroke services implemented a structured improvement programme supported by enhanced governance, performance monitoring & multidisciplinary review.
- Quality dashboards & performance reporting mechanisms were developed to support monitoring of incidents, patient experience, mortality, safeguarding & service performance.
- Clinical teams introduced new approaches to multidisciplinary working, including daily huddles, operational review processes & standardised improvement programmes.
- Stroke Services reported an increase in IPC Level 2 compliance from 73% to 89%.

IMPACT

- Stroke quality dashboards enabled monitoring of incidents, mortality, safeguarding & patient experience following service redesign.
- Daily multidisciplinary huddles & governance arrangements supported ongoing review of performance & improvement actions.

LOOKING AHEAD

- Continue focused improvement work on stroke performance, including access to CT scanning & Acute Stroke Unit admission.





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CONCERNS

TURNING PATIENT EXPERIENCES INTO LEARNING

During 2025/26, CTM UHB strengthened the way concerns are managed & used for learning through implementation of the Listening to People framework & closer integration of PALS, Early Resolution & Concerns functions. More consistent concerns processes were introduced, governance arrangements were strengthened, & patient feedback was increasingly used alongside quality information to support organisational learning & service improvement.

WHAT IMPROVED

- During the final quarter of 2025/26, Listening to People (LTP) was implemented across CTM UHB, supported by new processes, guidance & staff engagement.
- Learning identified through concerns is now more systematically captured & shared with services.
- Governance arrangements were strengthened to support learning, quality assurance & organisational oversight.
- Engagement & learning sessions supported implementation of LTP across CTM UHB.
- Future work will further strengthen how concerns, patient feedback, Datix information & other quality indicators are reviewed together to support organisational learning & improvement.

IMPACT

- Listening to People was implemented across CTM UHB during the final quarter of 2025/26, supported by new processes, guidance & staff engagement.
- Learning from concerns was captured & shared with services more systematically.
- Strengthened governance arrangements provided greater support for learning, quality assurance & organisational oversight.

LOOKING AHEAD

- Further strengthen the combined review of concerns, patient feedback, Datix information & other quality indicators to support organisational learning & improvement.





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LEGAL SERVICES

USING LEGAL LEARNING TO SUPPORT IMPROVEMENT

Legal insight was shared more systematically to support proportionate decisions, organisational learning & quality improvement. Reports & governance discussions increasingly focused on the relevance of case findings to service development & practice change. Governance reporting increasingly tested whether learning actions could be evidenced & sustained.

WHAT IMPROVED

- Reported inquest learning to the Quality, Safety & Experience Committee.
- Shared learning through Care Group Quality, Safety & Experience Committees.
- Presented legal learning at audit meetings.
- Used recurring causal themes to inform audits, training priorities & improvement activity.
- Used legal advice & investigation findings to inform service development.
- Strengthened reporting & escalation to increase visibility of completed & sustained actions.

IMPACT

- Learning identified through legal scrutiny informed work relating to:
- Capacity assessment & the application of the Deprivation of Liberty Safeguards.
- Follow-up of investigation results where delays in diagnosis had occurred.
- Standardisation of resuscitation trolleys across Wales.
- Implementation of Enhanced Supervision.
- Governance reporting also strengthened the connection between legal scrutiny, service responses & organisational assurance.

LOOKING AHEAD

- Further develop the Claims, Redress & Inquest teams through the Organisational Change Programme to strengthen learning, assurance & service improvement.





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INFECTION PREVENTION & CONTROL

EFFECTIVE IPC DEPENDS ON RELIABLE PRACTICE

Effective IPC depends on reliable practice, evidence-based guidance & learning from data. CTMUHB used surveillance, point prevalence surveys, audit, training, policy review & governance reporting to improve assurance & identify where practice needs to be strengthened.

Policies alone do not prove that safe practice is happening. Effective infection prevention requires direct observation, education, audit, feedback, leadership accountability & review of infection outcomes.

WHAT WE DID

- Point Prevalence Surveys (PPS): IPC used direct observation to assess Bare Below the Elbows, hand hygiene, personal protective equipment & device-related practice.
- Training & competence: The IPC team delivered 81 formal sessions to 509 staff & provided targeted education linked to risk, outbreaks, audits & practice findings.
- Governance & assurance: Quarterly reporting, annual reporting, risk-register review & Code of Practice assessment were used to provide assurance & identify gaps.

IMPACT

- Point Prevalence Surveys (PPS) work showed that repeated measurement & feedback can improve practice in several areas.
- The work clarified that high Bare Below the Elbows compliance does not automatically mean reliable hand hygiene or appropriate PPE use.
- Overall IPC training compliance remained 78.09%, with Medical & Dental compliance at 38.22%, making this an organisational priority.

LOOKING AHEAD

- Increase IPC Level 1 & Level 2 compliance to at least 85% overall by Quarter 4.
- Repeat PPS across acute sites covering Bare Below the Elbows, hand hygiene, Personal Protective Equipment (PPE), device care & aseptic practice.
- Develop an electronic learning/action tracker for infection reviews, outbreaks audits, PPS & decontamination learning.





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SAFEGUARDING



WHAT IMPROVED

- Reviewed the current safeguarding training programme aligned with the Wales National Safeguarding Training Framework & Intercollegiate Documents.
- Strengthened professional advice & support to frontline staff to ensure evidence-based safeguarding practice.
- Embedded learning from Single Unified safeguarding Reviews, national reports, & internal reviews into training & practice guidance.
- Development of structured safeguarding audit programme aligned to safeguarding priorities.

IMPACT

- Improved staff knowledge, skills, & confidence in safeguarding practice.
- Demonstrable learning from reviews influencing service improvement.
- Increased alignment of practice with policy & national standards.

LOOKING AHEAD

- Continue to align training to emerging national priorities (e.g., VAWDASV, exploitation, neglect).
- Enhance evaluation of training impact on practice & outcomes.
- Continue to embed SUSR learning into training & policy.





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Efficient services deliver care in ways that maximise value & reduce duplication.

EFFICIENT OVERVIEW

- Efficient service delivery has been enhanced by expanding digital tools, strengthening recruitment, & supporting retention. The Ward Accreditation Programme & Senior Nurse Development programme highlight CTMUHB's drive to improve practice through structured frameworks.

Key Areas of Focus:

- Ward Accreditation Programme implementation across three phases
- Recruitment of Band 5 nurses & internal lateral move retention
- Rollout of PROMs/PREMs through value-based projects
- Senior Nurse Development Programme pilot & revision
- Implementation of SafeCare & audit tracking systems





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CHILDREN & FAMILIES DIGITAL SOLUTIONS & SERVICE REDESIGN TO SUPPORT CARE DELIVERY

Children & Families progressed a number of service redesign & digital initiatives during 2025/26. This included implementation of digital systems, redesign of screening services, digital consent processes & developments to support data collection & service management.

WHAT IMPROVED

Implementation of the Badgernet Maternity Information System progressed during 2025/26, with community booking going live in March 2026 & full maternity record implementation planned as part of a phased rollout.

The School Entry Hearing Screening Service transferred to Audiology as part of the development of a new service model.

The School Nursing e-consent pilot achieved 86% uptake in Merthyr, with plans for implementation across CTMUHB.

Digital developments supporting the Fluenz programme included investment in digital & data support, development of a vaccination data capture tool & expansion of e-consent arrangements.

IMPACT

- Community booking through the Badgernet Maternity Information System went live in March 2026.
- The School Nursing e-consent pilot achieved 86% uptake in Merthyr.
- A vaccination data capture tool & expanded e-consent arrangements were developed to support the Fluenz programme.

LOOKING AHEAD

- Continue the phased rollout of Badgernet towards implementation of the full maternity record.
- Progress wider implementation of School Nursing e-consent across CTMUHB.





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DIAGNOSTICS, THERAPIES, PHARMACY & SCIENCES

DELIVERING HIGH-QUALITY CARE

During 2025/26, DTPS progressed digital, technological & workforce developments designed to support more efficient service delivery. This included implementation of new laboratory systems, preparation for Radiology system changes, workforce redesign initiatives & investment in technology to reduce reliance on manual processes.

WHAT IMPROVED

Cellular Pathology successfully implemented the TCLe Laboratory Information Management System (LIMS) during the week commencing 26 January 2026.

A cross-section of Radiology staff completed Super User training in preparation for implementation of the Radiology Information System Programme (RISP) in March 2026.

An Anaesthetics & Ventilation Technologist was appointed & began training to re-establish support at RGH & PCH.

Pathology launched a SimplyDo improvement challenge focused on specimen reception processes, workflow, communication & error reduction.

IMPACT

- TCLe Laboratory Information Management System (LIMS) was successfully implemented within Cellular Pathology, providing the new laboratory information management platform for the service.
- The Anaesthetics & Ventilation Technologist role was established to reintroduce local technical support at RGH & PCH & remove reliance on an external service contract.
- Ideas generated through the Pathology SimplyDo initiative were being progressed, with incident data planned to be used to assess impact on specimen reception errors. Outcome data were not reported during 2025/26.

LOOKING AHEAD

- Continue implementation of solutions to reduce manual transcription within Cellular Pathology & progress digital developments supporting more efficient workflows across Pathology & Radiology services.





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MENTAL HEALTH & LEARNING DISABILITY USING DATA & AUDIT TO STRENGTHEN QUALITY OVERSIGHT

Mental Health & Learning Disabilities strengthened quality oversight through improved use of data, audit & governance systems. During 2025/26, the Care Group implemented a Quality Dashboard, embedded the Audit Management & Tracking (AMAT) system across all wards, & continued to use quality assurance reviews & governance arrangements to identify themes, trends & improvement priorities.

WHAT IMPROVED

A fully functional Quality Dashboard was developed to support identification of themes & trends across services.

The Care Group introduced thematic analysis of complaints using dashboard reporting to support service improvement.

Audit Management & Tracking (AMAT) was embedded across all MHLDD wards, supporting monitoring of compliance & improvement actions. Performance against ward audit actions continued to be monitored through directorate Quality, Safety & Experience meetings.

Plans developed to further enhance reporting capability through operationalisation of the Quality Dashboard & implementation of Power BI.

IMPACT

- The Quality Dashboard made it easier for the Care Group to identify themes & trends across its quality information.
- Datix dashboard access enabled team & service leads to view formal & Early Resolution complaints & supported a focused approach to closing Early Resolution complaints.
- AMAT provided a consistent framework for monitoring ward audit compliance & outstanding actions through directorate Quality, Safety & Experience meetings.

LOOKING AHEAD

- Operationalise the Quality Dashboard for individual teams & services & then implement Power BI.





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PLANNED CARE

MAKING BETTER USE OF CAPACITY ACROSS PLANNED CARE

During 2025/26, Planned Care redesigned services, pathways & clinical capacity to make better use of available resources. Developments included dedicated elective orthopaedic capacity, Vanguard theatres, outpatient transformation, centralised ophthalmology services & standardised pre-assessment pathways to support patient flow & more structured use of available capacity.

What Improved

Endoscopy & surgical Vanguard theatres were introduced to increase planned care capacity.

A dedicated arthroplasty service was established at Princess of Wales Hospital, supported by dedicated theatre, ward & therapy capacity.

Cataract surgery was centralised within the Princess of Wales Ophthalmology Centre to increase treatment capacity.

Weekend outpatient activity supported additional review & assessment capacity across multiple specialties.

IMPACT

- Between 1 September & 22 October 2025, 239 elective arthroplasty procedures were undertaken at Princess of Wales Hospital.
- Over the same period, average length of stay was reported as 1.9 days, compared with 5 days at the equivalent point in the previous year.
- The finalised theatre timetable from 1 April 2026 was reported as matching capacity & demand of each service.

LOOKING AHEAD

- Embed the new theatre timetable following completion of the Royal Glamorgan Hospital theatre works & return of activity from the Vanguard unit to the main theatre suite.





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PRIMARY CARE & COMMUNITY IMPROVING SERVICE COORDINATION & USE OF RESOURCES

Primary Care & Community services progressed service redesign, workforce development & new models of care during 2025/26. This included the introduction of Enhanced Community Care, development of new operating arrangements within the Community Navigation Hub & implementation of service changes designed to support delivery of care across community settings.

What Improved

The Enhanced Community Care (ECC) team was introduced, reconfiguring existing services & providing new services for patients whilst maintaining existing clinical provision.

A new operating model for Advanced Paramedic Practitioners within the Community Navigation Hub was introduced, with staff co-located within the hub & directing the work of WAST resources.

The Respiratory Virtual Ward had 20 patients across Rhondda Taf Ely & Merthyr, with referrals from the Bridgend COPD team commencing during 2025.

WPrimary Care have implemented the WGOS 4 filtering services for glaucoma, wet age-related macular degeneration & diabetic retinopathy pathways.

IMPACT

- The District Nursing Single Point of Access was implemented across the Health Board.
- Enhanced Community Care reconfigured existing services whilst maintaining current clinical provision & increasing services available to patients.
- Unified Contract Assurance Framework desktop reviews were completed for GP practices for a second consecutive year.

LOOKING AHEAD

- Continue development of the CTM Single Point of Access model.
- Further develop Hospital at Home & Enhanced Community Care arrangements.





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UNSCHEDULED CARE

IMPROVING PATIENT FLOW THROUGH SERVICE REDESIGN & DIGITAL INNOVATION

Unscheduled Care introduced service redesign & digital approaches to support patient flow, operational decision-making & coordination across urgent & emergency care pathways. These included Optimise, UNITE, electronic ED huddles & digital task management. The available evidence supports these as improvement enablers, but does not yet demonstrate sustained efficiency outcomes.

What Improved

The Optimise programme was launched at Princess of Wales Hospital in October 2025, focusing on SAFER board round compliance & the Optimal Hospital Flow Framework.

The UNITE programme brought together multiple Unscheduled Care workstreams under one coordinated structure, including Acute Medicine/SDEC, frailty, ED, discharge & flow, UTC, Doccla & enabling projects.

Electronic ED Huddles were launched in December 2025 to support real-time visibility of patient flow, operational decision-making & data quality.

MyPorter was launched pan-CTMUHB in November 2025 to support real-time task allocation, patient transfers & operational flow.

IMPACT

- Optimise introduced a structured approach to patient flow, multidisciplinary coordination & decision-making.
- UNITE brought multiple Unscheduled Care improvement workstreams together under one coordinated structure.
- Electronic ED Huddles & MyPorter introduced digital tools to support real-time visibility of patient flow, operational decision-making & data quality.

LOOKING AHEAD

- Continue embedding Optimise, UNITE & digital flow initiatives to support patient flow & service transformation.





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CONCERNS

MAKING BETTER USE OF FEEDBACK, LEARNING & RESOURCES

During 2025/26, the Concerns & Patient Experience Service improved the way concerns, patient feedback & quality intelligence are used to support improvement. Closure of legacy workloads enabled resources to be redirected towards current activity, while closer integration between concerns, patient experience & quality intelligence functions reduced duplication & improved organisational awareness of key themes.

What Improved

Closure of legacy workloads enabled resources to be redirected towards current concerns & service improvement.

Improved integration between concerns, patient experience & quality intelligence functions reduced duplication across systems & processes.

Organisational awareness of recurring themes & learning was strengthened through more connected use of concerns & feedback information.

Closure of historic concerns enabled greater focus on supporting implementation of Listening to People arrangements.

Future work will continue to enhance the use of patient feedback, complaints & quality intelligence to identify themes & drive service improvement.

IMPACT

- Addressing legacy workloads enabled greater focus on current concerns & implementation of Listening to People arrangements.
- Closer integration of concerns, patient experience & quality intelligence functions reduced duplication across systems & processes.
- More connected use of concerns & feedback information strengthened organisational awareness of recurring themes & learning.

LOOKING AHEAD

- Continue enhancing the combined use of patient feedback, complaints & quality intelligence to identify recurring themes & support service improvement.





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LEGAL SERVICES STRENGTHENING CASE MANAGEMENT & REDRESS RECOVERY

Case management became more structured through standardised review, improved audit trails, clearer ownership & targeted work on older matters. Redress recovery activity focused on improving visibility of priorities, ownership, next steps & blockages through strengthened review, governance & monitoring arrangements.

WHAT WE DID/IMPROVED

Full review of open Redress cases undertaken.

Redress Tracker implemented.

Reintroduced weekly Legal Services review meetings.

Developed a revised end-to-end Redress process & governance framework.

Reconciled & cleansed case information to improve data consistency.

Developed shared resources, guidance & quality checks for formal submissions.

IMPACT

- 58 final response letters were issued, providing the outcomes of Redress investigations.
- 75 cases were closed, bringing those matters to a final conclusion.
- Case information was reconciled & cleansed to improve data consistency.

LOOKING AHEAD

- Embed regular file reviews & audit arrangements to support quality, consistency & effective case management.





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INFECTION PREVENTION & CONTROL

EFFICIENCY THROUGH PREVENTING AVOIDABLE HARM

IPC supports efficiency by preventing avoidable harm, reducing outbreak disruption & promoting appropriate use of resources. The service used risk-based audit, Hub working & PPE improvement work to support safety, sustainability & value.

Avoidable infection & outbreaks use resources through isolation, treatment, cleaning, staffing pressure & lost bed capacity. Efficient IPC means using evidence & risk assessment to focus action where it has greatest safety & quality impact.

WHAT WE DID

Risk-based audit: IPC continued to move from a static annual audit model to an areas-of-concern approach using AMaT, outbreak intelligence, incidents, infection reviews & local escalation.

Appropriate glove use: Point Prevalence Surveys (PPS) & Personal Protective Equipment (PPE) improvement work reinforced when gloves are needed & when hand hygiene is safer & more appropriate.

Resource coordination: The Hub model supported triage, prioritisation & cross-site deployment of IPC staff according to risk, demand & capacity.

IMPACT

- Non-sterile examination glove use reduced by approximately 605,800 individual gloves
- Non-sterile glove spend reduced by approximately £20,658, with overall expenditure reduced by approximately £20,658 when sterile & non-sterile categories were combined.
- Risk-based audit helped focus IPC support on areas with the weakest assurance

LOOKING AHEAD

- Continue appropriate glove-use work as a safety, sustainability & value project
- Use Audit Management & Tracking tool (AMaT) & action tracking to focus on areas of concern, not only audit scores.
- Evaluate Hub workflows & use demand data to improve standardisation & efficiency





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DEVELOPING CLINICAL LEADERS

During 2025/26, CTMUHB launched ASCEND (Advancing Senior Clinical Excellence in Nursing Development), a senior clinical leadership programme for Band 8a registered nurses. Building on learning from the original pilot, ASCEND provides a structured development pathway focused on workforce leadership, quality, safety, patient experience, governance & service improvement. Delivered through a blended learning model, the programme supports senior nurses to translate leadership into measurable improvement & assurance outcomes.

WHAT IMPROVED

Refined & strengthened the original leadership pilot.
Introduced a structured curriculum built around four clinical leadership domains.
Increased focus on governance, assurance & data-informed decision making.
Expanded learning in workforce leadership, systems leadership & service transformation.
Enhanced workplace application through blended learning & peer support.

Programme element	Indicative timeframe	Delivery method	Delivery format
Launch: Establishing Clinical Leadership Foundations	Week 1 16th Oct	Full-day facilitated session	Face to face / in person
Session 1: Leading a Skilled and Sustainable Clinical Workforce	Weeks 2–3 21st Oct	Virtual taught session with tailored breakout learning	Virtual
Session 2: Leading Quality, Safety and Patient Experience through Clinical Governance	Weeks 5–6 17th Nov	Full-day facilitated session	Face to face / in person

IMPACT

- ASCEND aims to support senior nurses to:
- Demonstrate enhanced clinical leadership capability.
- Lead effective & sustainable clinical teams.
- Strengthen assurance within governance frameworks.
- Deliver measurable improvements in quality, safety & patient experience
- Use data & insight to inform clinical & strategic decision making.

LOOKING AHEAD

- Implementation & evaluation of ASCEND will assess its contribution to leadership capability, workforce development, patient experience & service improvement across CTMUHB.





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SAFEGUARDING

WHAT IMPROVED

- Ensured safeguarding processes are consistently applied across all populations & service areas.
- Strengthened consideration of vulnerability, protected characteristics, & inequalities within safeguarding assessments.
- Continued partnership working to support equitable access to safeguarding services.



IMPACT

- Improved identification & response to individuals at increased risk due to inequality or vulnerability.
- Greater consistency in safeguarding decision-making

LOOKING AHEAD

- Further develop data to better understand disparities in safeguarding access & outcomes.
- Strengthen inclusion of equity considerations within audits & reviews.

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We are committed to removing barriers to access & ensuring that all individuals receive fair & inclusive care.

EQUITABLE OVERVIEW

CTMUHB has strengthened its commitment to inclusion & fairness. From staff wellbeing & bereavement care to data-informed safeguarding, the Health Board is taking steps to ensure equity in opportunity, access & support.

Key Areas of Focus:

- Support for Armed Forces & ERS Silver award status
- Launch of Armed Forces Café & Medical Stretch programme
- Pastoral care offers for international & BAME staff
- Safeguarding data reporting into national systems
- Bereavement Lead influence on national policy





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CHILDREN & FAMILIES

IMPROVING ACCESS & SUPPORT FOR DIVERSE & VULNERABLE COMMUNITIES

Children & Families progressed a number of initiatives during 2025/26 aimed at supporting children, young people, women & families with differing needs & circumstances. This included development of targeted services for vulnerable families, work to address digital exclusion, cultural competency certification activity & review of services where variation across sites had been identified.

WHAT IMPROVED

The BLOOM (Building Lives & Optimising Outcomes in Midwifery) pilot was launched in Bridgend, providing continuity-based midwifery care for families experiencing challenges including mental health issues, domestic abuse, substance misuse & late engagement with maternity services.

Work continued to support families experiencing digital exclusion, with the Digital Informatics Midwife recognised nationally for work with families experiencing digital exclusion & poverty.

Cultural competency certification progressed across the Care Group during 2025/26.

A review of allergy services commenced in response to increased referrals & inequity across sites.

A health visitor produced mini-webinars focused on equity in breastfeeding for Gypsy & Traveller communities.

IMPACT

- The BLOOM pilot provided a continuity-based model of midwifery care for families experiencing specified complex challenges.
- Cultural competency certification progressed across the Care Group.
- Resources were produced focusing on equity in breastfeeding for Gypsy & Traveller communities.

LOOKING AHEAD

- Continue the review of allergy services in response to increased referrals & inequity identified across sites.
- Continue work relating to digital exclusion, cultural competency & support for families with differing needs & circumstances.





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DIAGNOSTICS, THERAPIES, PHARMACY & SCIENCES

SUPPORTING EQUITABLE ACCESS

During 2025/26, DTPS undertook a number of initiatives designed to support equitable access to services. These included flexible approaches to service delivery, analysis of access patterns & service reviews intended to promote consistent access across CTM. The QSRE papers provide evidence of activity supporting equitable access but limited evidence demonstrating changes in equity outcomes.

WHAT IMPROVED

The Newborn Hearing Screening Wales Quality Assurance Audit identified flexible service provision to meet the needs of families in terms of appointment day & timing.

Audiology submitted data to the CIRCA-2 Audit, which includes referral analysis by postcode & deprivation index.

Initial engagement commenced for a review of Echocardiography resources across CTM, with the stated objective of ensuring equitable access & consistent service provision.

The Point of Care CRP Testing pilot was implemented in Primary Care, with all 27 participating sites live by February 2026.

IMPACT

- The Newborn Hearing Screening Wales audit highlighted flexible appointment arrangements as an area of good practice for families accessing the service.
- CTMUHB contributed data to the CIRCA-2 national audit, supporting analysis of access to cochlear implant referrals by postcode & deprivation index.
- The Echocardiography demand & capacity review was established with the stated aim of ensuring equitable access & consistent service provision across CTM.
- All 27 Primary Care sites that expressed an interest in the Point of Care CRP Testing pilot were operational by February 2026.

LOOKING AHEAD

- Continue participation in the CIRCA-2 audit programme & further work to understand access to cochlear implant services through referral analysis by postcode & deprivation index.





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MENTAL HEALTH & LEARNING DISABILITY SUPPORTING EQUITABLE ACCESS & PERSONALISED CARE

Mental Health & Learning Disabilities continued to support equitable care for people with learning disabilities through community-focused service development, annual health check improvement work & specialist liaison support within acute hospitals. During 2025/26, the Care Group contributed to Welsh Government learning disability priorities, supported specialist learning disability services through regional partnerships & continued initiatives aimed at improving health outcomes & reducing inequalities.

WHAT IMPROVED

The Care Group supported Welsh Government priorities to increase access to & uptake of Annual Health Checks for people with learning disabilities.

Additional support was introduced for young people waiting for specialist substance misuse services.

Work with Public Health colleagues explored additional approaches to support smoking cessation for people admitted to mental health inpatient services.

Specialist Learning Disability services continued to work towards reducing reliance on inpatient care & strengthening community provision.

Acute Learning Disability Liaison Nurses continued to support patients & staff across CTMUHB acute hospitals through training, advice & champion development.

A dedicated Quality Lead Nurse role continued to support improvement in health outcomes for people with learning disabilities.

IMPACT

- Three whole-time-equivalent Acute Learning Disability Liaison Nurses supported the three CTMUHB acute hospitals & delivered induction, deteriorating-patient & learning disability champion training.
- Additional nursing capacity, weekly waiting-list discussions & four-weekly communication with young people & families provided additional support while young people waited for specialist substance misuse services.
- The number of people requiring specialist learning disability inpatient care reduced from a high of 26 in 2020 to 20 reported in 2025.

LOOKING AHEAD

- Continue reporting progress on learning disability annual health checks & progressing work aligned to Welsh Government priorities for annual health checks, specialist services, data quality & reducing restrictive practices.





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PLANNED CARE

IMPROVING ACCESS TO SERVICES ACROSS CTM

Planned Care continued to develop services across CTM through specialist hubs, outpatient activity & alternative clinical pathways. These developments included the creation of new diagnostic & treatment services, expansion of weekend outpatient activity & development of virtual & same-day care pathways.

WHAT IMPROVED

A cataract treatment hub was developed within the Princess of Wales Hospital, Eye Unit.

A glaucoma diagnostics hub was established at Ysbyty Cwm Cynon Hospital.

Weekend outpatient activity was delivered across multiple specialties.

Virtual review pathways were developed through Surgical Assessment Services.

Trauma Same Day Emergency Care pathways were developed to support assessment & treatment as an alternative to ward admission for selected patients.

IMPACT

- Weekend outpatient appointments were delivered across nine reported specialties including Ear, Nose & Throat, Orthopaedics, Ophthalmology, Urology, Gynaecology, Dermatology, Gastroenterology, General Surgery & Cardiology.
- The Surgical Assessment Unit & Surgical Same Day Emergency Care watched virtual monitoring & review of GP referrals & follow-up patients.
- Patient & staff feedback following centralisation of cataract services was as positive.

LOOKING AHEAD

- Continue developing Trauma Same Day Emergency Care & virtual review pathways as alternatives to ward-based assessment for selected patients.





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PRIMARY CARE & COMMUNITY

IMPROVING ACCESS & CONSISTENCY ACROSS COMMUNITY SERVICES

Primary Care & Community services progressed a range of service developments during 2025/26, including prison healthcare improvement work, implementation of WGOS 4 services, development of District Nursing services & safeguarding support for primary care teams.

WHAT IMPROVED

At HMP Parc, the percentage of the prison population offered DBST increased from 78% to 97%, while the percentage screened increased from 34% to 89%.

District Nursing teams continued work towards the Community Nursing Specification, with CTM reporting the highest percentage of weekend capacity across Wales.

District Nursing safeguarding training was implemented & the general medical services team worked with safeguarding colleagues to develop a training programme for GP practices & wider primary care teams.

GP practice assurance visits commenced under the Unified Contract Assurance Framework, with multidisciplinary visits covering all 12 Quality Standards.

IMPACT

- At HMP Parc, the proportion offered Dry Blood Spot Testing (DBST) increased from 78% to 97%, with screening increasing from 34% to 89%.
- The Spring COVID-19 vaccination programme achieved uptake of 54.4%, above the Welsh average of 52.27%.

LOOKING AHEAD

- Deploy the Mobile Vaccination Unit to support vaccine access across communities.
- Continue work towards Hepatitis B & C elimination targets within HMP Parc.





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UNSCHEDULED CARE

IMPROVING CONSISTENCY & ACCESS ACROSS UNSCHEDULED CARE SERVICES

Unscheduled Care focused on improving consistency of care, supporting reduced variation between sites & enhancing access to support for vulnerable patients. Initiatives included extending support services & standardising clinical processes across hospital sites.

WHAT IMPROVED

Funding was allocated for three Health Independent Domestic Violence Advisors (IDVAs), with plans to extend the Emergency Department pilot model across all three acute hospital sites.

A Task & Finish Group was established to standardise enhanced supervision documentation, risk assessment processes & levels of observation across sites.

Marie Curie Companion Volunteers were introduced across inpatient wards & departments at PCH to provide emotional & social support, advance care planning support & bereavement support.

IMPACT

- Funding for Health IDVAs supported access to domestic abuse support within acute services.
- Standardisation work strengthened consistency of enhanced supervision processes across hospital sites.
- Marie Curie Companion Volunteers increased the support available to patients, families & carers at Prince Charles Hospital.

LOOKING AHEAD

- Continue extending support services & implementing standardised approaches to care across hospital sites.





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CONCERNS

ENSURING EVERYONE'S VOICE CAN BE HEARD

The Concerns Service continued to support equitable access to the concerns process by recognising individual communication, language & accessibility needs. Through Listening to People, individuals are offered communication & advocacy support, reasonable adjustments where required, & opportunities to raise concerns in ways that best meet their needs. Welsh language provision & accessible communication remain important components of delivering person-centred & equitable services.

WHAT IMPROVED

Communication is tailored to meet individual communication & accessibility needs.

Advocacy & support are available to individuals raising concerns.

Reasonable adjustments are considered to support people with disabilities & protected characteristics.

Support is available for people with language needs, disabilities & digital exclusion.

Welsh-speaking individuals can raise & discuss concerns through Welsh language provision, including access to Welsh-speaking staff.

IMPACT

- People are supported to raise concerns in ways that meet their communication, language & accessibility needs, helping ensure that everyone has equitable access to the concerns process.

LOOKING AHEAD

- The service will continue to strengthen accessible communication, Welsh language provision, advocacy support & reasonable adjustments to ensure concerns processes remain inclusive & equitable for all communities.





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LEGAL SERVICES

FAIR & CONSISTENT LEGAL PROCESSES

Greater standardisation supported fairer & more consistent management of claims, redress & inquests. Attention was given to communication needs, advocacy & reasonable adjustments to support meaningful participation in legal processes.

WHAT WE DID/IMPROVED

Introduced standard review arrangements & guidance to support consistency.

Considered advocacy & communication support needs.

Adapted communication & process arrangements where individual needs were identified.

Clarified escalation routes for delays & access issues.

IMPACT

- Introduced standard review arrangements & guidance to support consistency.
- Considered advocacy & communication support needs.
- Adapted communication & process arrangements where individual needs were identified.
- Clarified escalation routes for delays & access issues.

LOOKING AHEAD

- Continue to strengthen support, guidance & reasonable adjustments for patients, families & staff involved in claims, Redress & inquest processes.





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INFECTION PREVENTION & CONTROL

PROMOTING CONSISTENT INFECTION PREVENTION STANDARDS

IPC supports equity by promoting consistent infection prevention standards across acute, community & partner settings. CTMUHB strengthened Health Board-wide acute support & developed the Community IPC Team so prevention reaches patients & providers beyond hospital walls.

Community-onset infection represents a substantial part of the infection burden for *C. difficile*, *E. coli*, *Klebsiella* & *Staphylococcus aureus*. Equity requires IPC support across the whole pathway, including hospitals, community services, care homes, primary care & other providers.

WHAT WE DID

- Consistent acute-site support: The 12-hour model improved equity of access to IPC advice across Prince Charles, Royal Glamorgan & Princess of Wales Hospitals.
- Community IPC development: The Community IPC Team strengthened relationships with Public Health Wales, local authorities & care providers, including support linked to COVID-19 & scabies outbreaks.
- Care home audit & support: The community programme supported risk-based visits to nursing homes & residential homes.

IMPACT

- 25 of 27 nursing homes were audited, with 15 rated green, 8 amber & 2 red.
- Residential-home audit coverage began, with 15 of 37 homes audited during the reporting period.
- Community partnerships are creating a stronger foundation for work on community-onset infection & outbreak support.

LOOKING AHEAD

- Deliver risk-based audit/support visits to 100% of nursing homes & an agreed proportion of residential homes.
- Extend the IPC community offer to community clinics, GP surgeries & domiciliary care pathways.
- Identify IPC link/champions in nursing homes & at least 25% of GP practices by Quarter 4, subject to capacity.





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SAFEGUARDING

WHAT IMPROVED

Strengthened focus on the voice of the child & adults within safeguarding processes. Utilising feedback questionnaires from within the child protection medical hub, looked after children's service & health IDVAs.

Utilisation of feedback mechanisms (e.g., CIVICA) to capture patient & family experience.

Promoted person-centred safeguarding practice through applying professional curiosity, training & supervision.

IMPACT

- Increased evidence of individual perspectives informing safeguarding decisions.
- Improved quality of care planning & intervention

LOOKING AHEAD

- Further embed mechanisms for capturing & evidencing the voice of the individual.
- Strengthen co-production approaches where appropriate.





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PROMOTING INCLUSION & EQUITY OF EXPERIENCE

Work continued to improve inclusion & equity of experience by strengthening support pathways for groups whose voices may be less visible in traditional feedback routes.

WHAT IMPROVED

Engaged with carers & people with learning disabilities to better understand experience & access needs.

Continued Armed Forces Covenant work & support for the veteran community.

Promoted reasonable adjustments & accessibility.

Strengthened volunteer services as part of patient & community support.

Supported review of chaplaincy & spiritual care provision.

IMPACT

Seldom-heard voices were made more visible in-service improvement conversations, accessibility & strengthen equity of experience for patients, families, carers & communities.

LOOKING AHEAD

Build stronger evidence of outcomes for seldom-heard groups & use insights to improve services.

Strengthen mechanisms for capturing experience from communities who may not be heard.

Use learning from inclusion & equity work to inform service planning, staff development & training.





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Putting patients, carers, & staff at the centre of care decisions builds trust & improves outcomes.

PATIENT-CENTRED OVERVIEW

CTMUHB continues to promote person-centred care by embedding compassion, preference, & holistic support into practice. Chaplaincy, trauma support, & safeguarding conversations reflect how services are aligned to individual needs & values.

Key Areas of Focus:

- Chaplaincy response in trauma & bereavement settings
- Spiritual care embedded into staff & patient support
- Safeguarding staff trained to ask patients about feeling safe
- Care2Share & other service user feedback routes introduced
- Contribution to national nursing & midwifery curriculum





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CHILDREN & FAMILIES

LISTENING TO CHILDREN, YOUNG PEOPLE & FAMILIES



Children & Families reported a range of activity during 2025/26 relating to the involvement of children, young people, women & families. This included increased patient responses (through CIVICA), involvement of a young person in a senior recruitment process, appointment of a Maternity & Neonatal Voices Partnership (MNVP) Chair & listening events undertaken across maternity services.

WHAT IMPROVED

An increase in patient feedback responses (CIVICA) was reported across Children & Young People's services.

A young person aged 12 was included as a member of the appointment panel for the Head of Nursing for Children & Young People.

A remunerated Maternity & Neonatal Voices Partnership (MNVP) Chair was appointed in accordance with the Welsh Government Quality Statement for Maternity & Neonatal Services.

Director of Midwifery listening events were undertaken across sites, with feedback shared with individual staff & teams.

Positive feedback was received from a family regarding the dignified & compassionate care provided by the Community Children's Nursing Team to a child receiving end-of-life care.

IMPACT

- An increase in CIVICA responses was reported across Children & Young People's services.
- A young person aged 12 participated in the appointment panel for the Head of Nursing for Children & Young People.
- A remunerated MNVP Chair was appointed.
- Director of Midwifery listening events took place across sites, with feedback shared with staff & teams.
- A family provided positive feedback about the dignified & compassionate end-of-life care delivered by the Community Children's Nursing Team.

LOOKING AHEAD

- Care Group Listening to People systems to be in place.
- Learning events to be held across the Care Group.
- Listening to People training to be delivered to the Care Group.





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DIAGNOSTICS, THERAPIES, PHARMACY & SCIENCES

SUPPORTING PATIENT-CENTRED CARE

During 2025/26, DTPS continued to focus on providing services that reflected the needs of patients & families. Evidence from the QSRE papers highlighted flexible access arrangements, communication with bereaved families, positive patient feedback & work to support the death certification process.

WHAT IMPROVED

- The Newborn Hearing Screening Wales Quality Assurance Audit identified flexible service provision to meet the needs of families in terms of appointment day & timing.
- The CTM bereavement support webpage was updated to provide information regarding potential delays in receiving death certificates.
- A CTM Medical Examiner Service QR code was developed & launched in October 2025 to support the death certification process.
- Positive patient feedback continued to be reported within Ultrasound services across CTM, particularly regarding communication, professionalism & reassurance during examinations

IMPACT

- The Newborn Hearing Screening Wales audit highlighted flexible appointment arrangements as an area of good practice supporting families accessing the service.
- Bereaved families were provided with updated information regarding potential delays in the death certification process through the CTM website.
- The Medical Examiner Service QR code was reported to have had a positive impact in some areas & improved data capture to help understand where delays occurred.
- Patient feedback received by Radiology consistently highlighted communication, professionalism & reassurance provided during ultrasound examinations

LOOKING AHEAD

- Work will continue to address delays in the death certification process & support the Medical Examiner Service arrangements across CTM.





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MENTAL HEALTH & LEARNING DISABILITY IMPROVING PATIENT EXPERIENCE & INVOLVEMENT



Mental Health & Learning Disabilities continued to strengthen person-centred care by involving patients, young people & carers in service improvement, support initiatives & staff learning. During 2025/26, the Care Group introduced a Carers Café pilot, incorporated lived experience into staff training, involved young people in shaping service environments & developed initiatives to support patients preparing to leave hospital.

WHAT IMPROVED

- A Carers Café launched at the Royal Glamorgan Hospital, providing support, compassion & information for families & carers, with plans for phased rollout across inpatient sites.
- Personality Disorder training was developed & delivered by an individual with lived experience, helping staff gain insight from a patient perspective. Fifteen staff attended the session.
- Preparing for Discharge programme was introduced to support patients transitioning from hospital to home through structured sessions & community drop-in support.
- Executive & external review visits highlighted positive engagement with young people & recognised sustained improvement work at Ty Llidiard.
- Young people at Ty Llidiard contributed ideas & designs for future facilities, including a tuck shop & beauty salon.

IMPACT

- The Ward 22 Carers Café pilot provided a dedicated opportunity to offer support, compassion & clear information to families & carers.
- Fifteen staff attended personality disorder training delivered by a person with lived experience, with participants reporting the value of gaining insight from the patient perspective.
- Young people at Ty Llidiard directly contributed sketches & digital designs for proposed facilities, with their ideas passed to a local design company.

LOOKING AHEAD

- Progress the planned phased rollout of the Carers Café across inpatient sites & wider implementation of the Preparing for Discharge programme once embedded at Royal Glamorgan Hospital.





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PLANNED CARE LISTENING TO PATIENTS & RESPONDING TO FEEDBACK

Throughout 2025/26, Planned Care continued to develop ways of capturing patient feedback & using patient experience within governance & service improvement discussions. This included expanding patient feedback mechanisms, incorporating patient stories into governance discussions & introducing new approaches designed to support patients.

WHAT IMPROVED

- Patient & staff feedback was gathered through bespoke QR-code feedback systems across identified Planned Care clinical services.
- The feedback initiative expanded from Prince Charles Hospital to Princess of Wales Hospital, Bridgend Clinic & planned rollout to Royal Glamorgan Hospital.
- Patient stories were presented through Board & committee structures to support learning & improvement.
- A Call for Concern pilot was introduced for critical care discharges at Princess of Wales Hospital.
- Positive patient & staff feedback was reported following centralisation of cataract services.

IMPACT

- The bespoke feedback approach was expanded from Prince Charles Hospital to Ward 21 at Princess of Wales Hospital & Bridgend Clinic.
- A Planned Care patient story was presented to a Health Board committee to demonstrate the reported patient impact of Surgical Same Day Emergency Care.
- Feedback about care provided through the Vanguard theatres included: “All the staff were lovely”, “Everyone made me feel at ease”, “Nothing was too much trouble” & “I experienced 5 star treatment.”

LOOKING AHEAD

- Complete the planned rollout of the bespoke QR-code feedback system to Royal Glamorgan Hospital & continue using patient stories within governance & improvement discussions.





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PRIMARY CARE & COMMUNITY

IMPROVING PATIENT EXPERIENCE & INVOLVEMENT

Primary Care & Community services introduced a range of initiatives to support patient experience, feedback & wellbeing during 2025/26. This included development of patient information resources, opportunities for feedback & activities to support patients receiving care in community settings.

WHAT IMPROVED

- A patient information leaflet for District Nursing was developed, including a QR code for patients & families to provide feedback about their experience.
- Music therapy was introduced at Ysbyty Cwm Cynon & patient feedback was reported as very positive.
- A hairdresser service was introduced at Ysbyty Cwm Cynon & was reported as being well received by patients & relatives.
- Feedback from patients & families at Ysbyty George Thomas Hospital was reported as overwhelmingly positive, with comments highlighting the environment & visiting experience.

IMPACT

- A new District Nursing patient leaflet & QR-code feedback mechanism was developed for patients & families.
- Music therapy at Ysbyty Cwm Cynon received very positive patient feedback.
- Feedback from patients & families at Ysbyty George Thomas Hospital was reported as overwhelmingly positive.

LOOKING AHEAD

- Continue rollout & use of patient feedback tools across community services.





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UNSCHEDULED CARE ENHANCING PATIENT EXPERIENCE, WELLBEING & ENGAGEMENT

Unscheduled Care continued to strengthen patient experience through patient engagement, wellbeing initiatives & additional support services.

WHAT IMPROVED

- The Emergency Department PREM programme continued to achieve high levels of patient engagement, enabling teams to identify themes, respond to feedback & share “You Said, We Did” updates.
- The Dare to Dream charity programme continued to support patients within older persons’ services through music, wellbeing & therapeutic activities, receiving positive feedback from patients, visitors & staff.
- Marie Curie Companion Volunteers were introduced across inpatient wards & departments at Prince Charles Hospital to provide emotional support, advance care planning support & bereavement support for patients & families.
- Environmental improvements included refurbishment of patient & family areas, development of day-room facilities & implementation of an immersive room within Paediatric Emergency Care.

IMPACT

- High levels of PREM engagement enabled patient feedback themes to be identified & “You Said, We Did” updates to be shared with service users.
- Dare to Dream activities received positive feedback from patients, families, visitors & staff.
- Environmental improvements & additional support services enhanced patient & family experience across a number of care settings.

LOOKING AHEAD

- Continue using patient feedback & wellbeing initiatives to inform service improvement & patient experience priorities.





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CONCERNS

LISTENING EARLIER, RESPONDING TOGETHER

During 2025/26, CTM UHB strengthened how it listens & responds to patients, families & carers through implementation of the Listening to People framework & closer integration of PALS & Concerns services. Earlier engagement, Listening Discussions & improved access to support have increased opportunities for people to share their experiences, shape the resolution of concerns & influence learning & improvement.

WHAT IMPROVED

- Listening to People was implemented across CTM UHB, introducing a more person-centred approach to concerns management.
- Listening Discussions became a core part of the concerns process, helping people feel heard at an earlier stage.
- PALS Officers joined the Concerns Team to support enquiries, Early Resolution & Listening Discussions.
- Patients & families have greater opportunities to share their experiences directly with services & participate in identifying desired outcomes.
- Advocacy, support & accessible communication are available to help people engage with the concerns process in a way that meets their individual needs.

IMPACT

- Patients & families had greater opportunities to share their experiences directly with services & other engagement approaches.
- Earlier engagement supported clearer communication, earlier explanation of what was happening & in resolving concerns.
- Advocacy, communication support & reasonable adjustments helped ensure individual communication, language & accessibility needs.

LOOKING FORWARD

- The Health Board will continue to embed Listening to People, strengthening the role of concerns & remain central to learning & improvement.





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LEGAL SERVICES

SUPPORTING PATIENTS, FAMILIES & STAFF THROUGH LEGAL PROCESSES

Legal processes were supported through clearer coordination, sensitive communication & better preparation for patients, families & staff. Learning from concerns, complaints, claims & legal cases was considered together to support a more coherent approach to organisational learning.

WHAT WE DID/IMPROVED

- Coordinated support for staff involved in inquests.
- Approved & disseminated an inquest guidance document.
- Delivered inquest training sessions.
- Provided legal & governance input alongside Duty of Candour processes.
- Reviewed learning across concerns, complaints & claims collectively.
- Strengthened communication with complainants & legal representatives through Redress recovery activity.

IMPACT

- Staff involved in inquests had access to approved guidance, training & coordinated Legal Services support.
- Learning across concerns, complaints & claims was brought together to support a more coherent approach to organisational learning.
- Sensitive, timely & coordinated communication was emphasised throughout legal processes

LOOKING AHEAD

- Build on existing partnerships with patients, families & staff to support open communication, learning & person-centred legal services.





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INFECTION PREVENTION & CONTROL

PROTECTING PATIENTS, STAFF, FAMILIES & COMMUNITIES

IPC protects patients, staff, families & communities from avoidable infection while supporting safe, dignified care. The service focused on reducing infection harm, improving outbreak control, supporting staff practice & extending prevention into community pathways.

Patients & families experience IPC through safe environments, timely isolation, clear communication, reduced outbreak disruption & reliable staff practice. Person-centred IPC decisions must balance safety, dignity, patient flow, visitors, staff wellbeing & the wider community impact of infection.

WHAT WE DID

- Protecting people during outbreaks: IPC supported clinical teams to manage outbreaks, reduce transmission & enable safe recovery of affected areas.
- Improving everyday care: PPS & training focused on visible behaviours that matter to patients, including hand hygiene, Bare Below the Elbows, PPE & safe device care.
- Supporting care after discharge: Community IPC strengthened attention to infection outside the hospital.

IMPACT

- Outbreak data gave a clearer picture of the impact on patients, staff & bed capacity.
- The strengthened IPC model improved access to advice for staff, supporting community settings.

LOOKING AHEAD

- Strengthen learning from infection reviews, outbreaks & surgical-site infection surveillance so improvement is visible to patients & staff.
- Develop link worker/champion models to support local ownership & consistent messaging.
- Use the 2026/27 Annual Programme of Work to demonstrate measurable improvement in infection outcomes, training compliance, practice reliability & community prevention.





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CARERS AS PARTNERS IN CARE

Recognising unpaid carers as key partners in delivering person-centred care

During 2025/26, CTMUHB introduced the Carers Passport to support a more consistent approach to recognising & involving unpaid carers during hospital admission & inpatient care. Developed through co-production, testing & phased implementation, the Passport helps strengthen partnership working with carers while maintaining clear clinical accountability for care delivery.

WHAT WE DID

- Introduced the Carers Passport through a phased implementation approach across inpatient services.
- Used co-production, quality improvement methods & stakeholder feedback to refine the model.
- Secured support through the NHS Wales Spread & Scale Academy.
- Aligned implementation with Duty of Quality requirements & John's Campaign principles.
- Established clear governance arrangements & staff accountability.

IMPACT

- Improved recognition of carers as partners in care.
- Positive early feedback from staff & carers regarding involvement in care planning & support.
- Increased awareness of the important role carers play in maintaining wellbeing & continuity of care.
- Strengthened organisational understanding of how carers can contribute safely within inpatient settings.
- Learning from implementation is informing wider adoption across CTMUHB.

LOOKING AHEAD

- Extend the Carers Passport into community hospital & palliative care settings.
- Continue organisation-wide implementation across inpatient services.
- Strengthen evaluation of carer & staff experience.
- Increase awareness & uptake through staff education & engagement.
- Use learning from implementation to inform future patient & carer involvement initiatives.





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SUPPORTING & ENGAGING UNPAID CARERS

Improving recognition, support & engagement for unpaid carers across CTMUHB.

Alongside the implementation of the Carers Passport, CTMUHB continued to strengthen support for unpaid carers through staff education, partnership working, community engagement & digital innovation. This work has helped improve awareness of carers' needs, strengthen identification processes & inform future service development.

WHAT WE DID

- Delivered awareness & training sessions for staff across CTMUHB.
- Established a Staff Carers Café to support colleagues with caring responsibilities.
- Supported Carers Week activities across hospital & community settings.
- Strengthened processes to identify & record unpaid carers.
- Developed a carers' questionnaire to gather experience & feedback.
- Supported the development of digital information, advice & assistance resources, including an AI-enabled chatbot pilot.

IMPACT

- Increased awareness of the needs & experiences of unpaid carers.
- Improved early identification of carers within health services.
- Extended opportunities for carers to share feedback & inform service improvement.
- Strengthened support available to staff with caring responsibilities.
- Improved understanding of how digital solutions can enhance access to information & support.

LOOKING AHEAD

- Continue improving identification & recording of unpaid carers.
- Expand accessible information, advice & support for carers.
- Evaluate & develop digital solutions, including chatbot support.
- Use carer feedback to inform service improvement & co-production.
- Strengthen partnership working with local carers' organisations & community groups.





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COMPASSIONATE BEREAVEMENT SUPPORT

Strengthening compassionate, inclusive & consistent support for bereaved families.

During 2025/26, CTMUHB strengthened bereavement support through improved information, enhanced pregnancy & baby loss services, workforce development & partnership working. This has helped improve the consistency, accessibility & quality of support available to bereaved families across the Health Board.

WHAT WE DID

- Strengthened bereavement information & support resources for patients & families.
- Enhanced support pathways following pregnancy & baby loss.
- Delivered bereavement & baby loss training to staff across services.
- Strengthened partnership working with third-sector organisations & specialist support services.
- Embedded bereavement education within paediatric nurse training.

IMPACT

- Improved consistency of bereavement support across services.
- Increased staff confidence & capability in responding to bereaved families.
- Enhanced access to information, advice & support following bereavement.
- Strengthened coordination between services & external partners.
- Improved foundations for delivering compassionate & inclusive care during difficult & sensitive circumstances.

LOOKING AHEAD

- Further improve consistency of bereavement support across all care groups.
- Strengthen trauma-informed & culturally sensitive approaches to care.
- Continue workforce development & specialist bereavement training.
- Improve evaluation of patient & family experience.
- Use feedback & learning to continuously improve bereavement services.





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LISTENING, REMEMBERING & LEARNING

Using the experiences of bereaved families to inform learning, improvement & service development.

During 2025/26, CTMUHB strengthened opportunities for remembrance, engagement & feedback, ensuring the experiences of bereaved families continue to inform service development & improvement. Through partnership working & listening to lived experience, the Health Board has enhanced understanding of bereavement needs & strengthened the quality of support available across services.

WHAT WE DID

Supported Pregnancy Loss Awareness Week & remembrance activities across CTMUHB.

Delivered annual remembrance events for families.

Used family feedback & lived experience to inform service development.

Worked with partner organisations to improve awareness & accessibility of bereavement support.

Increased visibility of available bereavement services & support pathways.

IMPACT

- Strengthened opportunities for bereaved families to influence service improvement.
- Improved understanding of the experiences & needs of bereaved families.
- Increased awareness of bereavement services & sources of support.
- Strengthened partnership working across services & external organisations.
- Ensured learning from feedback continues to inform local priorities & developments.

LOOKING AHEAD

- Further strengthen the collection & use of family feedback.
- Continue aligning local developments with the National Bereavement Care Pathway & National Bereavement Framework.
- Expand opportunities for co-production & family involvement.
- Improve evaluation of bereavement services & support.
- Share learning across services to support continuous improvement.





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SAFEGUARDING

WHAT IMPROVED

Strengthened focus on the voice of the child & adults within safeguarding processes. Utilising feedback questionnaires from within the child protection medical hub, looked after children's service & health IDVAs.

Utilisation of feedback mechanisms (e.g., CIVICA) to capture patient & family experience.

Promoted person-centred safeguarding practice through applying professional curiosity, training & supervision.



IMPACT

- Increased evidence of individual perspectives informing safeguarding decisions.
- Improved quality of care planning & intervention.

LOOKING AHEAD

- Further embed mechanisms for capturing & evidencing the voice of the individual.
- Strengthen co-production approaches where appropriate.





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PATIENT EXPERIENCE

The People's Experience Service provides a strategic bridge between lived experience & service improvement across CTMUHB. During 2025 to 2026, the service strengthened how patient, family, carer & community voices are heard, understood & translated into learning, assurance & improvement.

WHAT WE DID

- Strengthened the use of patient stories, complaints, concerns & PALS insight to identify learning themes & improvement opportunities.
- Continued to develop volunteer services, chaplaincy, spiritual care & bereavement-related experience as key contributors to compassionate care.
- Improved focus on carer awareness, reasonable adjustments, Armed Forces & veterans support, & engagement with seldom-heard groups.
- Established the People's Experience Forum to bring together insight, learning & improvement across services.

IMPACT

- This strengthened the visibility of lived experience within quality, safety, planning & service redesign, helping services better understand what matters to patients, families, carers & communities

LOOKING AHEAD

- The People's Experience Service will continue to strengthen how lived experience informs quality, safety & service improvement across CTMUHB, with clearer evidence of action & outcomes. This will include a more ambitious & innovative approach to capturing patient experience, using a broader range of methods to hear from people in real time & in ways that are accessible, inclusive & meaningful.
- Embed experience intelligence more consistently into quality assurance, planning & service improvement.
- Strengthen evidence of actions taken & outcomes achieved in response to lived experience.
- Expand inclusive engagement so diverse voices continue to shape care, experience & outcomes.





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PATIENT STORIES

Patient stories are being used more consistently to bring lived experience into governance, assurance & improvement discussions across CTMUHB, helping services understand the human impact of care & identify opportunities for change.

WHAT WE DID

- Strengthened pathways for patients, families & carers to share their stories safely, respectfully & meaningfully.
- Embedded patient stories within governance & assurance forums to support learning & improvement discussions.
- Used stories alongside feedback, concerns & complaints intelligence to identify recurring themes & opportunities for service change.
- Developed public-facing materials to raise awareness & increase opportunities for people to share their experience.
- Supported staff & services to use patient stories as a source of reflection, learning & quality improvement.

IMPACT

- Patient stories helped bring the human impact of care into decision-making, strengthening organisational learning & supporting services to identify practical improvement opportunities informed by lived experience.

LOOKING AHEAD

- Develop a more consistent approach to evidencing actions & improvements made in response to patient stories.
- Strengthen the feedback loop so patients, families & carers can see how their stories have informed learning & change.
- Continue to embed patient stories as a routine source of assurance, learning & improvement across CTMUHB, increasing opportunities for inclusive & accessible participation.





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PATIENT EXPERIENCE, FEEDBACK & LIVED EXPERIENCE

Work focused on strengthening real-time patient experience intelligence through PROMPTLY, PALS & the developing Patient Experience & Engagement Officer role, recognising the move towards a broader approach to capturing, understanding & acting on lived experience. During 2025–26, PALS supported 3,306 people with advice, signposting & early resolution.

WHAT WE DID

- Expanded the use of PROMPTLY, patient feedback system, to capture timely patient feedback & experience insights.
- Strengthened Patient Advice & Liaison Service (PALS) pathways alongside the development of the Patient Experience & Engagement Officer role, supporting advice, signposting, early resolution & wider engagement with lived experience.
- Established the People's Experience Forum to review themes, share learning & drive improvement.
- Developed the People's Experience Strategic Plan to embed lived experience in decision-making.

IMPACT

- PROMPTLY, PALS & the Patient Experience & Engagement Officer approach provided more immediate & varied insight into patient experience, enabling services to identify themes, respond earlier to concerns & support continuous improvement informed by lived experience.

LOOKING AHEAD

- Increase PROMPTLY uptake & strengthen outcome measurement.
- Embed the Patient Experience & Engagement Officer role as part of a wider approach to capturing patient experience, strengthening evidence of service changes made in response to feedback.





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SUPPORTING THE ARMED FORCES COMMUNITY

CTMUHB strengthened support for veterans, their families & the wider Armed Forces community through partnership working, direct engagement & improved access to health & wellbeing advice.

WHAT WE DID

- Hosted the first CTM Veterans' Health & Wellbeing Day on Thursday 26 June 2025, during Armed Forces Week.
- Worked in partnership with Valley Veterans Group, Rhondda Cynon Taf County Borough Council, Community Voluntary Councils & third sector partners.
- Brought together more than 30 organisations to provide access to physical health, mental health, trauma, bereavement, housing, community & wellbeing support.
- Engaged more than 150 attendees, including veterans, families, healthcare professionals & community organisations.
- Used keynote speakers, lived experience, personal testimony & an interactive marketplace to better understand the health & care needs of the Armed Forces community.

IMPACT

- The event strengthened understanding of veterans' health & wellbeing needs, improved awareness of available support, & created stronger links between NHS services, local authority, voluntary sector partners & the Armed Forces community, supporting more equitable access to advice & support.



- Feedback & learning from the event informed positive actions including GP training, improved veteran signposting & work to support veteran identification in primary care.

LOOKING AHEAD

- Build on event learning to strengthen veteran identification, improve signposting & support staff awareness.
- Develop a more joined-up approach to Armed Forces community health & wellbeing across CTMUHB.
- Strengthen evidence of the impact on access, experience & outcomes.





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VOLUNTEER SERVICES

Volunteer Services helped strengthen person-centred care by supporting staff capacity, developing roles aligned to service need & improving integration with clinical teams & People's Experience programmes. The service also strengthened recruitment, governance, training & community engagement to support safe, effective & confident volunteering.

WHAT WE DID

- Volunteers supported non-clinical tasks, helping clinical teams focus on direct patient care.
- Recruitment approaches were strengthened to attract a more diverse volunteer base.
- Governance, training & support frameworks were enhanced.
- Volunteer roles were developed around priority areas including end-of-life care, patient feedback & experience initiatives.
- Community engagement & partnerships were strengthened

IMPACT

Volunteer Services contributed to dignity, compassion & person-centred care by helping patients feel seen, heard & valued beyond their clinical needs.

LOOKING AHEAD

Next steps include expanding volunteer roles, widening participation, improving inclusivity & strengthening alignment with CTM2030 & the People's Experience Strategy.





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CHAPLAINCY & SPIRITUAL CARE

Chaplaincy & Spiritual Care services have contributed significantly to the Health Board’s Duty of Quality by providing compassionate, person-centred support to patients, families, carers & staff at critical points of care. Through accessible, inclusive & responsive provision, the service has strengthened emotional, spiritual & bereavement support, improving experience & promoting dignity, wellbeing & equity across CTMUHB.



Patients, families & staff may experience emotional, spiritual & existential distress during illness, crisis, end of life & bereavement. Ensuring equitable access to timely & inclusive spiritual care is essential to delivering holistic, compassionate & person-centred care, while also supporting staff wellbeing & resilience.

Number of People Supported by the service	
Patients	4264
Relatives/Carer’s	1415
Staff	1794





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CHAPLAINCY & SPIRITUAL CARE

WHAT WE DID

Delivered a visible & responsive chaplaincy service across hospital & community settings, supporting patients, families & carers at times of vulnerability.

Provided pastoral & emotional support to staff, particularly in high-pressure clinical areas, supporting wellbeing & resilience.

Worked alongside clinical teams to enhance end of life & bereavement experiences for patients & families.

Strengthened an inclusive, multi-faith model of care to improve equitable access, including targeted action to address representation gaps through additional support for Muslim patients & families.

Provided peace lights across the HB footprint at Christmas for all our patients as a visible symbol of comfort & hope.

Built understanding of spiritual care among nursing & midwifery students, helping embed a more holistic & compassionate approach within the future workforce.

LOOKING AHEAD

- Improve data collection & strengthen how the impact of spiritual care is measured.
- Expand staff wellbeing & support offer
- Enhance community & multi-faith partnerships
- Advance service redesign to future-proof provision & align with emerging Spiritual Care Standards across Wales.
- Leading on work to collate a resource to support medical students across Wales 'Living out Faith in the NHS'.

IMPACT

This work has enhanced the compassion, quality & holistic nature of care across CTMUHB, ensuring patients & families feel supported & respected. It has strengthened staff wellbeing, improved consistency & visibility of spiritual care, & contributed to more equitable & person-centred service delivery.



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BEYOND STEEEP: CTMUHB'S BROADER DOMAINS OF QUALITY

While the STEEEP framework remains central to how we assess & improve quality, CTMUHB recognises that there are other essential domains that support high-quality care & a positive staff experience.

These broader domains are not standalone, they are embedded into our everyday practice & can be seen woven throughout the sections of this report.

Additional Domain	What It Means
Workforce	Supporting and developing a capable, sustainable workforce.
Culture	Fostering a just, inclusive, and values-based culture.
Information	Using robust data and digital tools to inform decisions and improve care.
Learning, Improvement & Research	Promoting innovation, continuous improvement, and evidence-led practice.
Whole Systems Approach	Collaborating across sectors to deliver integrated, person-centred care.
Leadership	Demonstrating visible, compassionate leadership at every level.





GLOSSARY

Term	Suggested Definition
CTMUHB	Cwm Taf Morgannwg University Health Board
iCTM	Improvement Cwm Taf Morgannwg
AMaT	Audit Management and Tracking system
CAMHS	Child and Adolescent Mental Health Services
IPC	Infection Prevention and Control
HCAI	Healthcare-Associated Infection
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MRSA	Methicillin-Resistant Staphylococcus Aureus
E. coli	Escherichia coli
IDVA	Independent Domestic Violence Advocate
NSA	Nurse Staffing Act (Wales) 2016
WTE	Whole Time Equivalent
PALS	Patient Advice and Liaison Service
PROMs	Patient-Reported Outcome Measures
PREMs	Patient-Reported Experience Measures
SDEC	Same Day Emergency Care
AMU	Acute Medical Unit
RSU	Respiratory Support Unit
STAMP	Standardised Acute Medical Pathway
VBHC	Value-Based Healthcare
DoLS	Deprivation of Liberty Safeguards
BAME	Black, Asian, and Minority Ethnic
EPICC	Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care

Term	Definition
Duty of Quality	A statutory obligation under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to continuously improve healthcare quality
Duty of Candour	Legal requirement to be open and honest with patients when care causes unexpected or unintended harm
SafeCare	A staffing and acuity tool used for real-time workforce monitoring and planning
Active Offer	Providing Welsh language services without requiring the service user to request them
Carers Passport	A document outlining a carer's preferred level of involvement during a hospital stay
Patient Experience Week	An annual campaign to gather and act on patient and carer feedback
STEEEP	Framework for quality healthcare: Safe, Timely, Effective, Efficient, Equitable, Person-Centred
John's Campaign	A movement supporting carer involvement in hospital care for people with dementia and others
Red/White/Bronze/Silver/Gold Accreditation	Tiered ward accreditation system within CTMUHB for quality assurance
Link and Learn	A training and learning delivery model via Microsoft Teams



Quality, Safety & Experience Committee

Redress Case Management

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Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Quality, Safety and Experience Committee is asked to NOTE • The Redress caseload remains a high organisational risk, with 440 active cases and 295 cases open for more than 12 months. • Improvement actions have stabilised performance and improved progression; however, they have not yet delivered the scale of reduction required to address the legacy backlog sustainably. • The principal constraint remains the volume of cases awaiting investigation and liability determination, with 197 of the over-12-month cases still at the Qualifying Liability Being Investigated stage. • Continued reliance on overtime and temporary support arrangements presents a workforce sustainability risk. • Sustainable improvement will require continued executive

	oversight, strengthened accountability across services, and consideration of longer-term capacity solutions to support both recovery of the legacy backlog and management of future demand.
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1. Situation /Background

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2025 supported by the Listening to People (LTP) Guidance 2026, provides the statutory framework in NHS Wales for managing concerns, complaints, and redress where harm may have occurred. Under this process, the Health Board is required to undertake proportionate investigation of incidents to determine whether a breach of duty of care has occurred and, if so, whether this has resulted in qualifying liability (harm). Where both elements are established within the financial threshold, the Health Board may offer redress, including financial compensation, apology, and remedial actions, as an alternative to formal litigation. The process is designed to ensure timely resolution, learning, and transparency, while maintaining a clear distinction between investigation findings and legal liability in higher value or complex cases that fall outside the redress scheme.

In June 2026, the Quality, Safety and Experience Committee received a report outlining concerns regarding the management of the Health Board's Redress caseload, including increasing backlog pressures, delays in progressing cases, challenges in maintaining timely communication with patients, families and legal representatives, and the associated risks to organisational learning, Welsh Risk Pool reimbursement and external confidence in the Redress process. The report also described the factors contributing to the position, including increasing demand following the introduction of Duty of Candour requirements, capacity constraints, process complexity and the cumulative impact of a growing multi-year caseload. An improvement and recovery plan was presented to Committee, setting out a programme of actions intended to stabilise performance, strengthen governance arrangements and improve progression of cases through the Redress pathway.

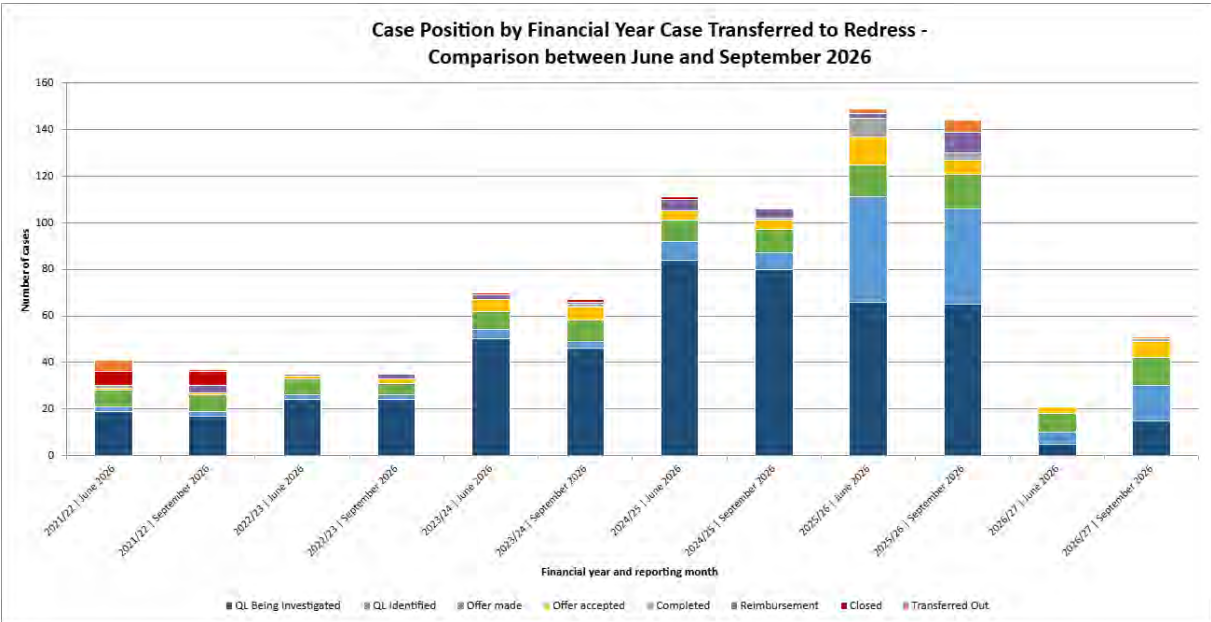
This report provides a follow-up update on the position previously reported to Committee and should be read in conjunction with the June 2026 report. The purpose of this update is to provide assurance regarding progress made since June, present the current Redress caseload position, assess the impact of improvement measures implemented to date, and identify the key risks and challenges that continue to affect performance. The report also provides an updated analysis of the active caseload, including changes in case profile and progression through the Redress process between June and September 2026.

Since the June report, significant work has been undertaken to implement the recovery actions approved by the Committee. This has included completion of a comprehensive review of open Redress cases, enhanced tracking and monitoring arrangements, strengthened governance and oversight processes, renewed engagement with claimants and legal representatives, and the continued development of a revised end-to-end Redress operating model. These actions have improved visibility of the caseload and supported progression of cases through the pathway. However, the Health Board continues to manage a substantial volume of legacy and newly received cases concurrently, and the overall position remains challenging.

2. Specific Matters for Consideration

As at September 2026, the active Redress caseload has increased from 427 cases reported in June 2026 to 440 cases. Whilst the overall caseload remains significant, there is evidence of movement through the pathway, including increases in the number of cases reaching the Qualifying Liability Identified, Offer Made and Reimbursement stages. Notwithstanding this progress, the current caseload continues to present a significant organisational risk, with delays having the potential to adversely affect patient experience, organisational learning, financial recovery, and external confidence in the Health Board's ability to manage Redress effectively.

Chart 1:



*2026/2027 data – 01.04.26 to 31.08.26

Chart 1 provides a comparison of the Redress caseload position at June 2026 and September 2026, grouped by the financial year in which the Redress record was opened and segmented by stage of the Redress process. The analysis provides

insight into both the age profile of the caseload and the extent to which cases are progressing through the pathway.

The data demonstrates that the Health Board continues to manage a significant legacy caseload, with the largest concentrations of activity arising from the 2024/25 and 2025/26 cohorts. These cohorts account for the majority of the current caseload and continue to place significant pressure on the service. Across all financial years, the largest proportion of cases remain within the Qualifying Liability Being Investigated stage, confirming that clinical investigation, evidence gathering, expert review and liability determination remain the principal constraints on progression through the Redress process.

Encouragingly, there has been evidence of movement through the pathway between June and September 2026. The number of cases reaching Qualifying Liability Identified, Offer Made and Reimbursement stages has increased, demonstrating that cases are progressing beyond the investigation phase and moving closer to resolution. In particular, reimbursement cases increased from 10 to 19 and offer-made cases increased from 53 to 58 over the reporting period. These changes indicate that the recovery actions implemented since June are having a positive impact on case progression and oversight.

However, the data also demonstrates that the volume of cases awaiting investigation has remained largely unchanged, reducing only marginally from 248 cases in June to 247 cases in September. This indicates that whilst cases are progressing through the pathway, the gains achieved are being offset by the ongoing complexity of investigations and the continuing inflow of new cases. As a consequence, the overall investigative workload remains substantial and continues to represent the most significant challenge within the Redress process.

The analysis further highlights the continuing impact of the historical backlog. Whilst more recent cases from the 2026/27 cohort have progressed into several stages of the pathway, a material number of cases originating from 2021/22, 2022/23 and 2023/24 remain open across multiple stages. These older cases continue to consume significant organisational resource and contribute to delays in achieving closure for patients and families, embedding organisational learning and securing Welsh Risk Pool reimbursement.

As at 7 September 2026, 295 currently open Redress cases had been open for more than 12 months, based on the date the Redress record was opened and excluding cases recorded at the closed stage. Of these, 197 cases remained at the Qualifying Liability Being Investigated stage, representing approximately two-thirds of the open cases aged over 12 months.

The remaining cases aged over 12 months were distributed across later stages of the pathway, including 36 at Offer Made, 26 at Qualifying Liability Identified, 16 at Offer Accepted, 13 at Reimbursement and 3 at Completed. A further four records were categorised as Transferred Out. This demonstrates that the age of the caseload is not solely attributable to delays in initial investigation. Some cases

have progressed substantively but remain open pending settlement, payment, reimbursement, completion of learning requirements or formal administrative closure.

The concentration of older cases within the investigation stage remains the principal concern. These cases frequently require review of historical clinical records, further clinical or expert evidence, determination of causation, and renewed engagement with patients, families or legal representatives. Their continued presence within the active caseload places sustained pressure on specialist capacity and increases the risk of further delay in providing resolution, confirming qualifying liability, implementing learning and securing reimbursement where applicable.

The over-12-month position reinforces the need for the next phase of the recovery programme to include a specific and measurable legacy-case reduction trajectory. This should prioritise the oldest and highest-risk cases, establish clear milestones for liability determination and resolution, and distinguish between cases requiring substantive investigative work and those awaiting final settlement, reimbursement, learning assurance or administrative closure. Progress against this trajectory should be monitored through the strengthened governance arrangements and reported routinely to the Committee.

Overall, the data suggests that the improvement measures introduced since June have stabilised the position and supported progression through the pathway. However, with 295 currently open cases having remained within the Redress process for more than 12 months, including 197 still at the Qualifying Liability Being Investigated stage, the scale and age of the caseload remain significant. Sustainable improvement will require continued focus on reducing the number of cases awaiting liability determination, accelerating progression and closure of legacy cases, and ensuring sufficient specialist and clinical capacity to manage both the historical backlog and new demand entering the system.

3. Key Risks / Matters for Escalation

Whilst a number of improvement initiatives have been implemented since June 2026 and have helped stabilise the position, the overall Redress caseload continues to represent a high organisational risk. The Health Board is currently managing an active caseload of 440 Redress cases, including 295 cases that have remained open for more than 12 months, of which 197 remain at the Qualifying Liability Being Investigated stage. This demonstrates that, despite progress in progressing cases through the pathway, the volume of cases requiring investigation and liability determination remains substantial and continues to constrain overall recovery.

Current improvement measures, including enhanced monitoring arrangements, strengthened governance, extensive use of overtime, temporary support arrangements, structured case reviews and prioritisation of older cases, have largely prevented further deterioration and enabled progress in a number of areas.

However, these actions have not yet delivered the scale of reduction required to address the legacy backlog and ongoing demand on a sustainable basis. The Health Board therefore remains exposed to significant risks affecting patient experience, organisational learning, financial recovery, Welsh Risk Pool reimbursement and external confidence in the Redress process.

A summary of the current risk associated with redress management are outlined below:

➤ **Delay in Progressing Redress Cases**

The most significant risk remains the continued delay in progressing Redress cases through investigation, liability determination and resolution. Although improvements have been seen in the number of cases progressing to Qualifying Liability Identified, Offer Made and Reimbursement stages, the number of cases awaiting investigation has remained largely static between June and September 2026. This indicates that gains achieved through case progression are being offset by the complexity of investigations and continued inflow of new cases. Prolonged delays increase waiting times for patients and families, reduce confidence in the organisation and increase the likelihood of escalation to external bodies. Current mitigation includes enhanced case review arrangements, weekly and monthly oversight meetings, prioritisation of legacy cases and escalation of long-standing matters. However, a sustained reduction in the backlog will require increased capacity dedicated to progressing investigations and decision-making.

➤ **Patient Experience and Reputational Risk**

Extended timescales continue to present a significant patient experience risk. Delays in receiving updates, decisions and resolution can cause additional distress to patients and families who have already experienced harm or believe harm has occurred. Caseload reviews continue to identify cases subject to repeated chasers from patients, families and legal representatives. Such delays increase the risk of complaints about the handling of Redress cases and can adversely affect public confidence in the organisation. Current mitigations include monitoring of claimant contact, escalation of high-risk cases and governance oversight. However, further work is required to improve communication standards, increase the frequency of proactive updates and strengthen monitoring of cases subject to repeated chaser activity.

➤ **Delay in Organisational Learning**

One of the fundamental objectives of the Redress process is to identify and implement learning arising from incidents where harm has occurred. Delays in progressing investigations and completing associated Learning from Events Reports (LFERs) risk delaying implementation of service improvements and reducing the organisation's ability to demonstrate effective learning. Whilst stronger links have now been established between Redress, governance and learning processes, delays in case progression continue to delay the completion of some learning actions. There is therefore a continuing risk that opportunities for improvement are not identified, shared and embedded at the earliest opportunity. Executive oversight of overdue learning actions remains essential.

➤ **Welsh Risk Pool Reimbursement Risk**

The Health Board continues to face a financial and governance risk arising from delays in completion of Case Management Reports (CMRs), Learning From Events Reports and supporting documentation required for Welsh Risk Pool reimbursement. Whilst monitoring arrangements have improved and reimbursement activity has increased since June, a number of cases remain open despite substantive progression because reimbursement and associated documentation remain outstanding. Any delay in completing reimbursement requirements risks deferred or reduced financial recovery and increases organisational exposure. Continued focus on completion of outstanding CMRs and supporting evidence remains necessary.

➤ **Financial Risk**

The current Redress position continues to present a financial risk to the organisation. Delays in progressing liability decisions and settlement discussions may increase compensation costs, legal expenditure and overall financial exposure. In addition, delays in reimbursement submissions may adversely affect financial recovery arrangements. Whilst processes are in place to identify and review cases where liability has been established, the volume of cases awaiting investigation continues to limit the pace at which liability and settlement decisions can be made. Opportunities to resolve cases at an earlier stage should continue to be prioritised where breach and causation positions are sufficiently established.

➤ **Workforce Capacity and Sustainability Risk**

A recurring theme throughout both the June and September reviews has been the impact of workforce capacity and service resilience. Significant progress has only been achievable through extensive use of overtime, prioritisation of specialist resources, temporary support arrangements and intensive management oversight. Whilst these measures have supported service recovery, they are not considered sustainable long term. Current activity has largely stabilised the position and prevented further deterioration rather than delivering the level of backlog reduction required. Without additional substantive capacity, there is a risk that progress will plateau and that gains already achieved may not be maintained. This remains one of the most significant barriers to sustainable improvement.

➤ **Regulatory and External Scrutiny Risk**

The Redress backlog currently sits within a heightened scrutiny environment. Delays in progressing cases and implementing learning continue to present a risk of scrutiny from Welsh Risk Pool, Welsh Government, Audit Wales, the Public Services Ombudsman for Wales and other stakeholders. Recent organisational experience demonstrates increasing external focus on timeliness, communication, learning assurance and governance arrangements. Failure to demonstrate measurable improvement and a sustained reduction in the age profile of the caseload could increase the risk of further external challenge and adverse findings.

➤ Growth in Demand

Although recovery activity has focused on reducing the legacy caseload, the Health Board continues to receive new Redress referrals which replenish the investigative workload. The data demonstrates that whilst cases are progressing through the pathway, the overall investigative caseload remains substantial because legacy cases and new referrals must be managed simultaneously. Without a recovery approach that addresses both historical backlog and current demand, there is a risk that overall caseload reductions will remain limited.

4. Next Steps

The focus of the next phase of improvement will be to move beyond stabilisation and deliver a sustained reduction in the active Redress caseload. Priority will be given to reducing the number of cases awaiting Qualifying Liability determination, particularly those that have remained open for more than 12 months, through targeted review of the oldest and highest-risk cases and strengthened accountability for progressing agreed actions.

Work will continue to strengthen governance and performance management arrangements, including enhanced monitoring of case progression, learning actions, reimbursement requirements and communication with patients, families and legal representatives. Particular focus will be placed on ensuring that cases which have progressed beyond the investigation stage are brought to conclusion as promptly as possible, enabling closure for patients and families and maximising Welsh Risk Pool reimbursement opportunities.

In parallel, the Health Board will continue to develop and implement the revised end-to-end Redress operating model, embedding clearer processes, responsibilities and escalation arrangements across services. Consideration will also need to be given to the longer-term workforce and capacity requirements necessary to support sustainable recovery, recognising that the current reliance on overtime and temporary support arrangements is unlikely to deliver the scale of improvement required over the longer term.

Future reporting to the Committee will focus on measurable outcomes, including reductions in the number of cases open for more than 12 months, reductions in the volume of cases awaiting Qualifying Liability determination, improvements in reimbursement performance, and evidence that learning arising from Redress cases is being implemented in a timely and effective manner.

5. 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)	Strategic Risk 2 Service Transformation & Outcomes
	If more than one applies please list below:



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)		
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, rhwch 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 This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment. Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE This is an overarching position report. If service change arises the specific	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:



	areas and activity impacted will be subject to the appropriate impact assessment. Summary of impact:	
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)	This report outlines key areas of quality across the Health Board	
Cyfreithiol / Legal	Yes (Include further detail below) This report relates to the management of the Redress process within the Health Board. Failure to effectively manage the Redress process will result in an increase of cases proceeding to Clinical Negligence Claims which can result in court proceedings and inflate associated costs.	
Enw da / Reputational	Yes (include further detail below) Activity where performance falls short of the Health Board's Redress performance measures may result in impact to the trust and confidence in the Health Boards processes. This can result in an increase in referrals to the Public Service Ombudsman for Wales and solicitor firms not wishing to pursue matters via the redress, opting to progress immediately via the claims route.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (include further detail below) The current Redress position has a significant indirect impact on organisational resources through the requirement for overtime, temporary support arrangements, clinical review, investigation activity and management oversight. Whilst no specific additional resource is being requested through this report, sustainable improvement is likely to require future consideration of substantive workforce capacity.	



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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PTR	Putting Things Right
LTP	Listening to People
PSOW	Public Service Ombudsman for Wales
WRP	Welsh Risk Pool
QL	Qualifying Liability



Quality, Safety & Experience Committee

Mortality Update

Eitem yr Agenda / Agenda Item	4.8
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Esther Flavell, Mortality Lead Matthew Smith, Mortality Review & Learning Manager Amelia Wills, Senior Quality Informatics Facilitator
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 required, report is for noting only
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	Not applicable
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhof'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 update the Quality, Safety & Experience Committee on compliance with the Cwm Taf Morgannwg University Health Board (CTMUHB) mortality review process in line with the All Wales Learning From Mortality Review Model Framework and to highlight the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

The report includes:

- Baseline population rates
- ME referral rates
- Mortality review completion rates and learning
- Use of CTMUHB dashboard
- NOK feedback reporting
- CMR 12 month rolling data
- Mortality board oversight
- Data from external partner matching CTMUHB against matched peer group detailing rates overall/care group and specialty and areas of concern
- Areas for improvement and development

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)

- Robust data now available from CTMUHB dashboard and external partner. This gives Health Board, Care Group and Speciality mortality rates and areas of concern.
- Deep dives and improvements with feedback to board established.
- Care groups accountability and use of health board wide groups such as RADAR (Recognition of Acute Deterioration and Resuscitation) for areas such as sepsis or DNACPR issues.

Beth Nesaf (crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau)

- Strengthened role of mortality board supported by care groups analysis and improvements based on analysis

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)

- Continual monitoring for areas of concern using a proactive approach to identified areas

Argymhelliad (Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).

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

Continued support for the expanding mortality team and processes

Highlighting to directorates and care groups regularly and involvement in the processes encouraged at individual level

1. Background / Context

The purpose of this report is to update the Quality, Safety & Experience Committee on compliance with the Cwm Taf Morgannwg University Health Board (CTMUHB) mortality review process in line with the All-Wales Learning From Mortality Review Model Framework and to highlight the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

The population Cwm Taf Morgannwg University Health Board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2025 for population of local areas to CTMUHB

Area	Estimated pop. 2025	People/km 2025
Bridgend	147000	586
RCT	241000	568
Merthyr	58400	524

SHMI and HMSR are versions of RAMI (Risk Adjusted Mortality Index) used in England. We have not used RAMI as a way of measuring Mortality in Wales since the 2014 Palmer Report which stated that All Deaths should undergo review (which we were already doing). England is still sampling.

The following table shows the number of deaths per area for each month of 2025 for each local authority area. Again, the datasets are from the ONS using their 2025 data.

Deaths per month by area 2025(ONS)

Area	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Bridgend	174	157	172	150	140	120	145	89	139	146	141	123
RCT	329	262	258	226	207	234	237	189	214	232	172	223

Methyr	72	68	61	58	65	69	57	42	50	50	60	66
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The table below outlines the number of ME referrals received (as of 12TH August 2026), since the introduction of the Datix Mortality Review Module on 1st April 2022 the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Screened - pending Dashboard update	Under Investigation/ Action Required	Closed
CTMUHB	5399	165 (3 %)	77 (1 %)	39 (1 %)	5118 (95 %)

2. Strategic Insights

Learning from Mortality Reviews

Medical Examiner Service is now reviewing all of CTMUHB, in-hospital deaths and deaths in the community setting since September 2024.

Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued across CTMUHB. An in-house target has been set of completion within 28 days of the decision made by CTMUHB Screening Panel that a HMR is required.

	Number of HMR	Number Complete	Completed <28 days of Screening
2022-23	619	619 (100%)	11%
2023-24	373	373 (100%)	84%
2024-25	377	377 (100%)	64%
2025-26	320	308(96%)	25%
2026-27	51	32(63%)	94%

The table below shows the number of cases identified for HMR since 2022-23 (as of 12th August 2026), the number where the review has been completed and the percentage completed within 28 days of screening panel.

Completion of HMR <28 days has dropped due to a shortage of HMR reviewers, and historic good will funding for 2 regular reviewers stopping end of March 2025. This has resulted in longer completion times and a backlog of cases accruing. We are now also undertaking an HMR for every in-hospital death where notified that a Coroner's Investigation or Inquest is taking place.

Hospital Acquired Influenza as well as Hospital Acquired Covid cases, are now automatically reviewed at HMR level. This added around 40 cases to the backlog as we made the decision to back date cases to April 2025.

Any patients with a known Learning Disability that die in a hospital setting are also automatically reviewed at HMR level.

There are currently 31 HMR cases outstanding. The table below is a breakdown of these cases:

	Number	Percentage
Coroner's Inquest/Investigation	14	45%
Hospital Acquired Covid	1	3%
Inappropriate Discharge Concerns	6	19%
Learning Disabilities Patients	1	3%
Other	9	29%

Stage 3 Mortality Review panel continues to be held on a monthly basis via Teams. There are currently 6 cases either waiting to be reviewed or in progress.

Each review with the medical examiner or at level 2 or 3 provides an opportunity to gather and share learning. A Themes database separate to the Datix Mortality Review Module has been created to capture this and feed into the Mortality Review (MR) Dashboard that is currently in development stage. This has given us the opportunity to differentiate between themes from issues noted by the Medical Examiner themselves or the family/next of kin during discussions with the Medical Examiners Service.

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

CTM Mortality Rate – 2.1%

Mortality Rates per DGH:

PCH – 1.71%

POW – 1.68%

RGH – 2.31%

Mortality Rates per Locality:

Merthyr – 1.92%

Bridgend – 1.77%

RCT – 2.52%

Mortality Board

An oversight Mortality Board has been established that oversees and receives assurance that processes are in place to learn from all deaths.

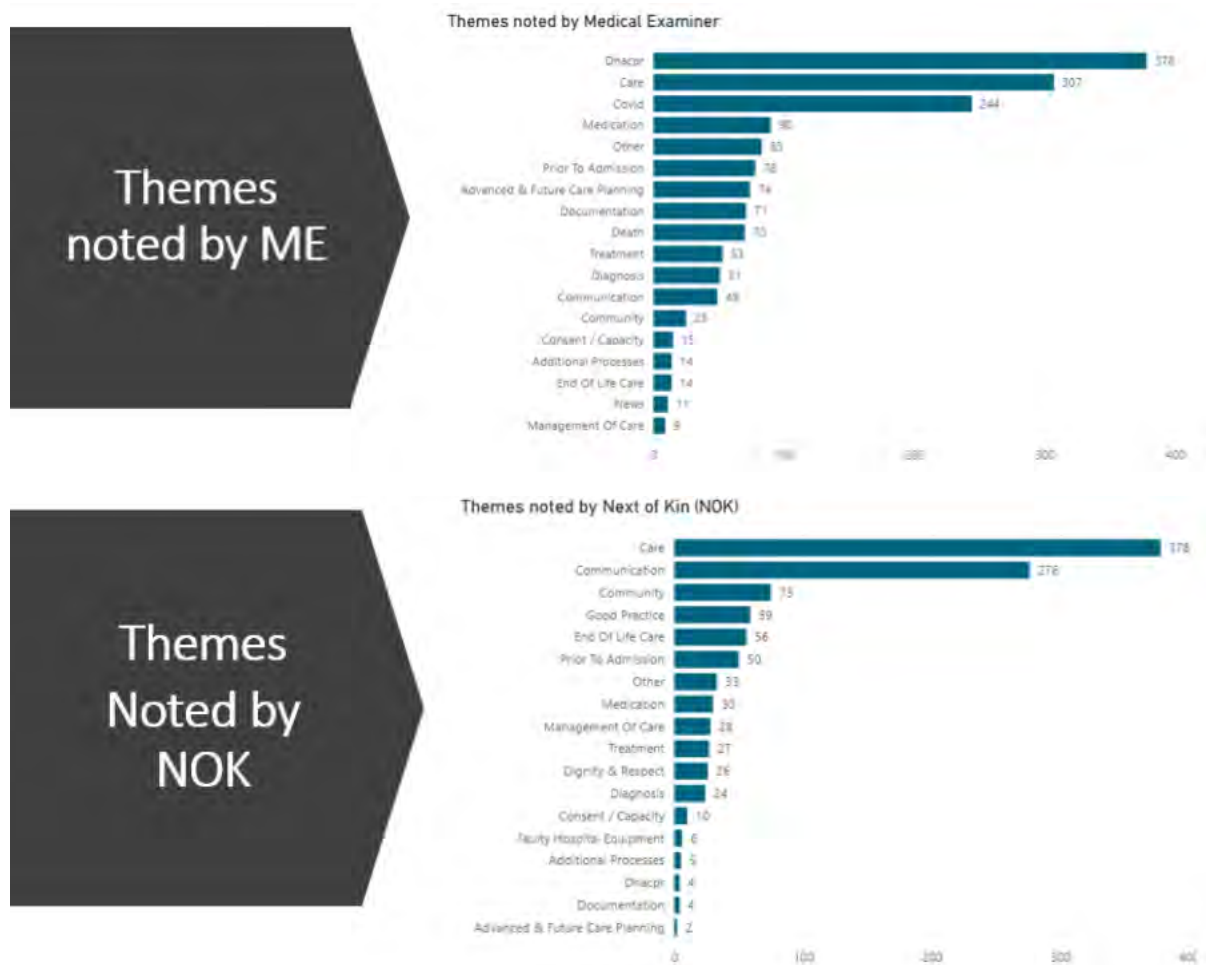
Membership includes Medical Director, Deputy Medical Director, Primary Care Medical Director, Clinical Lead for Mortality, Assistant Director of Nursing and Peoples Experience, Mortality Review Manager, Senior MR/Quality Informatics Facilitator, Bereavement Clinical Lead, Mortuary/Bereavement Manager, Head of Peoples Experience, Operations Lead, Allied Health Professionals (AHP) Representative and Medical Examiners Service Representative.

The Board meets quarterly, and oversees;

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

2. Strategic Insights

The following information has been taken from the MR dashboard. Due to IT issues, we are currently unable to add data for deaths in ED and Primary care. This is being investigated.





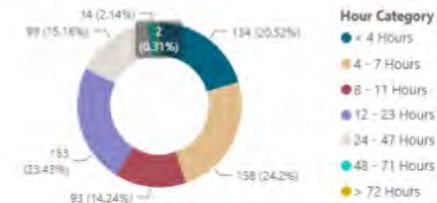
A&E Data

A&E Mortality by Site

Hospital Prince Charles Hospital Princess Of Wales Hospital Royal Glamorgan Hospital

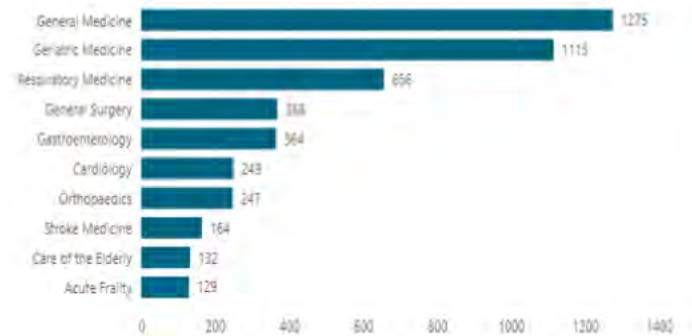


A&E Mortality Rate by Duration of Episode



Deaths by Specialty (Top 10)

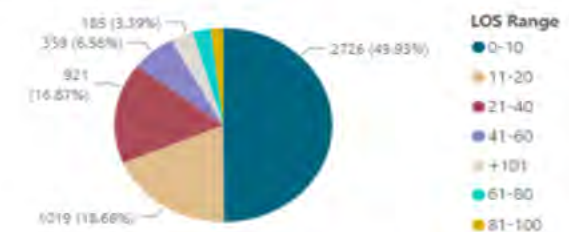
Mortality By Specialty



CTM Mortality

Acute Mortality by LOS Category

*From Admission Date



CTM Mortality by Age Group



Current CTMUHB Mortality Review data shows that there is room for improvement in care in around 32% of deaths.



Post HMR/Stage 3 Data

Grading of Overall Care



Avoidability of Death



CIVICA form has been developed to capture next of kin feedback noted in Medical Examiner referrals. Care Groups/Departments can view specific feedback related to their areas, facilitating targeted improvements as well as capturing compliments and the things that we do well to learn from and build upon. This gives us an understanding of a family/patient and their journey, and an opportunity to have the details of their experience within our health care system. Data has been captured in this system since August 2024.

By Feedback / Compliments

Feedback Compliments



Working together as a team within CTMUHB and outside agencies and external partners such as ME, coroners, to get robust data.

Care group led focus on data provided from external partner and insights that can be used to improve care at local level. Current workstreams include general surgical deaths, fractured neck of femurs and gastro. Care groups asked to analyse, external partner help with in person meetings re. data, feedback to board on areas of concern and improvements.

Mortality Board oversees this and directs further areas of improvement.

3. Risks and opportunities

Limited clinical reviewers with appropriate MR experience within each care group remains challenging and the biggest risk to the non-completion of the MR process.

There are many opportunities within each care group to look at conditions with higher mortality rates now that we have several robust data sources. This will guide improvements and improve care for our patients.

4. Compliance and Governance

Dashboard

The CTMUHB developed dashboard allows for local level themes by specialty, ward etc and feedback to individuals and from families to be collated. An oversight Mortality Board has been established that oversees and receives assurance that processes are in place to learn from all deaths.

Other

MDT working with links with ME, coroner, bereavement teams, patient experience to identify issues and work together to resolve this. Open discussion encouraged.

External partner data analysis of care group data and areas of concern investigated, and improvements suggested. These will then be presented to board and monitored as improvements progress. This will become an embedded part of culture, led by the care groups who will be accountable for improvements.

Example of recent deep dive

The mortality review team identified a spike in deaths on the dashboard in ED. This information was discussed with the ED clinical leads, who investigated the deaths looking for themes. This was presented at the last mortality board.

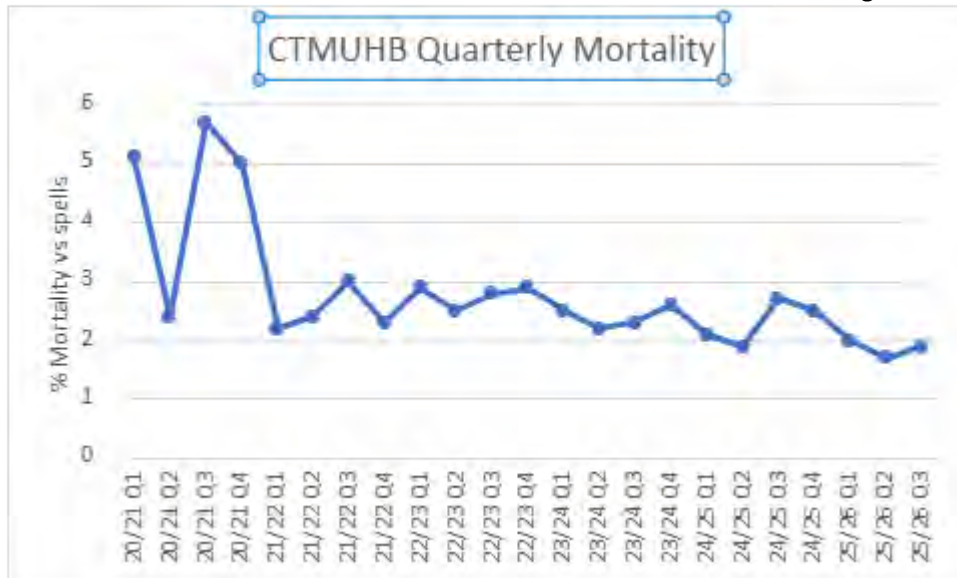
Specific findings included:

- A correlation between deprivation level in area of residence and higher mortality
- Change in highest mortality site since configuration
- More patients from out of area attending
- Issues with Welsh Ambulance Services Trust (WAST) waiting times impacting time in ED or outside ED
- Problem areas identified as nursing home residents admitted without clear reason and palliative care patients who may have benefited from an alternative health care facility.
- Improvements to include palliative care capture sheet, ambulance reporting for delays outside ED
- Re-report to board on progress

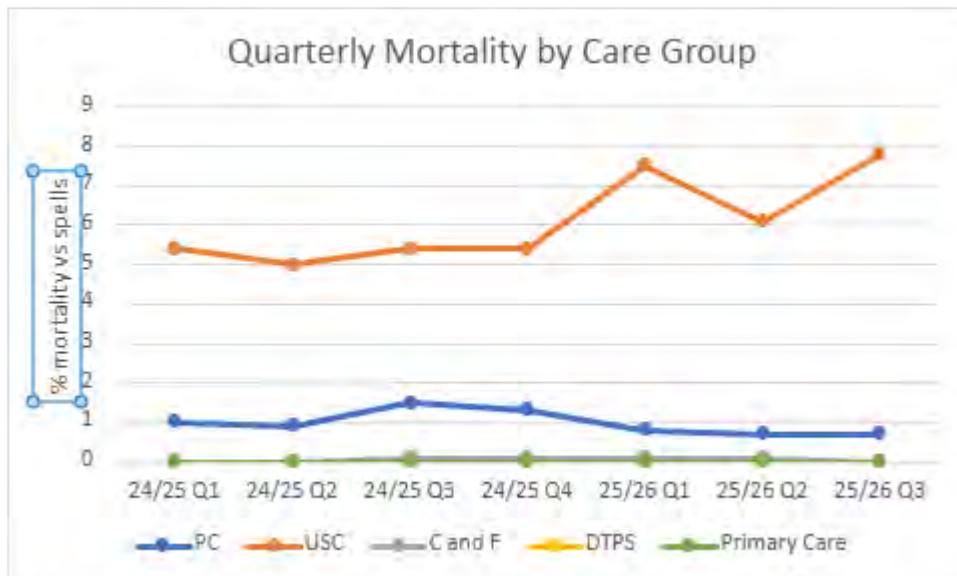
5. Benchmarks

External partner data benchmarks CTMUHB against a matched peer group with similar characteristics for deprivation/population. This gives data at a health board level and for care groups and specialties.

This graph shows quarterly mortality for the Health Board showing a reduction over time.



This graph shows quarterly mortality by care group for 24/25 and 25/26.



The data is peer matched, so specific conditions and specialities can be compared to peers. This has not been included in the above graph due to the inability to match with Care Groups (these don't exist as separate entities within other health boards/trusts).

This graph shows the quarterly data for the lowest performing specialities. Data is provided for each speciality that is coded. Many specialities have low mortality rates, and there are a few areas where coding concerns have been identified and will be looked at, such as specialty being recorded as Anaesthetics in 7.5% and a higher rate in Endocrinology. These will be looked at in more detail once coding issues are resolved.



The graph shows the highest mortality in General Internal Medicine, COTE and Respiratory, all within the Unscheduled Care group.

The Planned Care group had highest mortality in General Surgery/Colorectal, Gastroenterology and Trauma and Orthopaedics.

The Care Groups have access to this data to analyse in detail at care group level. Our current focus is on the above groups of patients, with the Clinical Directors for each speciality looking at the cases and feeding back to the Mortality Board. The first meeting with General Surgery and Trauma is August 25th to identify trend or themes. Care Groups are also being asked to provide plans to improve and to monitor these.

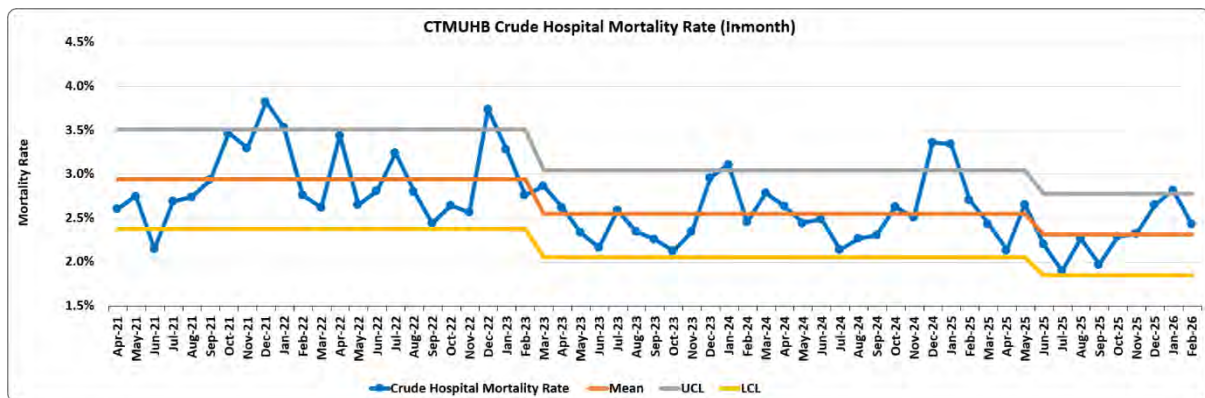
Sepsis has also been identified as a theme. The RADAR group is investigating this area as it covers all areas within the Health Board associated with deterioration and acute illness.



The above graph shows quarterly mortality compared to peers for two of the specialities detailed above. It is noted that the peer mortality is lower in both specialities. Care Group analysis will guide improvements and will be monitored at Mortality Board. It must be noted that the peer cohort are all trusts within England, so there may be some differences.

The NHS Wales planning framework sets priority areas and a rolling CMR over a 12-month period is one such area for 2026/27 and our latest performance graph is shown below.

CTMUHB baseline position – February 2026



6. Conclusion

Strengthened mortality team with increasing data from external partner and dashboard giving robust data to guide improvements.

Further areas of development include:

- Increased numbers of clinicians to conduct mortality reviews aided by ongoing work with job planning and SPA guidance now in place.
- Live dashboard allowing teams to analyse own data but need more engagement and triangulation with external partner data.
- Improve feedback mechanisms for family feedback. Already working with patient experience who report to board and CIVICA for feedback, but a strengthened care after death team could help issues to be addressed and guide improvements.
- Care Groups specific reporting into Mortality Board to update the Health Board on progress and support required.
- Continue to use external partner data to identify areas of concern and work with the care groups to learn from these areas and develop plans to address and be accountable using deep dives of specific specialities and conditions such as ongoing work with Gastroenterology and Sepsis.
- Continue to work with national programmes within Wales to share learning.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd

Strategic Risk 2 Service Transformation & Outcomes



<i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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	Not Applicable	
	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 <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i> Equality & Welsh Language Impact Assessment Outcome <i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	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. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i>	Not applicable	



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	
RADAR	Recognition of Acute Deterioration and Resuscitation
CTMUHB	Cwm Taf Morgannwg University Health Board
ME	Medical Examiner
NOK	Next of Kin
CMR	Crude Mortality Rate
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
MR	Mortality Review
MDT	Multi Disciplinary Team
SHMI	Summary Hospital-level Mortality Indicator
HMSR	Hospital Standardised Mortality Ratio

Quality, Safety & Experience Committee

Board Assurance Framework Report – September 2026

Eitem yr Agenda / Agenda Item	4.9
Dyddiad y Cyfarfod / Date of Meeting:	Tuesday 22 September 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:	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to: NOTE the risks under its remit*, and confirm that the updates provide adequate assurance and reflect recent discussions. *QSEC oversees Risks 1a,1b,2,3.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context:</i> <i>This report aligns to the following Strategic Pillars</i>	All Strategic Pillars
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>)	The Board Assurance Framework supports delivery of the Integrated Medium Term Plan and Annual Delivery Plan by identifying, monitoring and reporting the principal strategic risks that may affect delivery of the Health Board's objectives, priorities and statutory duties.
Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:

Dechreuwch drwy grynhai'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 Board Assurance Framework (BAF) sets out the Health Board's principal strategic risks and provides a structured view of the controls, assurances, gaps and mitigating actions in place to manage them.

QSEC has the following role in relation to the BAF, as set out in the Health Board's Risk Strategy:

- *Receive and scrutinise risks and provide onwards assurance to the Board in relation to risks assigned to them to provide oversight and scrutiny.*
- *Receive updates in terms of actions taken to mitigate the risks and provide feedback and challenge to risk owners on the actions taken and any further action required.*

This report presents the BAF risks which are assigned to QSEC, namely Risks 1a, 1b, 2 and 3.

All risks have been reviewed and updated by risk owners and handlers as part of the September 2026 refresh.

Particular focus has been placed on improving the articulation of strategic gaps, strengthening the description of mitigating actions, and evidencing the impact of actions taken to date.

Changes to the BAF are normally indicated in red text to aid visibility of changes. This has not been applied on this occasion due to the extent of the revisions, which would have significantly reduced the readability of the document.

A summary version of the BAF has also been produced for the September reporting round. This summary should be read alongside the full Board Assurance Framework, which provides the detailed risk descriptions, controls, sources of assurance, actions and supporting evidence. It does not replace the full framework or seek to reproduce all of its content.



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 September iteration of the BAF has focused on strengthening the articulation of strategic gaps, risk treatment narratives and evidence of the impact of mitigating actions.

In addition, the summary version provides an accessible overview of the Health Board's principal strategic risks and the current level of assurance over how they are being managed. It is intended to support Board and Committee discussion by highlighting the most significant gaps, the progress being made to address them, the factors that continue to limit assurance, and the expected direction of travel.

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 Health Board recognises that development of a mature assurance framework is an ongoing process. Next steps for the November 2026 iteration will include exploring how the assurance already contained within the detailed BAF can be summarised more visibly within this summary document, giving Board and Committee members more at-a-glance visibility of the current position, the effectiveness of mitigating actions, areas where assurance remains limited, and the overall direction of travel for each strategic risk.

The intention is not to replace the detailed assurance contained within the full BAF, but to make key assurance messages easier to identify and use.

Work is also underway to enhance the way the BAF is used within Board and Committee business. The Director of Corporate Governance and Board Secretary is currently leading a pilot within the Operational Delivery Committee (ODC) to test a more assurance-led approach to committee business, using BAF-assigned risks to focus scrutiny, triangulate evidence and support clearer assurance conclusions.

	Subject to evaluation of the pilot, learning may be used to inform future consideration of how assurance committees contribute to oversight of strategic risks and onward assurance to the Board.
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Committee is asked to: NOTE the risks under its remit*, and confirm that the updates provide adequate assurance and reflect recent discussions. <i>*QSEC oversees Risks 1a,1b,2,3.</i>
Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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)	All Strategic Risks on the BAF This report relates to the Board Assurance Framework as a whole and therefore has relevance to all strategic risks included within the BAF.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	All applicable The Board Assurance Framework supports consideration of the Health Board's strategic risks across all relevant Wellbeing Goals. Individual strategic risk entries identify specific implications where relevant.
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All applicable The Board Assurance Framework supports oversight of strategic risks that may affect all Enablers of Quality. The specific relevance of each enabler is reflected within individual strategic risk entries where appropriate.
Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Yes - Applicable This report is an assurance update and does not propose any service change or operational decision. Environmental and sustainability implications are considered within individual strategic risks where relevant.



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.)

No separate Equality & Welsh Language Impact Assessment has been undertaken as this report provides an assurance update and does not propose a new policy, service change or decision. Equality & Welsh Language implications are considered within individual strategic risks where relevant.

Named Executive/Board member sign off for no EWLIA completion:
Executive Sponsor: Director of Corporate Governance / Board Secretary

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 separate Quality Impact Assessment has been undertaken as this report provides an assurance update rather than proposing a service change or operational decision. Quality implications are reflected within individual strategic risks where relevant.

Cyfreithiol / Legal

Yes (Include further detail below)
Legal and regulatory implications are captured within individual strategic risk entries where relevant.

Enw da / Reputational

Yes (include further detail below)
The BAF is a key public assurance document. Reputational implications therefore arise from ensuring that the Health Board's principal strategic risks are accurately reflected and appropriately reported.

Effaith Adnoddau
(Pobl / Ariannol) /
Resource Impact
(People / Financial)

Yes (include further detail below)
This report does not request additional resources. Workforce, financial and other resource implications are considered within individual strategic risks where relevant.

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

Committee / Group
/ Individuals

Date

Outcome

Strategic risk owners and risk handlers	Aug-Sept 2026	Updates requested to support the September 2026 BAF refresh, including redrafting of the Gaps section and other elements.
Executive Leadership Group, Board and Committees	Various	Previous iterations of the BAF have been reviewed through the established governance cycle. The document is iterative and continues to respond to Executive, Board and Committee feedback.
Audit Wales feedback / Structured Assessment recommendation	2025/26	BAF template amended to strengthen reporting of the actual impact of mitigating actions, in response to the recommendation that the BAF should more clearly report the impact of actions taken to mitigate strategic risks.
Executive Leadership Group	14/09/2026	Review, moderation and management sign-off for presentation to the Board and committees.

Acronyms / Glossary of Terms	
BAF	Board Assurance Framework
CTMUHB	Cwm Taf Morgannwg University Health Board
ELG	Executive Leadership Group
IMTP	Integrated Medium Term Plan
P&I	Performance and Improvement

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT – SUMMARY VERSION – SEPTEMBER 2026
(RISKS OVERSEEN BY THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE)

This summary provides an accessible overview of the Health Board's principal strategic risks against the four CTM 2030 strategic goals, and the current level of assurance over how they are being managed. It is intended to support Board and Committee discussion by highlighting the most significant gaps, the progress being made to address them, the factors that continue to limit assurance, and the expected direction of travel.

The summary should be read alongside the full Board Assurance Framework, which provides the detailed risk descriptions, controls, sources of assurance, actions and supporting evidence. It does not replace the full framework or seek to reproduce all of its content.

The Health Board recognises that development of a mature assurance framework is an ongoing process. The September iteration of the BAF has focused on strengthening the articulation of strategic gaps, risk treatment narratives and evidence of the impact of mitigating actions.

Next steps for the November 2026 iteration will include exploring how the assurance already contained within the detailed BAF can be summarised more visibly within this summary document, giving Board and Committee members more at-a-glance visibility of the current position, the effectiveness of mitigating actions, areas where assurance remains limited, and the overall direction of travel for each strategic risk. The intention is not to replace the detailed assurance contained within the full BAF, but to make key assurance messages easier to identify and use.

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
 Creating Health / Creu Iechyd <i>Reducing health inequalities; Equal focus on mental and physical health; Supporting our communities; Being a healthy organisation</i> None of the four BAF risks assigned to QSEC are linked to "Creating Health".						
 Improving Care / Gwella Gofal <i>Delivering safe and compassionate care; Developing new models of care; Digital transformation for patients and staff; Ensuring timely access to care</i> All four of the risks assigned to QSEC are linked to "Improving Care", as well as other strategic goals (see below)						
1a	Enough capacity to meet elective demand Lead: Chief Operating Officer Committee: Quality, Safety & Experience Committee; and Operational Delivery Committee	Gap 1: Digital systems supporting planned care pathways are not yet fully developed or integrated. Gap 2: Cancer tracking and speciality-specific elective data remain insufficiently robust to support performance oversight and early intervention. Gap 3: Elective recovery and service redesign initiatives are not yet fully embedded across all specialties.	16 (C4xL4) 	12 (C4xL3)	2030	September 2026: The risk is actively managed through planned care recovery, productivity and service transformation programmes. Whilst progress continues across a number of areas, including cancer performance, elective capacity and reductions in long waits, the risk remains elevated due to ongoing workforce, operational and capacity constraints, particularly within Orthopaedics and Neurology. Further sustained improvement is required before elective capacity can consistently meet demand and support a reduction in risk score. Risk treatment: Treat with elements tolerated.
1b	Enough capacity to meet emergency demand Lead: Chief Operating Officer Committees: Quality, Safety & Experience Committee; and Operational Delivery Committee	Gap 1: Urgent and emergency care improvement actions are not yet fully embedded or delivering sustained improvements in performance	20 (C4xL5) 	12 (C4xL3)	2030	September 2026: The risk continues to be actively managed through urgent and emergency care improvement programmes and whole-system actions to improve patient flow, discharge and access to care. Whilst progress continues and the overall trajectory is positive, sustained demand, workforce pressures and patient flow challenges continue to constrain emergency care performance. Further improvement is required before sufficient assurance can be obtained that capacity is consistently able to meet emergency demand and support a reduction in risk score. Risk treatment: Treat with elements tolerated.
2	Ability to deliver improvements which transform care and enhance outcomes	Gap 1: Quality intelligence and assurance arrangements are not yet fully integrated to provide a comprehensive and timely organisational view of quality, safety and performance. Gap 2: Ward assurance, safeguarding and related quality governance arrangements require further development and	16 (C4xL4) 	12 (C4xL3)	TBC	September 2026: The foundations of the quality management framework are largely in place, with progress made in strengthening governance, oversight and assurance. The remaining challenge is to embed these arrangements consistently across the organisation and demonstrate sustained impact. As this work matures, assurance is expected to strengthen and the risk score to reduce over time.

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
	Lead: Executive Director of Nursing / Executive Medical Director Committees: Quality, Safety & Experience Committee and Operational Delivery Committee	consistent embedding to provide reliable assurance across all services and settings. Gap 3: Organisational learning, improvement and feedback arrangements are not yet consistently embedded, and the impact of improvement activity is not always systematically measured or demonstrated. Gap 4: Concerns, complaints, redress and legal services arrangements require further strengthening to provide timely resolution, organisational learning and sustainable assurance.				Risk treatment: Treat
3	Enough workforce to deliver the activity and quality ambitions of the organisation <i>(Including Culture, Values and Behaviours)</i> Lead: Executive Director for People Committees: Quality, Safety & Experience Committee and Operational Delivery Committee	Gap 1: Workforce planning is not yet consistently aligned to future organisational priorities, service transformation programmes and regional workforce requirements, limiting our ability to proactively shape the future workforce. Gap 2: Workforce deployment, productivity, digital systems and workforce intelligence capabilities are not yet sufficiently mature to optimise capacity, quality, efficiency and affordability. Gap 3: Recruitment, retention and attendance arrangements are not yet consistently delivering a sustainable, resilient and engaged workforce, resulting in workforce supply pressures and variable workforce experience. Gap 4: Organisational values, behaviours and approaches to staff experience are not yet consistently embedded across the Health Board, impacting engagement, wellbeing, leadership culture and organisational performance.	16 (C4xL4) 	8 (C4xL2)	March 2029	September 2026: This risk continues to be treated through targeted action under the CTM People Plan, workforce planning, recruitment, retention, and wellbeing, and productivity programmes. A reduction is expected over time, but remains constrained by national workforce supply, sickness absence, variable pay, affordability pressures and the pace of service change. Risk treatment: Treat with elements tolerated.



Inspiring People / Ysbrydoli Pobl

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

One of the risks assigned to QSEC is linked to "Inspiring People", namely Risk 3



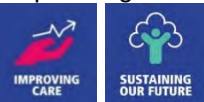
Sustaining Our Future / Cynnal Ein Dyfodol

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

All four of the risks assigned to QSEC are linked to "Sustaining our Future" as well as also being linked to other objectives.

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT – RISKS ASSIGNED TO QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Section 1 – Summary

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score	Target Score	Target Score Date	Risk Treatment / Status Update September 2026
1.	 Click Here for Risk 1a Click Here for Risk 1b	a) Enough capacity to meet elective demand	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4xL4)	12 (C4xL3)	2030	Treat with elements tolerated. The risk is actively managed through planned care recovery, productivity and service transformation programmes. Whilst progress continues across a number of areas, including cancer performance, elective capacity and reductions in long waits, the risk remains elevated due to ongoing workforce, operational and capacity constraints, particularly within Orthopaedics and Neurology. Further sustained improvement is required before elective capacity can consistently meet demand and support a reduction in risk score.
		b) Enough capacity to meet emergency demand			20 (C4xL5)	12 (C4xL3)	2030	Treat with elements tolerated. The risk is actively managed through urgent and emergency care improvement programmes and whole-system actions to improve patient flow, discharge and access to care. Whilst progress continues and the overall trajectory is positive, sustained demand, workforce pressures and patient flow challenges continue to constrain emergency care performance. Further improvement is required before sufficient assurance can be obtained that capacity is consistently able to meet emergency demand and support a reduction in risk score.
2.	 Click Here for Risk 2	Ability to deliver improvements which transform care and enhance outcomes	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4xL4)	12 (C4xL3)	TBC	Treat. The foundations of the quality management framework are largely in place, with progress made in strengthening governance, oversight and assurance. The remaining challenge is to embed these arrangements consistently across the organisation and demonstrate sustained impact. As this work matures, assurance is expected to strengthen and the risk score to reduce over time.
3.	 Click Here for Risk 3	Enough workforce to deliver the activity and quality ambitions of the organisation (<i>Including Culture, Values and Behaviours</i>)	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4xL4)	8 (C4xL2)	March 2029	Treat with elements tolerated. This risk will continue to be treated through targeted action under the CTM People Plan, workforce planning, recruitment, retention, and wellbeing, and productivity programmes. A reduction is expected over time, but remains constrained by national workforce supply, sickness absence, variable pay, affordability pressures and the pace of service change.

Section 2 Strategic Risk Heat Map

Current risk scores in black

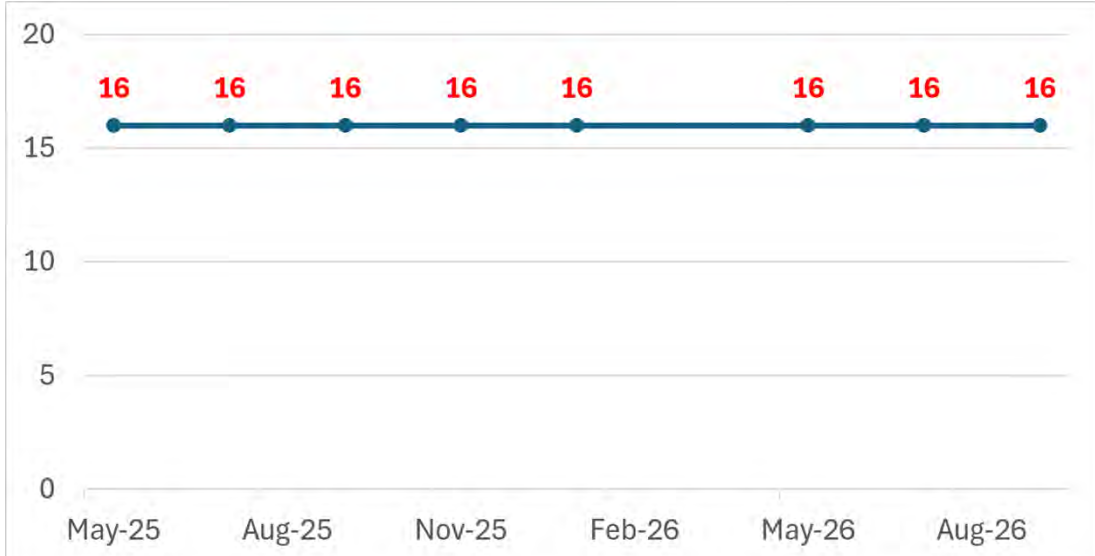
Target risk scores in *grey italic*

Consequence	5					
	4		3	1a,1b,2	1a,2,3	1b
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

SECTION 3 – STRATEGIC RISKS

Strategic Goal(s):			Risk score 16
	Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care •		
Strategic Risk: Enough capacity to meet elective demand - (Risk No.1a)			
<i>If the Health Board is unable to meet demands for services at all points in the patient journey.</i>	<i>Then its ability to provide high quality and affordable care and to meet access targets will be reduced</i>	<i>Resulting in avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community, ongoing overspends.</i>	

Risk Lead - Chief Operating Officer - Executive Director of Strategy & Transformation	Assurance committee - Quality, Safety & Experience Committee - Operational Delivery Committee (Performance Targets)
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	Consequence	Likelihood	Score	Risk Score Trend this Period:
Initial	4	5	20	No change to risk scores this period.
Current	4	4	16	
Target	4	3	12	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			Risk Score Trajectory
				
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				The risk score remains unchanged at 16 (C4xL4). Positive progress continues across a number of planned care, cancer and productivity improvement programmes, with sustained improvements in performance and capacity management. However, significant operational, workforce and capacity pressures remain, preventing a reduction in the risk score at this stage. Key progress during this period includes: Cancer performance has remained above the 60% Suspected Cancer Pathway (SCP) target, resulting in automatic de-escalation to Level 1 routine monitoring. CTMUHB has maintained the top position in Wales for four consecutive months and an updated trajectory has been submitted. With Junes positing being 64.9% the highest achieved to date.

	- Progress has continued in reducing long waits, with all specialties aiming to maintain waits below 104 weeks, with the exception of Orthopaedics and Neurology. Phased funding is being released to support the 104 delivery by March 2027. CTMUHB are currently working with the region to deliver this. - The Health Board's outpatient improvement programme has achieved zero patients waiting longer than 52 weeks, although Neurology waits transferred from Cardiff and Vale University Health Board continue to influence overall performance. - All theatres are now operational across the three acute hospital sites, supported by a revised theatre timetable introduced in April 2026 based on demand and capacity modelling. - Improvements have been made in theatre start times and in the use of See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) pathways. - The Orthopaedic Elective Unit at Princess of Wales Hospital continues to support dedicated elective activity, while consolidation of cataract surgery within the Princess of Wales Eye Unit has strengthened standardisation and delivery of High Volume Low Complexity (HVLC) pathways. - An increased focus on Ophthalmology productivity to achieve HVLC lists has commenced. - An Endoscopy Recovery Plan has been implemented to maintain recent improvements in performance. With additional weekend capacity commencing in September 2026. - The Productivity, Improvement and Transformation (PIT) Board has been refocussed on delivery of key specialty actions, including further implementation of SOS and PIFU pathways. - Continuous improvement has been demonstrated against elective demand trajectories across a range of services, including Mental Health and Learning Disabilities. However, the risk remains elevated due to: - Continued growth in patients waiting over 104 weeks, driven primarily by the recurring gap in Orthopaedics capacity and transfer of Neurology pathways from Cardiff and Vale University Health Board. - Routine operational pressures that continue to constrain elective capacity and reduce resilience during periods of increased demand. - Workforce recruitment challenges and reduced reliance on Additional Hours (ADH) and Waiting List Initiative (WLI) activity as pay arrangements are standardised. - The planned capital programme at Prince Charles Hospital, which will temporarily reduce theatre capacity while mitigation measures are developed. - Dependence on partner organisations, with financial and workforce pressures across local authority and third-sector services impacting the Health Board's ability to maintain capacity and patient flow. - The need to continuously evaluate both the opportunities and challenges arising from regional working arrangements. Whilst progress continues and the overall trajectory remains positive, further sustained improvement is required before the Health Board can demonstrate that elective capacity is sufficient to consistently meet demand and support a reduction in the risk score.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section.

Current Control Measures
1. Strategic Planning and Improvement Programmes A suite of strategic programmes is in place to increase elective capacity, improve productivity and deliver planned care transformation in line with national policy and organisational priorities. - Productivity, Improvement and Transformation (PIT) Programme. - Planned Care Recovery Programme.

- Clinical Services Plan.
- Integrated Medium Term Plan (IMTP).
- National Planned Care Programme.
- Specialty-specific improvement trajectories.

2. Demand and Capacity Management

Processes are in place to manage demand, prioritise patients according to clinical need and optimise the use of available capacity across the organisation.

- Annual Demand and Capacity Plan.
- Waiting list management arrangements.
- Centralised utilisation of available capacity.
- Demand and capacity modelling.
- Interventions Not Normally Undertaken (INNU) application processes.
- Recovery planning and seasonal planning arrangements.

3. Elective Capacity and Service Transformation

A range of service redesign and capacity initiatives support delivery of elective care and reduce waiting times.

- Endoscopy insourcing arrangements.
- Elective surgery reconfiguration.
- Regional Ophthalmology Service arrangements.
- Additional theatre capacity, including the South Theatre at Royal Glamorgan Hospital.
- Theatre optimisation initiatives.
- Llantrisant Health Park development proposals.
- Cross-cutting improvement programmes covering theatres, diagnostics, outpatients, pre-assessment and therapies.

4. Governance and Programme Oversight

Formal governance arrangements oversee delivery of planned care recovery, performance improvement and service transformation.

- Improving Care Board.
- Operational Services Management Board.
- Planned Care Recovery Board / Planned Care Recovery Operations Board.
- Cancer Board.
- Six Goals / Unscheduled Care Board.
- Innovation Board.

5. Regional Partnerships and System Working

Partnership arrangements support integrated planning, pathway redesign and system-wide approaches to improving patient flow and elective performance.

- Regional Partnership Board programmes.
- Partnership Leadership Team.
- Commissioning Group.
- South East regional recovery programmes.
- Regional pathology collaboration.
- Partnership working with local authorities to improve discharge and patient flow.

Sources of Assurance (Internal and External)

Assurance is derived from a combination of routine performance reporting, programme assurance, harm review processes, escalation reports and operational risk monitoring. These arrangements provide oversight of planned care performance, cancer pathways, waiting list management, service pressures and delivery of the planned care recovery programme.

Performance and Delivery Assurance

The Board and relevant Committees receive assurance on planned care delivery through regular performance and recovery reporting, including:

- Integrated Performance Report.
- Assessment Dashboard.
- Referral to Treatment and Cancer trajectories.
- Planned Care Recovery Update Report.
- PIT Programme reports.
- Planning, Performance and Finance monthly report.

Service-Specific Assurance

Additional assurance is provided through focused reports on areas experiencing operational or performance pressure. These reports support scrutiny of high-risk specialties and enable targeted intervention where required.

- Update reports on specific services experiencing pressure, including Ophthalmology and Urology.
- Follow-up reporting on outpatients not booked.
- Service improvement and recovery updates through relevant programme and operational governance routes.

Quality, Safety and Risk Assurance

The impact of planned care pressures on patient safety and experience is monitored through harm review processes, escalation arrangements and risk reporting.

- Harm Reviews.
- Escalation processes, including reporting to the Chief Operating Officer and Quality, Safety and Experience Committee.
- Care Group performance review meetings.
- Organisational Risk Register and Care Group Risk Registers.
- Tactical Intervention meetings.

Overall Assurance Position

Current assurance demonstrates that planned care performance is subject to regular monitoring, escalation and programme oversight. The assurance available indicates progress in a number of areas, including cancer performance, planned care recovery and specialty-level improvement activity. However, the risk remains open because assurance also shows that pressures continue in key pathways, waiting list recovery remains uneven, and further sustained improvement is required before the Health Board can be assured that elective capacity is sufficient to meet demand.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
1. Digital systems supporting planned care pathways are not yet fully developed or integrated.	Actions already taken • Digital dictation consolidation and standardisation. • Consultant Connect implementation. • Use of Attend Anywhere to support virtual activity. • Progression of Welsh Patient Referral Service (WPRS) rollout. Further actions required / in progress • Digital pre-assessment system. • Theatre system optimisation. • Digital outpatient system implementation. • Continued reduction in manual processes.	• Improved monitoring of speciality utilisation and non-compliance. • Reduced missed opportunities within planned care pathways. • Reduced referral demand through improved pathway management. • Reduced waiting lists. • Reduced cancellations and non-attendance.	Digital developments to date have improved access to virtual activity, strengthened pathway management and increased visibility of speciality utilisation and performance. Improvements in digital processes and system standardisation are beginning to support reductions in missed opportunities and more effective management of referral demand and waiting lists, However, further development of digital outpatient and pre-assessment systems is required before the full benefits can be realised.
2. Cancer tracking and speciality-specific elective data remain	Controls already in place • Weekly performance meeting	• Improved performance oversight and earlier identification and escalation of pathway risks.	Improvements in cancer tracking arrangements, performance oversight and staff training have

insufficiently robust to support performance oversight and early intervention.	- Training undertaken for all cancer trackers to ensure consistency and compliance with new guidance Further actions required / in progress - Implementation of online escalation process for all patients outside of agreed component waiting times. - CANISC (Cancer Network Information System Cymru) replacement ongoing. - Implementation of Breast, Urology & lower GI datasets	- Improved visibility of pathway performance and waiting list management. - Sustained Suspected Cancer Pathway (SCP) performance above 60%. - Reduction in waiting list backlog across cancer and elective pathways. - Improved consistency, accuracy and robustness of speciality-specific elective data. - Full implementation of new datasets and escalation processes to support timely intervention and decision-making.	strengthened the identification and escalation of pathway risks. Sustained performance against the Suspected Cancer Pathway and increased focus on waiting list management have contributed to reductions in backlog across a number of services. However, further work is required to fully embed new datasets and enhance the reliability of speciality-specific elective data.
3. Elective recovery and service redesign initiatives are not yet fully embedded across all specialties.	Actions already complete - Regional Ophthalmology service expansion Further actions required / in progress - Trauma service reconfiguration. - Completion of theatre workforce recruitment. - Continued business continuity arrangements (ongoing). - Clinical Services Plan development.	- Increase in activity - Reduced follow sessions - Reduction in waiting times Reduction in >104 week wait across all specialties except that with a recurring gap.	Elective recovery initiatives have increased activity and supported reductions in waiting times across a number of specialties. Progress has been made in reducing the number of patients waiting over 104 weeks and improving elective capacity through service reconfiguration and additional workforce support. However, improvements remain uneven and are not yet fully embedded across all pathways, particularly where recurring capacity challenges remain.

Linked National Priority Measures

Access to Timely Planned Care

- Number of patients waiting more than 104 weeks for treatment;
- Number of patients waiting more than 36 weeks for treatment;
- Percentage of patients waiting less than 26 weeks for treatment;
- Number of patients waiting over 104 weeks for a new outpatient appointment;
- Number of patients waiting over 52 weeks for a new outpatient appointment;
- Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%;
- Number of patients waiting over 8 weeks for a diagnostic endoscopy; and
- Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route).

Current Performance Highlights

Detailed RTT and elective performance information is reported separately through the Integrated Performance Report and Planned Care Recovery reporting arrangements. Current performance demonstrates ongoing progress in cancer performance, outpatient recovery and elective capacity initiatives; however, challenges remain in reducing long waits and sustaining sufficient capacity across all specialties.

Were there any significant incidents affecting this strategic Risk this period:

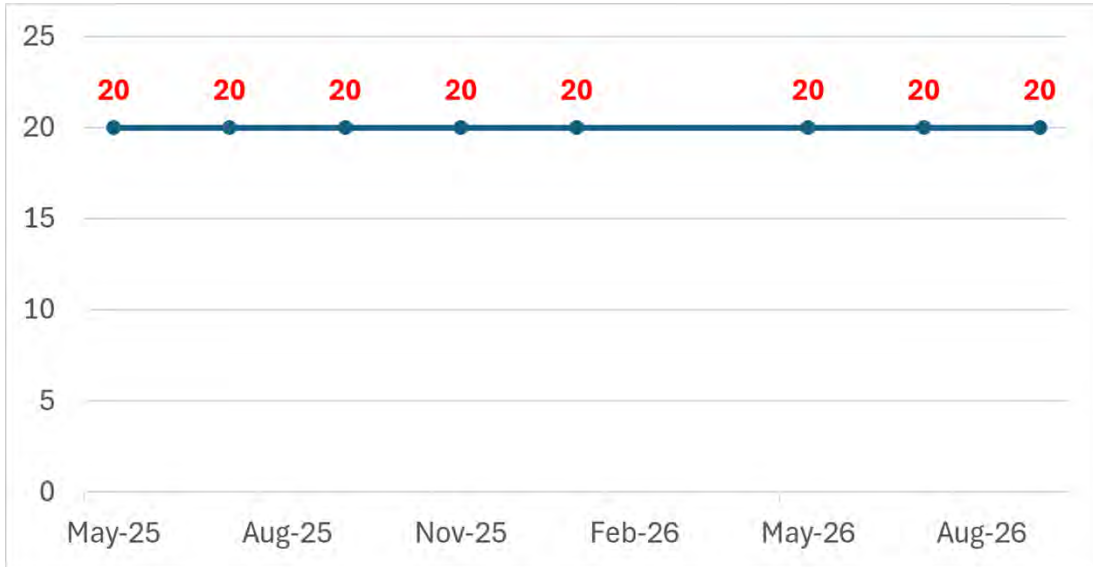
None

Associated Risks escalated to the Organisational Risk Register

Strategic Gap 1: Digital systems supporting planned care pathways are not yet fully developed or integrated		
<i>No directly aligned ORR risks are currently escalated. This gap is being managed through planned care improvement, digital development and pathway modernisation programmes.</i>		
Strategic Gap 2: Cancer tracking and speciality-specific elective data remain insufficiently robust to support performance oversight and early intervention.		
<i>No directly aligned ORR risks are currently escalated. This gap is managed through performance improvement arrangements, cancer tracking processes, data quality initiatives and planned care governance.</i>		
Strategic Gap 3: Elective recovery and service redesign initiatives are not yet fully embedded across all specialties.		
4491	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery. <i>This risk reflects wider capacity, flow and demand pressures affecting the Health Board's ability to reduce waiting times and sustain planned care recovery.</i>	16
6294	Insufficient consultant workforce in endoscopy and gastroenterology. <i>This risk reflects the challenges associated with maintaining sufficient specialist capacity to support timely diagnosis, treatment and elective recovery</i>	20
6280	Suspension of the Regional Hepato-Pancreato-Biliary Service Model. <i>This risk reflects the impact of regional service dependencies and commissioning arrangements on timely access to specialist planned care pathways.</i>	16
5045	Insufficient neurology capacity impacting timely access to services. <i>This risk reflects the ongoing impact of workforce shortages, diagnostic constraints and inherited waiting list pressures on elective performance and long waits.</i>	16

Strategic Goal(s):  Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care  Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future			Risk score 20
Strategic Risk: Enough capacity to meet emergency demand - (Risk No.1b)			
<i>If</i> the Health Board is unable to meet demands for services at all points in the patient journey.	<i>Then</i> its ability to provide high quality and affordable care and to meet access targets will be reduced	<i>Resulting in</i> avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community, ongoing overspends.	

Risk Lead	Chief Operating Officer	Assurance committee	- Quality, Safety & Experience Committee - Operational Delivery Committee (Performance Targets)
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	Consequence	Likelihood	Score	Risk Score Trend this Period:
Initial	4	5	20	No change to risk scores this period.
Current	4	5	20	
Target	4	3	12	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			Risk Score Trajectory
				
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				The risk score remains unchanged. Whilst progress continues across a number of urgent and emergency care improvement programmes, significant system pressures remain which continue to constrain patient flow, emergency care performance and service resilience. Key progress during this period includes: - Improvements against a number of urgent and emergency care trajectories, including 45-minute ambulance handover performance, 12-hour Emergency Department performance and a reduction in lost ambulance hours. - Continued development of clinical pathways and operational arrangements to support emergency demand and maintain service resilience.

	- Progress in workforce recruitment and the ongoing development of sustainable staffing models across urgent and emergency care services. - Continued regional collaboration and whole-system working to support patient flow and access to care. However, the risk remains elevated due to: - The ongoing impact of temporary changes to stroke service provision and associated effects on capacity across the wider system. - Reconfiguration of bed capacity and continued diversion of emergency admissions between sites, placing additional pressure on operational resilience. - A high number of clinically optimised patients remaining within core bed capacity, impacting patient flow and timely access to care. - Capacity constraints within partner organisations, including local authority and third-sector services, which continue to affect discharge pathways and whole-system flow. - Workforce pressures, alongside a reduction in Additional Hours (ADH) and Waiting List Initiative (WLI) activity associated with pay standardisation arrangements. - Continued financial, workforce and environmental constraints affecting the pace of improvement. Whilst the overall trajectory is positive and improvement continues in a number of key performance measures, further sustained progress in patient flow, capacity management and whole-system working is required before the Health Board can demonstrate that emergency care capacity is sufficient to consistently meet demand and justify a reduction in the risk score.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section.

Current Control Measures	
Urgent & Emergency Care Improvement Programme The Health Board's approach is aligned to the National Urgent and Emergency Care (UEC) Improvement Plan and associated local improvement programmes. Key areas of focus include: - Strengthening community capacity and alternatives to admission. - Single Point of Access (SPoA) providing central coordination. - Improving patient flow and discharge across the UEC pathway. - Improving patient safety and reducing harm associated with delays. - Delivering consistent models of care, including front-door and frailty pathways. - Improving demand and capacity management. - Supporting workforce development, data utilisation and quality improvement. Governance and Oversight A comprehensive governance framework is in place to oversee urgent and emergency care performance and improvement activity, including: - Improving Care Board. - Operational Management Board. - UEC Programme Board / Unscheduled Care Board. - Urgent and Emergency Care Collaborative (including STAMP). - Programme Boards for key service areas including Stroke, Diabetes, Frailty and Orthogeriatric services. - Project Boards including SDEC, UTC, Single Point of Access and FLS. Operational Performance and Capacity Management A range of operational controls support the management of urgent and emergency care pressures, including: - Annual demand and capacity planning.	

- Seasonal and winter resilience planning.
- Escalation and business continuity arrangements.
- Centralised management of capacity across the organisation.
- Clinically led prioritisation processes.
- Service recovery planning following periods of operational pressure.
- Interventions Not Normally Undertaken (INNU) arrangements where required.

Regional Working and System Collaboration

The Health Board works with regional partners to support patient flow, discharge and integrated care arrangements, including:

- Partnership Leadership Team arrangements with Local Authority and NHS partners.
- Regional commissioning arrangements.
- Regional programmes supporting patient flow and discharge pathways.
- Development of alternatives to admission and Discharge to Recover then Assess (D2RA) pathways.
- Collaborative work to address delays for patients medically fit for discharge.

Service Improvement and Transformation

A programme of service transformation is in place to improve urgent and emergency care pathways across the Health Board, including:

- Strategic Transformation of Acute Medicine Programme (STAMP).
- Stroke Improvement Programme
- Reduce waiting times for patients in Emergency Departments
- Single Point of Access developments.
- Same Day Emergency Care (SDEC) developments
- Optimise and Frailty programmes.
- Orthogeriatric improvement initiatives.
- Specialty-specific improvement trajectories.

Sources of Assurance (Internal and External)

Assurance is derived from a combination of routine performance monitoring, governance oversight, improvement programme reporting, targeted intervention arrangements and external review. Information is considered through established governance and performance structures, with escalation through executive and committee reporting arrangements where performance, delivery or emerging risks require additional oversight. At the time of reporting, assurance is focused on monitoring the effectiveness of improvement actions and delivery of sustainable improvements in urgent and emergency care performance, patient flow and service resilience.

Internal Assurances

The Board receives assurance through a range of internal performance, governance and improvement reporting arrangements, including:

- Executive Integrated Performance Meetings.
- Directorate Integrated Performance Meetings.
- Integrated Performance Reports.
- Assessment Dashboards and performance monitoring information.
- Planning, Performance and Finance monthly reporting.
- Performance trajectories, including Referral to Treatment (RTT) and Cancer performance.
- Follow-up reporting relating to outpatients not booked.
- Service-specific improvement and performance reports for areas subject to operational pressure, including Neurology and Stroke services.
- UEC Programme Board reporting.
- Same Day Emergency Care (SDEC) Programme reporting.
- Optimise Programme reporting.
- Ambulance Handover and Emergency Department Improvement Plan monitoring.
- Escalation processes, including reporting to the Chief Operating Officer and Quality, Safety and Experience Committee.
- Care Group performance review meetings.
- Organisational Risk Register and Care Group Risk Registers.
- Targeted Intervention (TI) meetings and associated improvement monitoring.

External Assurances

The Board also receives independent assurance through external scrutiny and oversight arrangements, including:

- Audit Wales Urgent and Emergency Care Audit.
- National performance monitoring and trajectory review arrangements.
- Regional oversight through the South-Central Stroke Operational Delivery Group.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
1. Urgent and emergency care improvement actions are not yet fully embedded or delivering sustained improvements in performance	Completed actions / controls in place • Urgent Emergency Care Action Plan developed using recommendations from national reviews and guidance. • Unscheduled Care Transformation Programme established, supported by governance through the Single Point of Access Board and wider health board oversight arrangements. • ED Flow Action Cards introduced, including monitoring of patient handovers, triage times, first assessment and reducing 12-hour waits. • Ambulance escalation arrangements implemented and ED 12-hour Action Plan completed. • Urgent Care Summit and whole-system improvement work undertaken to agree priorities for patient flow, discharge and admission avoidance. • Service redesign commenced through STAMP, Same Day Emergency Care development and reconfiguration of emergency care pathways and capacity. Further actions in progress • Review and implement the Safe Transfer of Patients Policy and associated actions. • Complete work to reduce the length of stay for patients in Emergency Departments, specifically patients >12hrs. • Progress implementation of Strategic Clinical Services Plan priorities and Pathway 1 redesign. • Further develop Extended Emergency Medicine Ambulatory Care (EEMAC). • Continue whole system work to improve admission avoidance, discharge processes and patient flow. • Embed improvement actions through the Unscheduled Care Transformation Programme and monitor delivery against performance measures.	• Improved urgent and emergency care performance. • Reduction in 12-hour waits and delayed patient handovers. • Improved patient flow across the whole system. • Reduced length of stay in the Emergency Department. • Reduced risk of harm associated with prolonged waiting times. • Improved patient experience and outcomes. • More sustainable emergency care arrangements and capacity management.	As of September 2026, actions completed to date have strengthened governance, coordination and oversight of urgent and emergency care improvement. Improved performance monitoring arrangements are in place through ED Flow Action Cards and escalation processes, with greater organisational focus on patient flow, admission avoidance, discharge planning and emergency care capacity. Service redesign work has commenced across a number of pathways, providing a foundation for sustainable improvement, although performance remains inconsistent and improvements are not yet fully embedded across the health board.

Linked National Priority Measures

Ministerial Measures:

Access to Timely USC Services

- Zero patients >45 mins ambulance handover by March 2027
- Continuous improvement of patients waiting >12-hours and not exceed 1000 by March 2027

Access to Timely Planned Care Services in USC

As per Planned Care BAF

Current Performance Highlights

Detailed operational performance information is reported separately through the Integrated Performance Report and specialist programme governance arrangements. The Board Assurance Framework focuses on the strategic implications of current performance and the effectiveness of actions being taken to address the risk.

Current Performance Highlights (September 2026)

- Performance against the continuous improvement trajectory for patients waiting over 12 hours remains below the level required to provide full assurance that the risk is effectively controlled. Prolonged waits within emergency care settings continue to present significant operational, quality and strategic challenges.
- The ambulance handover improvement trajectory for patients waiting over 45 minutes was delivered, providing evidence of progress against one of the key national priority measures.
- Improvement trajectories are in place, and some indicators demonstrate positive progress; however, variation remains across sites and further work is required to fully embed changes and deliver consistent improvement.
- Delivery of urgent and emergency care improvement programmes continues to be monitored through established governance, performance and escalation arrangements.
- Whilst progress has been made in a number of areas, sustained improvement in patient flow, emergency care performance and whole-system resilience remains necessary before the Health Board can demonstrate sufficient assurance that the risk is reducing towards the desired level.

Were there any significant incidents affecting this strategic Risk this period:

September 2026: The intent of the Stroke Service temporary arrangement is to support service resilience, enable more effective use of the available specialist workforce, and maintain access to stroke assessment, treatment and inpatient care while workforce recovery actions continue. Although recruitment progress and return from maternity leave have provided some improvement, the consultant workforce remains fragile, with two substantive consultants currently on restricted duties and further maternity leave in place. As a result, the service continues to operate with limited resilience, and this remains a significant risk to sustainable stroke service delivery.

Associated Risks escalated to the Organisational Risk Register

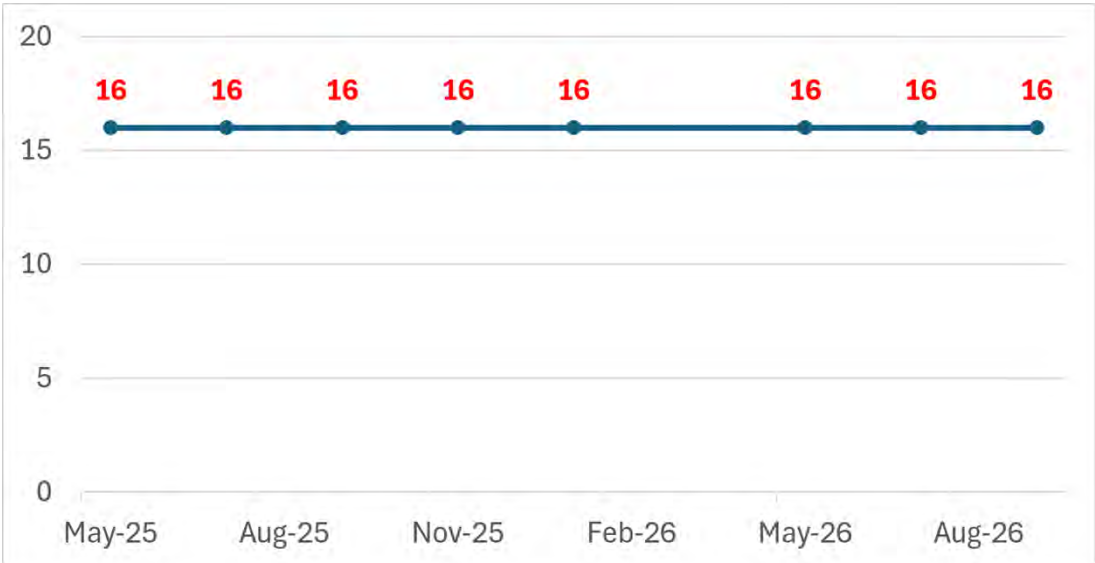
Strategic Gap 1: Urgent and emergency care improvement actions are not yet fully embedded or delivering sustained improvements in performance.

4491	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery. <i>This risk reflects wider system pressures across urgent, emergency, inpatient and community services, including the impact of discharge delays, workforce constraints and whole-system capacity challenges on patient flow and emergency demand.</i>	16
5045	Insufficient neurology capacity impacting timely access to services. <i>This risk reflects the impact of workforce shortages, diagnostic constraints and long waiting times on service capacity and timely access to care, contributing to wider pressures across the patient pathway.</i>	16
4632	Inability to deliver timely, high-quality stroke care across CTM. <i>This risk reflects continuing challenges associated with providing timely access to specialist stroke assessment, treatment and rehabilitation, including workforce, pathway and system capacity constraints</i>	16
3826	Emergency Department overcrowding impacting patient safety and quality of care. <i>This risk reflects the ongoing impact of patient flow, capacity and discharge pressures on Emergency Department performance, patient experience and delivery of national performance standards.</i>	15

Strategic Goal(s):			Risk score 16
 Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care	 Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future.		

Strategic Risk: Ability to deliver improvements which transform care and enhance outcomes (Risk No.2)		
If the Health Board fails to achieve fundamental quality standards or implement improvements in practice and innovations	Then we may not be able to deliver safe, timely, compassionate and effective care in accordance with the Duty of Quality	Resulting in avoidable harm to patients, poor patient experience, diminished staff morale, potential for greater regulatory intervention and loss of trust and confidence

Risk Leads	- Executive Nurse Director - Executive Medical Director	Assurance committee	- Quality, Safety & Experience Committee - Operational Delivery Committee
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	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk scores this period. Risk Score Trajectory 
Initial	4	5	20	
Current	4	4	16	
Target	4	3	12	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			

Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>	The risk score remains unchanged at 16. A wide range of quality improvement, patient safety, governance, learning and innovation arrangements remain in place and continue to provide assurance. However, the organisation recognises that further work is required to strengthen the framework, improve outcome-focused measures and ensure that assurance can be demonstrated consistently across all elements of this risk. The current score therefore remains appropriate while this work progresses.
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	Work has taken place this cycle to strengthen the articulation of this risk to provide clearer lines of accountability, more meaningful controls and measurable indicators of improvement against the Duty of Quality. This review includes rationalisation of controls and assurances, clearer identification of gaps, and a stronger focus on evidencing how improvement activity contributes to safer, more timely, effective and compassionate care. The Executive Director of Nursing, Midwifery and Patient Care, will be leading a strategic reconfiguration of the Board Assurance Framework for this section to enable more meaningful and measurable objectives that directly influence our ability to reduce the current Duty of Quality risk score to an organisationally tolerated level. This work is essential to ensure that our approach to quality is not only compliant but impactful supporting the delivery of safe, timely, compassionate and effective care. Without this shift, we risk avoidable harm to patients, poor experience, diminished staff morale, increased regulatory scrutiny and erosion of public trust. The revised framework will provide a clearer pathway to improvement, accountability and assurance. Work on the revised framework is ongoing, with progress continuing beyond the original March 2026 deadline to ensure a comprehensive and effective outcome. Upon completion, the framework will provide an enhanced structure for improvement, strengthened accountability, and clearer assurance arrangements
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	CTM is actively treating this risk through established quality, safety, improvement, governance and innovation programmes. The current programme of work is focused on strengthening organisational assurance, embedding continuous improvement and ensuring that quality outcomes can be measured more consistently across the organisation. CTM continues to target a risk score of 12, representing a level of risk that is considered organisationally tolerable.

Current Control Measures

- Our current control measures can be grouped into five main themes:
1. Quality Governance and Strategic Frameworks
 - Duty of Quality and Duty of Candour arrangements.
 - Clinical Governance Frameworks, policies and Standard Operating Procedures (SOPs).
 - Infection Prevention and Control Strategy.
 - Safeguarding Strategy.
 - Clinical Effectiveness Committee.
 - Medicines Management governance arrangements.
 2. Quality Assurance and Patient Safety
 - Mortality governance arrangements.
 - Harm Free Care Programme.
 - Ward Assurance Programme.
 - RADAR (Risk Assessment, Delivery and Assurance Review) governance arrangements.
 - Executive Patient Safety Walkabouts.
 3. Learning, Experience and Engagement
 - People's Experience Framework.
 - Listening and Learning Programme.
 - PREMS (Patient Reported Experience Measures) and PROMS (Patient Reported Outcome Measures).
 - Citizen Voice (Llais) engagement arrangements.
 - Staff Ideas Scheme.
 4. Improvement and Innovation
 - Improvement Community of Practice.

- Quality Improvement training programme.
- Leading for Patient Safety Programme.
- iCTM Improvement Programme.
- Service Improvement Groups.

5. Supporting Infrastructure

- Learning Academy.
- Research and Development Strategy.
- Workforce Productivity Programmes.
- EPMA (Electronic Prescribing and Medicines Administration) implementation.
- Legal, safeguarding and specialist quality functions.

Sources of Assurance (Internal and External)

Assurance is derived from a combination of external inspection, independent audit, annual statutory and professional reports, routine quality and performance reporting, and specialist governance oversight arrangements. Reports are reviewed through the relevant governance structures, with escalation by exception to the Quality, Safety & Experience Committee (QSEC) and Board where concerns or significant risks are identified. At the time of reporting, no significant assurance concerns have been identified beyond those already being managed through the Organisational Risk Register, Integrated Performance Report and established improvement programmes.

External assurances

The Board receives routine external assurance from a range of organisations and regulatory bodies, providing independent scrutiny of quality, safety, governance and workforce arrangements. Current sources of external assurance include:

- Health Education and Improvement Wales (HEIW) reviews of medical education and training environments for resident doctors.
- General Medical Council National Training Survey feedback.
- Annual undergraduate training reviews.
- Public Services Ombudsman for Wales Annual Letter and associated thematic learning.
- NHS Wales Performance & Improvement oversight of governance, incident management, and maternity and neonatal serious incident closures.
- Bi-annual Nurse Staffing Levels (Wales) Act compliance and assurance reporting to Board and Welsh Government.
- External thematic audits and benchmarking reviews, including pressure ulcer prevalence reviews undertaken in collaboration with external partners.

Recent significant external assurance findings:

- Healthcare Inspectorate Wales (HIW): Inspection of Ward 21, Ward 22 and the Psychiatric Intensive Care Unit at Royal Glamorgan Hospital in April 2026 identified a number of concerns with the potential to present an immediate risk to patient safety. Immediate and longer-term improvement plans have been developed and progress is being monitored through established governance arrangements
- Internal Audit: Review of People's Experience received a Substantial Assurance opinion.
- Internal Audit: Falls Audit (June 2026) received a Reasonable Assurance opinion.
- Pressure Ulcer Prevalence Review: External audit undertaken in collaboration with Arjo Huntleigh in June 2026, examining prevalence across emergency departments. Findings are due to be reported to Quality, Safety & Experience Committee in November 2026.
- External recognition and feedback from partner organisations, including positive feedback received from Public Health Wales regarding bowel screening services

Internal assurances

Annual Reports

Annual reports are reviewed through the appropriate specialist governance arrangements and reported to QSEC and/or Board as required. These include:

- Duty of Quality
- Duty of Candour
- Safeguarding
- Infection Prevention and Control
- Clinical Audit
- Clinical Education
- Medicines Management
- Organ Donation

- Improvement and Innovation

No significant concerns requiring escalation beyond existing governance arrangements have been identified through these reports during the current reporting period.

Routine governance and performance assurance reports

Quality and safety performance is routinely monitored through:

- Quality Dashboard
- Integrated Performance Dashboard
- Quality Governance and Regulatory Review updates
- Care Group Quality Reports
- Mortality reporting
- IPC reporting
- RADAR reporting
- National Clinical Audit and NCEPOD studies
- Improvement Portfolio reporting

No significant concerns requiring escalation beyond existing governance arrangements have been identified through these reports during the current reporting period.

Other internal assurance

A range of other internal assurance processes is in place:

Governance Oversight

- QSEC oversight.
- Executive Patient Safety Walkabouts.
- HIW tracker and improvement monitoring.
- Medicines safety governance.
- Safeguarding governance.

Accreditation and Compliance

- Ward assurance programme.
- Pathology ISO accreditation.
- Echocardiography accreditation.
- Patient Safety Solutions.

Learning and Improvement

- Learning from Events panels.
- Coroner and legal oversight meetings.
- Listening and Learning arrangements.
- Multi-agency safeguarding learning.

Workforce and Culture

- Staff survey.
- Nursing standards.
- Professional standards processes.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Actions underway / still to take	Intended Impact of Mitigating Actions	Actual impact of actions (once completed)
Gap 1: Quality intelligence and assurance arrangements are not yet fully integrated to provide a comprehensive and timely organisational view of quality, safety and performance.	• Mortality Board established and organisation-wide mortality data collection implemented. • CTMUHB representation established on the NHS Wales National Quality and Safety Framework workstream. • Benchmarking arrangements established through the National Quality and Safety Framework and NHS Wales Beacon Dashboard.	• Standardise mortality reporting across Care Groups. • Continue development and roll-out of clinical quality dashboards. • Further embed the National Quality and Safety Framework within organisational reporting. • Improve integration of quality, safety, performance and improvement intelligence.	• More comprehensive and timely quality assurance. • Improved visibility of quality and safety risks. • Better integration of intelligence from multiple sources. • Improved benchmarking and identification of variation. • Earlier identification and escalation of concerns requiring intervention.	As at September 2026, mortality oversight, national benchmarking and clinical quality dashboard arrangements have strengthened the availability and visibility of quality and safety information. The live dashboard within maternity and neonatal services has improved access to performance information, while participation in national arrangements has increased CTMUHB's ability to compare

	• Live clinical quality dashboard implemented within maternity and neonatal services.			quality measures with other NHS Wales organisations. However, information remains held across several systems and further work is required to achieve a fully integrated and timely organisational view.
Gap 2: Ward assurance, safeguarding and related quality governance arrangements require further development and consistent embedding to provide reliable assurance across all services and settings.	Controls already in place / actions completed • Ward assurance arrangements established, including routine assurance visits, targeted reviews and point prevalence audits. • Ward Accreditation Programme developed and introduced across a number of clinical areas. • Safeguarding Strategy and Framework implemented. • Safeguarding dashboard developed and piloted. • Once for Wales safeguarding module piloted. • Governance and tracking arrangements strengthened for looked-after children's health assessments.	Further actions required • Review ward assurance arrangements and support development of a consistent and sustainable all-Wales approach. • Continue targeted assurance visits while future accreditation arrangements are considered. • Further refine and embed safeguarding dashboard and reporting arrangements. • Continue implementation and oversight of the Safeguarding Strategy workplan.	Intended Impact of Mitigating Actions • More consistent assessment of quality and safety standards across clinical areas. • Improved triangulation of ward-level assurance information. • More comprehensive and accessible safeguarding information. • Earlier identification and escalation of ward and safeguarding concerns. • Stronger assurance to committees and the Board regarding compliance and quality standards.	Actual impact of actions (once completed) As at September 2026, ward assurance activity and targeted visits have improved visibility of standards and areas requiring support. Safeguarding oversight has also strengthened through the strategy, dashboard, tracking systems and revised governance arrangements. These developments provide a stronger foundation for assurance, although further work is required to embed consistent arrangements across all services and settings and to establish the future approach to ward accreditation.
Gap 3: Organisational learning, improvement and feedback arrangements are not yet consistently embedded, and the impact of improvement activity is not always systematically measured or demonstrated.	Controls already in place / actions completed • Staff Ideas Scheme implemented. • Improvement into Practice training programme established and delivered. • Permanent funding secured for PREMs, with implementation under way across the Health Board. • Viva Engage launched to support staff communication and engagement. • Arrangements established for capturing patient, staff and community feedback.	Further actions required • Continue roll-out and embedding of PREMs across services. • Increase awareness and use of staff and patient feedback mechanisms. • Further develop arrangements for integrating staff, patient, community and partner intelligence. • Continue promotion of improvement methodologies and staff engagement initiatives. • Strengthen measurement and reporting of the outcomes achieved through improvement activity.	Intended Impact of Mitigating Actions • Quality improvement increasingly embedded in everyday practice. • Staff have greater skills, confidence and opportunities to identify and implement improvements. • Staff, patient and community feedback is used more systematically to inform service design and improvement. • Better evidence of whether improvement activity is delivering the intended outcomes. • More integrated improvement intelligence to support organisational learning, decision-making and assurance.	Actual impact of actions (once completed) As at September 2026, the Staff Ideas Scheme, improvement training, PREMs and Viva Engage have increased opportunities for staff and patients to contribute ideas and feedback. PREMs information is now routinely reported to Care Groups and QSEC, strengthening oversight of patient experience. These developments represent progress towards a more integrated approach to organisational learning and improvement; however, feedback intelligence remains fragmented and the impact of improvement activity is not yet consistently measured or demonstrated.
Gap 4: Concerns, complaints, redress and legal services arrangements require further strengthening to provide timely resolution, organisational learning and sustainable assurance.	Controls already in place / actions completed: • Listening to People introduced as the national approach to managing concerns, complaints, incidents and redress. • Strengthened weekly oversight arrangements for concerns and complaints, including escalation and executive assurance. • Legal Services Organisational Change Process completed, with revised structures implemented and a recovery plan in place.	Further actions required / in progress: • Embed the revised Legal Services, Redress and Claims structures and operating arrangements. • Strengthen identification, management and oversight of cases that may qualify for redress. • Improve compliance with performance requirements and reporting across concerns, complaints and redress processes. • Strengthen the identification, dissemination and monitoring of learning arising from concerns,	Intended impact: • More timely, consistent and person-centred management of concerns, complaints and redress. • Improved compliance with statutory and organisational requirements. • A more sustainable and resilient Legal Services, Redress and Claims function. • Learning from concerns, complaints, claims, inquests and redress translated more consistently into service	Actual impact of actions (following completion): As at September 2026, Listening to People, the Legal Services Organisational Change Process and strengthened oversight arrangements have improved the organisational framework for managing concerns, complaints, legal activity and potential redress cases. Revised structures, governance arrangements and stakeholder engagement have strengthened oversight and support more consistent escalation and organisational learning.

	Governance arrangements, operating procedures and external stakeholder engagement strengthened to support more consistent management of legal, concerns and redress activity.	complaints, claims, inquests and redress.	improvement and organisational assurance.	However, recruitment to revised structures is not yet complete and the benefits are not yet fully embedded. Further evidence is required to demonstrate sustained improvement in compliance, timeliness and the translation of learning into measurable improvements in care and patient experience.
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Linked National Priority Measures

Delivery of this strategic risk contributes to a range of national quality, safety, experience and improvement priorities. Key areas of alignment include:

Quality, Safety and Improvement

- NHS Wales Quality and Safety Framework.
- Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and requirements relating to public engagement.
- National Value Based Healthcare Strategy.
- National Patient Experience Framework.
- Patient Safety Solutions Programme.
- NHS Wales national work on Learning and Improving.

These programmes support CTMUHB's approach to quality governance, organisational learning, service improvement, patient experience and assurance.

Infection Prevention and Control

- Six Tier One Infection Prevention and Control targets.
- National Infection Prevention and Control Guidance.
- NHS Wales National Infection Prevention and Control Framework.

These provide the national standards, governance arrangements and assurance mechanisms supporting safe care and infection prevention across all settings.

Safeguarding and Vulnerable People

- National Safeguarding Improvement Plan.
- Welsh Government programme to strengthen Mental Capacity Act implementation and Deprivation of Liberty Safeguards arrangements.
- Independent HIW/CIW review of Regional Safeguarding Board child protection arrangements.

These programmes support CTMUHB's safeguarding governance, assurance and continuous improvement arrangements.

Nursing, Workforce and Professional Leadership

- Chief Nursing Officer's Strategic Vision 2025-2030.
- National Nurse Education Standards.
- Dementia Care Standards.
- Chief Medical Officer priorities relating to clinical leadership and implementation of the Ministerial Advisory Group recommendations.

These programmes support workforce capability, professional leadership and the delivery of safe, high-quality care.

Population Health and Prevention

- Care Closer to Home priorities, including diabetes outcome measures.
- Children's Rights Charter.

These priorities support prevention, early intervention, improved outcomes and person-centred care.

Collectively, these national priorities provide the strategic and regulatory framework within which CTMUHB's quality, safety, experience and improvement programmes operate and against which ongoing assurance is measured.

Current Performance Highlights

Performance associated with this risk is monitored through the Integrated Performance Dashboard and associated quality, safety and experience reporting and governance. Key measures include:

Quality and Safety

- Quality Dashboard
- Maternity and Neonatal Dashboard
- Mortality Indicators
- Tier 1 Infection Prevention and Control Indicators
- Harm Free Care Outcome Measures (including falls, pressure ulcers and medication administration)
- Deteriorating Patient Measures (including Sepsis and NEWS scoring)
- Patient Safety Solutions compliance

Patient Access and Outcomes

- Cancer Standards
- Unscheduled Care
- Urgent and Emergency Care Programme
- Waiting List Delays

Mental Health

- Mental Health Measures

Experience, Learning and Concerns

- Listening to People (LTP) compliance measures (which have replaced Putting Things Right compliance reporting from 1 April 2026).

Collectively, these measures provide the principal sources of performance information used to assess delivery of this strategic objective and support triangulation of risk, performance and assurance.

Were there any significant incidents affecting this strategic Risk this period:

Nationally Reportable incidents (NRI) are managed in according with the Incident Management Framework and reported to the Quality, Safety & Experience Committee.
No Never Events since February 2026

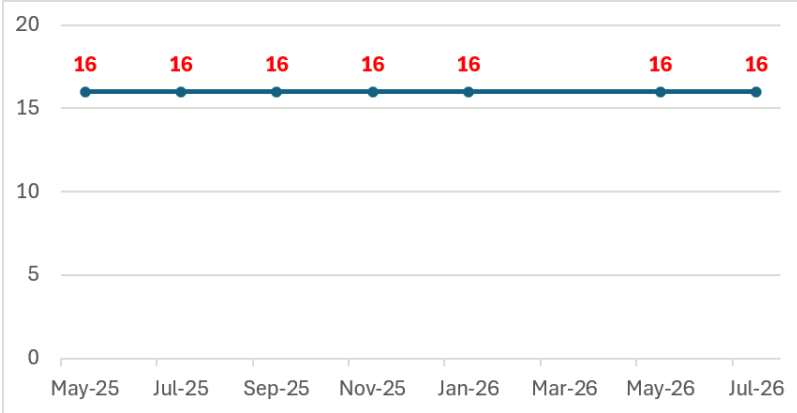
Associated Risks escalated to the Organisational Risk Register

Strategic Gap 1: Quality intelligence and assurance arrangements are not yet fully integrated to provide a comprehensive and timely organisational view of quality, safety and performance		
4672	Inability to achieve timely, accurate clinical coding and structured data standards.	15
Strategic Gap 2: Ward assurance, safeguarding and related quality governance arrangements require further development and consistent embedding to provide reliable assurance across all services and settings		
5554	Inability to meet Containment Level 3 standards, creating risks to patient and staff safety and statutory compliance.	20
6633	Failure to safely implement Blood Transfusion LIMS 2.0, including legacy data migration, testing and system deployment.	TBC
4632	Inability to deliver timely, high-quality stroke care across CTM.	16
6433	Midwifery workforce staffing.	15
4691	Provision of safe and appropriate estate for Mental Health inpatient services.	15
6766	Security incidents and vulnerabilities across Health Board sites.	16
6629	GMC/HEIW conditions on Prince Charles Hospital Emergency Department.	16
Strategic Gap 3: Organisational learning, improvement and feedback arrangements are not yet consistently embedded, and the impact of improvement activity is not always systematically measured or demonstrated		
<i>There are no risks underpinning this gap on the Organisational Risk Register at present</i>		
Strategic Gap 4: Concerns, complaints, redress and legal services arrangements require further strengthening to provide timely resolution, organisational learning and sustainable assurance.		
6231	Failure to effectively manage concerns.	15
6232	Sustainability of the Legal Services function.	15

Strategic Goal(s):			Risk score 16
 Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care	 Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future	 Inspiring People - Visible and inspiring leadership. - Promoting diversity and inclusion. - Embedding our values and behaviours. - Encouraging local employment	
Strategic Risk: Enough workforce to deliver the activity and quality ambitions of the organisation (<i>including culture, values and behaviours</i>) (Risk No. 3)			
<i>If</i> the Health Board fails to identify and plan for its current and future workforce requirements, and to promote CTMUHB as an attractive place to work	<i>Then</i> we may fail to ensure we have the right people with the right skills and experience, in the right place at the right time and cost to meet service demand.	<i>Resulting in</i> increased gaps in our workforce which adversely affect the quality of care, increased burden on other workforce and the employee experience, with a potential increase in variable pay impacting our ability to deliver high quality and affordable services fit for today and tomorrow.	

Risk Lead	Executive Director for People	Assurance committee	- Quality, Safety & Experience Committee - Operational Delivery Committee
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	Consequence	Likelihood	Score	Risk Score Trend this Period:
Initial	4	5	20	

Current	4	4	16	No change to risk scores this period.																		
Target	4	2	8																			
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			Risk Score Trajectory  <table><caption>Risk Score Trajectory Data</caption><thead><tr><th>Month</th><th>Risk Score</th></tr></thead><tbody><tr><td>May-25</td><td>16</td></tr><tr><td>Jul-25</td><td>16</td></tr><tr><td>Sep-25</td><td>16</td></tr><tr><td>Nov-25</td><td>16</td></tr><tr><td>Jan-26</td><td>16</td></tr><tr><td>Mar-26</td><td>16</td></tr><tr><td>May-26</td><td>16</td></tr><tr><td>Jul-26</td><td>16</td></tr></tbody></table>	Month	Risk Score	May-25	16	Jul-25	16	Sep-25	16	Nov-25	16	Jan-26	16	Mar-26	16	May-26	16	Jul-26	16
Month	Risk Score																					
May-25	16																					
Jul-25	16																					
Sep-25	16																					
Nov-25	16																					
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Mar-26	16																					
May-26	16																					
Jul-26	16																					
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				The workforce risk remains significant due to ongoing recruitment challenges, national supply constraints, sickness absence, variable pay reliance and workforce implications linked to service change. While turnover and sickness are showing improvement, gaps remain in hard to fill roles, job planning compliance and sustainable workforce models. The score remains unchanged at 16 because workforce challenges continues to affect service resilience, staff wellbeing, delivery of planned activity and a reliance on temporary staffing. The rolling 12-month sickness rate to June 2026 was 7.58% and is slightly higher than the equivalent rolling 12-month period of the previous year (7.00%). The in-month June 2026 sickness rate is 7.21% which is higher than June 2025 (6.78%). M&D agency spend for M4 2026/7 was £769k with a year to date spend of £2.741m. For Nursing and Midwifery agency spend, including HCSWs, the position for the year to date at M4 was reported as £3.023m. Turnover continues to fall, being 8.16% in July 2026, compared to 9.00% in July 2025. Job Planning compliance as at July 2026 was 47%. There is considerable variation between Care Groups and efforts to increase Job Planning figures continue to be addressed via the Medical Workforce Productivity Programme and new Recruitment Controls linking authorisation of Consultant Recruitment to speciality job planning rates.																		
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>				This risk is being treated through the CTM People Plan, workforce planning, recruitment, retention, and wellbeing, and productivity programmes. A reduction is expected over time but remains constrained by factors noted above including national workforce supply, sickness absence, temporary spend, affordability pressures and the pace of service model change.																		

Current Control Measures
Strategic workforce controls CTM People Plan, Integrated Medium-Term Plan (IMTP), Education & Training Plans (ETPs), national workforce planning frameworks and Welsh Government/NHS P&I drivers (e.g. Enabling Actions) provide the strategic controls for aligning workforce requirements with CTM2030, service change and national workforce priorities.
Recruitment and Resourcing

Job Evaluation, Vacancy Scrutiny Panel, Recruitment delivered via Trac and supported by NWSSP Recruitment Services, Medical Workforce Recruitment Planning, retention programme, lateral moves scheme, flexible working policy, and onboarding/exit insights are used to manage workforce supply, improve fill rates and support retention. Living Wage Employer – ensures fair pay and equity across CTM.

Workforce Productivity and Temporary Staffing

- Nursing & Midwifery Productivity Programme (NMPP) –includes bank and roster optimisation aligned to the Value and Effectiveness Programme.
- Medical Workforce Productivity Programme – includes increased job planning compliance, targeted medical recruitment, bank expansion agency reduction plans.
- HCRG Managed Service Provider for M&D Bank and Agency service (and AHP, PST and HCS agency requirements) - Live from July 2026.
- Rate Cards (Consultant and Non-Consultant) – ensure consistency and cost control.
- Bank KPIs and Agency Spend Tracker – phase 1 has been built and available in the nurse dashboard. Further work to develop the next phase remains under development with a specification to be agreed. This will support targeted improvement and oversight.
- Increased scrutiny and control in relation to both Worked WTE and temporary staffing use, led by the principles of P&I

Culture, Values and Behaviours (CVB)

- Organisational Values
- Leadership Development Programmes
- Staff Engagement and Recognition –and focus groups.
- Equality, Diversity and Inclusion Strategy
- Speaking Up Safely Guardians and anonymous reporting platform Work in Confidence (WiC) – strengthen psychological safety.
- Care Group Culture and Behaviour Plans – local responses to Staff Survey results embedded in delivery plans.

Sources of Assurance (Internal and External)

Workforce Data and Analytics

Internal assurance

- People/Workforce Metrics Report (staff-in-post, turnover, sickness (including RTW compliance), PDR, statutory and mandatory, age, bank and agency spend, WTE worked, gender pay gap and staff engagement index) to Operational Delivery Committee (ODC) and Local Partnership Forum (LPF); included in the Integrated Performance Report (IPR) to Board
- Workforce data included in Values & Effectiveness Board/ Nursing Productivity Programme Board/ Medical Workforce Productivity Programme Board.
- Workforce data included in Care Group Integrated Performance Meeting data packs
- People Dashboard

External assurance

- Quarterly vacancy returns submitted to Welsh Government for NHS vacancy statistics.
- Enabling Actions return

Medical Workforce Productivity Programme Board

Internal Assurance

- Medical Workforce Productivity Programme
- Patchwork/HCRG Dashboards
- Job planning compliance
- Audit Updates
- Medical & Dental Variable Pay Audit and M&D Job Planning Audit- recommendations on Audit Tracker (updated for July 2026)
- Majority of actions are incorporated into the FCP and SOP draft submitted to ARAC in February 2026. These are being updated to reflect HCRG being in post, the M&D bank and agency provider
- Final report of Medical Job planning Re-Audit circulated with outcomes of the audit will be presented at the Audit, Risk and Assurance committee meeting in August 2026
- Medical & Dental Medical Rostering Audit – this process is being revisited in light of the implementation of the new Resident Doctor contract.
- Medical & Dental Sickness Audit –management response July 2026
- M&D Job Planning Re-Audit, final report June 2026 and refreshed action plan
- SAS doctors regrading process in place.
- Resident Doctor contract changes CTM Implementation Group in place, alongside CTM membership at both NWSSP and NHS Employers led All Wales groups.

Nursing and Midwifery Productivity Programme Board

Internal Assurance

- Nurse Productivity Programme Board with associated data set updates, actions and targets.

Workforce Planning

Internal assurance

- Executive Leadership Group (ELG) approval of ETP Commissioning submission (Mar-26) to HEIW and regular updates relating to Student Streamlining (currently recruiting the September 2026 graduates)
- Audit Tracker oversight of actions.
- Strategic Workforce Planning update provided to SDC August 2026

External assurance

- HEIW feedback on Education Training Plan (ETP) submission (on receipt).
- HEIW Workforce Supply Oversight Group (WSOG) from February 2026 focussed currently on nursing/midwifery student streamlining vacancies for CTMs allocated graduating students for September 2026
- LHP Workforce Planning and OD section – LHP FBC currently with Welsh Government for scrutiny
- Welsh Audit Office – CTM Agency Usage and Workforce Planning follow up – self assessment August 2026

Culture, Values and Behaviours

Internal assurance

- NHS Staff Survey results reported to Board and CTM committees, local action plans in Care Groups and progress reported in integrated performance meetings. Staff attending survey briefings agreed (87%) with our corporate priority areas to tackle.
- Partnership forums: LPF and LNC listening and engagement reviews.

External assurance

All-Wales NHS Staff Survey benchmarks: response rate in 2024 was 26.8% (CTM) vs 21.8% (Wales), local target for improvement 40%; Employee Index 70.4% (CTM) vs 72% (Wales). Our focus on the NHS Wales Staff Survey has achieved a sustained improvement in response rates, from 18.1% in 2023, to 26.8% in 2024 to 35.6% in 2025, against a national average of 30%. This represents an additional 1,407 respondents in 2025. Our staff engagement index score increased to 70.5%, up marginally from 70.4%, but note one of only three NHS Wales organisations to improve at all.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Actions still in progress	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
Gap 1: Workforce planning is not yet consistently aligned to future organisational priorities, service transformation programmes and regional workforce requirements, limiting our ability to proactively shape the future workforce.	Actions already completed • Workforce planning has been incorporated into CTM2030, IMTP and Education and Training Plan arrangements. • Workforce requirements have been considered within priority service and transformation programmes, including Regional Orthopaedics and the Llantrisant Health Park Full Business Case. • Workshops have supported workforce planning for priority areas, including Perinatal, Ophthalmology and Theatres. • The Education and Training Plan commissioning submission was approved by the Executive Leadership Group and submitted to HEIW. • Student streamlining arrangements have supported recruitment of the September 2026 nursing and midwifery graduate cohort, with the Health Board meeting the majority of its commitments.	Actions still to do • Complete and embed local workforce plans across Care Groups and corporate directorates. • Strengthen the alignment between workforce, service, transformation and financial planning. • Continue to develop coordinated regional and service-specific workforce plans, building on the work undertaken for priority programmes. • Ensure workforce plans clearly identify future staffing and skills requirements, supply risks, assumptions and affordability implications. • Embed consistent governance and evaluation arrangements for new and extended roles. • Monitor whether workforce plans and new workforce models are delivering the capacity and skills required. Respond to any further findings arising from the Audit Wales follow-up review of agency usage and workforce planning.	Intended impact of mitigating actions • A sustainable, skilled, modernised and affordable workforce capable of delivering CTM2030 and IMTP priorities. • Better alignment between workforce planning, service redesign, regional programmes and financial planning. • Earlier identification and management of future workforce requirements, skills gaps, supply constraints and affordability risks. • Appropriate and effective use of new and extended roles to improve skill mix and workforce resilience.	Actual impact of actions taken to date Workforce planning has become more closely aligned to organisational priorities and major transformation programmes. In particular, the work undertaken for Llantrisant Health Park, Regional Orthopaedics and other priority services has improved the articulation of future workforce requirements, staffing models and associated risks. Governance arrangements for new and extended roles have also been strengthened. However, local and regional workforce planning is not yet consistently developed or embedded across all services. Further work is needed before the Health Board can be assured that future workforce requirements, affordability and delivery risks are being identified and managed consistently across the organisation.

	- A Strategic Workforce Planning update was provided to the Strategic Development Committee in August 2026. - Governance arrangements have been developed for new and extended roles, including Physician Associates, Advanced Clinical Practitioners and Registered Nursing Associates.			
Gap 2: Workforce deployment, productivity, digital systems and workforce intelligence capabilities are not yet sufficiently mature to optimise capacity, quality, efficiency and affordability.	Actions already completed - Medical and Nursing and Midwifery Workforce Productivity Programmes have been established, incorporating job planning, roster and bank optimisation, temporary staffing and agency reduction. - Scrutiny and control of worked whole-time equivalent capacity and temporary staffing use have been strengthened. - The Agency by Exception process has been introduced for nursing agency use. - A new managed service provider for Medical and Dental bank and agency staffing, and specified wider agency requirements, went live in July 2026. - Consultant and non-consultant rate cards have been introduced to support consistency and cost control. - Phase one of the Bank KPI and Agency Spend Tracker is available through the nursing dashboard. - Nursing and Midwifery establishment reports have been developed, and workforce information is increasingly included in Care Group performance arrangements and corporate reporting. - Medical Job Planning and Medical and Dental Sickness audits have been undertaken, with improvement actions identified. - The People Systems Group has been established and implementation of ESR Go has commenced. - The new Resident Doctor contract was implemented on 1 August 2026, with continuing actions incorporated into the Medical Workforce Productivity Programme.	Actions still to do - Continue delivery of the Medical and Nursing and Midwifery Workforce Productivity Programmes and evaluate their impact. - Improve Medical Job Planning compliance and reduce variation between Care Groups. - Complete the next phase of the Bank KPI and Agency Spend Tracker. - Agree and implement a consistent Health Board-wide approach to establishment reporting and control. - Continue to improve workforce data quality, dashboards and analytical capability. - Improve interoperability between workforce systems and reduce reliance on manual processes. - Continue implementation of ESR Go and prepare for the Future Workforce Solution. - Complete outstanding actions arising from workforce audits and implementation of the Resident Doctor contract. - Demonstrate sustainable improvement in workforce utilisation, agency use and expenditure, bank utilisation and affordability	Intended impact of mitigating actions - Improved deployment and utilisation of the substantive workforce. - More effective rostering and increased use of appropriately skilled bank workers. - Reduced reliance on agency staffing and improved control of variable pay. - Improved Medical Job Planning compliance and reduced variation between services. - Consistent establishment control and a clearer understanding of funded, worked and available workforce capacity. - More accurate and timely workforce intelligence to support strategic and operational decision-making. - Better-integrated workforce systems and reduced reliance on manual processes.	Actual impact of actions taken to date Governance, reporting and oversight of workforce utilisation, productivity and temporary staffing have strengthened. The Agency by Exception process has supported early reductions in nursing agency use, and the new Medical and Dental bank and agency provider has been operational since July 2026. Establishment reporting, workforce dashboards and the inclusion of workforce information within Care Group performance arrangements have also improved organisational visibility. The Resident Doctor contract was implemented on 1 August 2026, with continuing actions now monitored through the Medical Workforce Productivity Programme. However, it is too early to assess its full impact or that of the new managed service arrangements. Establishment control, workforce analytics and system interoperability are not yet consistently mature across the organisation. Medical Job Planning compliance remains at 47%, with variation between Care Groups. Further evidence is required to demonstrate that the strengthened arrangements are delivering sustained improvements in workforce capacity, productivity and affordability.

Gap 3: Recruitment, retention and attendance arrangements are not yet consistently delivering a sustainable, resilient and engaged workforce, resulting in workforce supply pressures and variable workforce experience.	Actions already completed - Recruitment and resourcing controls are in place, including vacancy scrutiny, job evaluation, recruitment through Trac and support from NWSSP Recruitment Services. - Recruitment training, guidance and SharePoint resources have been developed, supported by attraction and employer-branding activity. - Flexible working and lateral moves arrangements have been introduced. - The Moving On process was reviewed and relaunched in July 2026. - The Retention Steering Group has been re-established, supported by developing retention dashboards and exit information. - Sickness absence reporting and analysis have been expanded, including reporting to the Executive Management Board. - An organisation-wide approach to sickness absence has been developed, supported by a short-term Enhanced Case Management Support project within acute and community wards. - The Enhanced Case Management Support project has increased the volume of case reviews, with measures established to assess its impact. - The Health Board has maintained Living Wage Employer status.	Actions still to do - Finalise and approve the Recruitment and Retention Plan. - Complete and implement the revised Recruitment and Selection Policy and supporting procedures. - Continue targeted recruitment and attraction activity for hard-to-fill roles, workforce groups and specialties. - Complete the review of consultant job descriptions. - Embed the lateral moves and Moving On processes consistently across services. - Improve the quality and use of exit and retention information to support targeted interventions. - Continue delivery of the organisation-wide sickness absence action plan. - Evaluate the impact of the Enhanced Case Management Support project and use the findings to inform the longer-term approach. - Deliver and evidence progress towards the planned reduction in sickness absence during 2026/27. - Demonstrate sustained improvement in vacancies, recruitment, turnover, attendance and reliance on temporary staffing.	Intended impact of mitigating actions - Improved workforce availability, stability and organisational resilience. - More consistent and timely recruitment processes. - Improved recruitment and retention in hard-to-fill roles and priority services. - Better use of retention and exit intelligence to target interventions. - Reduced voluntary turnover and avoidable loss of experienced staff. - Reduced sickness absence and earlier, more effective support for staff. - Reduced workforce gaps and reliance on temporary staffing.	Actual impact of actions taken to date Recruitment guidance, workforce attraction activity and retention intelligence have been strengthened. The Moving On process has been relaunched and the Retention Steering Group re-established, providing a stronger basis for understanding and responding to retention concerns. Turnover was 8.16% in July 2026, compared with 9.00% in July 2025. This indicates improvement in the reported turnover position, although recruitment challenges remain within a number of hard-to-fill roles and specialties. Sickness absence reporting and case management arrangements have also been strengthened. However, the rolling 12-month sickness rate to June 2026 was 7.58%, compared with 7.00% for the equivalent period in the previous year. The Enhanced Case Management Support project was launched in August 2026 and its impact is still being assessed. Sickness absence therefore continues to affect workforce availability, and it is too early to determine whether the new arrangements will deliver sustained improvement
Gap 4: Organisational values, behaviours and approaches to staff experience are not yet consistently embedded across the Health Board, impacting engagement, wellbeing,	Actions already completed - Organisational values and culture, values and behaviours measures have been incorporated into the CTM People Plan. - Leadership development, staff engagement, recognition and focus-group arrangements are in place. - The Equality, Diversity and Inclusion Strategy supports the wider approach to staff experience. - Speaking Up Safely Guardians and the Work in Confidence anonymous	Actions still to do - Continue to embed local ownership of organisational values and expected behaviours across Care Groups, directorates and services. - Strengthen leadership accountability for delivery and evaluation of local culture and behaviour plans. - Continue leadership development, engagement, recognition and speaking-up activity. - Use Staff Survey and local workforce information to identify variation and target support.	Intended impact of mitigating actions - Greater local ownership of organisational values and expected behaviours. - Improved and more consistent staff experience across the Health Board. - Increased confidence among staff to speak up, raise concerns and contribute ideas. - Stronger local leadership and accountability for organisational culture.	Actual impact of actions taken to date Staff Survey participation increased from 18.1% in 2023 to 26.8% in 2024 and 35.6% in 2025. The staff engagement index also increased slightly from 70.4% to 70.5%. Staff Survey findings are being used to inform corporate priorities and local Care Group action plans, supported by divisional information, Integrated Performance Meetings and established speaking-up arrangements. This provides evidence of increased participation and a stronger organisational

leadership culture and organisational performance	reporting platform have been established. - Care Group culture and behaviour plans have been developed in response to Staff Survey findings. - Staff Survey results are reported to the Board and relevant Committees, with local actions monitored through Care Group delivery and Integrated Performance Meeting arrangements. - Divisional Staff Survey information is shared to support local action and leadership accountability. - Staff Survey briefings have supported development of corporate priorities, with 87% of attendees agreeing with the priority areas identified. - Planning for the 2026 NHS Staff Survey has commenced and the Survey Leads Group has been re-established.	- Deliver the 2026 Staff Survey and use the findings to assess progress and determine further priorities. - Evaluate whether local culture, leadership and engagement activity is improving staff experience and reducing variation. - Strengthen assurance to the Board and Committees concerning the impact of local culture and behaviour plans.	- Improved staff engagement and reduced variation in experience between services. - Clear evidence that culture and behaviour plans are producing sustained change.	focus on culture and staff experience. However, the current evidence does not yet demonstrate that improvements in staff experience, values and behaviours are consistent across all services or that local interventions have delivered sustained organisational impact.
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Linked National Priority Measures

Workforce

- 23. Agency spend as a percentage of the total pay bill
- 27. Percentage sickness rate of staff

Current Performance Highlights

Key Progress Highlights:

- Workforce Planning: LHP Phase 2 workforce section and workforce demand numbers- FBC submitted August 2026
- LHP OBC/FBC is to be finalised in June for sharing with HB Board Meetings in July 2026
- Productivity & Agency Reduction: Launch of new Managed Service provision for M&D bank and M&D/AHP agency staff contract July 2026
- AFC Bank: 800 Bank only workers identified, bank only workers following the Band 2-3 changes to ensure a viable, appropriately skilled and available bank workforce and on track to meet the deadline of July 2026.
- Recruitment: work progressing to update the Recruitment & Selection policy and associated SOPs, Consultant job description review underway. international recruitment for hard-to-fill medical roles 2025/26 with NWSPS progressed, with two specialist grade psychiatrist started. An ITU doctor has been offered via NWSSP's overseas campaign and joined in June 2026.
- Able to meet majority of commitments to Student Streamlining numbers for Summer 2026 recruitment
- Staff survey launch for 2026 agreed (October 6th 2026) survey leads group reestablished for programme development w.c. 30 Aug 2026

Were there any significant incidents affecting this strategic Risk this period:

None identified.

Associated Risks escalated to the Organisational Risk Register

Gap 1: Workforce planning is not yet consistently aligned to future organisational, service transformation and regional workforce requirements

6294	Insufficient consultant workforce in Endoscopy and Gastroenterology.	20
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model.	16

Gap 2: Workforce deployment, productivity, systems and workforce intelligence are not yet sufficiently mature to optimise workforce capacity and affordability

6629	GMC/HEIW Conditions on Prince Charles Hospital Emergency Department. Workforce, medical staffing and training arrangements are a key contributing factor to this risk. New escalation during the period.	16
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Gap 3: Recruitment, retention and attendance arrangements are not yet consistently delivering a sustainable and resilient workforce

6294	Insufficient consultant workforce in Endoscopy and Gastroenterology	20
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5753	Inadequate Special School Nurse Provision. <i>Sept 2026: Risk score reduced to 16. Whilst the risk cannot be fully eliminated, staffing is currently at establishment. Longer-term work is required with Local Authority partners to review the future model of care and determine the Health Board's ongoing management of the residual risk.</i>	20 16
6475	Patient safety and service delivery risks arising from industrial action impacting Health Visiting services	16
6232	Stability of the Legal Services Function.	15
5877*	DEESCALATED: Impact of new GP Out of Hours contract on service capacity and rota fill. <i>Score reduced; will not appear in future ORR reports.</i>	16 9
6397*	DEESCALATED: Shortage of GPs impacting urgent primary care service delivery. <i>Score reduced; will not appear in future ORR reports.</i>	16 12
6318*	DEESCALATED: SHED Team service capacity and resilience. <i>Score reduced; will not appear in future ORR reports.</i>	16 12
Gap 4: Organisational values, behaviours and approaches to staff experience are not yet consistently embedded across the Health Board		
<i>There are no risks currently escalated to the Organisational Risk Register under this strategic gap.</i>		

* For the September 2026 reporting cycle, some operational risks have reduced in score following organisational moderation and triangulation, reflecting a more consistent alignment between current risk scores, available evidence and the Health Board's risk policy and scoring matrix

Quality, Safety & Experience Committee

Organisational Risk Register – September 2026

Eitem yr Agenda / Agenda Item	4.10
Dyddiad y Cyfarfod / Date of Meeting:	Tuesday 22 September 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to: - Review the risks escalated to the Organisational Risk Register at Appendix 1. - Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context:</i> <i>This report aligns to the following Strategic Pillars</i>	Applies across all areas
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Supports delivery in general



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)

This report presents the September 2026 position of the Organisational Risk Register. It reflects the latest available position following review by Care Groups, directorates and Executive leads.

This report contains all ORR risks overseen by QSEC.

The September review has focused on improving the consistency and evidence base of organisational risk assessments. This has included greater challenge of risk scores, clearer articulation of controls and mitigating actions, and increased use of organisational intelligence to inform the assessment of current risk exposure.

The Operational Management Board has continued to develop its collective oversight of the full register. This complements the accountability of individual Executive leads and supports more consistent moderation and triangulation across the organisation.

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 overall organisational risk profile remains broadly stable but challenged. Many risks remain unchanged, including several risks rated at 20, reflecting continuing pressures relating to workforce, service capacity and demand, infrastructure, finance, digital resilience and statutory compliance.

The September register includes three new overarching or cross-cutting risks relating to Hydroxychloroquine retinal screening, security across Health Board sites and data protection compliance. It also includes the escalation of a midwifery workforce risk following an increase in score from 12 to 15.

Three risks have reduced in score but remain on the Organisational Risk Register. A further five risks have reduced below the organisational reporting threshold and have been de-escalated for continued management through local governance arrangements. Two risks have been closed on the Organisational Risk Register, including one whose scope and outstanding actions have transferred into a new overarching organisational risk.

The reductions should not necessarily be interpreted as equivalent improvements in the underlying operating environment. In several cases, they reflect more consistent application of the Health Board's risk methodology following moderation and triangulation,



	informed by the controls in place and available evidence about how risks are materialising.
<i>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)</i> <i>What Next (summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>	This is a standing report – the Organisational Risk Register is refreshed every two months.

<i>Argymhelliad (Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).</i> Recommendation (Linked to the "What Next" section above).	The Committee is asked to: - Review the risks escalated to the Organisational Risk Register at Appendix 1. - Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.
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1. Background / Context

- 1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.
- 1.2 The register includes risks rated 15 and above that require organisational oversight because of their potential impact or cross-organisational significance. It is supported by local risk registers, through which risks below the organisational threshold continue to be managed and monitored.

Review and Moderation

- 1.1. Care Groups and central directorates continue to review and update their assigned risks, including the current scores, controls, gaps, mitigating actions and review dates.
- 1.2. Individual Executive leads remain accountable for approving the content and escalation of risks within their areas of responsibility. Escalation of Care Group risks to the Organisational Risk Register is considered through the Operational Management Board and approved by the Chief Operating Officer.
- 1.3. For the July and September 2026 iterations, the Operational Management Board has strengthened its collective review of the full register. This has

supported greater consistency in the application of the Health Board's risk methodology and increased challenge and triangulation of risk assessments against available organisational intelligence.

- 1.4. The Executive Leadership Group (ELG) provides the final collective executive review before the register is submitted to the relevant Board Committees.

Risk Training

- 1.5. Monthly risk-management training and bespoke team sessions continue to support improved risk identification, articulation, scoring and management across the organisation.
- 1.6. Feedback following the September session was uniformly positive. Participants from the July and September sessions also expressed interest in more advanced risk-management training. This will be considered as part of the future development of the training offer.
- 1.7. Bespoke team sessions on Risk are also available by arrangement.

2. Strategic Insights

- 2.1 The September review indicates that the overall organisational risk profile remains broadly stable but under sustained pressure. A number of the highest-rated risks are long-standing and relate to workforce capacity, service demand, finance, infrastructure, digital resilience, statutory compliance and reliance on services or decisions outside the Health Board's direct control.
- 2.2 Several risks remain dependent on future recruitment, investment, national programmes, external funding or delivery by partner organisations. While local mitigations and strengthened oversight provide some assurance, they do not always address the underlying causes of the risk.
- 2.3 A number of risks have reduced in score. Some of these reductions reflect improved controls or preparedness, while others reflect organisational moderation and triangulation and a more consistent alignment between the evidence available and the score applied.

3. Risks and Opportunities

3 NEW RISKS AND NEW ESCALATIONS

DTPS Care Group

- As new organisational risk has been escalated to reflect the significance of the planned implementation programme and the potential impact of delays, system failure, data migration issues or inadequate testing on pathology service continuity, patient safety and regulatory compliance.
The risk is jointly owned by the Care Group, the Executive Director of Therapy and Health Science (strategic lead); and the Director of Digital.

- Risk ID 6633 - Failure to safely implement Blood Transfusion LIMS 2.0 including legacy data migration, testing, and system deployment.

Cross-Cutting Risks (affecting multiple care groups)

- The following new overarching / cross-cutting risk draws together and provide oversight for multiple risks relating to Hydroxychloroquine retinal screening which have been identified across care groups.
 - Risk ID 6767: Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery
- The following new overarching / cross-cutting risk draws together and provide oversight for multiple risks relating to safety and security which have been identified across care groups. It will incorporate and replace the current ORR 4417 (access control and site security)
 - Risk ID 6766: Security incidents across Health Board sites

3 CHANGES TO RISKS

Risk Score Increased and added to ORR

Children and Families Care Group

- The following risk has increased in score from 12 to 15, and been escalated to the ORR. The articulation of this risk and its mitigations on Datix is currently being reviewed:
 - Risk ID 6433: Insufficient Community Midwifery Staffing Capacity to Sustain Safe Maternity Services

Risk Score Decreased but Remaining on ORR

For the September report, the Care Groups, through the Operational Management Board (OMB), have focused on strengthening the quality and consistency of risk assessment across the organisation. This has included greater challenge of risk scores, improved articulation of controls and mitigating actions, and increased use of organisational intelligence to inform risk assessments.

As a result of this review, a number of risk scores have been reduced. This should not necessarily be interpreted as a reduction in the underlying risk. Rather, it reflects a more evidence-based and consistent application of the Health Board's risk scoring methodology, informed by a clearer understanding of existing controls, mitigations and the extent to which risks are materialising in practice.

Children and Families Care Group

- Risk ID5753 - *Inadequate Special School Nurse Provision*. Risk score reduced from 20 to 16. While the risk cannot be fully eliminated, staffing is currently at establishment. Longer-term work is required with Local Authority partners to review the future model of care and determine the Health Board's ongoing management of the residual risk.

DTPS Care Group

- Risk ID3567 - *Patient safety and service delivery risk due to insufficient Cellular Pathology space.* Work is underway to create additional sample preparation space at RGH as a short-term measure to support the phased disaggregation and repatriation of SBU services from November 2026. This planned approach has improved our preparedness and reduced the level of risk, resulting in the risk score being reduced to 16, albeit it remains on ORR.

Cross-Cutting Risks (affect multiple care groups)

- Risk ID4491 - *Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery.* A range of flow and capacity management measures continue to be progressed across urgent, emergency and planned care, including improvements to SDEC, Acute Medicine, ED flow and discharge arrangements. Enhanced executive oversight and routine performance management are supporting closer monitoring of patient pathway demand and capacity. In light of these controls and ongoing operational oversight, the risk score has been reduced to 16 (4x4), as agreed by the COO, DCOO, Planned Care and Urgent & Scheduled Care teams on 28.08.26.

Risk Score Decreased and deescalated from the ORR

DTPS Care Group

- Risk ID6498 - *Risk to patient safety from insufficient availability of compliant dynamic mattress systems.* Risk score reduced from 16 to 12 by the Care Group, and deescalated from ORR. A phased mattress replacement programme is underway, with patient risk assessments and mitigating actions in place. No Datix incidents or reportable patient safety events have been identified. Target score confirmed as 9.

Mental Health and Learning Disabilities Care Group

- Risk ID 6318 - *Tier 3 SHED (Severe and High-Impact Eating Disorders) Team Service Capacity and Resilience.* Care Group SLT has agreed to reduce the score for this risk. This reflects the appointment of a locum Psychiatrist servicing the SHED ED team. Risk remains open and managed by the care group but current score reduced to 12 and risk deescalated from the ORR

Primary and Community Care Group

- Risk ID5877 - *Impact of new GP Out of Hours (OOH) contract on service capacity and rota fill.* Contract still being negotiated, feedback from national negotiations indicates that there will be a number of options for GPs to take for engagement in OOH - reassessment of risk undertaken. Risk remains open and monitored by care group, but current score reduced to 9.
- Risk ID6397 - *Shortage of GPs impacting urgent primary care (OOH and Navigation Hub) service delivery.* Review of rota performance indicates that GP staffing gaps are primarily associated with bank holiday periods and are not a persistent issue during routine weekday operations. As a result, the risk score

has been reduced to 12. The risk will continue to be monitored through Care Group governance arrangements to ensure this position is maintained.

Facilities Directorate

- Risk ID6052 - Inadequate patient hydration and nutrition due to failure of beverage trolley infrastructure. Risk likelihood and consequence have been reviewed and reduced based on the number and type of incidents in the previous 6 months; the current score is therefore reduced from 20 to 12. Risk remains open and monitored by the care group but will no longer appear on ORR.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Facilities Directorate

- Risk ID 4417 - *Inadequate access control and site security across Health Board premises*. Risk closed on the ORR because its scope has been incorporated into new overarching organisational risk 6766. The underlying issues and outstanding actions will continue to be managed through that risk.

DTPS Care Group

- Risk ID 6429 - *Risk to patient safety from an unfit Physiotherapy MSK self-referral system*.

This risk has been closed following implementation of the new MS Forms self-referral system. No further Datix incidents/clinical risk have been identified since the launch. Staff have reported improved level of information to inform clinical triage. Time to Triage has improved. The Quality Improvement (QI) work will be written up and learning shared across therapies as other services move to MS forms for self-referral.

Emerging Risks Identified for possible future escalation

The following risks have been identified through recent Care Group and Directorate reviews as requiring further monitoring, development or consideration for future escalation. They are included for awareness but are not currently escalated to the Organisational Risk Register.

DTPS Care Group

- *Positive Patient Identification*. An increase in incidents relating to patient mis-identification has been noted during the last 12 months. Further work is underway to understand underlying causes, assess the extent of the risk and determine whether organisational escalation is required.
- *Point of Care Testing (POCT)*. An increase in incidents relating to patient identification and result attribution within POCT devices has been identified. The Care Group is reviewing controls, incident themes and mitigation arrangements.

Cross-cutting risks

- *Boarding Patients.* A number of operational risks have been noted in relation to the practice of boarding patients, i.e. where someone is cared for in an area not recognised as a single room or hospital bay. Work is underway to consolidate these into a single overarching risk for the ORR.

Primary and Community Care Group

- Risk ID6743: Community Lymphoedema Service Capacity and Demand. The Care Group has identified an emerging risk relating to sustained capacity and demand pressures within the Community Lymphoedema Service. Further work is underway to review the articulation of the risk, controls and mitigating actions.

People Directorate

- *Shift Pattern Alignment and Potential Industrial Action.* An emerging workforce risk has been identified relating to proposed shift pattern changes affecting nursing, midwifery and healthcare support workers. The position remains under active review by the Executive Director for People and Executive Nurse Director.

4. Compliance and Governance

- 4.1 The Organisational Risk Register remains a key component of the Health Board's assurance framework.
- 4.2 It supports the identification, oversight and mitigation of significant organisational risks; strengthens executive accountability and committee assurance arrangements; and promotes transparency through structured reporting and publication where appropriate.

5. Benchmarks

- 5.1 Whilst there is no formal benchmarking mechanism for the Organisational Risk Register, the Health Board's approach is informed by internal and external audit recommendations, together with learning and good practice shared through NHS Wales governance and risk management networks. This provides an element of continuous comparative review and supports ongoing development of the organisation's risk management arrangements.

6. Conclusion

- 6.1 The September 2026 ORR reflects the outcomes of a comprehensive review of all risks with risk handlers and owners.
- 6.2 Feedback on this report is invited, to support its ongoing improvement.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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)	All BAF risks are supported by related ORR risks, and these links are made explicit in the BAF report.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales The Organisational Risk Register supports long-term organisational resilience by identifying risks which may impact the sustainability of services, workforce, infrastructure and system working, and by supporting mitigation and continuous improvement.
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research The ORR strengthens organisational learning and continuous improvement by: • identifying areas of risk and vulnerability • supporting structured action planning • enabling oversight of risk management arrangements across the organisation
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	The ORR itself has no direct environmental impact. However, it includes risks related to environmental sustainability (e.g. estates, infrastructure and wider environmental responsibilities), supporting organisational oversight and mitigation of environmental risks.
Asesiad Effaith Impact Assessment	
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg (<i>Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhwch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.</i>)	Outcome for Equality: NEUTRAL The ORR is a governance and oversight document and does not directly impact on individuals or groups. Individual risks within the ORR may have equality implications, which are considered separately where relevant.
Equality & Welsh Language Impact Assessment Outcome	Outcome for Welsh Language: NEUTRAL The ORR itself does not directly impact Welsh language provision. Any impacts relating to



<i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	specific services or risks are considered within the relevant service or policy context.
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i> Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>	Quality Impact Assessment Outcome not required for the ORR as a whole. The ORR does not introduce service change but provides oversight of risks which may affect quality. Individual risks may be subject to Quality Impact Assessment where relevant.
Cyfreithiol / Legal	Yes (Include further detail below) Legal implications are inherent within a number of risks included in the ORR (e.g. statutory compliance, regulatory requirements and duty of care). These are captured and managed at individual risk level.
Enw da / Reputational	Yes (include further detail below) Failure to manage identified risks may result in: • adverse patient outcomes • regulatory or audit findings • loss of stakeholder confidence The ORR supports mitigation of reputational risk through structured identification, monitoring and escalation of organisational risks.
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (include further detail below) The risks within the ORR reflect pressures and dependencies relating to: • workforce capacity and capability • financial sustainability • infrastructure and service delivery resources The ORR supports visibility and management of these resource impacts at organisational level.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Comprehensive review of risks at care group and directorate team meetings	August and September 2026	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Executive Leadership Group
(ELG)

14 September 2026

Review and
moderation and
management sign-off

Acronyms / Glossary of Terms

Appendix: Organisational Risk Register (ORR) – Summary Version – September 2026

This summary shows the ORR divided into two broad categories of risk:

1. **Care Group-led risks**, where the primary accountability for management and mitigation sits within a Care Group, with executive oversight; and
2. **Directorate-led risks**, where the risk reflects a cross-organisational, enabling or system level issue owned directly by an Executive Director and not linked to a specific care group (for example, digital, workforce, finance, estates or commissioning related risks).

1. CARE GROUP-LED RISKS

Datix ID	Strategic Risk Owner	Risk Title	Rating July 26	Rating Sept 26	Trend
Planned Care Group					
6294	COO	Insufficient consultant workforce in endoscopy and gastroenterology	20	20	↔
6451	COO	Orthoplastics Pathway (<i>Business sensitive risk</i>)	15	15	↔
Unscheduled Care Group					
3826	COO	Emergency Department overcrowding impacting patient safety and quality of care	20	15	↓
5045	COO	Insufficient neurology capacity impacting timely access to services	16	16	↔
4632	ED T&HS	Inability to deliver timely, high-quality stroke care across CTM	16	16	↔
Children and Families Care Group					
5753	END	Inadequate Special School Nurse Provision	20	16	↓
6475	COO and END	Patient safety and service delivery risks arising from industrial action impacting Health Visiting services	16	16	↔
6433	tbc	NEW: Insufficient Community Midwifery Staffing Capacity to Sustain Safe Maternity Services	---	15	---
Diagnostics, Therapies, Pharmacy & Specialties Care Group					
5554	DTPS	Inability to meet containment level 3 (CL3) standards creating risks to patient safety and statutory compliance	20	20	↔
6633	ED H&TS	NEW: Failure to safely implement Blood Transfusion LIMS 2.0 including legacy data migration, testing, and system deployment (<i>Jointly owned risk with Executive Director of Therapy and Health Science; and Director of Digital</i>)	---	20	---
3567	DTPS	Patient safety and service delivery risk due to insufficient Cellular Pathology space	20	16	↓
5579	ED PH	Insufficient provision of children's weight management services	16	16	↔
6429	ED H&TS	CLOSED: Risk to patient safety from an unfit Physiotherapy MSK self-referral system	16	---	---
6498	COO	DE-ESCALATED: Risk to patient safety from insufficient availability of compliant dynamic mattress systems	16	12	↓
Mental Health and Learning Disabilities Care Group					
6318	COO	DE-ESCALATED: Tier 3 SHED (Severe and High-Impact Eating Disorders) Team Service capacity and resilience	16	12	↔
3337	COO & Director of Digital	Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS	15	15	↔
4691	COO	Provision of safe and appropriate estate for Mental Health inpatient services	15	15	↔
4973	COO	Clinical Medical Cover within CTM Adult Mental Health Services.	12	12	↔
Primary and Community Care Group					
No risks currently escalated under this Care Group					

Datix ID	Strategic Risk Owner	Risk Title	Rating July 26	Rating Sept 26	Trend
5877	COO	DE-ESCALATED: Impact of new GP Out of Hours (OOH) contract on service capacity and rota fill	16	9	↓
6397	COO	DE-ESCALATED: Shortage of GPs impacting urgent primary care (OOH and Navigation Hub) service delivery	16	12	↓
Cross-Cutting Risks (affecting multiple care groups)					
4491	COO	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery	20	16	↓
6767	COO	NEW: Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery	---	16	---
tbc	COO	EMERGING RISK: Boarding patients			
Facilities Directorate					
4417	COO	CLOSED: Inadequate access control and site security across Health Board premises	16	---	---
6052	COO	DE-ESCALATED: Inadequate patient hydration and nutrition due to failure of beverage trolley infrastructure	20	12	↓
6181	COO	EMERGING RISK: RGH car parking pressures	12	12	---
6766	See below under Executive Director of People - <i>Security across Acute & Community sites</i>				

2. Summary of Directorate-Led Risks

Datix ID	Risk Title	Rating July 26	Rating May 26	Trend
ED of Strategy & Transformation				
6280	See below under Executive Medical Director - Regional Hepato-Pancreato-Biliary Service (Jointly owned risk)			
5821	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB)	20	20	↔
Executive Director of Finance				
6235	Insufficient funding to address backlog maintenance across the estate.	16	16	↔
Executive Director of Public Health				
6179	High and increasing prevalence of overweight and obesity in children and adults.	20	20	↔
5579	See above under DTPS Care Group - Rising childhood obesity rates			
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding	12	12	↔
Director of Digital				
5276	Delay to LIMS 2.0 implementation impacting pathology service continuity (Jointly owned with Executive Director of Therapies and Health Sciences)	20	20	↔
6633	NEW: See under DTPS Care Group and Director of Digital (jointly owned risk) - Failure to safely implement Blood Transfusion LIMS 2.0 including legacy data migration, testing, and system deployment			
4671	Ageing digital infrastructure impacting service resilience	16	16	↔
4672	Inability to achieve timely, accurate clinical coding and structured data standards	15	15	↔
3337	See above under MH Care Group - Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS			
Executive Nurse Director				
5753	See above under Children & Family Care Group - Inadequate Special School Nurse Provision			
6231	Failure to effectively manage concerns	16	16	↔



Datix ID	Risk Title	Rating July 26	Rating May 26	Trend
6232	Sustainability of the Legal Services Function	15	15	↔
Executive Director of Therapies and Health Sciences.				
4632	See above under <i>Unscheduled Care Group</i> - Inability to deliver timely, high-quality stroke care across CTM			
5276	See above under <i>Director of Digital (jointly owned risk)</i> - Delay to LIMS 2.0 implementation impacting pathology service continuity			
6633	NEW: See above under <i>DTPS Care Group and Director of Digital (jointly owned risk)</i> - Failure to safely implement Blood Transfusion LIMS 2.0 including legacy data migration, testing, and system deployment			
Director of Corporate Governance / Board Secretary				
4885	Failure to deliver and sustain effective Policy Management System and Process	16	16	↔
Executive Medical Director				
5761	Cross Health Board Data Sharing	16	16	↔
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model	16	16	↔
6629	GMC/HEIW Conditions on PCH Emergency Department	16	16	---
Executive Director for People				
6766	NEW: Security incidents and vulnerabilities across Health Board sites	---	16	NEW
NOTE: Please see also Risk ID6475 (above): <i>Industrial action of SCPHN Health Visiting staff members of the UNITE union</i> . The risk to service delivery sits with the Care Groups, but the industrial relations element sits with the People Directorate.				
An emerging risk has been noted around shift pattern alignment, including the potential for industrial action, noting that the proposals impact a large proportion of our nursing/ midwifery and HCSW (over 3,000 staff). This is a shared risk owned by the Executive Director of People and the Executive Nursing Director.				

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL OPEN RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
Planned Care Group						
6294 Risk Owner: COO Risk Handler: Directorate Manager for General Surgery and Gastrointestinal Services Risk Domain: Workforce / Organisational Development / Staffing / Competence	Insufficient consultant workforce in endoscopy and gastroenterology IF the Health Board is unable to recruit and retain sufficient consultant workforce in endoscopy and gastroenterology THEN services may be unable to sustain safe and timely provision RESULTING IN delays in diagnosis and treatment, increased waiting times, service disruption and risks to patient safety	- Consultant recruitment campaign underway, with posts currently out to advert - Interim service continuation plans implemented in development - Ongoing Care Group and executive oversight following escalation Daily review of service provision. Incident and Datix monitoring in place	- Critically low consultant workforce, particularly following departure of locum staff - Limited or no agency interest to provide interim cover Service provision was fragile, particularly at Princess of Wales Hospital - Mitigations are limited and largely dependent on successful recruitment No sustainable short-term solution in place to stabilise the service	- Progress recruitment to substantive consultant posts Develop and implement plans to sustain service provision during recruitment period Continue to review and strengthen mitigations as requested by COG - Continue escalation and oversight through governance structures	September 2026: Risk reviewed by care group and continues to reflect position, with continued oversight and monitoring in place by care group. Further review in one month	20 ↔ C4 X L5 Target Score: 9 Opened: 07/08/2025 Last Updated: 01/09/2026
6451 Risk Owner: COO	Orthopaedic pathway BUSINESS SENSITIVE RISK	Due to business sensitivities the details of this risk will be covered in the closed session.				15 ↔
Unscheduled Care Group						
3826 Risk Owner: COO Risk Handler: Deputy Clinical Service Group Manager - Acute Medicine and ED Risk Domain: Safety & Well-being - Patients / Staff / Public	Emergency Department overcrowding impacting patient safety and quality of care IF the Health Board is unable to maintain patient flow across urgent, emergency, inpatient and community services THEN Emergency Departments will remain overcrowded RESULTING IN delays in treatment, increased risk of harm, poor patient experience and failure to meet national performance standards	- Urgent and Emergency Care improvement plans in place, aligned to national guidance (e.g. GIRFT, MAG, ED quality standards) - ED flow and performance action plans in place (including 12-hour wait reduction and ambulance handover improvements) - Urgent and Emergency Care Programme (UEC) / TRUE / UNITE programmes driving system-wide flow and demand management - Acute medicine transformation in place (e.g. AMU/SDEC models, early senior review, 72-hour model) - Discharge and flow improvements in place (including increased discharge rates and admission avoidance) - Workforce investment and recruitment underway to strengthen acute medical cover - Single Point of Access (SPOA) and integrated working with community services - Routine monitoring through dashboards, escalation processes and operational meetings Review of Emergency Department footprint and capacity requirements underway across all three hospital sites.	- Sustained system pressure continues to drive ED overcrowding - Flow remains constrained by inpatient capacity and discharge delays - Performance deterioration in 12-hour waits despite improvement actions - Whole-system dependency limits pace of improvement (e.g. community and partner capacity) - Improvements are not yet delivering consistent reduction in overcrowding - Workforce and demand pressures continue to challenge sustainability	- Progress ED 12-hour improvement plan and Safe Transfer of Patient policy - Deliver Urgent and Emergency Care action plan aligned to national recommendations - Continue development of long-wait reduction plans and ED performance improvement actions - Further embed acute medicine transformation and SDEC models - Continue recruitment to strengthen 7/7 acute medical workforce - Maintain system-wide focus on patient flow, discharge and admission avoidance - Engage with national UEC programmes and improvement forums	September 2026: In July 2026 a review was undertaken using 'The Community Emergency Department Overcrowding Scale (CEDOCS)' and the risk score was reduced to 15. This risk currently remains at 15 but is dynamic and linked to Risk ID4491. ("Failure to meet demand across the patient pathways...").	15 ↔ C3 X L5 Target Score: 12 Opened: 24/09/2019 Last Updated: 01/09/2026
4632 Risk Owner: ED Therapies and Health Sciences Risk Handler: Senior Nurse - Merthyr & Cynon ILG - Quality & Patient Safety Senior Quality & Safety Manager - Unscheduled Care Risk Domain: Safety & Well-being - Patients / Staff / Public	Inability to deliver timely, high-quality stroke care across CTM IF stroke prevention, urgent assessment, acute treatment and rehabilitation pathways are not consistently delivered across CTM THEN patients may experience delays in access to specialist assessment, treatment and rehabilitation RESULTING IN poorer outcomes, increased disability, longer lengths of stay, poorer patient/carer experience and failure to meet stroke quality standards	- Executive-led stroke governance and oversight arrangements in place Designated senior operational lead for stroke performance and improvement. Routine reporting to Board, Quality and Safety Committee and Performance, Planning and Finance Committee. - Temporary stroke service model at RGH agreed to continue to 31 March 2027 - Stroke improvement programme in place, with focus on key quality measures and targeted improvement actions. - Daily multidisciplinary huddles reviewing stroke presentations, breaches and actions - SOPs, escalation arrangements and medical clerking pathways in place - CNS presence in ED and routine daily/weekly performance reporting - Regional and national stroke programme engagement continuing, including preparations for revised thrombectomy arrangements and updated clinical guidance. - PDN now in post and supporting stroke specific competencies Fixed term post in place to cover maternity leave	- Stroke performance has declined and key quality measures are not consistently met - Temporary service model remains in place pending development of a sustainable future model - Delays remain in the early pathway, particularly time to CT and access to the Stroke Unit - Workforce fragility remains across aspects of the pathway - Flow, capacity and estate constraints continue to impact timely stroke care - Psychology support and full pathway rehabilitation provision remain areas of concern	- Deliver the launched stroke improvement plan, with immediate focus on the first 30 days - Develop trajectories for all stroke quality improvement measures, prioritising the first four hours of the pathway - Progress 3-month pilot for 7-day stroke service delivery from July 2026 - Use multidisciplinary stroke teams to support development of the future service model - Continue recruitment and workforce actions to support improvement work - Roll out improvement approach across PCH and POWH, informed by baseline data Stroke Service Redesign review in place with all key stakeholders: Task is to develop and implement targeted task-and-finish arrangements through the Stroke Strategy Group to address key pathway performance issues.	September 2026: Risk reviewed and controls updated to reflect improvement plan now in place, and Executive Team acknowledgement of improvements made. No changes to scoring at this stage but will keep under review.	16 ↔ C4 X L4 Target Score: 12 Opened: 11/05/21 Last Updated: 01/09/2026

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL OPEN RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
5045 Risk Owner: COO Risk Handler: Directorate Manager Speciality Unscheduled Care Risk Domain: Safety & Well-being - Patients / Staff / Public	Insufficient neurology capacity impacting timely access to services IF the Health Board does not have sufficient neurology workforce and diagnostic capacity THEN patients may experience delays in access to neurology assessment and treatment RESULTING IN delays in diagnosis and care, deterioration in patient condition, longer waiting times and increased risk of harm	- Recruitment to Consultant Neurologist posts underway, with one substantive appointment confirmed (May 2026 start) - Locum consultant in place supporting inpatient care and outpatient clinics - Plans in place to establish a neurology liaison model within CTM - Ongoing engagement with Cardiff and Vale regarding commissioned service capacity - Transfer of neurology waiting list reporting for PCH and RGH to CTM completed	- Neurology workforce remains below required establishment, with a second consultant post still vacant - Ongoing reliance on locum provision to maintain service delivery - Significant outpatient backlog and long waits remain - Limited access to neurophysiology diagnostics impacting pathway timeliness - Uncertainty regarding long-term sustainable service model and commissioned capacity - Delivery of a proportion of neurology activity remains dependent on CV UHB meeting its commissioned obligations	- Complete recruitment to remaining Consultant Neurologist post - Continue development and implementation of CTM neurology liaison service - Work with Cardiff and Vale to confirm delivery of commissioned activity - Monitor and reduce outpatient backlog and long waits - Review risk score following full implementation of additional consultant capacity	No changes to controls or scoring. A neurology recovery programme is underway, including waiting list validation, backlog reduction and escalation of commissioning concerns. Opportunities to reduce demand on specialist services have been identified, alongside plans to strengthen local provision.	16 ↔ C4 X L4 Target Score: 8 Opened: 09/03/2022 Last Updated: 01/09/2026
Children and Families Care Group						
5753 Risk Owner: Executive Director of Nursing Risk Handler: Senior Nurse Community Children's Nursing Services Risk Domain: Workforce / Organisational Development / Staffing / Competence	Risk to patient safety and children's access to education due to Inadequate Special School Nurse Provision IF the Health Board is unable to provide sufficient Special School Nursing capacity and a clear service model aligned with Local Authority responsibilities THEN the service will be unable to meet requirements across special schools RESULTING IN inequitable provision, risks to children and young people, and failure to meet national standards and partnership expectations	- All funded Special School Nursing posts are currently filled - Ongoing engagement with Local Authorities and education partners - Executive and Care Group oversight in place with escalation through governance routes - Welsh Government guidance now issued clarifying Health Board and Local Authority responsibilities - Active review of the service model and workforce arrangements underway	- No agreed, sustainable service model across Health Board and Local Authorities - SLA with Local Authorities not yet finalised - Service resilience remains fragile despite posts being filled - Lack of long-term clarity on roles, responsibilities and funding arrangements - Risk of inequitable provision across special schools	- Redraft and agree SLA with Local Authorities - Update service model in line with Welsh Government expectations - Continue engagement with stakeholders to agree responsibilities and funding - Develop updated paper for internal decision-making and next steps - Maintain escalation through governance routes pending resolution	September 2026: Risk score reduced to 16. Whilst the risk cannot be fully eliminated, staffing is currently at establishment. Longer-term work is required with Local Authority partners to review the future model of care and determine the Health Board's ongoing management of the residual risk.	20 16 ↓ C4 X L4 Target Score: 8 Opened: 16/04/2024 Last Updated: 01/09/2026
6475 Risk Owner: COO and Executive Director of Nursing Risk Handler: Head of Nursing CYP Risk Domain: Service / Business Interruption	Patient safety and service delivery risks arising from industrial action impacting Health Visiting services IF industrial action reduces the capacity of Health Visiting services to deliver the full programme of care, THEN the Health Board may be unable to provide the expected level of universal and targeted support to children and families, RESULTING IN reduced contact with vulnerable families, risks to early identification of need and safeguarding, and potential gaps in delivery of statutory and national programme requirements.	- High-risk families are prioritised for service delivery and support. - Daily "strike action cell" in place, led by senior leaders, to review staffing levels and reallocate available capacity. - Additional review meetings (cells) arranged as required to respond to changes in service demand and staffing. - Formal communications issued to Local Authorities and supported through corporate communications arrangements. - Use of FAQs and guidance to support staff understanding of roles and responsibilities during industrial action. - Agreed mitigation plan and ongoing dynamic risk assessment in place through senior oversight.	- Reduced workforce capacity due to ongoing industrial action limits service delivery. - Inability to deliver the full Health Visiting service offer across all families. - Reliance on prioritisation means lower-risk families may not receive routine contacts. - Sustained disruption to preventative and early intervention work. - Continued need for dynamic reallocation of staff to maintain safe service delivery.	- Continue prioritisation of high-risk families to maintain safeguarding and essential service delivery. - Maintain daily operational oversight through "strike action cell" and adjust deployment of staff as required. - Continue engagement and communication with Local Authorities and stakeholders. - Maintain dynamic risk assessment and escalation through governance arrangements. - Keep the risk under review as industrial action continues and service capacity changes.	September 2026: Risk remains unchanged and continues under review. Industrial action continues to impact Health Visiting capacity, with daily operational oversight and prioritisation in place to maintain support for high-risk families.	16 ↔ C4XL4 Target Score: 12 Opened: 21/01/2026 Last Updated: 01/09/2026
6433 NEW ESCALATION Risk Owner: tbc Risk Handler: Directorate Support Manager - Children & Young People Risk Domain: Safety & Well-being - Patients / Staff / Public	Midwifery workforce staffing Current risk description - under review: Birth rate plus workforce review has been completed in November 2025 which has identified a significant midwifery establishment shortfall which the greatest risk in the maternity unit in PoW. Current funded establishment is 57.59 WTE - Birth rate plus 2025 report has identified a deficit of 18.99 WTE midwives = 34.2% WTE deficit in providing clinical care. (required establishment 76.58)	Current Datix entry - under review: Birth-rate acuity app to monitor and support of flow across acute sites Escalation Policy (includes movement of staff to areas of highest risk inc community to acute Senior midwifery manager on call for MatNeo Senior Midwifery manager On call joins SMOG Weekly senior management operational meetings discussing staffing (based on BR+ 2023 recommendations for Mat Neo Electronic IOL diary for overnight weekly MDT meetings for planned surgical lists. Datix reporting for unsafe staffing PoW operational leads attend daily safe to start Non- clinical midwifery staff support clinical activity in periods of escalation In periods of escalation planed work is rescheduled and on occasions home birth service is stepped down when community midwives are unable to support.	Risk entry under review	Risk entry under review	Risk entry under review	12-15 ↑ C3 X L5 Target Score: 6 Opened: 26/11/2025 Last Updated: 01/09/26
Diagnostics, Therapies, Pharmacy & Specialties Care Group						

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL OPEN RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
5554 Risk Owner: Chief Operating Officer Risk Handler: Clinical and Laboratory Haematology Service Manager Risk Domain: Statutory Duty, Regulation, Mandatory Requirements	Inability to meet containment level 3 (CL3) standards creating risks to patient staff safety and meeting statutory compliance IF the CL3 laboratory does not meet required sealability and containment standards, THEN the Health Board may be unable to safely process hazard group 3 or hazard group 4 organisms RESULTING IN risks to patient safety due to delays to critical diagnostic services, and potential regulatory enforcement action.	- Where clinical details indicate potential high risk organisms, specimens are not processed on-site and referred to Public Health Wales laboratories (Singleton Hospital). - Advice sought and aligned with Public Health Wales and HSE-supported approaches. - Escalation through organisational governance, including review at senior leadership level. - Refurbishment programme initiated to address laboratory compliance issues. - Engagement with estates and procurement teams to progress required works. - August 2026: New architects appointed, with site and follow-up planning meetings completed to confirm CL3 requirements and validate the equipment specification. Design work is now in progress.	- CL3 laboratory remains non compliant with sealability requirements. - Fumigation is not currently possible in the existing environment. - Interim mitigations reduce but do not eliminate compliance and safety risks. - Refurbishment project delayed due to procurement issues and need to re tender. - Full compliance with HSE/COSHH standards not yet achieved.	- Progress detailed design, procurement and delivery of the CL3 laboratory refurbishment project. - Continue to implement and monitor interim mitigation measures to support safe operation. - Maintain engagement with HSE/Public Health Wales guidance to ensure mitigations remain appropriate. - Escalate funding and delivery requirements through governance routes to support timely resolution. - Review risk score in light of mitigations and progress, as requested by COO.	September 2026: Risk reviewed and mitigations updated. The score remains at 20 pending confirmation of the refurbishment programme. Context: The Health Board has previously been served with an improvement notice from the HSE for the management of the CL3 (containment level 3) facility. Currently the CL3 laboratory does not meet sealability requirements as advised with relation to COSHH.	20 ↔ C4XL5 Target Score: 4 Opened: 19/09/2023 Last Updated: 01/07/26
6633 Risk Owner: Executive Director of Public Health Risk Handler: Interim Head of Dietetics Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	Failure to safely implement Blood Transfusion LIMS 2.0 including legacy data migration, testing, and system deployment Current Datix entry - under review: RISK DESCRIPTION: Blood Transfusion remains the highest risk area within the LIMS 2.0 Programme due to unresolved legacy data migration issues, delayed testing, and system immaturity, resulting in significant risks to patient safety, regulatory compliance, service continuity, and financial stability. IF: the LIMS 2.0 Programme is unable to deliver a safe and fully functional Blood Transfusion system, including successful migration and validation of legacy patient data from Telepath to TCLE, and completion of User Acceptance Testing (UAT), validation, and regulatory sign-off within required timelines THEN the Health Board will be unable to safely transition Blood Transfusion services to the new LIMS and will be required to continue reliance on the existing Telepath system beyond its contracted and supported lives RESULTING IN: - Risk of serious patient harm due to inaccurate or incomplete transfusion data - Loss of traceability of blood products - Breach of MHRA regulatory requirements with risk to licence to operate - Failure or disruption of Blood Transfusion services impacting urgent and elective care - Continued reliance on an end-of-life system with increasing risk of system failure - Significant financial impact due to contract extensions, dual running, and programme delays		Current Datix entry - under review: CONTROLS IN PLACE: - National LIMS 2.0 Programme governance in place with oversight via Programme Board and executive reporting - Risk escalated to Organisational Risk Register (5276) - Adoption of discipline-based deployment approach to prioritise safe delivery Legacy data controls: - Multiple iterations of data migration, testing, and defect resolution - Side App and Legacy Data Repository (LDR) in place for migration and validation - Nationally coordinated data testing and validation processes Testing controls: - UAT framework in place - National test scripts and peer review approach - Defect logging and change control processes Business continuity controls: - Exploration of Telepath contract extension under negotiation to ensure service continuity - Consideration of Dedalus DLIMS system implementation as a last resort. Governance controls: - Regular reporting to Programme Board, LDP, and Executive teams Formal escalation of BT risks to senior stakeholders			
5579 Risk Owner: Executive Director of Public Health Risk Handler: Interim Head of Dietetics Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	Insufficient provision of children's weight management services IF the Health Board is unable to provide appropriate children's weight management services across all levels of need THEN children and young people will not receive timely access to appropriate support RESULTING IN worsening health outcomes, reduced opportunity for early intervention and increased demand on secondary and specialist services	- Level 1 service (PIPYN) in place in parts of CTM, with Health Board-wide rollout funded and underway - First-line advice and guidance available to referrers, families and carers - Stakeholder engagement in place to develop future service model - Business case under development for phased model across Levels 1–3 - Internal governance oversight and monitoring in place	- No established Level 3 service, with significant unmet need - Limited Level 2 provision and unclear full pathway - Service delivery remains dependent on future investment - True scale of demand and incidents likely under-reported - Current model does not provide a comprehensive, sustainable pathway	- Complete rollout of Level 1 PIPYN service across the Health Board - Develop and progress business case for Level 3 service provision - Map and formalise full pathway from prevention through to specialist services - Continue stakeholder engagement to agree sustainable service model - Identify and secure funding to support phased implementation	Sept 2026: Risk reviewed; score and mitigations remain the same. Currently analysing related incident reports on Datix; deep dive underway to establish impact and learning.	16 ↔ C4 X L4 Target Score: 8 Opened: 13/10/2023 Last Updated: 01/09/2026

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Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
3567 Risk Owner: Chief Operating Officer Risk Handler: Cellular Pathology Operations Manager Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	Patient safety and service delivery risk due to insufficient Cellular Pathology space IF there is insufficient laboratory and office space for Cellular Pathology to safely manage current and increasing workload, including service disaggregation and future Health Board requirements, THEN the service may be unable to operate safely, efficiently and in line with required quality, infection prevention, health and safety, and accreditation standards, RESULTING IN risk of diagnostic delay or error, poorer cancer performance, staff safety and wellbeing concerns, increased outsourcing costs, and inability to support service repatriation, digital pathology and regional service developments.	- SOPs in place to standardise practice and reduce variation caused by environmental constraints. - Local workflows adapted to maximise use of limited space. - Reception and dissection areas managed to reduce use as a thoroughfare, including signage and demarcation. - Block and slide filing removed from laboratory areas where possible. - Checking processes in place within dissection to reduce risk of error. - IPC, health and safety, fire safety and UKAS findings reviewed to inform ongoing mitigation. Office moves have created additional reporting space. Fire build form submitted to scope potential laboratory expansion: - Regional and local estate options being explored, including short-term improvements and medium-term solutions. Work underway to create sample preparation space to enable phased approach of SBU repatriation from November 2026 onwards (This is the short term option)	- Existing laboratory and office space remains insufficient for current and anticipated workload. - Current mitigations do not resolve the underlying estate constraint, but the estates work underway will further mitigate space issues in the short to medium term. Increased workload from service disaggregation and repatriation cannot be safely accommodated within the current footprint. - Limited space restricts ability to increase internal capacity, support additional staffing, introduce equipment, or reduce outsourcing. - Environmental constraints continue to present daily operational, patient safety, staff safety and accreditation risks. - Long-term regional or local estate solution has not yet been agreed or implemented.	- Complete costing of Phase 1 "make safe" arrangements for Statement of Need submission. - Progress scoping of laboratory expansion following submission of the fire build form. - Continue to develop local short-term estate options to improve safety and capacity. - Progress regional estate options through financial assessment. Continue to maintain under review the risk score and escalation following director review, including whether this should remain separate from Risk 5554. - Continue monitoring IPC, health and safety, fire safety, UKAS and operational impacts while estate options are progressed.	Sept 2026: Work is underway to create additional sample preparation space at RGH as a short-term measure to support the phased disaggregation and repatriation of SBU services from November 2026. This planned approach has improved our preparedness and reduced the level of risk, resulting in the risk score being reduced to 16, albeit it remains on ORR.	20 16 ↔ C4 X L4 Target Score: 6 Opened: 28/05/2019 Last Updated: 01/09/2026
Mental Health and Learning Disabilities Care Group						
3337 Risk Owner: COO and Director of Digital Risk Handler: Service Director, Mental Health and Learning Disability Risk Domain: Safety & Well-being - Patients / Staff / Public	Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS IF Mental Health services do not have a single integrated electronic patient record system, THEN clinical staff may not have access to complete and consistent patient information, RESULTING IN risks to patient safety, including potential for clinical decisions to be made on incomplete information and avoidable harm.	- Dedicated programme in place to procure and implement a single electronic patient record system. - Procurement process underway, with supplier engagement and contract negotiation planned/ongoing. - Programme governance arrangements in place, including Programme Board oversight. - Key programme roles (e.g. project and programme management) recruited to support delivery. - Workshops undertaken to review current systems, processes and information requirements. - Interim measures in place to support information sharing across existing systems (e.g. defined access and recording arrangements).	- No single integrated electronic patient record currently in place across Mental Health services. - Dependence on multiple systems and interim arrangements to access patient information. - Programme remains in procurement/delivery phase, with full implementation not yet confirmed. - Continued reliance on manual or workaround processes to access and share information. - Benefits of a fully integrated digital record not yet realised.	- Progress procurement, contract award and mobilisation of the new electronic patient record system. - Undertake detailed implementation planning with the selected supplier. - Continue programme governance and oversight to support delivery to planned milestones. - Maintain and refine interim arrangements to support safe information sharing until implementation. - Keep the risk under review as the programme progresses through procurement and into delivery.	August 2026: Risk reviewed, no changes at present. Project team awaiting commencement of MHSCR Programme Board. Contract negotiations are likely to take the whole of August and so it is hoped that we will achieve contract sign off by the end of August.	15 ↔ C5 X L3 Target Score: 6 Opened: 07/11/2018 Last Updated: 08/2026
4691 Risk Owner: COO Risk Handler: Service Director, Mental Health and Learning Disability Risk Domain: Safety & Well-being - Patients / Staff / Public	Provision of safe and appropriate estate for Mental Health inpatient services IF Mental Health inpatient environments do not meet required design, safety and quality standards, THEN care delivery may be constrained and the ability to provide safe, therapeutic and effective inpatient care may be compromised, RESULTING IN increased risks to patient and staff safety, reduced quality of care, and negative impact on patient experience and clinical outcomes.	- Inpatient Improvement Programme in place, including a workstream focused on safe and therapeutic environments. - Review and remodelling of adult inpatient services underway, with oversight through MHLD governance structures. - Feasibility work progressing to assess Mental Health inpatient estate requirements. - Engagement with Capital Team to support development of estate solutions. - Routine environmental and safety assessments undertaken, including ligature risk identification and mitigation. - Additional staffing measures implemented where environmental risks require enhanced observation or supervision. - Ongoing programme of service and workforce redesign supporting improvements in inpatient care delivery.	- Current inpatient estate does not fully meet required standards across all areas. - Long-term estate solution not yet agreed or implemented. - Reliance on interim mitigation (e.g. staffing adjustments) to manage environmental risks. - Feasibility and capital planning work not yet translated into a deliverable programme of change. - Environmental constraints continue to impact service delivery and patient experience.	- Progress feasibility work and develop options for improving Mental Health inpatient estate. - Work with Capital Team to develop and secure approval for estate solutions. - Continue inpatient service review and remodelling to align with future estate requirements. - Maintain environmental risk assessments and implement interim mitigations where required. Ensure recent incident review is complete and learning is shared operationally to enact improvements or mitigating actions - Keep the risk under review as estate planning and service redesign work progresses. - Progress with action plan following HIW published report following inspection.	September 2026: No change in risk position, with estate limitations continuing to impact inpatient environments while feasibility and capital planning work progresses, however, further actions noted following inspection at RGH and recent incident.	15 ↔ C3 X L5 Target Rating: 6 Opened: 15/06/2021 Last Updated: 01/09/2026
Primary and Community Care Group						
No risks are currently escalated by this Care Group						
Cross-Cutting Risks (affect multiple care groups)						

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Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
4491 Risk Owner: COO Risk Handler: Deputy COO Care Group: Business Manager for Chief Operating Office Domain: Safety & Well-being - Patients / Staff / Public	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery IF the Health Board is unable to meet demand across the full patient pathway (urgent, emergency, inpatient and planned care) THEN timely access to care and patient flow will be compromised RESULTING IN increased risk of harm, delays in treatment, poor patient experience and sustained operational and performance pressures	- Whole-system improvement approach in place across urgent, emergency and planned care Urgent and Emergency Care programme (UEC) and UEC action plans in place (including ED flow and ambulance handover improvements) - Planned Care Recovery and PIT programmes supporting demand and capacity management - Integrated discharge arrangements in place (e.g. D2RA, Hospital at Home, community services) - Admission avoidance and integrated front door models in operation - Targeted pathway interventions in high-pressure areas (e.g. ophthalmology) - Routine performance monitoring and escalation through governance structures	- Capacity constraints remain across the system, particularly impacting flow and emergency demand - Dependency on whole-system delivery (including partners and community capacity) limits pace of improvement - Persistent discharge delays continue to impact bed availability and flow - Workforce and estate constraints continue to limit sustainable capacity - Performance remains fragile in high-pressure areas despite improvement actions - Actions are extensive but not yet delivering consistent system-wide impact	- Continue delivery of urgent and emergency care improvement plans, including ambulance handover and ED flow targets - Progress Six Goals programme actions across admission avoidance, flow and discharge - Further develop integrated discharge models and community alternatives to admission - Continue elective recovery and demand management initiatives across specialties - Target high-pressure pathways (e.g. ophthalmology) for stabilisation and improvement - Maintain enhanced performance oversight and escalation arrangements Review and refine risk through Care Group level review (as requested by COO)	Sept 2026: A range of flow and capacity management measures continue to be progressed across urgent, emergency and planned care, including improvements to SDEC, Acute Medicine, ED flow and discharge arrangements. Enhanced executive oversight and routine performance management are supporting closer monitoring of patient pathway demand and capacity. In light of these controls and ongoing operational oversight, the risk score has been reduced to 16 (4x4), as agreed by the COO, DCOO, Planned Care and Urgent & Scheduled Care teams on 28.08.26.	20 16 ↔ C4 x L4 Target Score: 12 Opened: 11/01/21 Last Reviewed: 01/07/26
6767 NEW RISK Risk Owner: COO Risk Handler: Business Manager - COO Directorate Risk Domain: Safety & Well-being - Patients / Staff / Public	Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery IF the Health Board is unable to provide timely and sustainable retinal screening for patients prescribed Hydroxychloroquine (HCQ), due to insufficient capacity and delays in fully implementing the agreed screening pathway, THEN patients may experience delays in monitoring and the identification of retinal toxicity, RESULTING IN avoidable patient harm, including potential sight loss, increased incidents and complaints, and reduced assurance regarding the safety and effectiveness of the HCQ screening pathway.	- A pan-CTMUHB HCQ retinal screening pathway has been agreed and is being implemented through a WGOS-aligned community optometry model, with virtual consultant oversight and defined escalation routes to secondary care. - Rollout of OpenEyes, community optometry training and supporting governance arrangements is underway. - A phased approach is being taken to review and manage patients previously held on secondary care waiting lists. - Datix incidents are reviewed, with high-risk patients identified and managed accordingly. - An agreed referral proforma is used for patients prescribed HCQ, enabling Ophthalmology to risk-stratify and prioritise referrals. - Welsh Government support is available through funding and development of the WGOS community-based model. - Patient safety considerations form a key component of pathway planning and implementation.	- Full implementation of the HCQ retinal screening pathway remains dependent on successful embedding of the community optometry model. - Capacity and sustainability of the pathway continue to be monitored as implementation progresses. - Feedback and assurance from the Eye Care Collaborative Group is awaited. - Assurance regarding the effectiveness of the pathway and the clearance of historical backlog arrangements is still developing.	- Continue implementation of the HCQ retinal screening pathway and associated community optometry model. - Monitor delivery, capacity and patient safety outcomes through operational governance arrangements, including the Eye Care Collaborative Group and Improving Care Board. - Continue the phased review and management of patients affected by historical delays in screening. - Escalate any barriers to implementation through the appropriate governance and operational forums. - Seek and respond to feedback from the Eye Care Collaborative Group to inform further pathway development and assurance.	September 2026: New risk opened to reflect multiple risks relating to Hydroxychloroquine retinal screening, which have been identified across care groups, reflecting backlog, capacity constraints and early implementation of a new community-based pathway. A pan CTM approach has been agreed; however, delivery remains at an early stage.	16 ↔ C4 X L4 Target Score: 8 Opened: 20/08/2026 Last Updated: 01/09/2026
Facilities Directorate Risks						
Please see below under Executive Director of People: Risk ID6766: Security incidents and vulnerabilities across Health Board sites. (Jointly owned risk)						
ED of Strategy & Transformation						
5821 Risk Handler: Assistant Director of Transformation Risk Domain: Service / Business Interruption	Lack of sustainable commissioned provision for secondary care immunology services IF a sustainable commissioning solution for secondary care immunology services is not secured, THEN CTM residents may lack timely access to appropriate specialist assessment and treatment, RESULTING IN delays in diagnosis and management, increased clinical risk, and poor patient experience.	- Organisational working group in place and meeting regularly to oversee the risk and identify solutions Allergy Working Group refreshed, with updated Terms of Reference and chaired by the Assistant Medical Director for Quality and Governance - Review underway of Welsh Government immunology recommendations (2025) to inform future service model - Ongoing engagement with Welsh Government and regional partners on longer-term options - Referral management arrangements in place, including oversight of patients requiring onward management (where possible)	- No confirmed, sustainable commissioned provision for secondary care immunology services - Limited capacity from external providers, with previous arrangements not currently deliverable - Lack of consistent pathway for both urgent and routine referrals - Ongoing uncertainty pending outcome of national (Welsh Government) service model decisions	- Continue discussions with North Bristol Trust regarding potential commissioning of adult secondary care immunology services Executive discussion to confirm preferred commissioning approach and next steps (June 2026) Explore potential commissioning options with North Bristol Trust (scoping meeting July 2026) - Use Welsh Government review findings to inform development of a sustainable service model - Continue regional and national discussions to secure a longer-term solution	September 2026: The Allergy Working Group has been refreshed, with updated Terms of Reference and a new Chair appointed. Discussions continue with North Bristol Trust regarding potential commissioning arrangements, while work progresses to secure a sustainable long-term solution for secondary care immunology services.	20 ↔ C4 X L5 Target Rating: 4 Opened: 11/07/2024 Last Updated: 01/09/2026
Executive Director of Finance						

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL OPEN RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
6235 Risk Handler: Head of Governance Estates Risk Domain: Environmental / Estate / Infrastructure	Insufficient funding to address backlog maintenance across the estate. If the Health Board is unable to secure sufficient funding to address backlog maintenance across the estate, THEN it may be unable to maintain estate infrastructure to a safe and compliant standard, RESULTING IN increased risk of infrastructure failure, inability to replace ageing assets, non-compliance with statutory requirements, deterioration of the care environment, service disruption, and continued growth in backlog maintenance.	• Risk-based prioritisation of estates activity • Planned and reactive maintenance programme managed through the Planet Facilities Management System • Digitisation of estates operations (mobile working) to support real-time management and maintain performance • Applications to Welsh Government funding streams (Targeted Estates Funding (TEF), All Wales Capital Programme) • Use of discretionary capital funding and maximisation of available revenue funding for statutory compliance and high-risk issues • Oversight via Executive Capital Management Group and Capital Scheme Delivery Programme • Routine monitoring and reporting to Estates and Capital Governance Board and Estates Operational Management Team • Annual Estates and Energy Performance Report to Committee • Risk escalation through the Capital and Estates Risk Escalation Group • Internal and external audit programmes • External data submission (EFPMS) and ongoing reporting to Welsh Government • ISO14001 environmental management certification	• Available capital and revenue funding is insufficient to address the scale of backlog maintenance across the estate • Current funding streams (including TEF and discretionary capital) only address a small proportion of high-risk backlog items • Continued reliance on external funding opportunities limits the Health Board's ability to deliver a sustained, planned reduction in backlog • Inability to fully replace ageing infrastructure and equipment at end of life • Even where additional funding is secured, there are inherent delivery constraints (e.g. planning, procurement and physical works) which mean backlog maintenance can only be addressed over an extended timeframe	• Continue to pursue all available Welsh Government funding opportunities, including TEF and capital allocations • Target available funding towards highest-risk backlog maintenance and statutory compliance issues • Progress approved capital schemes (e.g. major refurbishment programmes) to reduce backlog at priority sites • Continue to use maintenance and interim interventions to extend the life of critical assets where replacement is not yet possible	September 2026: Risk reviewed; no change to scoring or controls	16 ↔ C4 X L4 Target Rating: 9 Opened: 04/07/2025 Last Updated: 01/09/2026
Executive Director of Public Health						
6179 Risk Handler: Assistant Director Public Health Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	High prevalence of overweight and obesity leading to increased demand and complexity of care If preventative actions are insufficient to reduce overweight and obesity, THEN prevalence will remain high, RESULTING IN increased demand, complexity and clinical risk, poorer outcomes, and ongoing financial and operational pressures, including challenges in safely managing patients with extreme body mass index (BMI).	• Whole-system healthy weight programme to influence population behaviours and environments • Weight management services in place, including Level 1 services for children supported through confirmed funding (e.g. Pipyn) • Healthy settings work (e.g. schools) to promote healthier environments • National policy framework in place, including Healthy Weight: Healthy Wales and forthcoming regulations	• Significant gap in Level 3 weight management provision, particularly for children and young people • Overall scale of services insufficient to deliver population-level impact • Limited capacity across the full weight management pathway	• Further development of services in line with the All-Wales Weight Management Pathway, including Level 3 provision • Implementation of refreshed national healthy weight action plan • Continued system-wide work to strengthen prevention and delivery at scale	September 2026: This risk has been reviewed by the Public Health Strategic Group in August 2026; the controls and scoring remain unchanged.	20 ↔ C4 X L5 Target Rating: 9 Opened: 06/05/2025 Last Updated: 01/09/2026
5820 Risk Handler: Assistant Director Public Health Risk Domain: Safety & Well-being - Patients / Staff / Public	Insufficient Health Protection resource to deliver vaccination, immunisation and wider health protection priorities If as a result of reduced Welsh government funding, Health Protection resources are insufficient, THEN the Health Board may be unable to deliver vaccination and immunisation programmes and fully respond to infectious disease and environmental hazards, RESULTING IN avoidable harm to patients and the public, health inequalities, and reputational risk.	• Health Protection governance arrangements established, including a Health Protection Board • Workforce structure approved, with recruitment underway to strengthen capacity • Collaborative planning with partners to develop a Health Protection strategy and optimise available resources • Ongoing engagement with Welsh Government regarding funding allocation	• Funding allocation remains insufficient to deliver the Health Protection strategic plan • Resource gap impacting ability to deliver vaccination/immunisation and wider health protection functions • Lack of parity in Health Protection funding across Wales	• Complete recruitment to agreed workforce structure and reassess remaining gaps • Continue work with partners to develop a deliverable Health Protection plan aligned to available resources • Ongoing discussions with Welsh Government to address funding gap and future allocations	September 2026: This risk has been reviewed by the Public Health Strategic Group in August 2026; the controls and scoring remain unchanged. For review in October	12 ↔ C4 X L3 Target Rating: 8 Opened: 10/07/2024 Last Updated: 01/09/2026
Director of Digital						

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL OPEN RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
5276 Joint Risk Owners: Director of Digital AND ED Therapies and Health Science. Risk Handler: Pathology Quality Manager Risk Domain: Service / Business Interruption	Delay to LIMS 2.0 implementation impacting pathology service continuity IF the LIMS 2.0 programme is not delivered within required timescales THEN pathology services may need to rely on unsupported or interim legacy systems RESULTING IN risks to service continuity, patient safety, regulatory compliance, financial sustainability and delivery of Blood Transfusion and laboratory services.	- Programme governance in place through LIMS Programme Board, Chief Executive Group and local Health Board oversight. - Regular executive updates and escalation routes in place for emerging operational, clinical and financial risks. - CTM working with DHCW, supplier and partner organisations on revised deployment sequencing. - Business continuity options being explored, including continued use or extension of legacy systems. - Expert review / stocktake completed and used to inform programme next steps. - Dedicated Pathology IT resource in place, although capacity remains limited. - Linked risks being developed for key themes including Blood Transfusion, staffing, finance and legacy data.	- Low confidence in delivery of the full programme within required timescales. - Revised deployment sequencing may be clinically or operationally difficult to deliver safely. - Blood Transfusion remains a significant concern due to system dependency and regulatory requirements. - Legacy system reliance creates operational, compliance and traceability risks. - Financial exposure remains unresolved, including additional programme delay costs and legacy support costs. - Programme delivery remains dependent on DHCW, supplier performance and all-Wales decisions outside CTM's direct control.	- Continue formal engagement with DHCW and partners to confirm safe and deliverable implementation plans. - Seek formal assurances on revised deployment sequencing, particularly for Blood Transfusion and Blood Sciences. - Complete assessment of the implications of bringing Tranche 4 ahead of Tranche 3. - Maintain executive escalation of clinical, operational and financial risks. - Progress business continuity planning for legacy system support beyond current timelines. - Develop and link supporting Datix risks for staff resource, finance, legacy data / compliance and Blood Transfusion.	September 2026: Microbiology (Tranche 3) went live across Wales on 24 August 2026 following a previously delayed implementation. This represents a significant milestone in the national LIMS 2.0 programme and provides further information to inform planning for subsequent deployment phases. However, the overall programme risk remains unchanged, with concerns continuing regarding delivery timescales, implementation sequencing, legacy system support, financial implications and the successful deployment of the remaining tranches, particularly Blood Sciences.	20 ↔ C5 X L4 Target Rating: 5 Opened: 03/05/2021 Last Updated: 01/09/2026
4671 (Business Sensitive Risk)	Ageing digital infrastructure impacting service resilience IF ageing digital infrastructure is not replaced or	Due to business sensitivities the details of this risk will be covered in the closed session.				16 ↔
4672 Risk Handler: Head of Information Risk Domain: Business objectives or Projects	Inability to achieve timely, accurate clinical coding and structured data standards IF clinical information is not recorded, coded and structured consistently and accurately, THEN the data used to support clinical, operational and strategic decision-making may be incomplete or unreliable, RESULTING IN reduced service effectiveness, poorer decision-making, failure to meet national standards, and delays in delivering digital transformation and organisational objectives	- Coding performance, productivity and backlog are monitored through key performance indicators. - Clinical coding quality is subject to national audit and supported by an ongoing coding improvement programme - Automated coding tools are in place to support coding accuracy and efficiency. - Day-forward scanning is maintained within a 48-hour turnaround target to support timely access to records. - Digital developments are underway to improve structured data capture, including e-forms, integrated care records and digitisation programmes. - Strategic digital and data planning is underway through the Tektology partnership and alignment to IMTP priorities.	- Workforce capacity and specialist skills remain insufficient to fully support coding and data quality requirements. - Data quality, completeness and consistency remain variable across some services. - Reliance on paper records and scanning processes continues in parts of the organisation. - Use of structured and standardised clinical data remains limited in some systems and processes. - Access to and sharing of clinical data across organisational boundaries remains constrained.	- Continue delivery of the clinical coding improvement programme. - Progress digitisation and structured data capture through e-forms, integrated records and future EPR developments. - Develop workforce capacity and capability to support coding quality and data management. - Reduce reliance on paper records through ongoing digitisation and scanning programmes. - Continue improvement of data sharing, interoperability and access to clinical data - Maintain active management of coding performance, backlog and data quality.	September 2026: Risk reviewed; no change to scoring or controls	15 ↔ C3 X L5 Target Rating: 9 Opened: 05/06/2021 Last Updated: 01/09/2026
Executive Nurse Director						
6232 Risk Handler: Deputy Executive Director of Nursing Risk Domain: Safety & Well-being - Patients / Staff / Public	Sustainability of the Legal Services function IF: the Health Board does not sufficiently resource and support the Legal Services function THEN: it may not have the capacity, resilience or capability to meet its statutory and operational responsibilities RESULTING IN: increased staff turnover, reduced wellbeing and morale, and an increased risk of failing to meet legal obligations, with consequent reputational impact.	Revised Legal Services structure implemented following completion of the Organisational Change Process (OCP). - Organisational Change Process (implemented May 2026), including additional approved posts, recruitment currently delayed through recruitment approval process with the aim of achieving full recruitment to the revised establishment by 31 July 2026. - Lead for Legal Services in post, providing operational leadership and oversight of the service. Claims & Redress Manager post recruited to (August 2026) - Temporary workforce and redeployment arrangements utilised where required to support continuity of service delivery.□ - Routine monitoring of workload, demand, inquests, claims, redress cases and statutory response requirements. Established governance, performance and risk reporting arrangements with executive oversight. (new) Development and implementation of standard operating procedures and process documentation across Legal Services functions. (new) Health Board wide Listening to People (LTP) process implemented from April 2026.	- Recruitment to the full approved establishment remains incomplete, resulting in ongoing capacity and resilience pressures within the service. - Benefits arising from the revised structure and recovery programme are not yet fully embedded. - Continued reliance on interim arrangements to support some aspects of service delivery. - Ongoing workforce pressures present a risk to staff wellbeing, retention and long-term service stability. Demand for legal services activity, including claims, redress, inquests and statutory processes, remains variable and may exceed available capacity. □	- Complete recruitment to vacant posts within the approved establishment. - Continue implementation and embedding of OCP and LTP changes. - Continue monitoring demand, activity and performance, aligning workforce capacity where possible. Review and strengthen workforce resilience and succession planning arrangements. Continued review and updating of SOPs, process documentation and governance arrangements across the service.	September 2026: The risk to remain at its current level until above recruitment (RE: OCP) is concluded and the revised staffing arrangements for the Legal Team are fully in place. Progress will continue to be monitored through routine governance and risk reporting. Although progress is being made, additional elements are required to reduce the likelihood. This will be reviewed again in November 2026.	15 ↔ C3 X L5 Target Rating: 6 Risk opened: 03/07/2025 Last updated: 01/09/2026

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL OPEN RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
6231 Risk Handler: Deputy Executive Director of Nursing Risk Domain: Statutory Duty, Regulation, Mandatory Requirements	Failure to effectively manage concerns IF the Health Board does not comply with, or effectively manage, concerns under the former Putting Things Right arrangements and the transition to the new Listening to People framework THEN it may not manage concerns in a timely, consistent and person-centred way RESULTING IN delays in learning and improving patient safety and experience, missed opportunities for early resolution, increased likelihood of cases progressing to litigation with associated costs, and reputational impact, as well as reduced confidence that concerns are handled openly and effectively.	- Putting Things Right (PTR) procedures in place - legal matters still in process and potentially will be for a number of years - Engagement with Legal & Risk Services - Concerns Handlers in post Claims & Redress Manager post recruited to (August 2026) - Legal Services Recovery Plan in place to improve capacity, processes and systems - Organisational Control Process (implemented May 2026), including additional approved posts - recruitment currently delayed through recruitment approval process (recruitment underway) - Health Board wide Listening to People (LTP) process implemented from April 2026 - Head of Concerns, Clinical Audit and Compliance role established - PALS staff (4.0 WTE) have been integrated within the Concerns Team to support early resolution under LTP - Routine performance monitoring of response and acknowledgement standards with executive oversight Ongoing review of demand, caseloads and statutory requirements across complaints, redress, claims and inquests Development and implementation of standard operating procedures and process documentation across Legal Services functions	- Capacity and resilience constraints within the Redress and Claims Team pending completion of recruitment - Improvements arising from Organisational Change Process (OCP) and LTP changes not yet fully embedded Continued reliance on interim arrangements pending full establishment of the approved staffing model	- Continue implementation and embedding of OCP and LTP changes - Strengthen performance against response and acknowledgement standards through ongoing monitoring and oversight Continued review and updating of SOPs, process documentation and governance arrangements across the service	September 2026: The risk to remain at its current level until the recruitment associated with the OCP is concluded and the revised staffing arrangements for the Redress & Claims Team is in place, including full recruitment to the posts. Progress will continue to be monitored through routine governance and risk reporting	15 ↔ C3 X L5 Target Rating: 8 Opened: 03/07/2025 Last Updated: 01/09/2026
Director of Corporate Governance / Board Secretary						
4885 Risk Handler: Head of Quality Assurance and Compliance Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	Failure to implement and sustain an effective policy management system and governance process IF the Health Board is unable to maintain a clear and effective system and governance framework for managing policies (including review cycles, approval routes, version control and accessibility), THEN staff may not have access to current and appropriately approved guidance, RESULTING IN inconsistent practice, unclear accountability risk of non-compliance with legislation and standards, and potential exposure to legal or regulatory challenge.	- Policy on Policies and supporting guidance in place - Centralised SharePoint policy library (non-clinical) with controlled access - Master policy register and supporting archive arrangements maintained - Ongoing Directorate engagement to improve baseline position and compliance - Templates, guidance and governance support available - Oversight via Executive Management Board - Training and user support in place - Initial work underway to develop a clearer policy categorisation and approval framework	- Reliance on manual processes and workarounds - No clearly defined or consistently applied framework for policy approval routes, leading to reliance on judgement and precedent - Ambiguity in delegation between Board, committees and executive groups - Variable user understanding and engagement - Baseline policy position not yet fully confirmed; some policies overdue review - Clinical policies not yet fully aligned within the system - Capacity constraints continue to impact pace and sustainability	- Finalise baseline policy position - Develop and implement a clear policy categorisation and approval framework (via the Scheme of Delegation) - Provide targeted Directorate support to improve policy review compliance from baseline position	September 2026: Risk reviewed - no change to controls or scoring	16 ↔ C4 X L4 Target Rating: 8 Opened: 26/10/2021 01/09/2026
Executive Director for People						
6766 Risk Handler: Assistant Director of Health, Safety & Fire Risk Domain: Safety & Well-being - Patients / Staff / Public NEW RISK	Security incidents across Health Board sites IF there is a lack of robust and consistent security arrangements across Health Board sites, THEN the Health Board may be unable to respond appropriately to security incidents, see an increase in incidents, including violence and aggression, unauthorised access and absconding, RESULTING IN harm to patients, staff and visitors, disruption to services, and regulatory, legal and organisational consequences.	- Security Vulnerability Risk Assessments (SVRAs) undertaken across sites. - Existing security measures, incident reporting and escalation arrangements in place. - Departmental Violence and Aggression Risk Assessments completed and reviewed. - Statutory and mandatory training provided to support staff in managing violence and aggression incidents. - Preparatory work underway to support compliance with Martyn's Law requirements.	- Rising levels of violence and aggression continue to test existing arrangements. - Security provision, escalation processes and staff preparedness are not consistently applied across sites. - Compliance with required security, violence and aggression training is inconsistent. - Accountability for site security, particularly out of hours, requires clarification. - Community and shared-occupancy sites present additional security vulnerabilities. - Current controls do not provide consistent assurance across all Health Board locations - The effectiveness of current controls is limited, with significant reliance on planned future mitigations to address identified risks.	- Review security governance arrangements and accountability, including consideration of a Senior Responsible Officer model. - Strengthen compliance with mandatory security, violence and aggression training requirements. - Develop a consistent Health Board-wide approach to security incident management, escalation and response. - Strengthen security arrangements for community and shared-occupancy sites. - Progress Martyn's Law preparedness and associated compliance requirements. - Monitor incident trends and review the effectiveness of controls through established governance arrangements.	September 2026: New organisational risk established to provide a broader assessment of security risks across Health Board sites, including violence and aggression, site security, emergency response arrangements and compliance requirements. This risk incorporates and supersedes Risk 4417 (Inadequate access control and site security across Health Board premises).	16 ↔ C4 X L4 Target Rating: 12 Opened: 20/08/2026 Last Updated: 01/09/2026
Executive Medical Director						

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Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
5761 Risk Handler: Medical Directorate Manager, YMH Risk Domain: Safety & Well-being - Patients / Staff / Public	Cross Health Board Data Sharing IF digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts THEN clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data RESULTING IN potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	- The Health Board has escalated this as a significant patient safety issue since 2024 and continues to press Digital Health and Care Wales (DHCW) for resolution. - The specific system issues and requirements have been clearly articulated. - The matter is regularly raised through national forums, including the All-Wales Medical Directors' meetings, to maintain visibility and support collective escalation.	- Resolution is dependent on DHCW and wider national agreement on provider status and data sharing arrangements. - The Health Board does not have direct control over system changes or delivery timescales, and no confirmed implementation date has been provided.	Ongoing escalation and monitoring through national forums, with continued engagement with DHCW to seek progress updates, clarity on delivery timelines, and exploration of potential alternative solutions.	September 2026: The risk remains unchanged, with ongoing reliance on national partners (DHCW) to resolve system and data sharing issues, and no confirmed delivery timescales.	16 ↔ C4 X L4
						Target Rating: 8
						Opened: 26/04/2024 Last Updated: 01/09/2026
6280 Risk Handler: Directorate Manager for General Surgery and Gastrointestinal Services Risk Domain: Safety & Well-being - Patients / Staff / Public	Suspension of the Regional Hepato-Pancreato-Biliary service model IF the commissioning of this service is not prioritised as part of the regional commissioning arrangements THEN there will be no Regional service for Severe Acute Pancreatitis RESULTING IN suboptimal care for this group of acutely unwell patients	- The risk has been formally recognised and escalated within the Health Board, with executive ownership assigned to the Executive Director of Strategy, Transformation and Planning and the Executive Medical Director. - Individual patient cases are reviewed on a case-by-case basis with neighbouring Health Boards to enable access to specialist input where possible. - The issue is subject to internal discussion through Planned Care forums and has been identified for escalation through regional commissioning	- There is currently no commissioned regional service model in place for Severe Acute Pancreatitis. - The interim case-by-case arrangements are not a formalised pathway and may introduce delays to time-critical care. - Resolution is dependent on regional commissioning decisions and ongoing funding through the Joint Commissioning Committee, which is outside the direct control of the Health Board.	- Ongoing engagement with regional partners and the Joint Commissioning Committee to seek agreement on a sustainable commissioned service model and associated funding. - Continued internal escalation through Planned Care and executive oversight to support regional resolution.	September 2026: Interim case-by-case arrangements remain in place following suspension of the regional service model, with resolution dependent on regional commissioning decisions and associated funding.	16 ↔ C4 X L4
						Target Rating: 9
						Opened: 06/08/2025 Last Updated: 01/09/2026
6629 Risk Handler: Medical directorate manager, YMH Risk Domain: Safety & Well-being - Patients / Staff / Public	GMC/HEIW Conditions on PCH Emergency Department IF the recommendations from the General Medical Council (GMC) and Health Education and Improvement Wales (HEIW) following the targeted review of Prince Charles Hospital Emergency Department are not implemented, THEN there is a risk that clinical supervision, workforce capacity and training environments will not be sufficiently robust, RESULTING IN potential impacts on the safety, quality and timeliness of care for patients attending the Emergency Department.	- Following the Health Education and Improvement Wales (HEIW) targeted visit to Prince Charles Hospital (PCH) Emergency Department in March 2026, a comprehensive action plan has been developed by the ED Clinical Lead, ED Leadership Team and the Unscheduled Care Group. - This addresses key areas including clinical supervision, training opportunities, rota sustainability, recruitment, leadership engagement and patient flow. - Progress is being monitored through established governance arrangements, with ongoing engagement with HEIW. - Strengthened consultant supervision, rota redesign, protected educational time, weekly teaching provision, and enhanced educational governance arrangements. - Governance and oversight arrangements are now established and enhanced escalation pathways for trainees and educators have been made	- The effectiveness of the action plan is dependent on sustained delivery of improvements across workforce, supervision and patient flow. - Until these improvements are embedded and evidenced, there remains a risk of continued scrutiny from HEIW and the General Medical Council (GMC), and potential impact on trainee experience and retention.	Implementation and ongoing monitoring of the HEIW action plan, with regular review through governance structures and continued engagement with HEIW to demonstrate progress and address any further concerns.	September 2026: Residual risk remains in relation to workforce resilience, completion of outstanding job planning, sustaining protected educational time, and delivery of the planned cultural and behavioural improvement programme. Continued executive oversight is in place to ensure delivery of remaining actions and provide evidence of sustained compliance before GMC conditions can be considered fully addressed.	16 ↔ C4 X L4
						Target Rating: 9
						Opened: 06/08/2025 Last Updated: 01/09/2026

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL DEESCALATED RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
Diagnostics, Therapies, Pharmacy & Specialties Care Group						
6498 RISK DEESCALATED Risk Owner: COO Risk Handler: Care Group Service Director - DTPS & Children and Family Risk Domain: Safety & Well-being - Patients / Staff / Public	Risk to patient safety from insufficient availability of compliant dynamic mattress systems IF there are insufficient compliant dynamic mattress systems available across the Health Board, THEN the delivery of appropriate pressure area care may be compromised, RESULTING IN avoidable patient harm, including increased incidence of pressure damage, extended lengths of stay, and reduced assurance of safe and effective care.	- Phased replacement programme in place to increase availability of dynamic mattress systems. - Ongoing monitoring of incidents and reporting related to pressure care. - Clinical teams alerted to shortages to support enhanced observation and clinical decision-making. - Individual patient risk assessments undertaken to prioritise high-risk patients. - Patient care plans in place to manage pressure care needs. - Contract with current provider under review ahead of expiry. - Escalation and governance processes in place to monitor and manage the risk. - A phased mattress replacement programme is underway	- Current supply of compliant dynamic mattresses remains insufficient to meet demand. - Replacement programme not yet complete and insufficient to fully mitigate the risk. - Continued reliance on prioritisation and workarounds to manage shortages. - Risk of ongoing incidents and harm while full compliance is not achieved, however current Datix incident reporting does not indicate that this risk has materialised. - Contract renewal and long-term supply arrangements not yet secured.	- Continue phased replacement programme to increase the number of compliant mattress systems. - Progress review and renewal of supplier contract to ensure sustainable provision. - Maintain close monitoring of incidents and pressure care outcomes. - Ensure continued prioritisation of high-risk patients through clinical assessment and care planning. - Escalate through governance routes to secure a clear plan and actions to address the risk.	Sept 2026: Risk score reduced from 16 to 12 by the Care Group, and deescalated from ORR. A phased mattress replacement programme is underway, with patient risk assessments and mitigating actions in place. No Datix incidents or reportable patient safety events have been identified. Target score confirmed as 9. Will not appear on future ORR reports.	16 12 ↔ C4 X L4
						Target Score: 9
						Opened: 11/02/2026 Last Reviewed: 01/09/2026
Mental Health and Learning Disabilities Care Group						
6318 RISK DEESCALATED Risk Owner: Chief Operating Officer Risk Handler: Directorate Manager - CAMHS and Specialist Services (Mental Health and Learning Disabilities) Risk Domain: Safety & Well-being - Patients / Staff / Public	Tier 3 SHED (Severe and High Impact Eating Disorders) Team Service Capacity and Resilience IF the Health Board and partner organisations are unable to provide sufficient workforce capacity and sustainable arrangements for the Tier 3 SHED service THEN the service may not be able to deliver safe, effective and consistent care RESULTING IN risks to patient safety and outcomes, reduced service effectiveness and increased operational and organisational pressure	- Regular joint working with Cardiff and Vale UHB, including established monthly oversight meetings - Improved governance, communication and escalation arrangements between organisations - Temporary service mitigations in place (e.g. nurse practitioner support, drop-in clinics, physical health monitoring) - Staff training and service development actions underway - Ongoing monitoring through Care Group and executive governance structures	- Workforce capacity challenges remain unresolved - Service sustainability remains dependent on partner organisation capacity - Temporary mitigations do not provide a long-term solution - Continued pressures on service delivery and effectiveness - Underlying structural issues not yet addressed	- Continue joint working with CAVUHB to develop sustainable service arrangements - Maintain regular oversight and monitoring through established governance routes - Progress workforce and service model improvements - Continue implementation of agreed actions arising from joint reviews and reports	September 2026: Care Group SLT has agreed to reduce the score for this risk. This reflects the appointment of a locum Psychiatrist servicing the SHED ED team. Risk remains open and managed by the care group but current score reduced to 12 and risk deescalated from the ORR	16- 12 ↔ C4 X L4
						Target Score: 6
						Opened: 29/08/2025 Last Updated: 01/09/2026
Primary and Community Care Group						
5877 RISK DEESCALATED Risk Owner: COO Risk Handler: Development Manager - Out of Hours Risk Domain: Service / Business Interruption	Impact of new GP Out of Hours (OOH) contract on service capacity and rota fill IF changes associated with the new GP Out of Hours (OOH) contract and Working Time Regulations reduce GP availability for OOH shifts, THEN rota gaps will increase, particularly for weekday evening cover, RESULTING IN reduced OOH service capacity and potential increased pressure on ambulance services, Emergency Departments, and timely patient access to urgent care.	- Regular oversight of the GP OOH rota. - Liaison with the GP pool to fill additional shifts where possible. - Alternative recruitment routes have been explored, including locum platforms. - Additional GP recruitment remains a key mitigation. - Procurement team engaged to progress local procurement of the Adastra clinical system, following advice that Health Boards should procure locally.	- NHS Employers and BMA negotiations remain unresolved, creating uncertainty about the final contract position and local impact. - Current recruitment routes are not sufficiently agile or flexible for how GPs book OOH shifts, often at short notice. - Additional GP recruitment remains critical to sustaining the service. - Weekday evening cover is expected to be particularly affected where GPs are unable to work late OOH shifts and then work in practice the following morning. - The Adastra contract ends in December 2026, with limited alternative providers available and local procurement still to be completed.	- Continue to monitor the outcome of NHS Employers and BMA negotiations and assess the local implications for GP OOH rota cover. - Maintain regular oversight of the GP rota and continue liaison with the GP pool to fill shifts where possible. - Continue to explore alternative recruitment and engagement routes for GPs. - Progress local procurement for Adastra to support continuity of the GP OOH and Navigation Hub clinical system. - Keep the risk under review as the contract position, rota impact and procurement position become clearer.	Sept 2026: contract still being negotiated, feedback from national negotiations indicates that there will be a number of options for GPs to take for engagement in OOH reassessment of risk undertaken. Risk remains open and monitored by care group, but current score reduced to 9; will not appear on future ORR reports.	16- 9 ↓ C4 X L4
						Target Score: 8
						Opened: 07/08/2024 Last Updated: 01/09/2026
6397 RISK DEESCALATED Risk Owner: COO Risk Handler: Development Manager - Out of Hours Risk Domain: Service / Business Interruption	Shortage of GPs impacting urgent primary care (OOH and Navigation Hub) service delivery IF there is an ongoing shortage of GPs to deliver urgent primary care services, THEN rota gaps will persist, particularly for home visiting and out of hours shifts, RESULTING IN unfilled shifts and increased conveyance of patients (including palliative and end of life) to Emergency Departments.	- All GPs on holding lists have been contacted to maximise available workforce. - Recruitment adverts placed via bank routes to encourage GP applications. - Shift cover maintained through senior GP leadership where required (e.g. over peak periods such as winter). - Risk remains under close monitoring by the care group, with ongoing review of position and mitigation.	- Bank recruitment processes are not aligned to how GPs prefer to work (lack flexibility and do not support short-notice shift fill). - Persistent shortage of GPs available for urgent primary care roles. - Ongoing challenges in filling specific shift types, particularly home visiting. - Reliance on senior clinical staff to cover gaps is not sustainable. - No substantive change in control effectiveness since previous reviews.	- Continue to promote recruitment through existing bank and holding list routes. - Maintain active monitoring of shift fill rates and escalation through care group governance. - Develop revised mitigation proposals for Executive consideration (as identified by the care group review process). - Keep the risk under review and update mitigation as workforce position changes.	September 2026: Review of rota performance indicates that GP staffing gaps are primarily associated with bank holiday periods and are not a persistent issue during routine weekday operations. As a result, the risk score has been reduced to 12. The risk will continue to be monitored through Care Group governance arrangements to ensure this position is maintained.	16- 12 ↔ C4 X L4
						Target Score: 12
						Opened: 31/10/2025 Last Updated: 01/09/2026

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Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
Facilities Directorate Risks						
6052 RISK DEESCALATED Risk Owner: COO Risk Handler: Assistant Director OSS (Facilities) Risk Domain: Statutory Duty, Regulation, Mandatory Requirements	Inadequate patient hydration and nutrition due to failure of beverage trolley infrastructure IF the Health Board is unable to maintain or replace ageing beverage trolleys THEN patient meal and beverage services may be disrupted RESULTING IN risks to patient hydration and nutrition, alongside non-compliance with safety, IPC and quality standards	• Reactive repair arrangements in place to maintain existing trolley fleet • Partial replacement programme underway, with funding secured for a limited number of new trolleys • Procurement of additional trolleys in progress, with delivery expected end June 2026 • Use of decommissioned trolleys for spare parts to extend life of remaining fleet • Investment bid submitted through IMTP to support wider replacement programme • Estates condition assessments commissioned to understand current fleet risks • Operational prioritisation in place where trolley availability is constrained	• Ageing fleet (10+ years) no longer compliant with maintenance contracts • Insufficient funding to replace the fleet at the required scale • Current capacity below service standard (not one trolley per ward) • Ongoing risk to food safety, infection prevention and staff safety due to equipment condition • Interim repair approach is not sustainable and does not address underlying risk • Procurement delays mean benefits of replacement not yet realised	• Complete delivery and deployment of procured trolleys (June 2026) • Progress phased replacement programme through revenue and IMTP funding routes • Develop and implement a sustainable long term replacement plan • Review risk score following operationalisation of newly delivered trolleys • Continue condition assessments to support prioritisation of further replacements • Explore additional funding options to accelerate fleet renewal	September 2026: Risk likelihood and consequence have been reviewed and reduced based on the number and type of incidents in the previous 6 months. Risk remains open and monitored by the care group but will no longer appear on ORR.	20-12 ↔ C4 X L5 Target Rating: 8 Opened: 15/01/2025 Last Updated: 01/09/2026

Organisational Risk Register (Risks Graded 15 and Above) - Review as at September 2026 - ALL CLOSED RISKS

Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	September 2026 Status	Rating (current) and details
Diagnostics, Therapies, Pharmacy & Specialties Care Group						
6429 RISK CLOSED Risk Owner: ED Therapies and Health Sciences. Risk Handler: Physiotherapy Manager for Rehabilitation Risk Domain: Safety & Well-being - Patients / Staff / Public	Risk to patient safety from an unfit Physiotherapy MSK self referral system IF the Physiotherapy MSK self referral system does not safely triage patients or identify those requiring urgent medical assessment, THEN patients may remain within the physiotherapy pathway when they should seek urgent or alternative care, RESULTING IN delays in appropriate clinical intervention and potential patient harm.	- Existing self referral form remains in use to provide access to physiotherapy services. - Attempts made to improve the form, including development of enhanced triage and safety netting functionality. - Engagement with digital colleagues to develop a replacement MS Forms solution with improved functionality. - Approval in principle obtained to proceed with updated digital form. - Welsh language and DPIA requirements being progressed to support implementation. - Ongoing monitoring of incidents related to the self referral process via Datix reporting.	- Current self referral form is not fit for purpose and does not reliably support safe triage. - Increased demand has exceeded triage capacity, leading to delays in assessment. - Patients requiring urgent medical care may not be appropriately identified at point of referral. - Safer digital solution not yet implemented due to system and approval dependencies. - Continued reliance on an unsafe or suboptimal process while alternative solution is in development	- Progress implementation of the revised MS Forms self referral system. - Secure final approvals required for digital solution and publish on Physiotherapy internet page. - Review performance and safety of the new system once live, including impact on incidents and triage timeliness. - Continue monitoring Datix incidents and adjust controls as required. - Keep the risk under review until a safe and sustainable referral system is established.	Sept 2026: No further datix incidents/clinical risk identified since new MS Forms launched. Staff reported improved level of information to inform clinical triage. Time to Triage improved. QI work will be written up and learning shared across therapies as other services move to MS forms for self-referral. Will not appear on future ORR reports.	16 closed ↓ C4 x L4 Target Score: 1 Opened: 24/11/2025 Last Reviewed: 01/09/2026
Cross-Cutting Risks (affect multiple care groups)						
4417 RISK CLOSED Risk Owner: COO Risk Handler: Assistant Director of Operations MH and LD Risk Domain: Safety & Well-being - Patients / Staff / Public	Inadequate access control and site security across Health Board premises IF access control systems and site security arrangements across Health Board premises are not consistently implemented and maintained THEN there is an increased risk of unauthorised access, absconding and inability to safely manage patients and visitors RESULTING IN risks to patient and staff safety, breaches of security protocols and potential harm and reputational impact	- Access control assessments completed across acute sites, with wider programme of work established - Phase 1 security improvement works underway at Princess of Wales Hospital - Capital funding approved for initial works at POW and PCH - Programme of works overseen through Operational Capital Group - Incident monitoring and review in place to inform risk assessment - Standard operating procedures and action plans in place for high-risk areas	- Inconsistent access control systems across sites, with known vulnerabilities (particularly historically at POW) - Programme of works not yet completed across all sites (phase 2 pending) - Reliance on capital funding and prioritisation processes to progress improvements - Ongoing incidents indicating that risks are not fully mitigated - Full impact and effectiveness of improvements not yet evaluated	- Complete Phase 1 works at Princess of Wales Hospital - Scope and deliver Phase 2 programme across remaining sites - Develop further capital bids to support wider rollout - Maintain an analysis of incidents to inform risk scoring and prioritisation - Keep under review and consider alignment with overall Health Board risk relating to security	Sept 2026: Risk closed on the ORR because its scope has been incorporated into new overarching organisational risk 6766. The underlying issues and outstanding actions will continue to be managed through that risk.	16 ↔ C4 X L4 Target Score: 8 Opened: 30/09/2020 Last Updated: 01/07/2026

Quality, Safety & Experience Committee

Avoidable Mortality and Health Inequalities

Eitem yr Agenda / Agenda Item	5.1
Dyddiad y Cyfarfod / Date of Meeting:	22.09.26
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Sammer Tang, Consultant in Public Health
Cyflwynydd yr Adroddiad / Report Presenter:	Philip Daniels, Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action or decision required, report is for noting only.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	Creating Health
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Creating Health is part of the CTM 2030 strategy. The associated objectives sit across all elements of the IMTP and are reported annually.

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:

<i>Beth (crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)</i> <i>What (summary of current position / issue & why it matters and evidence to support that position etc)</i>	Population health outcomes in Cwm Taf Morgannwg (CTM) are deteriorating relative to historical trends and remain among the poorest in Wales. Life expectancy gains have stalled, healthy life expectancy has declined, and avoidable mortality has plateaued in recent years. CTM now records the highest avoidable mortality rates for both males and females of any health board in Wales. These outcomes are not distributed evenly across the population. They reflect longstanding and widening health inequalities associated with deprivation, unhealthy environments, poorer health behaviours, earlier onset of chronic disease, and unequal opportunities to live healthy lives. More than half of CTM residents live within the two most deprived quintiles in Wales.
<i>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)</i> <i>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)</i>	While life expectancy remains important, the greater challenge for CTM is the widening gap between life expectancy and healthy life expectancy. People are spending a growing proportion of their lives living with ill health, disability and multiple long-term conditions, driving increasing demand for health and care services. The strategic objective for CTM should therefore be not only to help people live longer, but to help them remain healthy for longer by compressing ill health into a shorter period at the end of life. This would improve quality of life, support economic participation, reduce inequalities and moderate future healthcare demand.
<i>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)</i>	Consider how investment in prevention, early intervention and action on the wider determinants of health alongside with providing quality and sustainable healthcare service is essential to improve population health outcomes and ensure the long-term sustainability of health and care services across CTM.

What Next (*summary of intended action and benefits supporting the choices and recommendation(s) being made*)

Argymhelliad (*Wedi'i gysylltu â'r adran "Beth Nesaf" uchod*).

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

The committee is invited to recognise that:

- Population health outcomes are worsening
- Health inequalities are the primary driver
- Investment in the early years to maximise life-long benefit
- Compression of morbidity should become a strategic objective
- Note that prevention requires sustained investment
- Support plans to map current and future prevention spend
- Note that future service redesign should shift further upstream

1. Background / Context

1.1 CTM serves one of the most socioeconomically disadvantaged populations in Wales. Key demographic and socioeconomic trends include:

- 51.9% of the CTM population live within the two most deprived quintiles in Wales.
- Merthyr Tydfil and Rhondda Cynon Taf contain some of the highest concentrations of deprivation nationally (Figure 1).
- The population aged 65 years and over is projected to increase by approximately 30% by 2047.
- Deaths have exceeded births each year since 2021.

These demographic pressures are set against a backdrop of poorer health outcomes, increasing prevalence of chronic disease and growing demand for healthcare services.

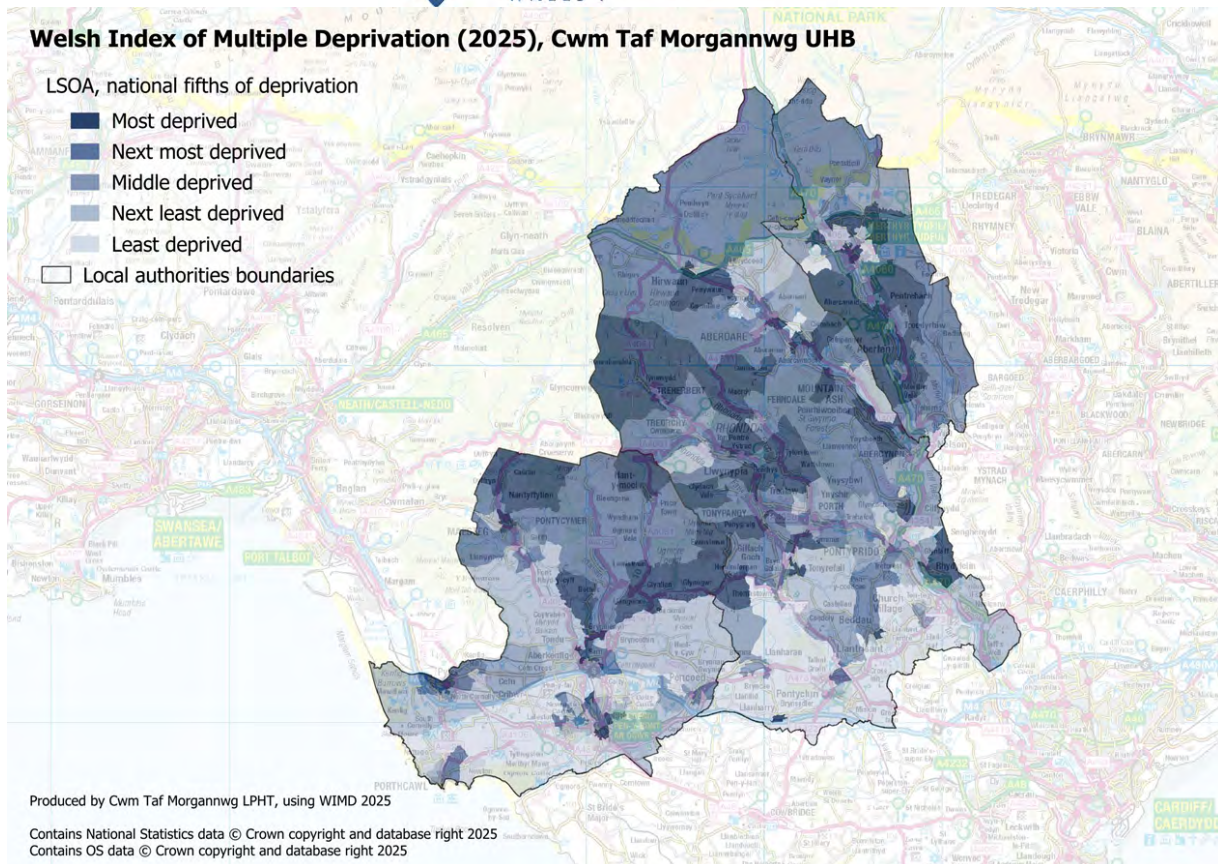


Figure 1: Welsh Index of Multiple Deprivation (2025), CTMUHB

2. Strategic Insights

2.1 Worsening Population Health Outcomes

2.1.1 Falling Healthy Life Expectancy

Although life expectancy improvements have stalled nationally, CTM continues to experience lower life expectancy and healthy life expectancy than the Wales average. Healthy life expectancy has declined since 2019-21, indicating that residents are spending more years living with illness and disability.

Current evidence indicates:

- Healthy life expectancy in CTM is consistently below the Welsh average.
- Healthy life expectancy has been declining in recent years.
- Men and women in CTM can expect to spend approximately 10 years in poor health before reaching State Pension Age.

This trend has profound implications for quality of life, labour market participation, productivity, health service demand and social care requirements.

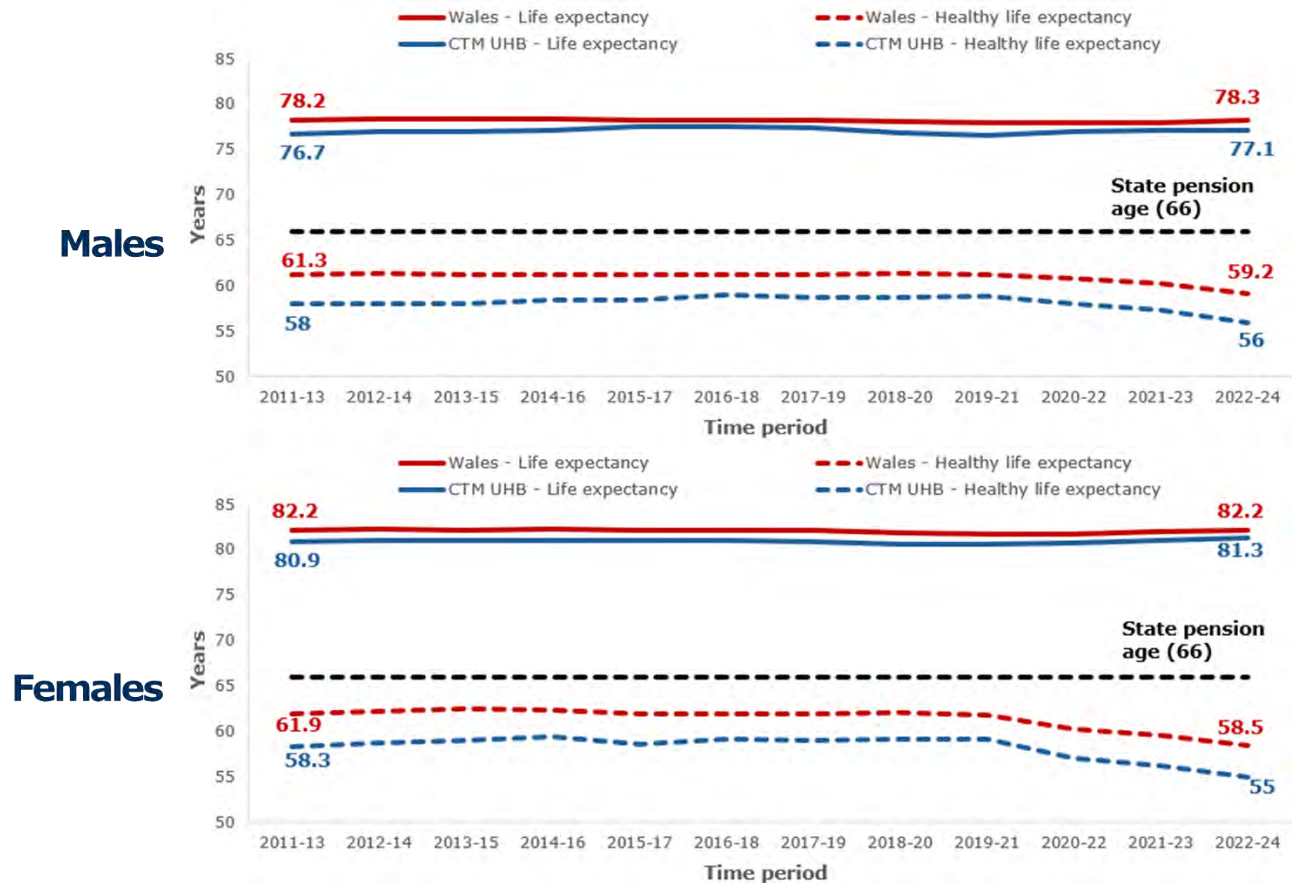


Figure 2: Life expectancy and healthy life expectancy trends in Cwm Taf Morgannwg UHB

2.2 Loss of Momentum in Reducing Avoidable Mortality

Avoidable mortality provides an important indicator of the effectiveness of both public health action and healthcare services.

In 2024:

- CTM had the highest avoidable mortality rate among Welsh health boards
- Rates were significantly higher than the average for Wales.

Recent trend data demonstrate that after decades of improvement, rates have begun to worsen.

Trends in avoidable age-standardised mortality in 2001-2023, persons, CTM UHB and Wales

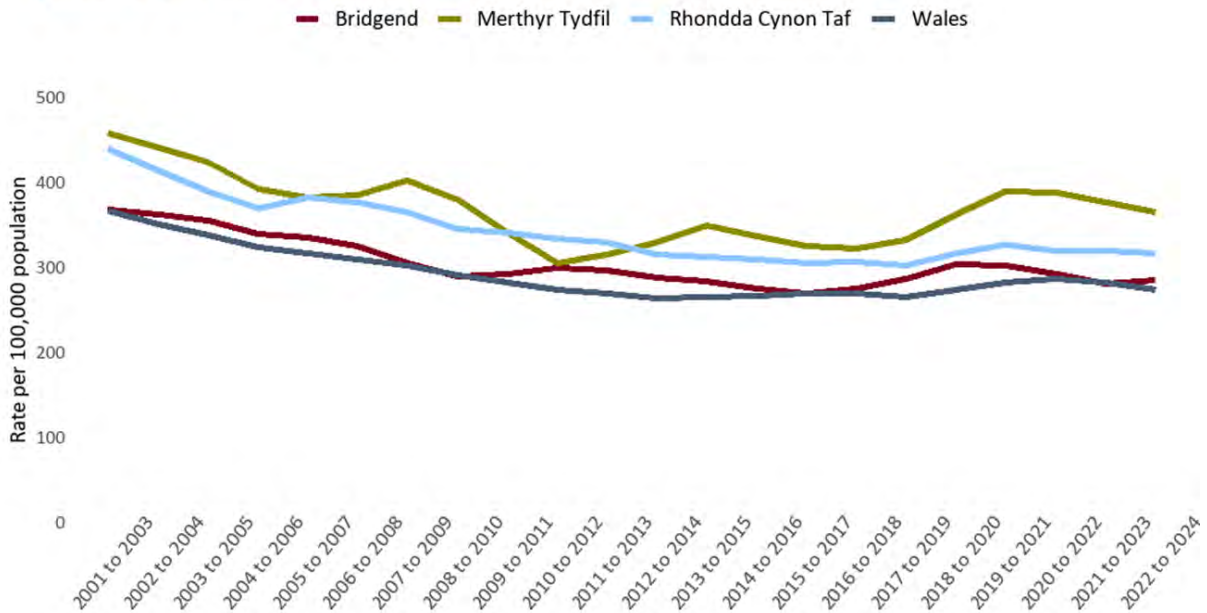


Figure 3: Trends in avoidable age-standardised mortality in 2001-2023, persons, CTM UHB and Wales

This is particularly concerning because avoidable mortality reflects deaths that may be prevented through effective policy, prevention, early intervention and healthcare.

2.2.1 Preventable Mortality

Preventable mortality refers to deaths that could largely be avoided through effective public health measures and action on wider determinants of health.

Examples include deaths related to:

- Smoking.
- Obesity.
- Alcohol-related harm.
- Physical inactivity.
- Air pollution.
- Injury prevention.

Although long-term trends have improved, CTM has seen a recent increase in preventable mortality.

Trends in preventable mortality, 2001-2003 to 2022-2024, EASR per 100,000, Cwm Taf Morgannwg local authorities and Wales

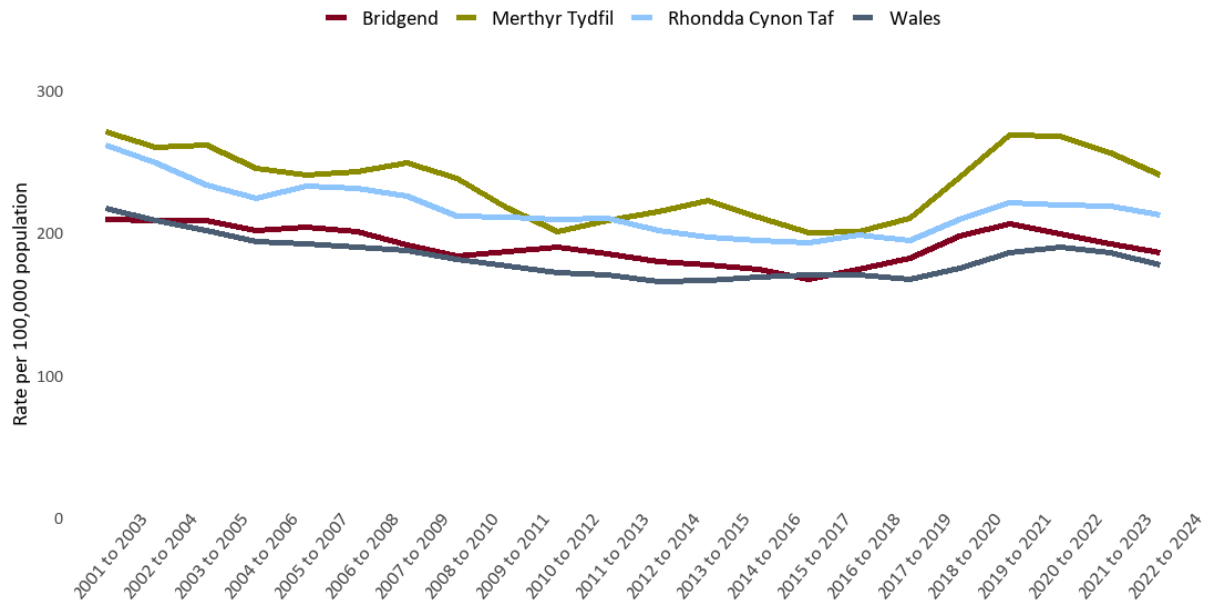


Figure 4: Trends in preventable age-standardised mortality in 2001-2023, persons, CTM UHB and Wales

This suggests that the underlying causes of ill health continue to affect CTM communities disproportionately and that opportunities for primary prevention remain significant.

2.2.2 Treatable Mortality

Treatable mortality refers to deaths that could potentially be avoided through timely and effective healthcare interventions after disease has developed.

While overall long-term improvements have been observed, recent increases in treatable mortality in CTM are concerning.

Trends in treatable mortality, 2001-2003 to 2022-2024, EASR per 100,000, Cwm Taf Morgannwg local authorities and Wales

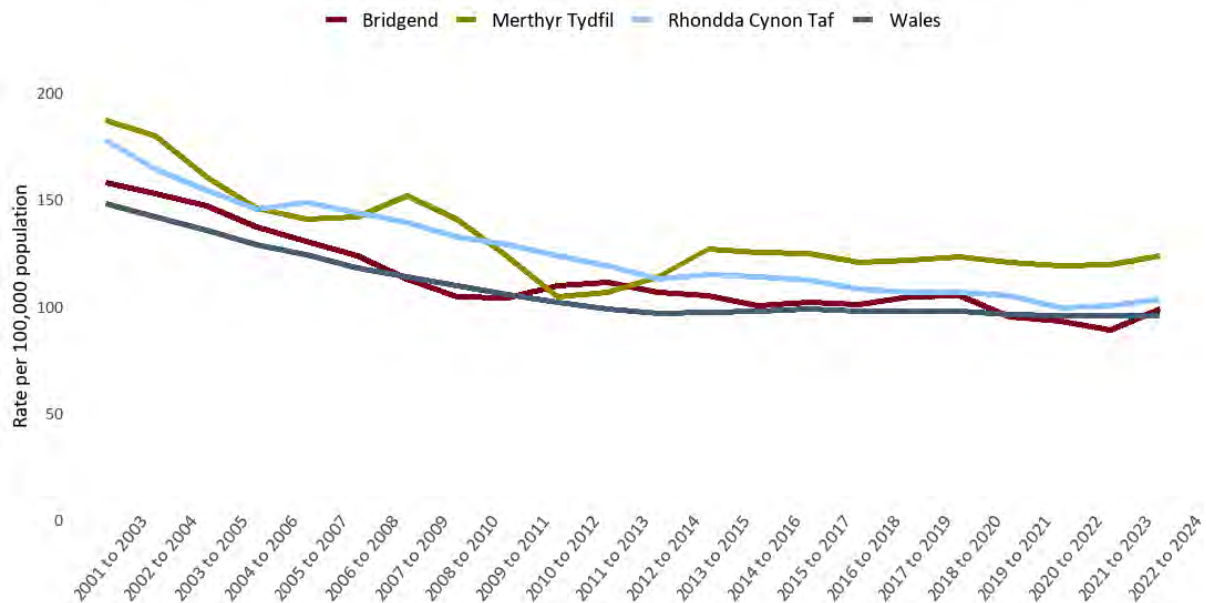


Figure 5: Trends in treatable age-standardised mortality in 2001-2023, persons, CTM UHB and Wales

This reinforces the importance of maintaining high-quality healthcare services whilst simultaneously reducing the incidence of disease through prevention. Healthcare services alone cannot fully offset the impact of worsening population health and widening inequalities.

2.3 Health Inequalities Are Driving Poor Outcomes

Evidence consistently demonstrates that poorer outcomes in CTM are strongly linked to deprivation and wider social determinants of health.

Within CTM:

- Men living in the least deprived communities live approximately seven years longer than those living in the most deprived communities.
- Women in the least deprived communities live approximately five years longer.
- Residents in the least deprived communities experience approximately 10 to 12 additional years of good health.

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



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



Figure 6: Life expectancy and healthy life expectancy in Cwm Taf Morgannwg UHB for the most and least deprived population, 2018-2020

Additional evidence includes:

- More deprived residents experience multimorbidity around a decade earlier than those in affluent communities.
- CTM has among the highest levels of childhood obesity in Wales.
- Adult obesity exceeds the Welsh average.
- Healthy lifestyle behaviours consistently lag behind Wales averages.

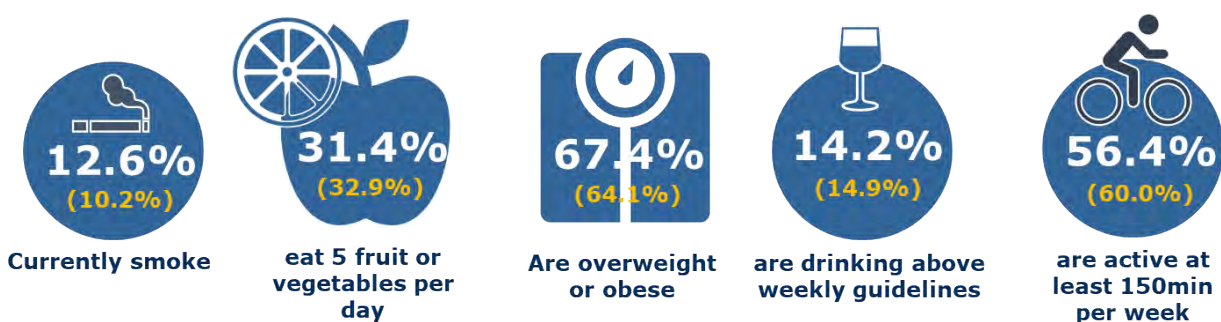


Figure 7: Adult Healthy Lifestyle Behaviours in CTM (figures in bracket is the Welsh average)

Health inequalities are therefore both a moral issue and a major driver of healthcare demand, service utilisation and population outcomes.

2.4 Compression of ill Health: A Strategic Goal for CTM

The most important population health challenge facing CTM is not simply how long people live, but how long they live in good health.

The substantial gap between healthy life expectancy and life expectancy means many residents spend a prolonged period of their lives living with chronic disease, disability, frailty and multimorbidity. These years are also associated with the highest use of healthcare and social care services.

Healthcare demand is not spread evenly across the life course. The greatest demand is concentrated during periods when people experience multiple long-term conditions, functional decline and increasing dependency.

Consequently, the strategic ambition should be to achieve compression of morbidity. This means delaying the onset of illness and disability faster than gains in life expectancy, enabling people to:

- Spend a greater proportion of life in good health.
- Remain independent for longer.
- Participate economically and socially for longer.
- Experience fewer years living with disability.
- Require intensive health and social care support for a shorter period before death.

For CTM, successful compression of morbidity would mean delaying the onset, and subsequently shortening the duration of long terms conditions such as:

- Diabetes.
- Cardiovascular disease.
- Chronic respiratory disease.
- Frailty and disability.

Improving population health should therefore be viewed not simply as reducing mortality, but as increasing the number of healthy years lived and reducing the years spent requiring health and care services.

For an ageing population such as CTM, this offers one of the most important opportunities to improve outcomes while addressing long-term service sustainability.

3. Risks and Opportunities

3.1 Risks

3.1.1 Failure to Improve Population Health Outcomes

Continued deterioration in healthy life expectancy and increasing avoidable mortality would result in poorer outcomes for the population of CTM, widening the

gap between CTM and the Welsh average and potentially increasing inequalities between communities.

3.1.2 Increasing Demand for Healthcare Services

An ageing population combined with increasing levels of obesity, diabetes, cardiovascular disease, respiratory disease and multimorbidity is likely to generate substantial increases in demand across primary care, community services, mental health services, urgent care and acute hospitals.

Without action to improve population health, healthcare demand may continue to grow at a pace that exceeds the capacity of existing services.

3.1.3 Failure to Compress Ill Health

If the gap between life expectancy and healthy life expectancy continues to widen, increasing numbers of residents will spend a greater proportion of their lives living with frailty, disability and multiple long-term conditions.

This would increase pressure on health services, social care, carers and communities, whilst reducing opportunities for individuals to remain independent and economically active.

3.1.4 Widening Health Inequalities

If current trends continue, residents living in the most deprived communities may continue to experience earlier onset of chronic disease, poorer quality of life and premature mortality.

Widening inequalities would undermine CTM's ambitions to improve outcomes equitably across the population and could further increase avoidable demand on healthcare services.

3.1.5 Financial Sustainability

A continued shift towards managing increasingly complex illness without corresponding improvements in prevention may place additional pressure on financial resources and reduce the organisation's ability to invest in transformation and innovation.

3.1.6 Strategic and Reputational Risk

As CTM has some of the poorest population health outcomes in Wales, including the highest avoidable mortality rates, there is a risk that failure to demonstrate progress could impact confidence in the organisation's ability to improve population health and reduce inequalities.

3.2 Opportunities

3.2.1 Improving Healthy Life Expectancy

Investment in prevention provides an opportunity to increase the number of years people spend in good health, improving quality of life, wellbeing and independence across the population.

3.2.2 Compressing Ill Health into Later Life

Successfully delaying the onset of chronic disease and disability could reduce the period of life spent in poor health.

This would enable more residents to live independently for longer, reduce healthcare utilisation in later life and support a more sustainable health and care system.

3.2.3 Reducing Future Demand

Evidence-based prevention programmes focused on smoking, obesity, physical inactivity, alcohol-related harm, vaccination, screening and mental wellbeing have the potential to reduce the future burden of disease and moderate growth in service demand.

Particular attention should be given to investment in the early years, where there is considerable evidence that interventions can deliver health, social and economic benefits across the life-course. Improving the health and wellbeing of children and families can help reduce future inequalities, improve healthy life expectancy and lower the risk of developing many of the chronic conditions that drive demand for health and care services in adulthood.

By delaying the onset of disease and disability, prevention can help compress ill health into later life, improving quality of life for individuals whilst contributing to a more sustainable health and care system.

3.2.4 Reducing Health Inequalities

Targeted investment in deprived communities offers an opportunity to narrow inequalities in life expectancy, healthy life expectancy and avoidable mortality.

Reducing inequalities is likely to generate the greatest overall improvement in population health outcomes across CTM.

3.2.5 Supporting CTM's Strategic Objectives

A stronger focus on prevention aligns closely with CTM's ambitions around population health, value-based healthcare, prudent healthcare, sustainability and long-term service transformation.

3.2.6 Strengthening Partnership Working

Many of the drivers of poor health lie outside the healthcare system. There is an opportunity for CTM UHB to work with local authorities, the third sector, education, housing and employers to address the wider determinants of health and create healthier communities.

3.2.7 Creating Long-Term Value

Investment in prevention should be viewed as investment in the future health, productivity and resilience of the population. While benefits may take time to emerge, prevention offers one of the greatest opportunities to improve outcomes whilst supporting long-term financial and service sustainability.

4. Compliance and Governance

4.1 Compliance, Governance and Strategic Alignment

The issues described in this paper have significant implications for CTM UHB's ability to deliver its statutory duties, strategic objectives and long-term sustainability.

The case for greater investment in prevention, reducing health inequalities and increasing healthy life expectancy is strongly aligned with Welsh Government legislation and policy direction.

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

The Well-being of Future Generations Act places a statutory duty on public bodies, including Local Health Boards, to improve the economic, social, environmental and cultural well-being of Wales through sustainable development. The Act requires organisations to adopt a long-term approach, prevent problems from occurring or worsening, work collaboratively and involve communities in decision-making. It also establishes the seven national well-being goals, including A Healthier Wales and A More Equal Wales.

The worsening trends in healthy life expectancy, avoidable mortality and health inequalities outlined in this paper reinforce the importance of applying the Act's prevention and long-term planning principles. Investment in prevention and population health improvement directly supports CTM's responsibilities under the Act.

4.1.2 Social Services and Well-being (Wales) Act 2014

The Social Services and Well-being Act places prevention, early intervention, well-being and partnership working at the centre of service planning and delivery. The legislation promotes action to prevent or delay the development of care and support needs and encourages health and social care organisations to work together to improve outcomes and independence.

The evidence presented within this paper demonstrates the importance of delaying the onset of chronic illness and compressing ill health into later life. Such an approach supports the principles of prevention, independence and sustainable services embedded within the Act.

4.1.3 A Healthier Wales: Our Plan for Health and Social Care

"A Healthier Wales" sets out the national vision for a whole-system approach focused on prevention, early intervention, seamless care and improved population health outcomes. The strategy recognises that long-term sustainability requires a shift away from reactive models of care towards prevention, population health improvement and tackling the wider determinants of health.

The challenges identified in CTM, including rising avoidable mortality, declining healthy life expectancy and increasing long-term conditions, reinforce the relevance of this strategic direction. Investment in prevention is consistent with the ambition to deliver better health outcomes whilst reducing future demand on services.

4.1.4 Prudent Healthcare

The principles of prudent healthcare emphasise prevention, value-based approaches, reducing harm, addressing unwarranted variation and making the best use of finite resources. A prudent approach seeks to maximise health gain whilst ensuring sustainability of healthcare services.

Improving healthy life expectancy and compressing morbidity into a shorter period at the end of life represents a prudent and value-based response to increasing healthcare demand. Prevention offers an opportunity to improve outcomes whilst making better use of available resources.

4.1.5 NHS Wales Planning and Population Health Duties

As a Local Health Board, CTM UHB has a responsibility to improve population health, reduce inequalities and contribute to sustainable health and care services. These responsibilities are reflected within the NHS Wales planning framework, Health Board Integrated Medium-Term Plans (IMTPs), Regional Partnership Board priorities and Public Services Board well-being objectives.

The findings within this paper support the need for prevention, health inequality reduction and population health improvement to remain central components of strategic planning, resource allocation and service transformation programmes.

4.2 Governance Implications

The trends highlighted in this paper should be regarded as strategic risks for the organisation due to their implications for:

- Population health outcomes.
- Health inequalities.
- Healthcare demand.
- Workforce pressures.
- Financial sustainability.
- Delivery of CTM's strategic objectives.
- Compliance with Welsh Government policy and legislative requirements.

Conversely, successful investment in prevention and population health improvement presents a significant opportunity to improve outcomes, reduce inequalities, increase healthy life expectancy, compress ill health into later life and contribute to the long-term sustainability of health and care services across CTM.

5. Recommendation

5.1 The Strategic Case for Prevention

Without intervention, CTM is likely to experience:

- Increasing prevalence of diabetes, cardiovascular disease and respiratory disease. More people living with multiple long-term conditions.
- Rising demand across primary care, community care, unscheduled care and acute services.

- Growing financial pressures on the health and care system.

Current projections indicate substantial future increases in conditions such as diabetes, heart failure, hypertension and chronic respiratory disease should current trends continue.

While treatment services remain essential, no health system can sustainably treat its way out of increasing levels of preventable illness.

The evidence suggests that the greatest opportunities for long-term improvement arise from:

- Preventing disease before it occurs.
- Delaying the onset of long-term conditions.
- Increasing healthy life expectancy.
- Compressing ill health into later life.
- Addressing the social determinants of health.
- Reducing inequalities between communities.

Investment in prevention should therefore be viewed as a strategic investment in future sustainability rather than discretionary expenditure.

Recommended Strategic Direction

The committee is invited to recognise that:

1. Population health outcomes are worsening

Declining healthy life expectancy and rising avoidable mortality represent a significant strategic risk to both population health and organisational sustainability.

2. Health inequalities are the primary driver

Reducing inequalities should be viewed as a fundamental mechanism for improving outcomes and managing future demand.

3. Compression of morbidity should become a strategic objective

Success should be measured not only through longer life expectancy but through increasing the proportion of life spent in good health and reducing years spent living with complex illness and disability.

4. Prevention requires sustained investment

Priority areas include:

- Tobacco control.
- Healthy weight and obesity prevention.
- Physical activity promotion.
- Early years interventions.

- Vaccination and screening programmes.
- Mental wellbeing promotion.
- Community-based prevention.
- Partnership action on poverty, housing, education and employment.

5. Understanding prevention resource

Understanding the resource currently associated with prevention and how this can be incrementally increased over time, will be critical to enabling effective preventative interventions. Work in the health board should be undertaken to effectively map current and future spend on prevention to maximise opportunity and commitment to tackle preventative illness early on.

6. Future service redesign should shift further upstream

All major transformation programmes should consider opportunities to increase investment in prevention and early intervention as a means of moderating future healthcare demand.

6. Conclusion

6.1 CTM faces a significant population health challenge. Healthy life expectancy is declining, avoidable mortality is increasing, and profound inequalities continue to shape health outcomes across communities. These trends are occurring alongside population ageing and increasing prevalence of long-term conditions.

The challenge is not simply to help people live longer. The challenge is to ensure they live longer in good health.

The widening gap between life expectancy and healthy life expectancy means too many residents are spending a significant proportion of their lives living with preventable illness, disability and dependency. These are also the years associated with the greatest healthcare demand and cost.

Investment in prevention offers an opportunity to reverse these trends by reducing avoidable mortality, narrowing inequalities, delaying the onset of disease and compressing ill health into later life. Doing so will improve quality of life for residents, support sustainable services and contribute directly to CTM UHB's long-term strategic objectives.

6.2 The Committee is invited to discuss how prevention, health inequality reduction and the compression of ill health can be further embedded within CTM UHB's strategic planning and resource allocation decisions.

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

All Strategic Risks Apply

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	All Wellbeing Goals Apply	
	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)	N / A	



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) As CTM has some of the poorest population health outcomes in Wales, including the highest avoidable mortality rates, there is a risk that failure to demonstrate progress could impact confidence in the organisation's ability to improve population health and reduce inequalities
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (include further detail below) Consideration of current and future resource associated with prevention will be needed

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

Progress against CTMUHB's R&D Strategy Action Plan and annual review with Welsh Government

Eitem yr Agenda / Agenda Item	5.2
Dyddiad y Cyfarfod / Date of Meeting:	22 September, 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Professor John Geen, Assistant Director for R&D and Rhian Beynon, R&D Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Lauren Edwards, Executive Director of AHPs and Health Sciences
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Sciences
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For noting only – no action/decision required.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	Improving Care If more than one applies please list below: Creating Health Sustaining our Future Inspiring People
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Inclusion in the Health Board's IMTP planning processes and inclusion of the R&D Strategic Action Plan (on a page) in the final IMTP.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhofi'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)

CTMUHB's Research & Development Strategy sets out the ambition to embed research as a core component of clinical service delivery for improving patient outcomes, staff development, and organisational performance.

This report provides an update on progress since the approval of the R&D Strategy by Board in July 2025, the latest annual assessment against the NHS R&D framework (February 2026), and recent WG annual review (July 2026).

29/32 actions complete or in progress.

3/32 actions are delayed. Delayed actions are not deemed to present a significant risk to the Strategy delivery and plans are underway to support their delivery.

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 has made positive progress against the objectives set out within the R&D strategic action plan and NHS R&D framework assessment, to include:

- growth in research activity,
- increased patient recruitment to studies,
- developing designated research space
- continued development of partnerships with academic, local authority and industry collaborators,
- workforce development
- enhanced engagement at Board and senior management level
- inclusion of R&D in the Health Board's IMTP process.

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

Continue delivery against the R&D Strategic Plan, to include:

- Further development the UHB's commercial research portfolio to support sustainable re-investment in the research infra-structure and capacity.
- Continue to progress identification and development of designated research clinical



benefits supporting the choices and recommendation(s) being made)

and administrative environment at Prince Charles and Princess of Wales Hospitals to increase research activity and equitable access to research for patients and researchers across the UHB.

- Continued development of processes to support meaningful inclusion of R&D in the Care Group and directorate IMTP submissions, with specific actions to support delivery of the UHB's strategic action plan.
- Confirm and progress agreed actions from the Annual review with WG in July 2026.
- Support Health and Care Research Wales's Embedding Research in the NHS Programme
- Deliver on the National Contract Value Review (NCVR) process
- Deliver on the UK 150 day Study set up target
- Deliver on Research Governance and Regulatory Compliance, to include new MHRA processes
- Develop the CTMUHB Cancer research portfolio
- Plan and deliver the CTMUHB's Annual R&D Conference, November 25th 2026.

Argymhelliad (Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).

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

QSEC is asked to note progress.

1. CTM R&D Strategic Action Plan update

The NHS R&D Framework, published in July 2023 outlines "what research excellence looks like within NHS Organisations in Wales where research is embraced, integrated into services, and is a core part of the organisation's culture" and defines ten key pillars that support the development of a research active and supportive NHS organisation.

One of the framework's key pillars is for the organisation to have an up-to-date R&D Strategy and a refresh of the previous strategy was undertaken through 2024/25.

Developed through extensive consultation with Welsh Government, Health and Care Research Wales, Higher Education Institution partners, and colleagues across CTMUHB, CTMUHB's R&D Strategy 2025–2030 was approved by the Board in July 2025 and formally launched at the CTMUHB R&D Conference in November 2025.

It sets out a clear ambition to strengthen research across the organisation by increasing activity, enhancing infrastructure and visibility, and fostering a positive

research culture. [R&D Strategy 2025-30 - Cwm Taf Morgannwg University Health Board](#). Covering primary, secondary, community and social care, population health, and all professional groups the strategic plan aims to establish research as a core Health Board function, supporting high-quality care and aligning with national and organisational priorities.

The R&D Strategy is supported by a comprehensive action plan to enable progress and monitoring by the R&D Group and Executive Board.

A dashboard (appendix 1) is used to monitor the progress being made against the CTMUHB R&D Strategic Action Plan (2025-2030).

There are 33 actions in total:

- 15 / 32 are complete or in place.
- 14 / 32 are not yet due for completion but are progressing within expected timeframes.
- 3 / 32 are delayed with work underway to try to resolve with partners.

Delayed actions

Three actions are behind schedule but none of these are deemed to be high risk. All possible actions have been completed by R&D colleagues and require input from partners outside of the team who are aware and are managing the requests in the context of their own workplans. The delayed actions are listed below.

- Support the implementation of the UK wide commercial Site ID system, to include the development of a marketing profile to promote CTMUHB and maximise commercial research opportunities – July 2025: delays at a national level, local work is complete
- The R&D Department will develop a publicly accessible internet page to promote, support and disseminate the scope of research being undertaken across CTMUHB and the resultant outputs and impact to the NHS – July 2025: content is currently with IT colleagues to create the site before final review and activation; a public-facing page has been drafted in line with HCRW guidance, which is due to be launched in the autumn.
- The R&D Department will further develop its communications plan and work with the communications teams from CTMUHB and Health and Care Research Wales to promote research and research studies across the UHB and partners – Jan 2026: R&D team working in partnership with Communications and Engagement Manager to develop a communications plan but meeting has been delayed.

2. Welsh Government – NHS R&D Annual Review Meeting

CTMUHB's annual review meeting with Welsh Government was held in July 2026, with attendance from the Executive Lead for R&D, Independent Member champion for R&D, Assistant Director (AD) for R&D, and R&D Manager.

The 2026 assessment against the NHS R&D Framework formed the basis of the discussions.

CTMUHB was confirmed as the only health board to have been deemed as fully compliant with the four areas of the audit of compliance with the Research Delivery Funding (R&D Strategy, Public-facing Annual Report, Financial Management, Adherence to NCVR)

CTMUHB's strong commitment to embedding research across the organisation was recognised, supported by the recently launched R&D Strategic Action Plan, visible Board-level engagement and support, and recent developments to the IMTP planning process.

Positive feedback was received on the detail of the assessment document with clear examples of progress, in addition to positive feedback on research activity, research governance, financial oversight and collaborative working with academic partners and national research initiatives. The team were congratulated on their many achievements.

Welsh Government identified four draft actions for the UHB which are currently under review to agree the final wording. The actions relate to:

- ways in which the workforce and culture-related ambitions within the R&D Strategy can be further integrated into the organisation's People and Culture programmes and activities
- a Board Development session focusing on R&D within CTM
- a plan to further strengthen links with academic institutions
- development of a document outlining CTM's research strengths, demonstrates the contribution to addressing population health needs, and the alignment with organisational and national priorities.

7. Conclusion

The Research and Development department are making good progress with the actions detailed in the CTMUHB R&D Strategic Action Plan. They are working with individuals, teams, senior leaders, and executives across all portfolios to ensure progress against specific actions. Three actions are currently delayed and conversations are ongoing with partners to ensure their completion. None of the delayed actions are considered high risk to the delivery of CTM's R&D ambitions.

A positive annual review by HCRW/Welsh Government was completed in July 2026, along with confirmation of full compliance with the annual audit against the terms and conditions of the funding contract (the only Health Board in Wales to achieve this outcome this year). Both of these provide a positive independent assessment of CTMUHB R&D processes, activity and oversight.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd

Strategic Risk 2



<i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i>	If more than one applies please list below:	
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)		
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: A Prosperous Wales A resilient Wales More Equal Wales A Wales of Cohesive Communities A Globally Responsible Wales	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research	
	If more than one applies please list below: Data to Knowledge Culture and Valuing People Leadership Whole-systems Perspective	
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 <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	Outcome for Equality (delete as appropriate): POSITIVE Summary of impact: Working to increase participation in Research and to improve outcomes across our communities	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Equality & Welsh Language Impact Assessment Outcome <i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	Outcome for Welsh Language (delete as appropriate): NEUTRAL	Lauren Edwards, EDAHPHS



	Summary of impact: no impact. All patient and public information available bilingually, including web page development	
Canlyniad Asesiad Effaith Ansawdd (Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwrch 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)	This report provides an update against the R&D Strategy delivery. The strategy has already received Board approval in July 2025.	
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
N/A	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CRP	Clinical Research Portfolio
CTIMP	Clinical Trial of an Investigational Medicinal Product
CTMUHB	Cwm Taf Morgannwg University Health Board
GCP	Good Clinical Practice
HRA	Health Research Authority
HCRW	Health and Care Research Wales
HDRC	Health Determinants Research Collaboration
MHRA	Medicines and Healthcare Products Regulatory Agency
NIHR	National Institute for Health and Care Research
R&D	Research and Development

Appendix 1:

Dashboard RAG rated progress against the Research and Development Strategic Action Plan (2025-2030).

CTMUHB R&D Strategy Action Plan 2025-30					
<i>The Health Board will continue to develop a culture where research is recognised as a core aspect of its purpose and essential for clinical effectiveness, service redesign and improvement.</i>					
	Action	Timescale for delivery	Key partner(s) to facilitate delivery	Status	Progress
a	Inclusion of research as a regular agenda item at Health Board Executive level meetings within and outside the Health Board.	April 2025	Corporate services	On Track	The R&D Strategic Action Plan was endorsed at the Quality Safety and Experience Committee on July 22nd and approved by the Board on 31st July, 2025. 22nd May 2026, The Executive Lead for R&D provided an overview of the NHS R&D Framework to the Public Board. 27th May 2026 The Assistant Director for R&D delivered a presentation on CTMUHB's R&D strategic objectives, R&D activity and inclusion of research into care groups' IMTPs at the Improving Care Board.

					3rd June CTMUHB's Chair and Executive Director for Strategy and Transformation attended a "walk around" at the Clinical research Centre, RGH. Report on progress against R&D Strategic Action plan submitted for review at the EMB, 1st September 2026 and the Quality, Safety and Experience committee on 23rd September, 2026.
b	Inclusion of research in all strategic documentation developed across CTMUHB to include the organisation's annual report.	March 2027	Strategic Planning, Corporate team, Care Group, Directorate and Senior Leaders	On Track	Executive R&D provided an R&D section for inclusion in CTMUHB's annual report 2025-26. A standalone R&D Annual report 2025-26 has been compiled for publishing awaiting EMB and QSEC endorsement September 2026.
c	Development and reporting of R&D metrics at internal and external meetings (e.g. Executive - Care Group performance meetings) to include number of open studies, number of research participants, active researchers by profession, number of research active staff (e.g. Principal / Chief Investigators / Associate PI's), Number of sessions awarded for Research (SPA/ other HCP sessions) (not exhaustive).	October 2025	Executives, Care Group, Directorate and Senior Leaders	In Progress	R&D team evolving the current Care Group report to include: R&D activity (open studies and recruits) (complete) Active Researchers by Profession Associate PI's – To be completed (TBC) PI's/ CI's – TBC Commercial Research Income - TBC Currently these data are already reported to the CTM R&D Group.
d	Inclusion of research plans in the IMTP for each Department and Care Group.	March 2026	Strategic Planning, Corporate team, Care	On Track	26th February The Assistant Director for R&D and R&D Manager met with the Assistant Director for Strategy and Transformation (EB) as a follow up to the previous

			Group, Directorate and Senior Leaders		meeting the Executives (LE and CT) to discuss progress and inclusion of R&D in the HB's IMTP submission 5th March 2026 R&D provided a comprehensive R&D section for inclusion in the UHB's IMTP (2026-2029), to include the R&D Strategic Action Plan on a page, with key R&D priorities documented. R&D Manager to attend the corporate IMTP meetings to facilitate the discussion of embedding research into IMTP prior to submission, with Senior leadership teams from all Care Groups/Directorates.
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The Health Board will provide and support the required infrastructure for the sustainable delivery of high-quality research activity and workforce development.

	Action	Timescale for delivery	Key partner(s) to facilitate delivery	Status	Progress
a	Secure additional clinical and administrative space for research activities at Prince Charles and Princess of Wales Hospitals.	March 2027	Executive Directors, Strategic Planning, Senior Leaders, Facilities	In Progress	Designated research space (clinic room and administrative office) has been allocated to R&D as part of Phase 1 at Prince Charles Hospital from October 2026. Discussion with site team ongoing re planned refurbishment requirements. Currently awaiting the findings of a PoWH walk around by the Service Project Manager, Capital Planning (IP), with a view to them identifying suitable space. AD has outlined requirements by email.

b	Continue to review the R&D infrastructure to further develop research capacity and capability.	March 2026	Care Group, Directorate and Departmental Directors and Senior Leaders	On Track	CTMUHB R&D invested in 1.0 wte Junior Research Fellow in Cardiology in support of the Commercial Research Portfolio at Princess Of Wales Hospital. Funding for 12 months, after which the objective is that the funding will be self sustainable from Commercial research income. X2 Band 6 Research Nurse posts (x2 1.0wte) developed from Delivery and Commercial research income to increase delivery capacity. Vacancy for band 5 Research Officer filled to support the Research governance process in meeting the 150 day timeline for opening Commercial studies. Welsh Govt funding (VPAG) to fund 1.0 wte Junior Research Fellow in Gastroenterology, Research nurse and sessional Consultant time to support of the Commercial Research Portfolio at Princess Of Wales Hospital. Funding for 12 months, after which the objective is that the funding will be self sustainable from Commercial research income.
c	Include R&D activity when assessing capacity required for service delivery when undertaking workforce planning.	March 2027	Workforce & OD, Care Group, Directorate, Departmental Directors and Senior Leaders	In Progress	Highlight awareness of this strategic objective and inclusion of Research function and time for all professional groups, when presenting at all meetings across all specialities to include the Grand Round in May 2026.
d	The R&D Department will facilitate an increase in the number of CTMUHB Chief	March 2027 and March 2030	Clinical Researchers	In Progress	Chief Investigators 2025/26 = 7 Chief Investigators 2026/27 = 4 (part year)

	Investigators, with the aim of having 10 Chief Investigators by March 2027 and 15 Chief Investigators per year by 2030.				
e	Provide dedicated research time for medical staff through the provision of SPA for research. The UHB will have a target of 10% of SPA sessions providing support for research activity by 2026 and 15% by 2030. Research activity (e.g. Studies opened and supported) will be reviewed annually through the Job planning process.	March 2026 and March 2030	Workforce & OD, Medical Directors, Clinical Directors, Care Group Managers, Researchers	In Progress	AD for R&D met with Executive Medical Director on 31 st July, 2026 to discuss the inclusion of research as part of SPA time for the medical workforce. Discussions ongoing to collate the number of research sessions currently awarded as no current mechanism for collating SPA data. The MD was supportive of promoting research as an SPA activity and was seeking to include during Job planning and revalidation and signposting Medical colleagues to the research department in the developing SPA document, to facilitate discussion and seek advice on how to get involved in research.
f	All Job Descriptions at Band 7 (and above) for Advanced Practice roles to include research with associated designated sessions. Research activity (e.g. Studies opened and supported and outputs) will be reviewed annually through the PDR process.	March 2027	Workforce & OD, Clinical Directors, Departmental, Directorate & Care Group Managers	In Progress	Highlight awareness of this strategic objective and inclusion of Research function and time for all professional groups, when presenting at all meetings across all specialities to include the Grand Round in May 2026. Consider inclusion of research related metrics during PDR's for non-medical staff (e.g. PI roles, studies supporting)
g	Continue to develop joint clinical and research roles in services critical for research	March 2027	Workforce & OD, Clinical Directors, Departmental, Directorate and Care	On Track	R&D funding supports: Specialty Registrar Rheumatology 0.45wte Research Physiotherapist 0.5wte



	delivery include Pharmacy, Pathology, Allied Health Professions, Healthcare Scientists, Nursing and Midwifery, Public Health, Imaging and Medicine.		Group Managers, Assistant Director for R&D		Clinical Research Scientist 0.5 wte Laboratory Support Worker 0.6wte Clinical Trials Pharmacists 1.4wte Pharmacy Technician 0.5 wte Radiographer 0.2wte Public Health 0.6wte CTMUHB R&D invested in Junior Research Fellow in Cardiology (1.0wte) in support of the Commercial Research Portfolio at Princess Of Wales Hospital. Funded for 12 months, after which the objective is that the funding will be self sustainable from Commercial research income. HDRC fund 5% of time of CTM R&D Principal Researcher in Public Health
<i>The Health Board, with R&D departmental support, will maximise research related income and investment (See Appendix 2)</i>					
	Action	Timescale for delivery	Key partner(s) to facilitate delivery	Status	Progress
a	Continue to work with Health and Care Research Wales to maximise opportunities to secure additional NHS R&D funding.	Commencing May 2025	Health and Care Research Wales	In Progress	Successful application to HCRW (VPAG funding August 2026) for additional funding to develop Commercial research opportunities in Gastroenterology (notably IBD). £327,401 awarded over 3 years, after which, objective is that funding should be self-sustainable from Commercial research income.

					Awaiting outcome of discussions with WG on identified shortfall in pay uplift for several posts for x3 years (18-19, 19-20 and 20-21)
b	Increase the number of grant applications submitted by CTMUHB researchers to 10 per year by 2030. (See Appendix 2)	Commencing May 2025	Academic, Industry, Third Sector & Local Authority Partners, Researchers	In Progress	2025/26 collaborative grants awarded = 6 2026/27 Grants Awarded = 1 Awaiting Outcome = 4
c	Secure additional research funding from all non-commercial sources to £1 million to include cost recovery, excess treatment costs, grant funding, government funding schemes and third sector by 2028.	March 2028	Academic, Industry, Third Sector & Local Authority Partners	In Progress	Excluding the HCRW Delivery Funding and Commercial Research Income the following funding has been identified: 2024-2025: Total £380, 548 2025-2026 Total £237, 714 Note the income has been calculated based on the funding coming directly to CTMUHB and for a given year.

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

	Action	Timescale for delivery	Key partner(s) to facilitate delivery	Status	Progress
a	Increase the number of joint multi-professional and multi-disciplinary (non-commercial) projects by 5% year on year with our academic, industry, third sector and local authority partners, signposting our	May 2025	Academic, Industry, Third Sector & Local Authority Partners	On Track	2025/26 open CRP studies = 73 (Target was 76) 2.6% decrease from previous year (75 open studies) Part year open CRP studies 2026/27: 38 (33 at same time point 2025/26) 2025/26 CRP study recruits = (Non-Commercial) 1837

	partners to potential Chief Investigator and Principal Investigators.				7.6% increase from previous year (Action plan Target met). 1855 in Total when including commercial study recruitment. 2026/27 (part-year) number of participants recruited to CRP studies 2026/27: CRP = 349 (689 at same time point 2025/26) There are a number of potentially larger recruiting studies currently being processed. In 2025/26, 100% of CRP studies have closed having met the CTMUHB agreed recruitment to time and target. CTMUHB was highest recruiting additional site for the QuicDNA study (Lung Cancer) and Tiptoe Study. CTMUHB recruited 1st patient in Wales for MH-EF Clinical trial and Colocap study. CTMUHB top recruiting site for the PANDA and Snap-2 studies in May 2026
b	CTMUHB will continue to provide financial support, through the R&D Department, to continue to run an annual research collaboration funding call to facilitate NHS-Academic partnership working.	May 2025	Finance team	On Track	Annual Collaborative Academic Research Funding scheme to support staff to develop new research ideas and partnerships with an academic institution to address current healthcare challenges. 4 applications were awarded funding (See Appendix 3)
c	CTMUHB will support the development of research partnerships with local businesses.	March 2026	Local Businesses	On Track	R&D have supported research studies with local businesses such as Cansense (CANFIT, RAMAN, CRAFT, COLOSPECT, BrCa-SPECT).

					Cultech: Investigating the effects of Probiotics on the well-being of UHB staff.
d	Develop training and work experience opportunities for all Health care professions seeking experience of research as part of their education and development.	May 2025	Academic and Educational Institutions and Organisations	On Track	7 Student nurse placements hosted by R&D in 2025-26. 3 student nurses hosted by R&D to date in 2026/27. Two-week placement for a Medical Student in August 2026.
e	The Health Board will work with Academic Partners to explore the development of Clinical Academic roles with a clinical, education and research portfolios.	March 2030	Academic and Educational Institutions and CTM Clinical Education Department	In Progress	Awaiting Final report from HCRW sub project of the Embedding Research in the NHS", on Clinical Academics, that could inform definition and guidance on how to progress.
f	Work with Patient and Public Involvement (PPI) networks to ensure the representation, involvement and engagement of patients and the public in the establishment of research priorities and the design, delivery and dissemination of research. This will include the involvement and recruitment of underserved populations.	May 2026	CTMUHB's Research Active Professionals Patient Experience Team, Patients, Health and Care Research Wales	In Progress	Working with Llais and Patient and Public Involvement team at HCRW to find a representative for the CTMUHB R&D Group. Demographic profile of 941 CTMUHB research participants 2023/24 (delivery supported by R&D) indicated participants are representative of CTMUHB population (socio-economic status and gender). Collation for 2024/25 to be undertaken and discussions with principal Researcher and Information Governance are ongoing with a view to explore data on disability and ethnicity.
g	Continue to work with Health and Care Research Wales towards a Once for Wales and	Commencing May 2025	Health and Care Research Wales, NHS Organisations	On Track	When Once for Wales studies are being progressed, CTMUHB R&D facilitate and support the Once for Wales process

	One Site Wales approach, where appropriate.				
<i>Develop the Commercial Research Portfolio of the Health Board and support the Local and National Life Sciences and Pharmaceutical Industry</i>					
	Action	Timescale for delivery	Key partner(s) to facilitate delivery	Status	Progress
a	Support the implementation of the UK wide commercial Site ID system, to include the development of a marketing profile to promote CTMUHB and maximise commercial research opportunities.	July 2025	Health and Care Research Wales, CTMUHB Communications, CTMUHB ICT Service	Delayed	IG leads in discussion and DHCW being chased by HCRW re whitelisting the NIHR Site ID app Drafting of Marketing Profile in progress. Awaiting further confirmation re potential alternative. A CTMUHB profile has been drafted for inclusion in a commercial research section for the CTMUHB external web page.
b	Increase the number of Commercial research studies to 15 per year by 2030.	April 2030	Industry, Health and Care Research Wales, Clinical Researchers, Academic Partners	In Progress	2025/26 open studies = 6 (same as previous year). Target was 7 Commercial studies. 2026/27 open studies (part year) = 3
c	Increase the number of participants recruited to commercial research studies to 100 per year by 2030.	April 2030	Industry, Health and Care Research Wales, Clinical Researchers, Academic Partners	In Progress	Part year number of commercial participants recruited 2026/27: 17 (7 at same time point 2025/26 from a total of 18 recruits: 23 recruits for 2024-2025)

					Part year open commercial studies 2026/27 = 4 (same at this time point last year) In 2025/26, 100% of commercial studies have closed at CTMUHB, having met their recruitment to time and target. CTMUHB POW were top UK recruiting site alongside St. Barts Hospital in the AD Trust study April, 2026 CTMUHB recruited 1st UK patient for the Shells study.
d	Increase the UHB's generation of commercial research income by 50% by 2030.	April 2030	Industry, Health and Care Research Wales, Clinical Researchers, Academic Partners	On Track	Commercial Income invoiced 2024-2025 £78,656 2025-2026 £310,621

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

	Action	Timescale for delivery	Key partner(s) to facilitate delivery		
a	The R&D Department will work with all services to raise patient and population awareness of research activity across the Health Board and utilise their	March 2026	Clinical Services, Medical appointments, Communications / ICT Patient Experience team and Patients	In Progress	The R&D team are promoting the recently launched Health and Care Research Wales Patient Experience Survey for Research Participants in Wales to gather feedback on participants' experiences throughout the research pathway, including study information and

	stories and experiences of research participation.				support received, interactions with research staff and overall research experience. Opportunities for patient and staff recruitment for research continue to be promoted through CTMUHB's communication channels as appropriate.
b	The R&D Department will develop a publicly accessible internet page to promote, support and disseminate the scope of research being undertaken across CTMUHB and the resultant outputs and impact to the NHS.	July 2025	CTMUHB Communications, CTMUHB ICT Service	Delayed	CTMUHB R&D internet site content is currently with the IT Department to create the site before final review and activation, to include content received from HCRW. A publicly accessible internet page has been drafted in line with the template provided by Health and Care Research Wales, which is due to be launched in the autumn.
c	The R&D Department will further develop its communications plan and work with the communications teams from CTMUHB and Health and Care Research Wales to promote research and research studies across the UHB and partners.	January 2026	Health and Care Research Wales & CTMUHB Communications	Delayed	R&D team meeting with Communications and Engagement Manager to develop an R&D communications plan.
d	Develop mechanisms for recording, documenting and sharing the impact of research.	April 2026	CTMUHB Communications	On Track	Collation of information in progress to be reported as required 2025/6 publications = 7 2026/27 (part-year) publications = 3 R&D Conference 2025: 256 delegates, 60 posters and 10 oral presentations. Keynote Speaker was Prof Chris

					George, Director of the National Cardiovascular Research Network. R&D conference is scheduled for Wednesday, 25th November, 2026 at the Vale Hotel Resort, Hensol with the call for abstracts currently open until September 14th, 2026. Examples of best practice & good news stories continue to be developed in partnership with CTMUHB’s communications team and HCRW and shared through channels. CTM R&D Comms links below: https://www.gov.wales/rapid-diagnostic-testing-bacterial-infections-be-rolled-out-primary-care https://ctmuhb.nhs.wales/news/latest-news/think-quit-empowering-nurses-to-help-patients-quit-smoking/ https://ctmuhb.nhs.wales/news/latest-news/ctmuhb-delivering-quicdna-lung-cancer-study/ https://www.cardiffmet.ac.uk/news/2025/new-research-on-long-covid-offers-hope-for-patients-living-with-condition.php Physiotherapy trial aims to speed up recovery and tackle cost of hip fractures Health Care Research Wales
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					Royal Glamorgan Hospital recruits first patients in Wales onto pioneering heart failure trial - Cwm Taf Morgannwg University Health Board Red4Research Day: Spotlight on Critical Care Outreach and the Power of Research - Cwm Taf Morgannwg University Health Board
<i>Adopt novel research design, methodologies, digital technologies and advanced therapies to inform future clinical service delivery</i>					
	Action	Timescale for delivery	Key partner(s) to facilitate delivery	Status	Progress
a	Embrace emerging design and technologies for use in the efficient delivery of research (e.g. research registries, recruitment applications and QR codes, virtual research visits, electronic site file platforms, research registries), in accordance with relevant data protection requirements.	May 2025	ICT Service	On Track	Implementation of a national an electronic site file platform (FLORENCE) to streamline the management of investigator site files and study monitoring activities.
b	Support the development and delivery of research involving the use of routine health data and facilitate access to internal	March 2026	Information / Analyst Team	On Track	Can be Research study dependent. R&D Department always able to advise on access to data and data repositories and signpost to the Health Boards IG team for expert advice.

	data sources and external repositories e.g. SAIL.				
c	Support the development and delivery of research evaluating the use of applications, digital tools, Artificial Intelligence (AI), Genomics and Advanced Therapies, maximising access to innovative treatments, personalised medicine and care pathways for CTMUHB's population.	May 2025	Clinical Researchers, Research Partners	On Track	Nvivo and Analyse It software packages funded by R&D Department to support for qualitative and quantitative data analysis. CTMUHB is the key site in Wales working with WG and Oxford University (SPARROW study), researching the utility and behavioural aspects of Point of Care CRP testing and Antimicrobial prescribing for Respiratory tract infections in the Community. CTMUHB R&D supporting a study investigating the clinical utility of Point of Care devices for measuring high sensitivity Troponin. Working in partnership with BCUHB and ED.



Quality, Safety & Experience Committee

CTMUHB Research and Development Annual Report 2025-26

Eitem yr Agenda / Agenda Item	5.3
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Professor John Geen, Assistant Director for R&D Rhian Beynon, R&D Manager Catrin Vaugahn, Deputy R&D Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Rhian Beynon, R&D Manager
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Sciences
Diben yr Adroddiad / Report Purpose:	Endorse for Board Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee are being asked to Endorse for Board Approval for publication.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	Improving Care If more than one applies please list below: Creating Health Sustaining our Future Inspiring People
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Inclusion in the Health Board's IMTP planning processes and inclusion of the R&D Strategic Action Plan (on a page) in the final IMTP.



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)

CTMUHB R&D Annual Report 2025-26 has been developed in accordance with Welsh Government guidance and fulfils a mandatory requirement associated with the receipt of Research Delivery Funding. The report provides a public-facing overview of the Health Board's research activity, achievements, impact, income and future priorities during 2025-26.

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)

Publication of CTMUHB's annual report will demonstrate compliance with Welsh Government audit requirements, supporting ongoing assurance relating to CTMUHB's receipt of Research Delivery Funding.

The annual report supports the delivery of the CTMUHB R&D Strategy 2025-30 by highlighting progress against key strategic objectives, as well as raising awareness of research activity, opportunities and impact across the UHB, which supports the strategic vision to embed research as a core function across the UHB.

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

Subject to approval, the report will be published as CTMUHB's public-facing R&D Annual Report for 2025-26 and will be shared with Welsh Government as evidence of compliance with Research Delivery Funding requirements.

made)

Argymhelliad (Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).

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

QSEC is asked to note the contents of the report and endorse for Board approval for publication.

1. Background / Context

1.1 The publication of an annual public-facing Research and Development (R&D) report is a requirement of receiving Research Delivery Funding from Welsh Government.

1.2 Welsh Government guidance sets out the expected content of the report, which includes R&D leadership and governance arrangements, alignment with national and organisational strategic priorities, a summary of research activity and achievements, R&D income received and future strategic priorities.

1.3 The target audience for the annual report is NHS colleagues (including the Executive Board), researchers, industry, interested members of the public and Welsh Government policy officials.

1.4 CTMUHB's R&D Annual Report 2025-26 has been developed in line with Welsh Government guidance and provides an overview of research activity, achievements, impact and future ambitions.

2. Strategic Insights

2.1 The development and publication of the CTMUHB R&D Annual Report 2025-26 supports the delivery of the CTMUHB R&D Strategy 2025-30 and contributes to the strategic vision of embedding research as a core function of the University Health Board. The report promotes the value and impact of research on patient outcomes, service delivery and workforce development, while raising awareness of research activity and achievements among patients, the public, staff and partner organisations. The report also demonstrates progress against key strategic objectives relating to research delivery, research infrastructure, collaborative working with partners and research impact.

2.2 Key achievements highlighted in the annual report include:

- Approval and launch of CTMUHB's R&D Strategy 2025-30.
- Completion of a refreshed assessment against the Health and Care Research Wales NHS R&D Framework and favourable annual review with Welsh Government.
- Growth in participant recruitment to clinical research portfolio (CRP) studies across a broad range of specialties.
- Further development of research infrastructure notably staffing and space (Prince Charles Hospital, scheduled for occupation from October 2026).

- 100% recruitment to time and target for closed commercial and closed CRP studies.
- Continued collaboration with our academic, third sector and industry partners to include the award of external grant funding.
- Promotion of research through student nurse placements, R&D presentations to internal and external staff and signposting to national training opportunities.
- Delivery of the Health Board's 15th Annual R&D Conference, showcasing multidisciplinary research activity across CTMUHB.
- Examples of research impact through case studies demonstrating how research has contributed to cancer diagnostics, long COVID, physiotherapy following hip fracture and smoking cessation.

3. Risks and Opportunities

3.1 No Risks relating to the publication of CTMUHB's R&D Annual Report 2025-26 have been identified.

3.2 The report highlights opportunities to continue to develop and increase R&D activity across CTMUHB in line with the CTMUHB's R&D Strategy 2025-30.

4. Compliance and Governance

4.1 Publication of a public-facing R&D Annual Report is one of the Terms and Conditions outlined in the Research Delivery Funding Grant Award Letter, issued by Welsh Government for the receipt of Research Delivery Funding. Compliance with this requirement forms part of the annual review discussion and audit compliance process undertaken by Welsh Government.

5. Benchmarks

5.1 Welsh Government undertook an audit of compliance against the Research Delivery Funding Grant Award Letter 2024-25. CTMUHB was the only organisation in Wales compliant in all 4 areas (R&D Strategy, Public-facing Annual Report, Financial Management and Adherence to National Contract Value Review (NCVR)).

6. Conclusion

6.1 The report fulfils Welsh Government requirements for annual reporting and provides a comprehensive overview of the research leadership, achievements, activity and income during 2025-26, as well as outlining the key strategic priorities to further develop CTMUHB's research agenda.

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 Service Transformation & Outcomes
	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: A Prosperous Wales A Resilient Wales More Equal Wales A Wales of Cohesive Communities A Globally Responsible Wales

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research
	If more than one applies please list below: Data to Knowledge Culture and Valuing People Leadership Whole-systems Perspective

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 Summary of impact: Working to increase participation in Research and to improve outcomes across our communities Outcome for Welsh Language (delete as appropriate): /NEUTRAL/ Summary of impact: no impact. Report will be made available in Welsh.	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)	Not applicable for this report.	



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) Publication of the R&D Annual Report will enhance CTMUHB's reputation as a research active NHS organisation.
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	
Clinical Research Portfolio	CRP
CTMUHB	Cwm Taf Morgannwg University Health Board
IMTP	Integrated Medium Term Plan
NCVR	National Contract Value Review
R&D	Research and Development



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

RESEARCH & DEVELOPMENT ANNUAL REPORT 2025-2026

CWM TAF MORGANNWG
UNIVERSITY HEALTH BOARD

Photograph Acknowledgments

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

"River Cynon Autumn Colours" by Martin Agg

"Southerndown" by Tamsyn Clark

"Graig Sunrise" by Mike Richards



Mae'r ddogfen / ffurflen hon hefyd ar gael yn Gymraeg.

This document / form is also available in Welsh.

Foreword

We have pleasure in sharing Cwm Taf Morgannwg University Health Board's Research and Development (R&D) Annual Report 2025–26, highlighting our performance, achievements and progress throughout the year. This has been a year of significant progress, reflecting our continued commitment to embedding research as a core function of the organisation and ensuring that our workforce, the people and communities we serve can benefit from, contribute to and participate in research.

We are particularly pleased that this year saw the approval and launch of CTMUHB's R&D Strategy 2025-30, providing a clear direction of travel and reaffirming our ambition to create a thriving research culture in which research is valued and supported throughout the organisation. We also completed a refresh of our NHS R&D Framework assessment, providing an opportunity to reflect on our progress and identify priorities for future development.

This year has seen an increase in clinical research portfolio study recruitment and we have made important strides in developing a stronger commercial research pipeline, with notable successes continuing in cardiology and dermatology. Investment in our research infrastructure has continued, with the expansion of dedicated research space at Prince Charles Hospital confirmed for October 2026 and discussions continuing with the senior leadership team to secure clinical and additional administrative space at Princess of Wales Hospital. These developments will strengthen our ability to attract high-quality research opportunities for our population.

We were delighted to host our 15th Annual R&D Conference on 26th November 2025; our best attended yet, showcasing the breadth and quality of research taking place across our organisation in collaboration with our academic, industry and third sector partners.

The achievements outlined within this report demonstrate the dedication and collaborative efforts of our staff, partners, patients and public contributors, whose support is integral to the success of our research portfolio. We would also like to express my sincere gratitude to the members of our communities who have participated in our research studies. Their willingness to take part in research is fundamental to advancing knowledge, improving healthcare services and delivering better outcomes for current and future generations.

At CTMUHB, we recognise that research is essential to the delivery high-quality healthcare. By continuing to foster a strong and inclusive research culture, we can help shape a health and care system that is preventative, person-centred, evidence-based and responsive to the needs of our population. We are proud of what we have achieved together over the past year and look forward to building on this success in the year ahead.

Professor Lauren Edwards
Executive Lead for R&D

Professor John Geen
Assistant Director for R&D

Who's Who



Professor Lauren Edwards, Executive Lead for Research & Development

Lauren is the Executive Director of Allied Health Professions and Health Science at Cwm Taf Morgannwg University Health Board, appointed in April 2022. She provides clinical leadership and strategic direction for AHP, healthcare science services and the wider organisation, driving service transformation, workforce development, and improved outcomes. Lauren is a Visiting Professor at the University of South Wales and is the Health Board's lead Executive for Research and Development. She is also a Trustee of the Royal College of Speech and Language Therapists.

Lauren is committed to advancing the impact of AHPs and healthcare science, championing research and innovation, value-based healthcare, and equitable access, and working across partnerships to ensure services meet the needs of the population.



Professor John Geen, Assistant Director for Research & Development

After obtaining his PhD in 1999 and FRCPath in 2006, John became a Consultant Clinical Biochemist in 2007. John is the Clinical Lead for CTMUHB's Clinical Biochemistry and Point of Care Testing Services.

He is a Visiting Professor of Clinical Science at the University of South Wales and Honorary Professor of Clinical Biochemistry at Cardiff Metropolitan University. John is the Clinical Lead for Workforce and Education, working with the National Performance and Improvement Pathology Programme team.

John's research interests include point of care testing, renal disease, and biomarkers. Other professional roles and interests include teaching at undergraduate and post graduate levels, exploring and progressing career development routes for Health Care Scientists in the NHS and developing and supporting research access and opportunities for all professions in the NHS.



Mrs Carolyn Donoghue, Board Champion for Research

Mrs Carolyn Donoghue is an experienced, highly skilled senior executive and Non-Executive Director with significant experience in the NHS and Higher Education in England and Wales. Originally qualifying as a Registered General Nurse, she later developed a clinical career – including a period of time in Western Australia – before moving into training and senior management. Carolyn held a number of senior roles in the NHS in Bristol before moving into Higher Education in the University of Bristol and latterly Cardiff University as College Registrar.

Carolyn has now developed a portfolio career which includes the role of Magistrate, Chair of the South East Wales Student Mental Health Project, Chair of the Welsh Wound Innovation Centre and Independent Member of the Board of Governors, University West of England. She also holds various voluntary roles in the local community.

Carolyn is a passionate advocate of the benefit of theatre and choirs, having participated in amateur dramatics and local choirs for many years. A more recent passion is Park Run, both volunteering and running.

Introduction

Research is central to improving health and care outcomes across Wales and supports the Welsh Government's ambitions to enhance the social, economic, environmental and cultural well-being of the population, as set out in the *Well-being of Future Generations (Wales) Act 2015*. Through a whole-system approach to health and social care, aligned with *A Healthier Wales* (2018), research drives innovation, supports prevention and early intervention, informs evidence-based practice, and contributes to improved outcomes for patients, service users and communities.

Within CTMUHB, research is a key enabler of the CTM2030 Strategy: Our Health, Our Future, supporting the prevention of ill-health and delivery of high-quality, evidence-based care across all stages of life. By generating new knowledge and translating evidence into practice, research can help ensure that local people can live happier and healthier lives for as long as possible.

Welsh Government is responsible for health and social care research policy, strategy and funding in Wales, and funds and oversees Health and Care Research Wales, which provides the infrastructure necessary to support the national research and development agenda. As part of this infrastructure, NHS research and development departments provide local leadership and support for the governance, management and delivery of research across NHS Wales.

Within CTMUHB, the Research and Development (R&D) Department plays a key role in enabling the delivery of high-quality research, supporting researchers and clinical teams, and ensuring that research is accessible, relevant and beneficial to the people and communities we serve. The Department also contributes to a range of national initiatives led by Health and Care Research Wales, including the Embedding Research in the NHS Programme and the PRIORITY Project, helping to strengthen research culture, capacity and capability across NHS Wales.

Health and Care Research Wales NHS R&D Framework

The NHS R&D Framework published in July 2023 outlines “what research excellence looks like within NHS Organisations in Wales where research is embraced, integrated into services, and is a core part of the organisation’s culture”. The Framework defines ten key pillars that support the development of a research active and supportive NHS organisation. Following completion of a baseline assessment in 2023, Cwm Taf Morgannwg University Health Board (CTMUHB) undertook a refreshed assessment in March 2026. The findings, which were submitted to Welsh Government and discussed as part of the annual review process, demonstrated significant progress across a number of key areas and identified opportunities for further development.

10 Pillars of a research supportive organisation



10 Pillars of a Research Supportive Organisation outlined in the NHS R&D Framework

R&D Leadership and Governance

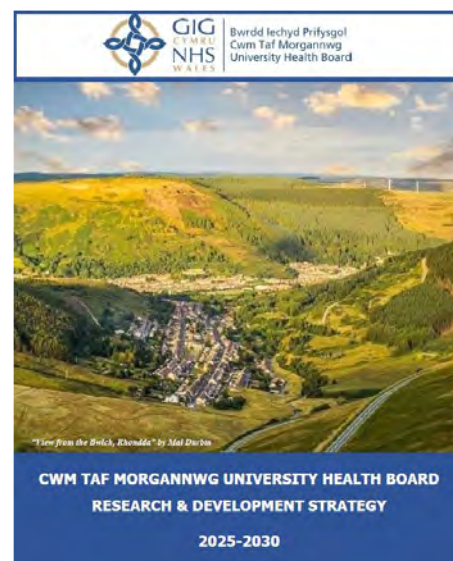
The Executive Director of Allied Health Professions and Health Science was appointed as the CTMUHB's Executive Lead for Research and Development (R&D) in November 2025. Together with the Assistant Director for R&D, they provide strategic, professional and clinical leadership for the Health Board's R&D functions, staff and financial resources. A nominated Independent Board member continues to champion R&D at the Board and across the organisation.

The R&D Group continues to meet triannually to set the strategic direction of the UHB's research agenda, oversee departmental performance, and assure the Health Board via reporting to the Quality, Safety and Experience Committee that arrangements are in place for the effective strategic management of R&D activities across the UHB. Membership includes representatives from the clinical executives, care groups, academic partners and the Rhondda Cynon Taf's Health Determinants Research Council (HDRC).

CTMUHB R&D Strategy 2025-30

Developed through extensive consultation and collaboration with Welsh Government, Health and Care Research Wales, Higher Education Institution partners, and colleagues from across CTMUHB, the Research & Development Strategy 2025–2030 was approved by the Board on 31 July 2025 and formally launched at the CTMUHB R&D Conference in November 2025.

The strategy sets out a clear vision for strengthening and expanding research across the organisation and aims to increase research activity, enhance visibility, develop infrastructure, and foster a vibrant research culture. A central ambition is to establish research as a core function of the Health Board, supporting the delivery of high-quality care and aligning with UK, Welsh national, and CTM UHB priorities and policies.



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

The strategy sets objectives that span primary, secondary, community and social care, as well as population health, and applies to all specialties and professional groups, both clinical and non-clinical. It is supported by a comprehensive action plan, enabling monitoring and reporting on the delivery of the strategy to the R&D Group, Executive Leadership Group and Quality, Safety and Experience Committee. [R&D Strategy 2025-30 - Cwm Taf Morgannwg University Health Board](#)

CTMUHB R&D Infrastructure

The role of CTMUHB’s R&D team is to facilitate the set-up, delivery and quality assurance of research across CTMUHB to include primary, secondary and community care and population health. The provision of support and advice relates to all matters pertaining to the research pathway from the generation of a study idea to research findings dissemination. The R&D team assesses organisational capacity and capability for both hosted and sponsored studies and allocates Research Nurse, Research Midwife, Research Physiotherapist, Research Officer and Research Assistant time

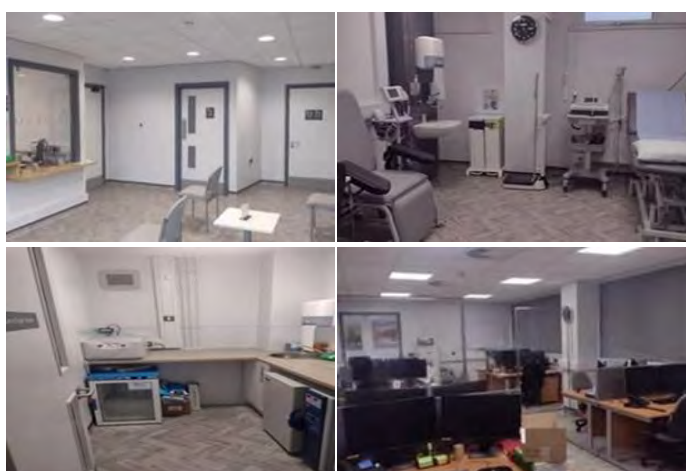
based on study needs and available capacity. The R&D Department also funds ring-fenced time within Public Health, Pathology, Pharmacy and Radiology to ensure essential support services are available for research, as well as an R&D Finance Analyst to manage research income, study costing and excess treatment costs.



CTMUHB's R&D team at the annual CTMUHB R&D Conference 2025

The continuous review of the R&D staffing infrastructure led to the addition of a Band 6 Research Nurse to support non-commercial and commercial research. Furthermore, local investment has supported the recruitment of a Band 6 Research Nurse and a Junior Clinical Research Fellow to support the delivery of commercial research in Cardiology at Princess of Wales Hospital.

Following the establishment of the Clinical Research Centre at Royal Glamorgan Hospital, opportunities to deliver both commercial and non-commercial research have been significantly enhanced. A key strategic objective has been to expand the R&D infrastructure at Prince Charles Hospital and Princess of Wales Hospital through the provision of dedicated clinical and administrative space to further support research delivery. As part of a phased development at Prince Charles Hospital, dedicated clinical and administrative accommodation has been secured for R&D, with occupation scheduled from October 2026. At the Princess of Wales Hospital, discussions with the Health Board's Senior site leadership team continues to secure dedicated clinical and additional administrative space, to further support the expansion of research activity at this site and the provision of equitable research support and access to research across the UHB.



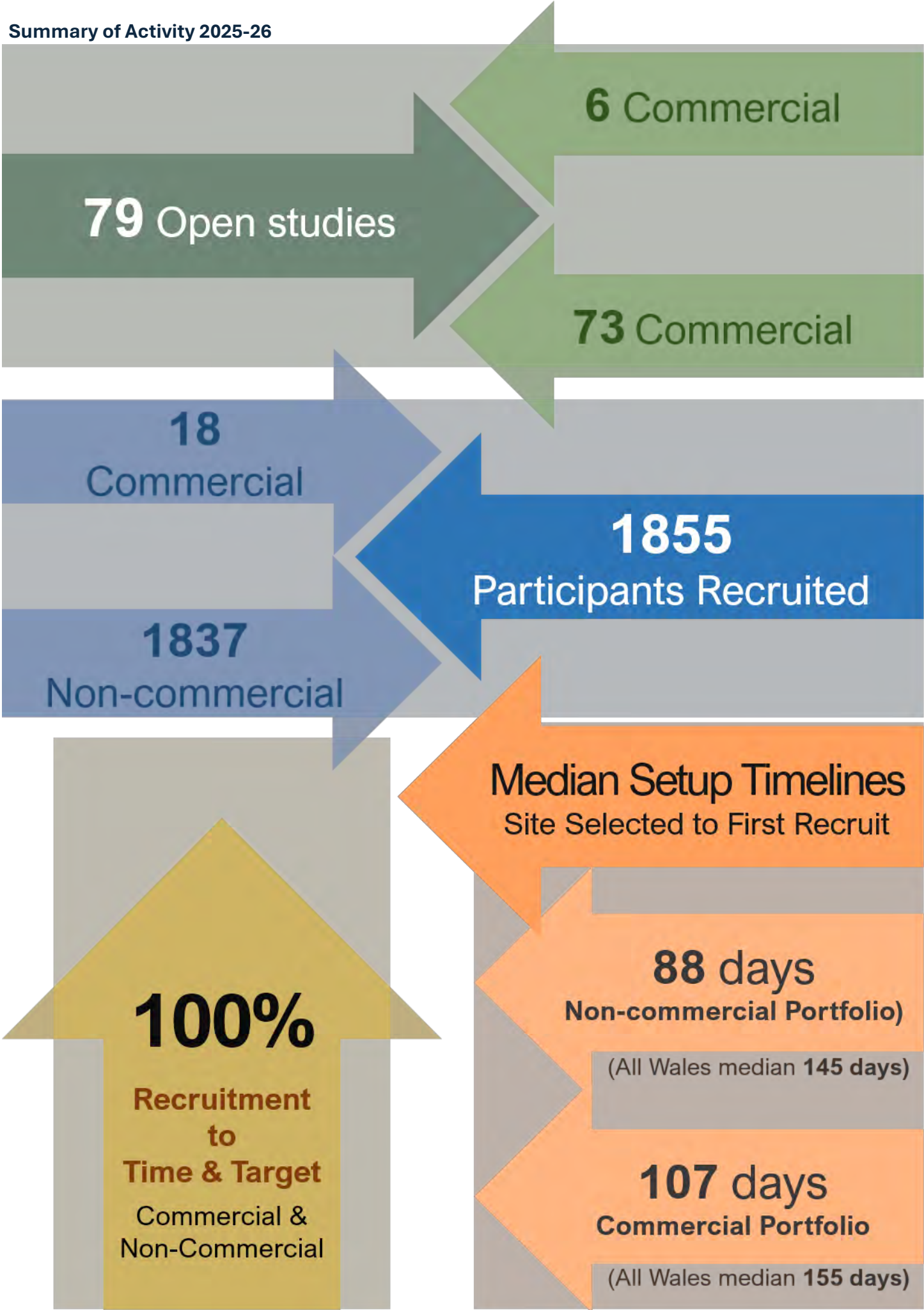
Clinical Research Centre, Royal Glamorgan Hospital

The R&D Department has enhanced its digital research infrastructure through the implementation of the Florence electronic Investigator Site File (eISF) system, supporting more efficient and streamlined study management. The R&D Department also provides CTMUHB researchers with access to software that supports both qualitative and quantitative data analysis.

R&D Activity

Clinical Research Portfolio activity during 2025–26 has remained strong, with continued expansion and sustained growth in participant recruitment across a range of specialties to include rheumatology, gastroenterology, ENT, critical care, stroke, oncology, surgery, mental health, midwifery, endocrinology, respiratory, population health, physiotherapy and diagnostics.

The delivery of commercial research remains a key strategic objective and in addition to continuing activity in cardiology, dermatology and primary care, the R&D team have supported the set-up of a commercial study in endocrinology and are supporting the delivery of a commercial study in psychiatry (dementia). Research active colleagues in rheumatology, neurology, endocrinology and ENT are working with the R&D team to seek appropriate studies and complete expressions of interest to develop their commercial research portfolios.



Highlights



**CTMUHB
Highest
Recruiter**

TIPTOE
QuicDNA
expansion



**1st Recruit in
Wales**

Colocap
ME-HF



**1st Recruit in
UK**

SHELLS

Collaboration with industry, academic and local authority partners

The R&D Department continues to meet and collaborate with its academic, industry and local authority partners to optimise research opportunities and promote the development of joint grant applications. The R&D team actively shares grant and personal award opportunities and supports researchers with costing, and application completion. The R&D team actively promotes patient and public involvement (PPI) throughout the research process, encouraging the appropriate inclusion of public involvement in grant applications, sufficient funding for their time, and ensuring representatives are named as co-applicants.

Collaborator	Funder	Project Title	Amount Awarded
Cardiff University	Kidney Research UK Allied Health Professional Fellowship (Clinical)	Arteriovenous Fistula Stenosis and Failure: Identifying individuals at risk and exploring their perspectives. A sequential mixed-methods study	£181,467
Cardiff Metropolitan University	Health and Care Research Wales Integrated Funding Scheme	Maximising the Impact of Speech and Language Therapy for children with Speech Sound Disorder Phase 2	£295,887
Llusern/ University of South Wales	SBRI Centre of Excellence	Reducing preterm births by improving antenatal infection screening pathways in a high-risk population	£57,500
Get U Better Ltd	SBRI Centre of Excellence	Scaling Innovative Pelvic Health Support for Women and Girls in Wales	£124,130
Imperial College, Cardiff University, Cardiff & Vale UHB	Engineering and Physical Science Research Council	Multi-platform pipeline for engineering human shoulder joint function	£2,635,227.27
N/A	Health and Care Research Wales	VPAG Workforce Fellowships 2025/26 Audiology)	£4784
N/A	Health and Care Research Wales	VPAG Workforce Fellowships 2025/26 (Pharmacy)	£1507

CTMUHB Successful Collaborative grants/personal awards 2025/26

Previously awarded research grants continue to be supported to include the delivery of the PREDICT-EV study, looking at identification of novel biomarkers to predict stroke risk after transient ischaemic attack, in collaboration with Cardiff Metropolitan University and the set-up of a trial to evaluate a treatment for hypothyroidism, in collaboration with Cardiff University. Following the award of an NIHR Programme Development Grant to Cardiff University for “*Living with ADHD: Developing a Nationwide Platform for ADHD*”, CTMUHB agreed to act as the NHS host organisation, enabling the funding to be released. The grant agreement was completed and the study has now commenced.

CTMUHB continues to support the Rhondda Cynon Taf Health Determinants Research Collaboration (HDRC), which secured £5 million National Institute for Health and Care Research (NIHR) funding from January 2024 to December 2028. The partnership, involving Rhondda Cynon Taf County Borough Council, Interlink RCT, Cardiff University and CTMUHB is developing research infrastructure and capacity within the local authority to strengthen the use of evidence and research in addressing the wider determinants of health across the county.

CTMUHB’s R&D Collaborative Academic Research Funding Scheme 2025-26

CTMUHB’s Department provides an annual Collaborative Academic Research Funding scheme to support staff to develop new research ideas and partnerships with an academic institution to address current healthcare challenges. 4 applications were awarded funding:

Collaborator	Project Title	Amount Awarded
Cardiff Metropolitan University	PREDICT-EV: Identification of brain biomarkers associated with Transient Ischemic Attack (TIA)	£3432
Cardiff Metropolitan University	Co-designing an ACL prehabilitation pathway to enhance surgical readiness and patient outcomes across CTMUHB	£2500
Swansea University	Understanding stakeholder requirements for an Electronic Medication Administration Records (eMAR) Platform for Domiciliary Care in Bridgend: A qualitative study to inform specification and implementation	£2360
Cardiff University	Evaluation of Phase 2 of a Specialist Parent-Infant Relationship Service in CTM	TBC

CTMUHB’s R&D Collaborative Academic Research Funding Scheme 2025-26 Successful Applications

Financial Summary

Research Income	Current Year	Previous Year
Research Delivery Funding	£1,472,086	£1,364,024
Excess Treatment Costs	£51,385	£28,995
VPAG funding	£38146	£122,826
Non-commercial grant income – HCRW	£0	£54,000
Non-commercial grant income – Charities	£28,156	£131,905
Non-commercial grant income – NIHR	£49,118	£38,859
Non-commercial grant income – other	£53,538	£3,963
Commercial research income	£310,621	£78,656
TOTAL INCOME	£2,003,050	£1,823,228

R&D Training & Engagement

The R&D Department continues to work with the University of South Wales and CTMUHB's Nurse Education team to host placements for student nurses with 7 placements hosted during 2025-26 and positive feedback received.

Presentations on the CTMUHB and national strategic approach, agenda and ambitions continue to be made to staff groups both within and outside the UHB. The R&D team also continues to signpost CTMUHB staff to the NIHR and Health and Care Research Wales training programmes and Associate Principal Investigator (API) Scheme, with 29 having completed the API Scheme since its inception.

R&D Conference

CTMUHB's 15th annual R&D conference took place on 26th November 2025 at the Vale Resort, Hensol, showcasing the high quality multi-disciplinary and multi-professional research being undertaken across the UHB, as well as providing an opportunity for delegates to network and develop further research collaborations. In addition to the keynote speaker, Professor Christopher George, Chair of the National Cardiovascular Research Network, there were 10 oral and 63 posters presentations documenting the considerable range of research being undertaken by all professions. The event was the best attended to date, with 256 delegates from the NHS, academia, industry, Welsh Government and patient representatives. The event was shared through CTMUHB's and Health and Care Research Wales's social media.

R&D Conference 2025 Prize Winners:

1st Prize:

Integration of liquid biopsy into lung cancer diagnostic pathway: QUICDNA by Professor Magdalena Meissner, Medical Oncology Consultant at Velindre Cancer Centre and Clinical Senior Lecturer at Cardiff University.

2nd Prize:

UTI-Friday: A review of antibiotic prophylaxis in the management of recurrent UTI in primary care by Avril Tucker, Principal Pharmacist in Antimicrobials and Immunology, Cwm Taf Morgannwg University Health Board.

3rd Prize:

Co-producing and refining a behaviourally-informed intervention to empower nurses to address smoking and promote smoking cessation by Dr Jessica Baillie, Principal Researcher – Public Health, Cwm Taf Morgannwg University Health Board.



Professor John Geen- Assistant Director for R&D with the 1st, 2nd and 3rd place researchers for oral and poster presentations- CTMUHB R&D Conference 2025.

Case Study: Evaluating a Blood Test for Earlier Detection of Bowel Cancer

CTMUHB partnered with Welsh life sciences company CanSense to evaluate CanSense-CRC, an innovative blood test designed to support the earlier detection of bowel cancer and pre-cancerous polyps.

Bowel cancer is one of the most common cancers worldwide and remains a significant cause of death. Early diagnosis is critical to improving survival rates; however, symptoms are often vague and can make timely diagnosis difficult.

Patients with bowel symptoms are typically assessed using the Faecal Immunochemical Test (FIT), which analyses stool samples to determine whether further investigations are required. Patients identified as higher risk are usually referred for colonoscopy, an invasive procedure that places considerable demand on NHS diagnostic services.

Growing demand for colonoscopies has increased pressure on healthcare services, highlighting the need for innovative approaches that can support earlier diagnosis and improve patient pathways.

CanSense-CRC uses a technique called Raman Spectroscopy, where a laser light is directed at a blood sample to produce a unique spectral pattern. This pattern is then analysed by advanced artificial intelligence software to assess the likelihood of bowel cancer or early-stage growths known as polyps. It functions much like a barcode scanner, but for blood, providing a fast and accurate risk assessment.

By combining the CanSense-CRC blood test with the existing FIT pathway, researchers aim to improve cancer detection rates while



reducing unnecessary invasive investigations.

CTMUHB is the only health board in Wales participating in this research study, with patient recruitment taking place at Prince Charles Hospital and Royal Glamorgan Hospital. The study is led by Professor Dean Harris, Consultant Colorectal Surgeon at Swansea Bay UHB and Clinical Director of Cansense with Professor John Geen, Consultant Clinical Biochemist and Mr Parin Shah, Consultant Colorectal Surgeon acting as Chief Investigator and Principal Investigator respectively.

The project is funded through the Cancer Challenge Fund, a collaboration between the SBRI Centre of Excellence in Wales and the Innovation and Market Development Unit in Northern Ireland, supported by the Welsh Government and the Northern Ireland Department for the Economy.

The project demonstrates CTMUHB's commitment to supporting innovation and collaboration with Welsh industry partners. The findings are expected to inform how the technology could be integrated into future NHS diagnostic pathways, with the potential to improve patient outcomes, reduce waiting times, and ease pressure on diagnostic services. The project was detailed as a key project in the Wales Cancer Plan.

Case Study: Advancing Lung Cancer Diagnostics Through the QuicDNA Study

CTMUHB successfully participated in the QuicDNA Study, a multi-centre research project led by Cardiff and Vale University Health Board and Cardiff University's Centre for Trials Research. The study explored whether a simple blood test, known as a liquid biopsy, could be used alongside routine diagnostic pathways to help guide treatment decisions for patients with lung cancer more quickly.

Traditionally, patients attending Rapid Access Lung Clinics undergo a tissue biopsy, where a sample of tumour tissue is analysed to identify the genetic changes driving the cancer. While effective, this process can take time and may require additional procedures.

The QuicDNA study investigated whether fragments of tumour DNA circulating in the bloodstream, known as circulating tumour DNA (ctDNA), could provide the same genomic information through a blood sample. Researchers assessed whether this approach could deliver results more rapidly, enabling patients to start the most appropriate treatment sooner and

potentially reducing the need for repeat biopsy procedures.

CTMUHB joined the study in May 2024 when it was expanded across Wales. By the time recruitment closed, CTMUHB had recruited 165 participants, making a significant contribution to the study.

CTMUHB's successful delivery of this project reflected the commitment of all involved and a strong collaboration between the Respiratory and R&D teams.

The research has contributed to progress in an emerging field of diagnostics that is expected to play an increasingly important role in future cancer investigation pathways, with the potential to improve patient outcomes and reduce delays in accessing targeted treatments.

The CtDNA blood test has been formally incorporated into the Optimal Lung Cancer Diagnostic Pathway for England and Wales.



Case Study: Advancing Understanding of Long COVID

Researchers from Cardiff Metropolitan University and CTMUHB (Critical care, Clinical Biochemistry) collaborated on a study investigating the biological factors linked to Long COVID, a condition that can cause ongoing symptoms such as fatigue, breathlessness, pain, and cognitive difficulties following COVID-19 infection.

Funded through the CTMUHB Collaborative Research Fund, the study involved 175 participants who had previously contracted COVID-19. Researchers analysed blood and DNA samples to investigate the role of Interleukin-6 (IL-6) and IL-6 Receptor (IL-6R), key components of the body's immune response. Participants also completed questionnaires about their symptoms throughout the year to examine the impact of seasonal changes.

The study found that individuals experiencing Long COVID had higher levels of IL-6 than those who had fully recovered. Findings also suggested that people with a specific genetic variation of the IL-6R gene may be at increased risk of developing Long COVID.

These findings provide important insights into the biological mechanisms underlying Long COVID and highlight the potential for IL-6-related markers to be used in identifying individuals at greater risk of the condition.

The research has laid the foundation for further studies aimed at developing targeted treatments and improving long-term outcomes for patients living with Long COVID, while strengthening research collaboration between CTMUHB and Cardiff Metropolitan University.



Dr Richard Webb, Cardiff Metropolitan University



Case Study: Improving Hip Fracture Recovery Through Research

CTMUHB is participating in WHiTE 15 – Initiate, a national physiotherapy research trial sponsored by the University of Oxford and delivered at Royal Glamorgan Hospital. The study aims to determine whether enhanced physiotherapy and earlier mobilisation following hip fracture surgery could help patients recover more quickly, return home sooner, and maintain their independence for longer.

Hip fractures are among the most serious injuries affecting older adults, often leading to reduced mobility, loss of independence and significant health and social care costs. Recovery can be challenging, with many patients unable to regain their previous level of function following surgery.

As a participating site, CTMUHB has provided patients with access to an important national research study exploring new approaches to rehabilitation. The trial is investigating the impact of additional physiotherapy support during the first week after surgery, including tailored exercise programmes, walking practice, patient information and psychological support to encourage early movement and recovery.

John Rice, Advanced Practitioner and Research Physiotherapist at CTMUHB, highlighted the importance of the study, noting that how best to deliver physiotherapy-led rehabilitation after hip fracture surgery has been a longstanding unanswered question and an identified research priority for patients, families and healthcare professionals. He also emphasised CTMUHB's commitment to embedding research into clinical practice and ensuring patients have opportunities to participate in studies that can improve future care.

Through its involvement in WHiTE 15 – Initiate, CTMUHB contributed to research that has the potential to shape future rehabilitation pathways for hip fracture patients. The study reflects the Health Board's commitment to research-led improvement, helping to generate evidence that could enhance recovery, support independence, improve patient outcomes and reduce pressures on health and social care services.

Case Study: Think Quit – Empowering Nurses to Support Smoking Cessation

Smoking remains the leading cause of preventable death worldwide, CTMUHB serves a population with some of the highest smoking rates in Wales. Although the national Help Me Quit service significantly increases a person's chances of successfully quitting, referral rates from healthcare professionals remained low.

To address this, researchers from CTMUHB, the University of South Wales, and the Behavioural Science Unit at Public Health Wales secured funding from the Burdett Trust for Nursing to deliver the Think Quit study between June 2024 and August 2025.

The study explored the factors that influenced nurses' willingness to discuss smoking cessation with patients and make referrals to Help Me Quit. One of the key barriers identified was that nurses rarely received feedback about the outcomes of their referrals, making it difficult to see the impact of these conversations.

Working closely with nurses and key stakeholders, the research team co-designed the Think Quit intervention. Launched at Royal Glamorgan Hospital in November 2025, the initiative provided nurses with feedback on the outcomes of their referrals, helping them understand the value of their actions and increasing confidence in initiating conversations about smoking cessation.



Think Quit research team sharing co-designed materials

Feedback from participating nurses showed the intervention helped demonstrate that referrals were worthwhile, encouraged greater engagement with the referral process, and reinforced that supporting smoking cessation is a shared responsibility across healthcare teams.

The Think Quit project demonstrated CTMUHB's ability to lead and deliver high-quality, externally funded research focused on improving public health outcomes. By empowering nurses to play a greater role in smoking cessation, the study has the potential to increase referrals to support services and improve long-term health outcomes for patients. The project also showcased the strength of collaboration between CTMUHB, academic partners and public health organisations in developing practical, evidence-based solutions to healthcare challenges.

The Think Quit study led to the development of a feedback loop providing nurses with feedback on the results of their smoking cessation referrals, helping them feel confident and empowered to start these conversations with patients. The ThinkQuit intervention was launched at the Royal Glamorgan Hospital in November 2025.

Forward Look

The R&D Department will continue to support and work across the UHB with all stakeholders, to embed research as a core function in all that we do at CTMUHB through the inclusion of research in the organisation's service delivery, workforce development and Integrated Medium Term Plan.

The R&D Department will support the successful set-up and delivery of high-quality research aligned with organisational priorities and the population health needs of the communities we serve.

Through re-investment of research income, continue to develop the R&D infra-structure to increase the number of Commercial studies open and recruiting across CTMUHB.

Aim to develop and secure designated space for clinical and administrative functions of the research department at Princess of Wales Hospital sites, to provide equitable access to research for the local population.

R&D department to work closely with the Wales Cancer Research Network (WCRN) to increase cancer research across CTMUHB, facilitated by the identification of a CTMUHB champion for Cancer research.

The R&D department will continue to monitor study set up and delivery metrics to ensure compliance with the new and existing nationally agreed measures of performance.

Horizon scan for new technologies, diagnostics and health care infra-structure (e.g. Llantrisant Health park, Health Determinants Research Collaborations) to optimise research opportunities that will inform future NHS service delivery.

Continue to evaluate the demographic profile of participants recruited and investigate the potential of recording additional data for analysis e.g. ethnicity, health status.



Your Voice Matters

A Patient Experience Survey for Research Participants in Wales

What is it?

A short (approx. 10 minutes to complete), confidential survey about your experience of taking part in research, to help improve how research is delivered across Wales.

Who can take part?

Anyone who has had a research appointment or study activity.

What will you be asked?

- How clearly the study was explained
- The information you received
- Your interactions with research staff
- How comfortable and supported you felt
- Your overall experience of taking part in research

How do I complete it?



Scan the QR code on your phone or email CTMUHB_RD@wales.nhs.uk for other ways to take part (paper or email, where available).

Also available in:

- **Cymraeg**
- **Polski**
- **Română**
- **Punjabi**
- **Urdu**
- **Português**
- **Español**
- **Bengali**
- **Gujarati**
- **Arabic**
- **Italiano**
- **Easy Read**
- **British Sign**

Why your feedback matters:

- Helps improve patient experience
- Shapes how research is delivered in Wales
- Makes research more accessible and inclusive for everyone

Taking part is voluntary and your care will not be affected.

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday, 21 July 2026, 09:00 - 12:00PM
Venue	Virtually via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Hayley Proctor	Independent Member
	Kath Palmer	Vice Chair
	Rhys Goode	Independent Member
	Neil Mesher	Independent Member
	Patsy Roseblade	Independent Member
In Attendance	Gethin Hughes	Chief Operating Officer (In part)
	Philip Daniels	Executive Director of Public Health
	Richard Hughes	Executive Director of Nursing
	Lauren Edwards	Executive Director of Allied Health Professionals & Healthcare Sciences
	Sharon O'Brien	Care Group Nurse Director – Planned Care
	Gaynor Jones	Staff Side Representative
	Chris Beadle	Assistant Director of Health, Safety & Fire
	Nigel Downes	Assistant Director of Quality & Safety
	Carl Verrecchia	Care Group Service Director, DTSP and Children & Families
	Gary Howell	Clinical Director, Allied Health Professionals
	Lucie Owen	Care Group Nurse Director – Primary Care & Community
	Debbie Jones	Head of Midwifery, Gynaecology, ISH and Neonates (In part)
	Owen Weeks	Medical Director, Unscheduled Care
	Becky Gammon	Interim Deputy Director of Nursing
	Deborah Matthews	Care Group Nurse Director – Unscheduled Care

	Louise Stait	Interim Assistant Director of Governance & Risk
	Anthony Gibson	Deputy Medical Director (In part)
	Claire Taylor	Llais Cymru
	Hannah Wilton	Chief Pharmacist
	Emma Walters	Head of Corporate Governance & Board Business
	Nia Giles	Physiotherapist (In part)
	Jacqueline Francis	Care Group Nurse Director – Mental Health
	Stephen Gardiner	Facilities Service Director
	Nadine Long	Deputy Head of Safeguarding (In part)
Meeting Observers		

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: • Dom Hurford, Executive Medical Director • Suzanne Hardacre, Director of Midwifery • Stephanie Muir, Head of Concerns, Clinical Audit & Compliance
1.3	Declarations of Interest
	Declarations of interest were received and noted.
2.	CONSENT AGENDA BUSINESS
2.1	C Donoghue reminded Members that the agenda included consent items at the end of the agenda. She asked if there were any items from the Consent Agenda that Committee Members wished to bring forward to the main agenda for discussion. There were no items Members wished to bring forward.
3.	GOVERNANCE/COMMITTEE BUSINESS ACTIVITY
3.1	Action Log
	The Committee reviewed the action log and agreed the proposed actions for closure. Members noted the updates provided against ongoing actions.
Resolution	The Committee NOTED the Action Log.
Action	None identified.
3.2	Matters Arising not Contained within the Action Log
Resolution	The Committee NOTED that there were no further matters arising.
Action	None identified.



3.3	Committee Annual Self Effectiveness Survey Outcome 2025-2026 & Improvement Plan
	C Donoghue presented the Committee Annual Self Effectiveness Survey Outcome 2025-2026 and Improvement Plan to Members for discussion. Key actions included refreshing the Committee Cycle of Business to align with the Integrated Performance Review, reviewing the visibility of staff safety issues through the role of the Health, Safety and Fire Committee, and exploring opportunities to increase the use of Welsh language within the Committee meeting. Members discussed the Welsh language feedback arising from the Committee's self-effectiveness review. L Edwards welcomed greater use of the Welsh language within Committee meetings, and L Stait advised that there were a number of practical measures that could be implemented to support this. It was agreed that further discussions would take place with the Welsh Language Team to identify opportunities to increase the use of Welsh within Committee meetings, with feedback to be provided to the Committee in due course.
Resolution	The Committee NOTED the survey outcome and improvement plan.
Action	Further discussions to take place with the Welsh Language Team to identify opportunities to increase the use of Welsh within Committee meetings, with feedback to be provided to the Committee in due course.
3.4	Annual Review of the Committee Terms of Reference
	L Stait presented the report and advised that the Board had previously reviewed and approved the Terms of Reference. No amendments were proposed at this stage
Resolution	The Committee NOTED the annual review of the Committee Terms of Reference.
Action	None identified.
4.	IMPROVING CARE
4.1	Shared Listening & Learning Story - Falls Prevention in the Community
	N Giles presented the Shared Listening and Learning Story, which focused on falls prevention in the community. L Edwards welcomed the prevention-focused, community-based approach and its alignment with Health Board priorities. She sought assurance regarding how the service integrated with wider falls prevention activity and highlighted the importance of confidence-building in reducing the future likelihood of falls. In response, N Giles advised that, whilst a range of falls-related services existed, provision remained fragmented and would benefit from a more integrated multidisciplinary pathway. She highlighted the need for a coordinated regional falls pathway involving a range of disciplines, including medical, dietetic, podiatry and continence services. R Hughes welcomed the service as an example of the Health Board's community-first approach and queried how its impact could be measured against wider falls data. He highlighted the importance of evaluating longer-term outcomes and noted the potential benefits in reducing loneliness and social isolation. N Giles advised that the service had now reached a stage where longer-term behavioural change and outcomes could be assessed, including participation in



community exercise programmes and potential reductions in future admissions related to frailty and falls.

K Palmer sought assurance regarding the sustainability of the service, opportunities to scale up provision to meet increasing demand and potential use of online resources for patients, families and carers. N Giles confirmed that funding was currently sustainable, but demand was exceeding capacity, requiring careful management of referrals and publicity. She also acknowledged the significant benefits of peer support and outlined plans to introduce a 12-month follow-up event to support long-term behavioural change. She also confirmed that online resources had not yet been developed but agreed there was potential to explore this in the future.

G Howell informed Members that the service benefited from permanent Welsh Government funding and highlighted ongoing work to explore the use of the “Keeping Me Well” digital platform to provide information and signposting for the public.

G Hughes emphasised the importance of integrating the service with wider falls prevention initiatives and highlighted the psychological impact of falls on confidence and independence. He suggested that expert patients and peer-support networks could be used to strengthen and extend the service model.

H Proctor welcomed the service and highlighted its positive impact on patient outcomes and service demand. She emphasised that falls are often linked to a range of factors beyond strength and balance and supported the development of a multidisciplinary approach to falls prevention. N Giles confirmed that patients were already being signposted to relevant services but agreed that a fully integrated multidisciplinary model would represent the gold standard approach.

P Daniels welcomed the service as an example of population health management in practice and emphasised the importance of measuring long-term outcomes, including healthcare utilisation, to demonstrate the impact of preventative interventions. He also noted that it was encouraging to see the tangible benefits and patient outcomes arising from the application of population health management data. N Giles welcomed this approach and agreed that future evaluation should focus on longer-term outcomes and healthcare impacts.

B Gammon highlighted the opportunity to align the Falls Prevention Service with the Falls and Deterioration Operational Workstream and Harm Free Care Programme to strengthen multidisciplinary collaboration and support wider organisational learning. Nia Giles confirmed that the service was already engaging within this network and welcomed further collaboration.

C Donoghue welcomed the presentation and recognised the significant contribution the Falls Prevention Service was making to prevention, independence, community wellbeing and reducing future demand on acute services. She echoed Members’ comments and commended the service as an excellent example of preventative, person-centred care. She recognised the evidence demonstrating the positive impact of the service and highlighted the

	importance of developing a more integrated multidisciplinary approach to falls prevention. C Donoghue congratulated N Giles and the wider team on their achievements and highlighted the importance of maintaining a strong focus on prevention and early intervention to support independence and reduce avoidable demand on acute services
Resolution	The Committee NOTED the Shared Listening and Learning Story on falls prevention in the community.
Action	None identified.
4.2	Thematic Spotlight Presentation - Hospital at Home
	L Owen presented an overview of the Hospital at Home Service, highlighting its contribution to supporting earlier discharge from hospital, reducing delayed transfers of care and enabling more care to be delivered within the community. P Roseblade sought assurance regarding patient readmission rates and queried whether an action plan was in place to address areas requiring further improvement. In response, L Owen confirmed that readmission data was collected by the service and advised that, whilst improvement actions were being progressed, a consolidated action plan would be developed to support oversight and monitoring. C Donoghue queried whether workforce gaps were attributable to funding constraints or recruitment challenges. L Owen advised that both factors had contributed and explained that the ongoing service evaluation would help determine the future workforce model and staffing requirements needed going forward. K Palmer welcomed the positive outcomes achieved by the service and sought assurance regarding opportunities to scale up the model and ensure its long-term sustainability. She also queried the assessment process for patients identified as suitable for discharge but subsequently found not to be appropriate for the pathway. In response, L Owen advised that such cases were reviewed through the Integrated Discharge Board and highlighted that patient needs were assessed daily. She confirmed that further work was underway to improve the accuracy of pathway allocation and discharge information. L Owen also noted the challenges associated with multiple digital systems operating across community services and welcomed the suggestion that a formal action plan be developed to support oversight and service improvement. In response to a question from P Roseblade regarding delays in transferring patients to longer-term care arrangements, G Hughes provided additional context regarding the service, highlighting its positive contribution to reducing delayed transfers of care and supporting patients within their own homes. He advised that the service had demonstrated positive early outcomes and formed part of a wider programme of community-based care. He acknowledged challenges associated with transferring patients to longer-term care arrangements, particularly where delays in care package provision affected service capacity and confirmed that discussions were ongoing with local authority partners to address these issues. G Hughes further emphasised the



	importance of developing admission avoidance pathways and strengthening links with community-based services. H Proctor welcomed the progress made by the service and highlighted the importance of accelerating development of the admission avoidance model to reduce pressure on emergency departments and support long-term sustainability. She also queried the impact of earlier service changes on admission avoidance capacity and requested that future reporting provide a broader Health Board-wide picture of performance. L Owen confirmed that the evaluation would inform future workforce requirements and that live performance dashboards were being developed to support improved reporting and oversight. D Matthews queried the patient cohorts supported by the service, including referral sources, the impact of local authority demand, and whether the model could be extended beyond Pathway 1 to support the increasing number of Pathway 3 patients and those with cognitive impairment. In response, L Owen advised that detailed patient cohort and local authority data was available and acknowledged that further work was required to understand barriers affecting patients with cognitive impairment and to explore opportunities to support a broader range of patient pathways. N Mesher congratulated the team on the service development and queried how the model could be expanded and supported through digital solutions. He also highlighted the potential wider system benefits of supporting patients in their own homes and suggested learning could be drawn from similar models elsewhere. L Owen acknowledged the progress made to date, the significant work undertaken to establish the service and the need for continued development as the service matured. C Donoghue welcomed the positive impact of the Hospital at Home Service, recognising its role in preventing admissions, supporting earlier discharge, reducing delays and enabling more care to be delivered closer to home, thereby reducing reliance on acute services. She congratulated L Owen and the wider team on their achievements and looked forward to receiving the evaluation report, together with the review of future workforce and service requirements.
Resolution	The Committee NOTED the thematic spotlight presentation on Hospital at Home.
Action	A consolidated Hospital at Home action plan to be developed to support oversight and monitoring of service improvements, informed by the ongoing service evaluation, including future workforce requirements, admission avoidance pathways, pathway allocation, digital reporting and opportunities to support a broader range of patient cohorts. The action plan and evaluation report is to be presented to a future meeting.
4.3	Thematic Spotlight Presentation – Nutrition & Catering
	S Gardiner share a presentation providing an overview of the work being undertaken to improve nutrition and hydration across the Health Board, including the reinstatement of the Nutrition and Hydration Steering Group, implementation of catering bed plans, staff training, menu development and ongoing work to improve data collection, digital solutions and patient feedback.



D Matthews welcomed the report and highlighted the benefits of the digital catering bed plan approach, noting that it had improved efficiency, reduced risk and enhanced support for patients requiring assistance at mealtimes. She also raised concerns regarding the impact of extended visiting hours on catering staff. In response, S Gardiner acknowledged the challenges associated with open visiting and welcomed continued ward-level leadership support to address these issues.

L Owen welcomed the move towards a standardised catering approach across CTM and highlighted the benefits this would bring for patients transferring between community hospital sites.

G Howell welcomed the report and highlighted the importance of the work being undertaken to improve nutrition and hydration across the Health Board. He emphasised that malnutrition remained a significant issue amongst the inpatient population and noted that, whilst areas such as pressure ulcers and diabetes often receive considerable attention, a significant proportion of inpatients were at risk of malnutrition. He highlighted the importance of the initiatives outlined within the report in improving patient outcomes and acknowledged the need to explore options for specialist catering dietetic support, noting that work was ongoing in this area.

R Hughes welcomed the report and noted that the detail provided helped to demonstrate the operational work underpinning the nutrition and hydration agenda. He highlighted the importance of linking this work more closely with the Harm Free Care Programme and emphasised the need to continue developing digital solutions to support a more consistent and efficient approach across the Health Board. He also acknowledged the challenges associated with open visiting arrangements and noted the importance of supporting ward teams to ensure nutrition and hydration needs continued to be met effectively.

K Palmer welcomed the report and the focus being given to nutrition and hydration. Drawing on her lived experience, she queried how menus were tailored to meet the needs of different patient groups and sought assurance that patients were being offered appropriate food choices. She also highlighted the importance of access to drinks and refreshments and queried progress in relation to beverage and breakfast trolleys. In addition, K Palmer enquired how improvements in nutrition and hydration outcomes would be measured and reported in future.

In response, S Gardiner advised that menus were developed to meet a broad range of nutritional needs; however, he highlighted the importance of dietetic involvement in menu development to ensure that meals provide appropriate nutritional and calorific value for patients. He noted that further collaboration with dietetic colleagues would support future menu development and service improvement. He also confirmed that replacement beverage and breakfast trolleys were being procured and advised that work was underway to develop performance measures, patient feedback mechanisms and key performance indicators to support future monitoring and improvement.

	B Gammon advised that an evaluation of visiting arrangements was underway and would include consideration of the impact on mealtimes. She also highlighted ongoing work to improve the consistency and measurement of nutrition and hydration data through the Nutrition and Hydration Operational Group. H Proctor queried the variation in catering models across hospital sites and sought assurance regarding future consistency of service delivery. In response, S Gardiner advised that wider implementation of ward-based catering had previously been considered by the Board; however, progression remained subject to financial and operational constraints. N Giles highlighted an opportunity to support patient independence and reduce deconditioning by encouraging appropriate patients to collect their own food and refreshments during their hospital stay. Members welcomed the suggestion and supported further consideration of the proposal. G Hughes welcomed the suggestion that appropriate patients could be encouraged to collect their own food and refreshments to support independence and reduce deconditioning. He also highlighted that CTM was fully compliant with Welsh Nutrition Standards and provided assurance regarding the quality controls and governance arrangements in place within the Central Production Unit. P Roseblade queried whether food waste was routinely monitored and whether analysis was undertaken to identify trends in meal uptake and opportunities to improve menu planning and portion sizes. In response, S Gardiner advised that overall food waste was monitored across sites, but plate waste was not currently measured consistently. He acknowledged the importance of understanding food waste, portion sizes and patient consumption and advised that further work was required in this area to support future service improvement. C Donoghue acknowledged the significant work that had been undertaken to improve services and highlighted key themes arising from the discussion, including digitalisation, patient feedback, staff education, ward-based support and food waste. C Donoghue thanked S Gardiner and the wider team for their work and recognised the challenges involved in delivering high-quality nutrition and catering services across the Health Board.
Resolution:	The Committee NOTED the presentation
Action:	None identified
4.4	The Path to Safer Beginnings in Wales: A National Assurance Assessment of Maternity and Neonatal Care Services (Holland 2026)
	D Jones presented the findings of the National Assurance Review, commissioned by Welsh Government, and provided an update on progress within CTM. She explained the key developments including the implementation of the BadgerNet digital system, establishment of the Maternal and Neonatal Assurance Oversight Group, progress in maternity triage arrangements, workforce review activity, strengthened governance processes and enhanced engagement with families and service users.



	R Hughes welcomed the report and recognised the progress being made within CTM, whilst highlighting the importance of remaining mindful of the wider national context and the increasing focus on maternity services arising from a number of national reviews and inquiries. He noted that these reviews had heightened public, political and regulatory interest in maternity services and emphasised the importance of ensuring that learning from external reviews continued to inform local improvement activity. He stressed the need to provide robust assurance regarding the quality and safety of maternity services whilst maintaining proportionate governance arrangements that supported frontline staff and clinical leaders in delivering safe and effective care. R Hughes further highlighted the importance of reviewing data, workforce requirements and models of care to ensure services remained sustainable and responsive to the needs of women and families. He advised that discussions had taken place with the Committee Chair and Vice Chair regarding the future development of reporting arrangements to ensure the Committee received meaningful assurance on service quality, safety and improvement activity. K Palmer welcomed the establishment of the Maternal and Neonatal Assurance Oversight Group and queried whether sufficient capacity and resources were available to deliver the range of improvements required. In response, R Hughes acknowledged the importance of ensuring that sufficient capacity and resource were available to support both service improvement and assurance activity. He advised that dedicated resource was already in place within the Maternity Service to support a number of the improvement programmes and emphasised the need to maintain an appropriate balance between service delivery, governance and improvement activity. He confirmed that capacity requirements would continue to be reviewed as the work progressed. D Jones added that improvements in data visibility and accessibility would enable more meaningful scrutiny, challenge and assurance to be provided in future. C Donoghue welcomed the progress being made and highlighted the importance of undertaking a gap analysis to ensure that learning from national maternity reviews and inquiries was captured within local improvement plans. She noted that communication, consistency and culture were recurring themes across a number of reviews and stressed the importance of receiving meaningful assurance in these areas through future reporting.
Resolution	The Committee NOTED the national assurance assessment of Maternity and Neonatal Care Services.
Action	None identified.
4.5	Sexual Health Safeguarding Issues - Closure Report
	N Long presented the closure report relating to safeguarding issues identified following the review of the Test and Post Service, which had previously been reported to the Committee. Members noted that the review had identified a number of safeguarding concerns and that significant progress had since been made to strengthen arrangements. Key developments included strengthened governance and safeguarding processes, enhanced training, revised pathways,

	the establishment of the Child and Family Assurance Group, and the implementation of audit and assurance work plans. P Roseblade noted that, whilst the report primarily focused on issues identified within the Public Health Wales service, concerns remained regarding local digital processes. She highlighted that, in addition to issues relating to referral inboxes, there were limitations within the digital forms themselves, particularly in relation to age verification, which had also been identified through Independent Member visits. P Roseblade suggested that further consideration should be given to the Health Board's IT provision for sexual health services and that this should be reflected within the recommendations. In response, N Long acknowledged that age verification and the lack of real-time assessment had been identified as key learning points through the review. She advised that changes had since been implemented, including enhanced safeguarding assessments and real-time intervention processes, and confirmed that further work would continue to strengthen local systems and safeguarding arrangements. R Hughes noted the issues raised and advised that they would continue to be considered through the CTM Safeguarding Group. He noted that, whilst the review originated from issues affecting the Public Health Wales service, there was important learning for all organisations across Wales. He further advised that assurance reviews undertaken jointly by the Health Board, Public Health Wales and safeguarding partners had not identified any high-risk cases that had not already been reviewed. R Hughes emphasised the importance of embedding the learning arising from the review within local safeguarding arrangements and governance processes and confirmed that the Health Board would continue to work closely with Public Health Wales and safeguarding partners to ensure improvements were sustained. P Daniels welcomed the report and commended the way in which the issues had been managed. He highlighted the positive partnership working demonstrated across organisations and noted that services had been maintained whilst improvements were implemented and safeguarding arrangements strengthened. He described the response as an example of effective organisational learning and collaboration within CTM. C Donoghue welcomed the progress made and emphasised the importance of ensuring that operational issues identified through Independent Member visits and assurance reviews were addressed promptly. She noted that, whilst some concerns may appear operational, they could impact service quality and safety if not appropriately monitored and acted upon. C Donoghue highlighted the need for clear mechanisms to track, report and provide assurance that actions arising from Independent Member visits had been implemented and sustained.
Resolution	The Committee NOTED the Sexual Health Safeguarding Issues Closure Report.
Action	Clear mechanisms to be established for tracking, reporting and providing assurance that actions arising from Independent Member visits and assurance reviews are implemented and sustained.
4.6	Patient Boarding within CTM UHB, Quality, Safety and Strategic Position



R. Hughes presented the report on patient boarding within CTM UHB, including the quality, safety and strategic position. Members noted that patient boarding had been discussed at the previous meeting, where concern was raised that the practice should not become normalised and should remain subject to continued Committee oversight.

R Hughes advised that boarding continued to be used as a mechanism to support patient flow and there were increasing levels of boarding now being observed outside of the traditional winter period. Whilst boarding remained a recognised escalation measure, concerns remained regarding its impact on patient experience and the ward environment.

He advised that a formal review of current boarding practices was being commissioned to assess compliance with existing policies, understand the associated risks and identify opportunities to reduce reliance on boarding arrangements. He confirmed that the scope of the review was currently being developed and that the findings would be considered by the Executive Management Board before being reported back to the Committee

G Hughes provided additional context, advising that the use of boarding was a symptom of wider system pressures relating to admissions, discharge processes and patient flow. He highlighted the importance of addressing underlying issues, including delayed discharges and the timing of patient discharges, and advised that the review would support understanding of how reliance on boarding could be reduced over time.

K Palmer welcomed the planned review and queried whether it would consider the suitability of individual boarding spaces, noting that she had observed considerable variation in the quality and layout of boarding areas during visits. She also requested clarification regarding the difference between double and triple boarding. In response, G Hughes explained the operational arrangements associated with boarding and confirmed that the physical environment and associated risks would be included within the scope of the review.

C Donoghue noted that the discussion also highlighted the importance of language and terminology, stating that the term “boarding” could potentially minimise the impact of what, in some circumstances, was comparable to corridor care.

H Proctor welcomed the proposed review and emphasised the importance of ensuring that it was undertaken comprehensively across all hospital sites and specialties to provide a complete overview of the risks and impacts associated with boarding. R Hughes acknowledged the point and confirmed the importance of ensuring a robust and comprehensive review.

G Jones queried whether the review would also consider the use of empty ward areas that were not routinely staffed, and the impact this had on staffing, particularly where staff were required to move between wards to provide cover. She highlighted the stress this could place on both patients and staff. In response, R Hughes acknowledged concerns raised by Trade Union colleagues and advised that, whilst the initial focus would be on boarding spaces, the wider

	consequences of boarding and the use of additional capacity would also require consideration. This would include workforce impacts, patient safety, equipment availability and staff wellbeing. He also highlighted the potential for moral injury among staff and emphasised the importance of gaining greater assurance that appropriate staffing, equipment and safety arrangements were consistently in place when additional capacity was opened. S O'Brien highlighted concerns regarding the environmental conditions within some boarding areas, particularly during periods of extreme heat and cold. She noted that when boarding had been suspended during periods of extreme heat, additional surge capacity had been opened elsewhere within the organisation. She suggested that the review should consider whether the suspension of boarding had any impact on patient flow and capacity management. She also emphasised the importance of capturing patient feedback, including feedback from patients located adjacent to boarding spaces, to better understand the wider impact on patient experience. C Donoghue reiterated the Committee's concerns regarding boarding and emphasised that it should not become normal practice. Whilst recognising the operational pressures facing the Health Board, she highlighted the importance of fully understanding the risks associated with boarding for both patients and staff. The Committee welcomed the proposed review and looked forward to receiving further assurance regarding boarding arrangements, associated risks and opportunities to reduce reliance on boarding.
Resolution	The Committee NOTED the report on patient boarding within CTM UHB and the associated quality, safety and strategic position.
Action	A formal, comprehensive review of patient boarding arrangements to be undertaken across hospital sites and specialties, to assess compliance with existing policies, understand the quality, safety, workforce and patient experience risks, consider the suitability of boarding spaces and wider use of additional capacity, and identify opportunities to reduce reliance on boarding. The findings are to be considered by the Executive Management Board and reported back to the Committee for assurance.
5.	CREATING HEALTH
5.1	Infection, Prevention & Control Annual Report 2025-2026
	R. Hughes presented the Infection, Prevention and Control Annual Report 2025-2026 and highlighted the key matters for Members' attention. C Donoghue welcomed the report and recognised the significant progress that had been made in developing the community Infection Prevention and Control service. She highlighted the importance of continuing to address compliance with Infection Prevention and Control training, particularly amongst medical and dental staff, and welcomed the actions being taken to strengthen assurance and performance in this area. K Palmer welcomed the report and highlighted the importance of infection prevention and control from both a patient safety and workforce perspective. She noted the impact that healthcare-associated infections could have on bed capacity, patient flow and staff sickness absence, and emphasised the



	importance of ensuring that infection prevention and control remained a Health Board-wide priority. R Goode welcomed the report and queried the relatively low compliance levels in infection prevention and control training amongst medical and dental staff. In response, R Hughes acknowledged the concern and advised that discussions were taking place regarding whether a different approach was required for this staff group. He noted that the current approach had not achieved the desired level of compliance and advised that a review was underway to better understand barriers and determine the most appropriate way forward. He confirmed that this would continue to be monitored through the Infection Prevention and Control Committee. B Gammon advised that further work was being undertaken to improve data capture relating to medical staff training compliance, noting that some staff groups did not use ESR in the same way as other employees. She also confirmed that the vacant Band 7 post had been redesigned into a Practice Development role and had now been successfully appointed to, which would support future education and training activity. C Donoghue welcomed the report and recognised the significant progress made in developing the community infection prevention and control service.
Resolution	The Committee NOTED the Infection, Prevention and Control Annual Report 2025-2026.
Action	None identified.
	ADDITIONAL ITEM: Health Visitor Industrial Action
	C Donoghue requested an update on the ongoing Health Visitor industrial action, specifically seeking assurance regarding the arrangements in place to mitigate risks associated with service disruption, particularly in relation to quality, safety and safeguarding. In response, R Hughes advised that a risk-based approach had been implemented from the outset of the industrial action, prioritising support for the most vulnerable children and families. He explained that this had involved increased collaboration with partner agencies, including local authorities, police and education services, together with support from other Health Board services such as community midwifery and children's community nursing teams. R Hughes acknowledged that, whilst a prioritised service continued to be delivered, the full universal Health Visiting offer was not currently being provided due to capacity constraints arising from the ongoing industrial action. He noted that the situation continued to generate concern amongst constituents and Senedd Members, with whom he had recently met to discuss the potential impact on children and families. R Hughes advised that the position remained under close operational review and that a current position paper was being prepared for Board consideration. It was agreed that, once considered by Board, the paper would be brought back to the Committee to provide further assurance and enable Members to

	triangulate the information presented to Board with the Committee's ongoing quality, safety and safeguarding oversight responsibilities.
Resolution	The Committee NOTED the update regarding the ongoing Health Visitor industrial action and that a current position paper was being prepared for Board consideration
Action:	Following Board consideration, the Health Visitor Industrial Action Position Paper to be brought back to the Committee to provide further assurance and enable Members to triangulate the information presented to Board with the Committee's ongoing quality, safety and safeguarding oversight responsibilities.
6.	CONSENT AGENDA
6.1	FOR APPROVAL
6.1.1	Unconfirmed Minutes from the meeting held on 3 June 2026
Resolution	The Unconfirmed Minutes of the Committee Meeting held on 3 June 2026 were APPROVED.
6.1.2	Unconfirmed Minutes from the In Committee held on 3 June 2026
Resolution	The Unconfirmed Minutes of the In Committee meeting held on 3 June 2026 were APPROVED.
6.2	FOR NOTING
6.2.1	Non-Routine Committee Business (Forward Plan)
Resolution	The Committee NOTED the Forward Plan.
6.2.2	Annual Cycle of Business
Resolution	The Committee NOTED the Annual Cycle of Business.
6.2.3	Controlled Drug Accountable Officer (CDAO) Report: April 2025 – March 2026
Resolution	The Committee NOTED the report.
6.2.4	National Prescribing Indicators
Resolution	The Committee NOTED the report.
6.2.5	Human Tissue Act Compliance Report
Resolution	The Committee NOTED the report.
6.2.6	Organ Donation Sub Committee Highlight Report
Resolution	The Committee NOTED the report.
6.2.7	Clinical Audit Update – for Awareness on Clinical Outcomes from Audits Report (January – June 2026)
Resolution	The Committee NOTED the report.
7.	CLOSE OUT BUSINESS
7.1	Committee Highlight Report to the Board
	The Chair and Committee considered the key matters to be included within the Committee Highlight Report to the Board. C Donoghue advised that she would provide a verbal update to Board, highlighting key areas including patient boarding and the proposed review, ongoing Health Visitor industrial action, maternity and neonatal assurance themes arising from A Path to Safer Beginnings, and positive assurance received in relation to Hospital at Home and Falls Prevention.
7.2	Meeting Feedback
	C Donoghue invited feedback from Members, including whether the Committee had managed its time effectively, maintained a strategic focus and received sufficient assurance from a range of sources.



	R Hughes reflected on the recent scheduling of Committee meetings and noted that having meetings in close succession had enabled more time for discussion and detailed consideration of key quality, safety and experience issues. He acknowledged the additional effort required from Care Groups and supporting teams in preparing papers within shorter timescales but considered that the approach had facilitated valuable discussion, highlighted areas of good practice and supported focused consideration of areas requiring further attention. C Donoghue welcomed the feedback and noted that the revised meeting format had provided greater opportunity for discussion of key issues. She suggested that this could be considered further during future agenda planning to ensure an appropriate balance between assurance reporting and meaningful Committee discussion.
Resolution:	The Committee NOTED the feedback
Action:	The revised format from this meeting to be considered for future agenda planning discussions.
7.3	Any Other Business
	C Taylor from Llais highlighted ongoing concerns regarding the sustainability of Special School Nursing provision, particularly in light of the planned opening of a new school. She advised that concerns regarding workforce sustainability and vacancies had previously been raised and requested clarification regarding future arrangements. In response, Richard Hughes advised that the matter would be referred to the Children and Families Care Group for consideration and that an update would be provided to the Committee through the appropriate governance route
Action:	Ongoing concerns raised by Llais Cymru regarding the sustainability of Special School Nursing provision to be referred to the Children and Families Care Group for consideration. Update to be provided to a future meeting of the Committee through the appropriate governance route
8.	PRIVATE/CLOSED SESSION BUSINESS
8.1	Private/Closed Session Business
	There were no matters requiring discussion in closed session on this occasion.
9.	DATE & TIME OF NEXT MEETING
9.1	Date and Time of Next Meeting
	The next meeting is scheduled to take place on Tuesday 22 September 2026 at 9:00am.



Quality, Safety & Experience Committee

Health, Safety and Fire Subcommittee Highlight Report

Eitem yr Agenda / Agenda Item	6.1.2
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
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, Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee are being asked to NOTE the report and APPROVE the revised Fire Safety Policy
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context:</i> <i>This report aligns to the following Strategic Pillars</i>	Sustaining Our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable - this is a routine Committee Highlight Report to the Board.

1. Introduction

1.1 This report has been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its meeting held on 21 July 2026.

1.2 Key highlights from the meeting are reported under Section 3 below.

2. Purpose of this Meeting

2.1 The purpose of the Health, Safety & Fire Sub Committee is to provide assurance to the Quality, Safety & Experience Committee in relation to the Health Board's arrangements for the effective management of health, safety and fire matters across the organisation.

3. Highlight Report

Alert / Escalate	The Sub Committee agreed that the recurring issue of inappropriate storage and obstruction of fire escape routes should be highlighted to the Quality, Safety & Experience Committee. This issue has been raised at previous meetings and remains a site-wide concern requiring continued operational focus and oversight. The matter was specifically identified during discussion of the Fire Safety Report, with members agreeing that it should be included in the Committee's onward reporting.
Advise	- The Sub Committee received a verbal update on the future governance arrangements for health, safety and fire. Members were advised that work is underway to consider whether the current forum should remain an assurance committee or move towards a more management-focused model. This will include consideration of overlap with patient safety, consistency of reporting across care groups and the level of operational detail currently presented to the Sub Committee. A further report will be brought back to the next HSFC meeting. - The Sub Committee endorsed the revised Fire Safety Policy(appendix 1) for approval by the Quality, Safety & Experience Committee at its next meeting - Members were advised that a new organisational risk is being developed in relation to violence and aggression, unauthorised access and site-specific vulnerabilities. This is intended to unify and improve visibility of strategic health and safety risk themes which "cut across" multiple Care Group risk registers.
Assure	The Sub Committee received a shared listening and learning story on the management of nitrous oxide within Maternity Services. Members received assurance on the work



undertaken to assess and manage staff exposure risk, including environmental monitoring, improved controls, staff training and risk management assessments. Monitoring had been completed at Prince Charles Hospital and Princess of Wales Hospital, with further work progressing at Royal Glamorgan Hospital.

In response to a member query, the Sub Committee was advised that enquiries had not identified confirmed cases of harm associated with staff exposure to nitrous oxide, and that staff feedback on the work undertaken had been positive.

- The Sub Committee received the Assistant Director of Health, Safety & Fire Report. Members noted that there had been no formal Health and Safety Executive inspections or reportable incidents requiring follow-up intervention, while also noting ongoing work in relation to hazardous medicinal products and asbestos management.
- Members received assurance on the Health Board's manual handling equipment replacement programme, including Welsh Government capital funding for the replacement of ageing hoists and flat lifting equipment. The Sub Committee also noted that work is being undertaken with Estates and Procurement colleagues to ensure appropriate maintenance arrangements are in place.
- The Sub Committee received the Fire Safety Report and noted that one active fire enforcement notice remains in place at Prince Charles Hospital, relating to a small area of H Block. Members were advised that the previous notice relating to theatre areas at Princess of Wales Hospital was no longer active following refurbishment works.
- The Sub Committee received the Overarching Care Group Health, Safety & Fire Report. Key matters highlighted included community lift reliability, heatwave-related pressures, parking issues at Royal Glamorgan Hospital, boarding arrangements and statutory and mandatory training compliance. Members were advised that health and safety governance arrangements are now in place at Care Group level, with information feeding through operational governance structures.
- The Sub Committee received assurance from the Estates Safety and Compliance Report on asbestos management. Members noted the NHS Wales Shared Services Partnership audit outcome of reasonable assurance, with five of six areas receiving substantial assurance and two medium-priority



	recommendations relating to the Authority to Proceed process and training compliance. Members were advised that actions were well advanced, with asbestos training compliance reported at 98%. • The Sub Committee received the Health, Safety & Fire Performance Report and noted key themes from incidents, claims and statutory and mandatory training compliance. Members were advised that violence and aggression remained the most reported staff safety incident type and that work continued to improve incident coding, reporting and targeted support.
Inform	• The Sub Committee approved the draft minutes of the meeting held on 4 September 2025 and the draft minutes of the In Committee meeting held on 4 September 2025. • The Sub Committee noted the Annual Cycle of Business and the Estates Assurance follow-up report. • Members thanked Dilys Jouvenat for her contribution and leadership as Chair of the Sub Committee, noting the progress made in strengthening governance and organisational oversight of health, safety and fire matters during her tenure.
Appendices	Not applicable

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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)	Not applicable — this report provides a routine summary of Sub Committee business. However, the matters considered support the Health Board's wider arrangements for managing quality, safety, workforce and organisational risk.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A More Equal Wales A Healthier Wales A Resilient Wales



Link to Wellbeing of Future Generations Act – Wellbeing Goals	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Leadership
	Culture & Valuing People
	Learning, Improvement & Research
Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
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: Not applicable — this is a routine Committee Highlight Report. Outcome for Welsh Language: Not applicable — this is a routine Committee Highlight Report. Named Executive/Board member sign off for no EWLIA completion: Gareth Watts, Board Secretary and Director of Governance
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 — this is a routine Committee Highlight Report and does not propose a service change or decision requiring a Quality Impact Assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report Any relevant regulatory matters are being managed through the appropriate operational and governance routes.
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
Resource implications relating to specific operational matters are managed through the relevant operational and executive routes.

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

Committee / Group / Individuals	Date	Outcome
Health, Safety & Fire Sub Committee	21/07/2026	Key matters noted, endorsed or escalated as set out in this report.

Acronyms / Glossary of Terms

CTMUHB	Cwm Taf Morgannwg University Health Board
HSE	Health and Safety Executive
NWSSP	NHS Wales Shared Services Partnership
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
QSEC	Quality, Safety & Experience Committee
ORR	Organisational Risk Register
V&A	Violence and Aggression

Fire Safety Policy

Document Type:	Policy
Indicate Clinical or Non-Clinical:	Non-Clinical
Document Reference:	HSF02
Document Author (Title Only):	Assistant Director of Health, Safety & Fire / Senior Fire Officer
Document Executive Director Sponsor	Executive Director of Workforce & Organisational Development
Date Equality and Welsh Language Impact Assessment Completed:	01/09/2021
Freedom of Information Act Status (For Policies Only)	Open
	If indicated as closed please indicate exemption that has been applied: ()
Approving Forum:	Quality, Safety & Experience Committee
Approval / Effective from Date:	01/09/2021
Review date due by:	02/09/2029
Document Version:	1.0
Target Audience	All Staff

Disclaimers

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

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



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Cwm Taf Morgannwg
University Health Board



Components

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

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

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non-Clinical Policy Development please contact:

ctm.qualityassurancecompliance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint.

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Policy Reference Number: HSF02

Policy Title: Fire policy

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Introduction

1. Policy Statement

CTMUHB, as with all NHS organisations in Wales, must comply with legislation relating to fire safety and the Welsh Government policy.

CTMUHB is committed to comply with all the statutory requirements of fire safety legislation, operationally and for existing and new builds. CTMUHB must be satisfied that all buildings within its control meet current legislation, for the protection of the relevant person(s).

Where occupation of other buildings by CTMUHB staff is known the 'responsible persons' for these buildings are made aware of their responsibilities towards fire safety legislation and the safety of the CTMUHB staff and users.

All contracts for health services placed by commissioners must contain clauses to ensure the premises comply with, and will continue to comply with, all statutory fire safety legislation, CTMUHB Fire Policy and associated Fire policy documentation, and provisions relevant to the building and service provided.

When commissioning new buildings, leasing new buildings, or occupying buildings under PPP/PPI contract, the HB must be satisfied that such buildings comply with the legislation relating to fire safety.

Definitions (as defined in the RR(FS)O)

Relevant person: Any person (including the responsible person) who is or may be lawfully on the premises and any person in the immediate vicinity of the premises who is at risk from a fire on the premises.

Responsible person:

(a) in relation to a workplace, the employer, if the workplace is to any extent under his control;

(b) in relation to any premises not falling within paragraph (a)—

(i) the person who has control of the premises (as occupier or otherwise) in connection with the carrying on by him of a trade, business or other undertaking (for profit or not); or

(ii) the owner, where the person in control of the premises does not have control in connection with the carrying on by that person of a trade, business or other undertaking.

2. Scope of Policy

This Policy is aimed at those who may use CTMUHB premises, especially those who may be classed as the responsible person(s), relevant persons (as defined in the RRFSO 2005) managers, staff, volunteers, and other agencies working, or undertaking duties within CTMUHB.

Independent contractor services are responsible for identifying and managing their own risks, due to the CTMUHB's contractual relationship with them. To achieve that, CTMUHB has robust processes in place to identify areas of high risk and address concerns and are committed to supporting the independent contractor services with risk management.

3. Aims and Objectives

3.1 Text This Policy has been produced by Cwm Taf Morgannwg University Health Board (CTMUHB) to meet the requirements of current fire legislation - Regulatory Reform Fire Safety Order RR(FS)O 2005, NHS Firecode – Welsh Healthcare Technical Memorandum 05 series (WHTM) and codes of practice. It applies to all premises used by CTMUHB and where CTMUHB patients receive treatment.

The aim of CTMUHB is that of the Welsh Government, to minimise the:

- incidence of fire and unwanted fire signals;
- impact of fire on life safety, delivery of service, the environment and property.

CTMUHB has noted the contents of the Welsh Government fire policy issued under cover of WHC [2006] 74.

3.2 This Policy forms part of the CTMUHB health and safety regime and is augmented by other fire safety related documentation and procedures (available electronically via the Fire webpage of the intranet).

The organisation through the Chief Executive will ensure:

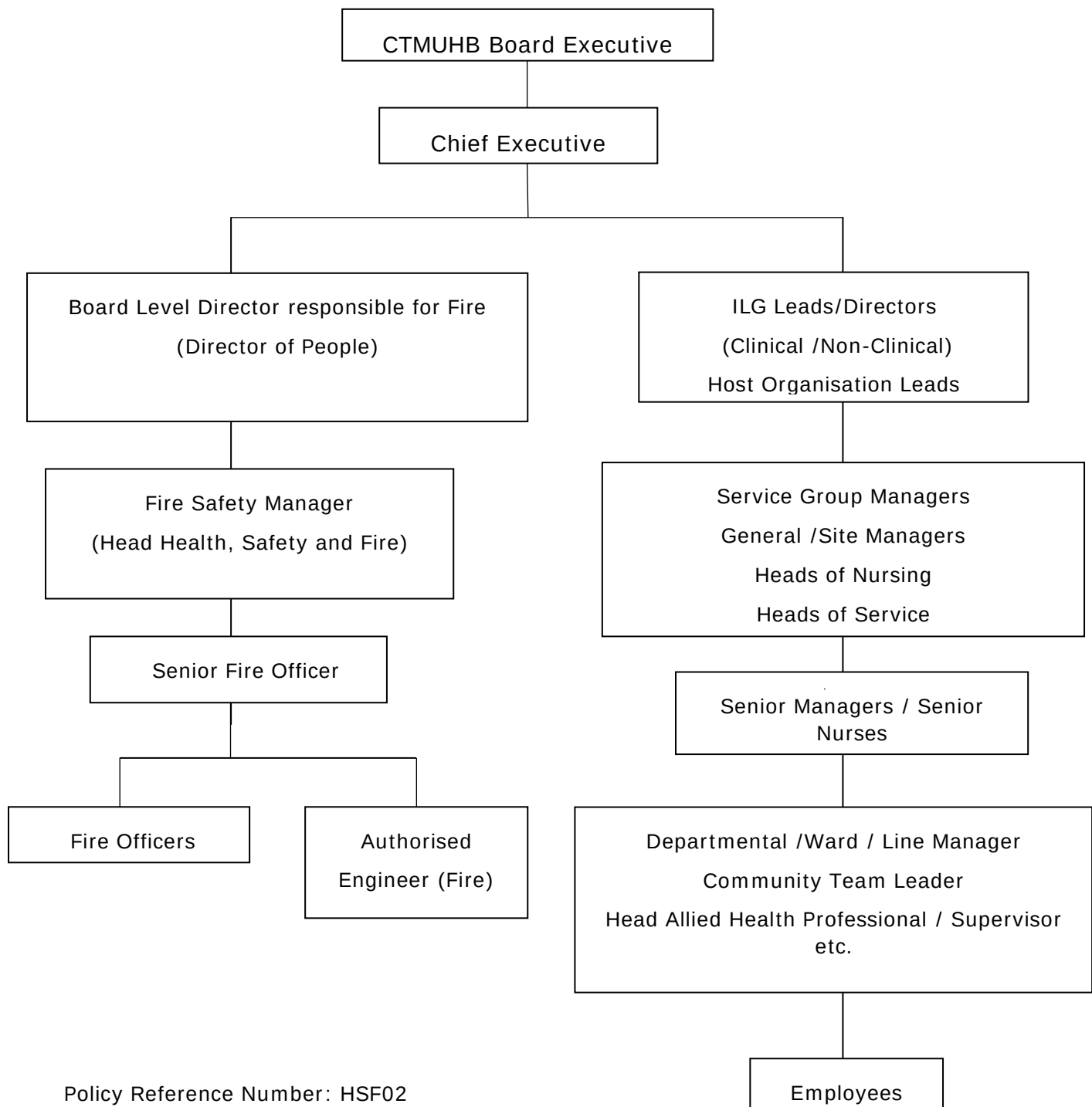
- that it creates a safe work environment by undertaking the required risk assessments of the significant findings involved in the work activities of the organisation, implementing the identified control measures and providing relevant fire safety training for all its employees / volunteers based on safe working practices, current legislation and training needs analysis;

- the Board supports the development of appropriate organisational structures and a culture, which encourages risk control and secures the full participation of everyone, in a manner that is consistent with the Regulatory Reform Fire Safety Order 2005 RR(FS)O;
- the commitment of senior managers to workplace fire safety is maintained, ensuring the management of workplace fire safety is given at least equal importance as all other management functions;
- it maintains, improves, monitors and reviews the effectiveness of this Fire Policy, its organisation and arrangements annually;
- the appointment of a Board Level Director (BLD) to champion Fire Safety; (*Director of People*);
- the appointment of a Fire Safety Manager (FSM) (*Head of Health, Safety and Fire*) and the provision of a suitably resourced fire safety function. To meet the requirements of current legislation and given the authority required to act as the “competent person(s)”, Fire Safety Officers (FSO), providing the assistance the organisation requires to comply with current fire safety legislation / WHTM. All employees specifically appointed to assist in the provision of fire safety advice or support will be provided with the necessary fire safety training / qualifications or special expertise and continual professional development to ensure they can carry out their duties, where this cannot be provided internally external advice will be outsourced;
- it will establish and maintain effective fire safety group(s) and structure, which meets the requirements of current legislation / WHTM guidance, and the needs of the organisation and its employees;
- it will promote effective cooperation and communication between management, staff and external agencies relative to fire;
- it will provide the facilities, resources and time to enable managers and safety representatives to carry out their tasks and duties;
- the formal delegation of fire safety duties and responsibilities to ILG, Service Group and Departmental Management Teams, via this policy and the issuing of Fire Risk Assessments (FRA);

- the effective control of contractors who may come onto organisation premises, ensuring such contractors are competent;
- this Policy is brought to the attention of all employees.

4. Responsibilities

Managerial Responsibilities



4.1 CTMUHB Board

It is the responsibility of the Board to ensure that the organisation meets its legal obligations under the current fire legislation. The Board must ensure adequate funds and resources are available to meet the organisations fire safety requirements and periodically review the effectiveness of the Policy and personnel under their control to whom fire safety responsibilities have been assigned.

4.2 Chief Executive

The Chief Executive shall have overall responsibility for the Policy and fire safety within all CTMUHB owned / head leased premises, and for staff occupying other buildings for CTMUHB business purposes. The Chief Executive shall ensure:

- all statutory requirements are observed and implemented;
- the implementation of Firecode or any fire safety legislation applicable to organisations premises;
- the provision of appropriate fire safety policies and programmes of work for maintaining and improving precautions at all the organisations premises;
- that an Executive Director shall be appointed with nominated responsibility for fire safety matters;
- the appointment of a Fire Safety Manager for the organisation.

4.3 Director with Nominated Responsibility for Fire (BLD for Fire) Director of People

The Director of People is responsible for leading fire safety issues and will assist the Chief Executive and Board in their responsibilities for fire safety. They will ensure that fire safety issues are brought to the attention of the Board and the Chief Executive. The Director of People in conjunction with the Fire Safety Manager will be responsible for the upkeep of the Fire Policy, the coordination of fire safety management and be the point of contact for any fire safety issues for the organisation. As nominated Director they will ensure:

- a Fire Safety Manager is appointed;
- the relevant authorities are informed for serious or untoward fire related incidents;
- the organisation obtains suitable and sufficient competent advice regarding fire safety from either within or external sources where appropriate;
- the organisation obtains competent advice regarding Dangerous Substances Explosive Atmosphere Regulations;
- the development and implementation of the Fire Policy in line with the organisations Risk Management Strategy;
- a procedure is in place for the supervision of contractors carrying out work in the organisation's premises.

4.4 Fire Safety Manager (Head of Health, Safety and Fire)

It is not possible or desirable to fully define the roles and responsibilities of the Fire Safety Manager. However, they should be responsible for the following:

- an awareness of all fire safety features and their purpose;
- sufficient and suitable resources to address fire safety compliance are available;
- fire safety risks particular to the organisation;
- requirements for disabled staff and patients (relating to fire procedures);
- ensuring appropriate levels of management are always available to ensure decisions can be made regardless of the time of day;
- compliance with legislation;
- development of the organisation's fire safety documentation;
- development of an effective training programme;
- cooperation between other employers where two or more share the premises;
- the reporting of fire incidents in accordance with current practice;
- monitoring and mitigation of unwanted fire incidents;
- liaison with enforcing authorities;
- liaison with other managers;
- monitoring of inspection and maintenance of fire safety systems.

Whilst these roles have been noted these roles may be encompassed in other Service Group responsibilities such as maintaining fire safety provisions, such as extinguishers, alarms, compartmentation, fire safety manuals. The upkeep of records relating to these provisions lies with the Director of Finance

Compliance with Fire Risk Assessments and findings lies with the persons identified in the Fire Risk assessment significant findings action plan.

4.5 Senior Fire Officer / Fire Officers

It is not possible or desirable to fully define the roles and responsibilities of the Fire Safety Officers. However, they will have responsibility for assisting the Fire Safety Manager in the following:

- providing professional and technical advice to the Fire Safety Manager and Board Level Director responsible for fire (Director of People) and to all levels of the organisation;
- providing guidance and direction to all levels of the organisation in relation to fire safety;
- devising, developing, managing and delivering fire safety training to all staff within the organisation;
- development of strategies, policies, protocols and procedures to ensure fire safety;
- undertaking and compiling Fire Risk Assessments (FRA) for all departments and organisations premises in conjunction with the appropriate departmental or premises responsible person(s);
- undertaking and compiling Fire Risk Assessments or providing guidance to hosts of CTMUHB staff in relation to workplace fire safety for premises

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outside the organisation where organisation staff are employed in conjunction with the appropriate organisational or premises responsible person;

- undertaking and monitor by means of audit, Fire Risk Assessments, and the organisations performance against legislative guidance;
- liaison with various external authorities and agencies where fire safety issues may be involved;
- monitoring compliance with general fire safety duties outlined in relevant fire legislative or guidance documents and the organisations fire policy;
- organising and supervision of CTMUHB evacuation exercises;
- monitoring all fire safety systems provided to ensure compliance to statutory and mandatory legislation;
- analysing building development plans and alterations for the organisation to ensure compliance to various statutory requirements;
- investigation of all fires and false alarms, and ensure the organisation meets statutory requirements to reduce unwanted fire signals (false alarms);
- researching products that will be of benefit to the organisation or improve fire safety within the organisation.
-

Whilst this list is not exhaustive other areas of expertise and knowledge in associated fire relative subject matter may be required. Where the expertise and knowledge are beyond the Health Boards Fire Safety Officers remit external specialist advice will be outsourced, such as fire engineering, smoke control / fire suppression system expertise, Dangerous Substances Explosive Atmosphere Regulations specialists.

4.6 Authorised Fire Engineer

CTMUHB does not employ a full-time Fire Engineer but utilises the organisations Fire Officers, Estates Officer's and NWSSP – Facilities Services experience and knowledge for operational areas. If other specialist advice is required, this will be outsourced.

4.7 Fire Involvement with Groups / Departments / ILG/ Site Fire Safety Groups

Fire Safety management does not exist in isolation, many decisions are made at all levels without the thought of what implications they would have on fire safety, the management of fire safety, or the threat of fire to life or property. Any groups or departments making decisions on structural, staffing or operational issues must consider fire implications. Therefore, the fire safety management processes must involve either the Fire Safety Manager, the Senior Fire Officer, or the site relative Fire Officer.

Combined involvement internally and externally with authorities and services such as Local Authorities, Fire, Police, Community Partnerships,

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Local and Government Services, will ensure that fire safety for the patients, visitors, staff and anyone who uses the organisations property is maintained to a high standard.

A Strategic Health, Safety and Fire Safety Committee will review and address the operational and organisations provisions, alterations, provisions and fire safety issues. This group is a subgroup of the Quality and Safety Committee. Each ILG has its own Health Safety and Fire Group which reports to the Health, Safety and Fire Committee.

A Building Development Fire Safety Group will review and address the CTMUHBs Estate structural provisions, alterations, provisions fire safety issues. This group will feed into the CTMUHB Strategic Health, Safety and Fire Committee.

Fire safety will be a standing agenda item at the Health and Safety Coordinating Group meetings to ensure any issues can be addressed and discussed at Service Group, Management, staff level, groups or committees.

This list is not exhaustive, and fire safety can be involved in other group meetings.

4.8 ILG leads/ Clinical / Non-Clinical Directors (Responsible Persons)

Within their sphere of responsibilities, under the RR(FS)O article 5(3) ILG Leads and Service Group Managers are responsible for:

- staff and departments within their remit and maintaining the required level of compliance of fire safety;
- acting upon Fire Risk Assessments (FRA) issued on their areas of responsibility, and report upwards onto the Service Group risk register;
- act upon Fire Service notification (INO/ENO) issued on their areas of responsibility and report on the corporate risk register;
- acting upon any departmental fire issues raised;
- cooperating with others where areas of responsibility are shared, ensuring levels of compliance are maintained;
- the safety of patients under their control and ensuring that there is a system or local procedure in place to ensure the safe evacuation of all users of their areas of responsibility, a means of identifying persons missing, and where applicable these systems or procedures take into account highly infectious, contagious disease or bariatric requirements;
- attending fire training specific to their role and level of responsibility, and ensuring all staff under them attend fire training specific to their role and responsibility;
- the supervision of contractors employed through their Service Group carrying out work in organisations premises;

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- staff under their control have the required fire training and have access to up-to-date training records for audit purposes.

4.9 Service Group Managers / Host Organisation Leads (Responsible Persons)

Within their sphere of responsibilities, under the RR(FS)O article 5(3) Service Group Managers / Host Organisation Leads are responsible for:

- acting upon Fire Risk Assessments (FRA) issued on their areas of responsibility, and report upwards onto the Service Group / organisational risk register;
- act upon Fire Service notification (INO/ENO) issued on their areas of responsibility and report on the Service Group / organisational risk register;
- ensuring compliance with general fire safety duties outlined in relevant fire legislative / guidance documents and the CTMUHB Fire Policy;
- attending fire training specific to their role and level of responsibility, and ensuring all staff under them attend fire training specific to their role and responsibility;
- the supervision of contractors employed by their Service Group carrying out work in organisation premises;
- staff under their control have the required fire training and have access to up-to-date training records for audit purposes;
- ensuring that satisfactory written arrangements (local ward / dept fire procedures) are in place for the safe evacuation of all staff, patients and visitors including, if appropriate, the safe evacuation and housing of the disabled, highly infectious / contagious disease or bariatric patients;
- ensuring any building leased or utilised for the Service Groups use must have clearly documented definitive fire responsibilities. To include the named responsible person for the building, a FRA, fire plan, and information on maintaining and testing of the structural fire systems and fire provisions, prior to occupation. If already occupied this information must be obtained and available for inspecting authorities.

4.10 Department, Line, Ward, Residential, Bank, Agency, Volunteer Managers (Responsible Persons)

Within their sphere of responsibilities under the RR(FS)O article 5(3)

Department, Line, Ward Managers are responsible for:

- ensuring that satisfactory written arrangements (local ward / dept fire procedures) are in place for the safe evacuation of all staff, patients and visitors including, if appropriate, the safe evacuation and housing of the disabled, highly infectious / contagious disease or bariatric patients;
- ensuring that their workplace area is checked, inspected and maintained to ensure a fire safe environment is maintained. However, the role and tasks of the Department or Line Manager in relation to fire can be, if required, delegated to another staff member. Whilst the role can be delegated, the Department or Line Manager is still responsible for the fire safety issues within their remit;

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- ensuring they are aware of all electrical equipment that is to be used in their sphere of responsibility and that it is tested by Estates or Clinical Engineering dependant on equipment classification prior to its use;
- ensuring that where any cooking takes place, e.g. toasters, microwaves, is in a recognised and dedicated room for cooking and a safe system of work is in place to mitigate the chances of unwanted fire signals (false alarms);
- acting upon Fire Risk Assessments (FRA) issued on their areas of responsibility, and report on the department risk register;
- acting upon Fire Service notification (INO/ENO) issued on their areas of responsibility and reporting deficiencies upwards to senior management and ensuring the department risk register is up to date;
- reporting any fire related issues to their Service Group Manager;
- staff under their control have the required fire training and have access to up-to-date training records for audit purposes;
- ensuring they are familiar with fire procedures for their area and the site;
- ensuring that staff are appropriately trained in the use and location of specialist equipment such as evacuation aids and
- ensuring that staff are appropriately trained in the use and location where there are specific risks such as oxygen and/or medical gases;
- cooperating with others where areas of responsibility overlap;
- the safety of patients under their control and ensuring that a system or local procedure is in place and up to date to ensure the safe evacuation of all users of their areas of responsibility, a means of identifying persons missing, and where applicable these systems and procedures take into account highly infectious or contagious diseases and bariatric requirements;
- the supervision of the evacuated ward or department and account for staff, patients and visitors at the assembly point in a fire emergency;
- disseminating local ward and department procedures to all staff on a regular basis including new starters or bank staff, and this training is recorded and available;
- attending fire training specific to their role and level of responsibility, and ensuring all staff under them attend fire training specific to their role and responsibility;
- the supervision of contractors employed by their department carrying out work in organisation premises.

Should the Ward or Department Manager wish to pass these responsibilities onto a member of staff to act on their behalf (fire warden/marshal role) the manager must be fully aware of their roles and requirements of that role still lies with them as the manager and the responsibility lies with that relevant manager to ensure there is no conflict in the managing fire safety. The Ward or Department Manager is still the responsible person as defined under the RRFSo and is always accountable. They will be responsible for ensuring there is clear written guidance for the role of the 'Fire warden/member of staff' looking after duties for fire. They will also be responsible for training them in their roles and duties they require them to undertake, as the role of fire warden/marshal is not a recognised role within this organisation).

4.11 Employees, Volunteers, Bank or Agency Staff

All employees have a personal responsibility and a statutory duty of care in respect of fire safety, must maintain high standards and vigilance at all times to reduce the risk of fire. All employees must:

- read and sign to state they have read and understood their ward / dept local procedures for where they are employed;
- raise specific fire hazards and or fire safety issues directly with their Line Manager or via their staff side H&S rep before escalating to the HB Fire Officers;
- strictly adhere to risk assessments and safe systems of work;
- respond to incidents as appropriate;
- attend fire training specific to their role and level of responsibility;
- cooperate with management on Fire Risk Assessments issued on their areas;
- cooperate with management on Fire Service notification (INO/ENO) issued on their areas;
- cooperate with all other employers and employees in relation to fire safety matters;
- report to Line Manager any fire safety concerns or issues;
- not interfere with provisions provided for fire safety.

Specifically in relation to this Policy, Safety Representatives are entitled to:

- make representation to Managers on general matters affecting the health, safety or welfare at work of any employee;
- represent employees in consultations at the workplace with inspectors of the Health and Safety Executive, or with any other enforcing authority, in relation to health and safety matters affecting any employee;
- undertake training and receive accreditation from the organisation;
- investigate potential hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace;
- carry out inspections of the workplace in accordance with Regulations 5, 6 and 7 of the Safety Representative and Safety Committee Regulations 1977;
- be represented at, or attend, meetings of the Quality and Safety Committee and Service Group Safety Groups.

Specifically in relation to this Policy, Safety Representatives are entitled to:

- make representation to Managers on general matters affecting the health, safety or welfare at work of any employee;
- represent employees in consultations at the workplace with inspectors of the Health and Safety Executive, or with any other enforcing authority, in relation to health and safety matters affecting any employee;
- undertake training and receive accreditation from the organisation;
- investigate potential hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace;

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5. Implementation / Policy Compliance

5.1 Procedure Implementation

The organisation is required to communicate its commitment to fire safety, provide documented evidence to the inspecting authority in relation to its fire safety management and procedures. This will include:

- a current Fire Policy;
- the undertaking, recording and dissemination of fire risks
- a means of accessing fire related information relating to its premises, systems, service or risks; (*CTMUHB intranet – Fire web page*);
- site specific fire relative information - (*located on sites within fire documentation cabinets, and within the CTMUHB intranet fire safety site*);
- the reporting and investigation of fire / false alarm incident / unwanted fire signals (*CTMUHB intranet Fire / False Alarm / Near miss incident reporting form*);
- demonstrating and evidencing of local management of general fire safety provisions, (*Ward / Departmental Fire Safety Management folders*), to include within:
 - o copies of Fire Risk Assessments and actions taken;
 - o copy of the local Fire Orientation plan (where applicable);
 - o local departmental fire procedures for dealing with a fire emergency;
 - o records of training;
 - o Ward / Department Checklist;
 - o Reference to the location of Planned Emergency Evacuation Procedures (PEEPs) for disabled staff or staff requiring assistance in an evacuation;
 - o copies of any correspondence (INO/ENO etc) from the Fire Authority;
 - o record of any actions taken to address Fire Safety issues, significant findings from the FRA / ward / departmental checks etc;
- information availability of fire safety provisions and procedures for maintaining fire safety provisions – (*Planned Preventative Measures (PPM) information provided by Estates*);
- procedures for addressing any Fire Authority notices served on the UHB (*Fire Risk Assessment (FRA) – Notice of deficiency (INO) / Enforcement notice procedure (ENO)*);
- procedures for addressing building alterations, changes of use, new builds etc (*Fire Build forms*);
- evidence of management / wards / departments and acting upon significant findings from FRAs, INO and ENO notices.

This list is not exhaustive, and documentation / procedures will be developed to assist in addressing any issues as they arise.

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5.2 Reporting of Fires and/or False Alarms

The Fire Service recommends they are to be called to all fires.

All fire related incidents including false alarms must be reported to the CTMUHB Fire Safety team within 24 hrs. This must be done via Fire incident reporting system on the Fire Website. This will allow the HB Fire Officers to investigate at the earliest opportunity.

For inpatient sites this must be completed by the Fire Incident Coordinator (Senior / Acting-up Nurse for the site / Site Manager / Hospital at night coordinator / Bed Manager) at the time of the incident.

For all other sites the Fire Incident form must be completed by the senior person present from the department where the incident occurred.

E.g. multi use building incident happens within department B the senior person from department B must complete the form, unless the building is served by a reception then the receptionist is to complete the form (if manned at the time of the incident) refer to the site-specific documents.

Where the incident occurs outside of normal working hours and HB staff respond to it (e.g. Estates on call, Facilities) these should complete the fire incident form providing as much information as possible.

A copy or notification of the incident should be made known to the Line / Ward / Department / Accommodation Manager for where the incident occurred (if they are not present at the time of the incident).

For an actual fire the area / item must be cordoned off / isolated to allow CTMUHB Fire Officers to investigate and confirm cause etc.

Where the fire area involved is required for urgent operational reasons then only then should photographs be taken to provide the investigating officer with the necessary photographic evidence. Any item involved in a fire should not be reused until CTMUHB Fire Officers have carried out their investigation.

All fires must also be reported to Estates where damage to equipment or fabrication of the building occurs, if the item is clinical then clinical Engineering must also be informed.

Any activation of the fire alarm will require the system to be reset and the cause established. The FIC/NIC, HB Fire Officer, Fire Service may determine the cause and authorise the silencing and reset of the system. The silence of the system must only be undertaken by someone trained in silencing for that site / system and resetting must only be done by a competent person from either Estates or the alarm maintenance contractor.

All fires / fire alarm activations must be reported to Estates via the Estates helpdesk during normal working hours, or for out of hours to the "Estates Officer on call" via the RGH / PCH / POW switchboard.

Where asbestos is known to exist, any in-depth investigation requiring the removal of walls, floors, ceiling panels or tiles is required to ascertain the cause of the activation, then Estates must be informed via the Estates helpdesk during normal working hours, or for out of hours to the "Estates Officer on call" via RGH / PCH / POW switchboards.

Arson: Hospitals and clinics are vulnerable to arson attacks from both intruders, patients or visitors. Within inpatient areas a high level of control of ignition sources should be employed. This is to protect all other occupants from a fire being started deliberately and minimise the disruption to inpatient facilities. Even a small fire in a ward area has massive implications to inpatient services.

Also, there are areas within our sites such as drug or equipment storage which appeal to the opportunist. These areas should have higher levels of control and management and ensure these areas are locked as an arsonist may set a fire to conceal the theft of goods.

Where arson is suspected this must be made known to the senior management for the area at the time of the incident and cascaded up to senior management, Fire Safety Manager. Arson can be suspected if:

- more than one fire occurs at the same time or reasonably close to each other;
- the fire occurs in a low-risk area or improbable location;
- items that would not normally be located where the fire occurs are present (bedding, rags, rubbish);
- there are unusual smells not normally associated with the area the incident occurred (petrol, thinners);
- the same person appears at more than one fire, or is the same person raising the alarm on different occasions;
- the fire would not have started on its own;
- anything else unusual about the area, the fire growth gives you reason to suspect arson.

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Note if it is known that an arsonist is being treated within our property this must be made known to the managers of the area and additional vigilance employed whilst the patient is within our property.

If arson is suspected the Fire Safety Manager or Fire Officers (during normal working hours), on Call Director (outside of normal working hours) must be informed immediately and the area cordoned off for investigation.

FIRES INVOLVING DEATHS, INJURIES, DAMAGE OR ARE OF SPECIAL INTEREST E.G. ARSON MUST BE PASSED IMMEDIATELY TO THE FIRE SAFETY MANAGER during normal working hours and out of normal working hours the 'ON CALL DIRECTOR' must be informed via the switchboard. Out of hours: this information must then be passed onto the Board Level Director responsible for Fire (BLD for Fire) and the Fire Safety Manager (FSM) who will ensure this information is passed onto the Chief Executive and all relevant persons. Additionally, the BLD for Fire and/or FSM is responsible for ensuring the nearest Health and Safety Executive regional office is informed.

5.3 Monitoring of Fire Safety Compliance

The organisations fire safety compliance is monitored internally by:

- the FSM via the CTMUHB Fire Officers, fire risk assessments and Fire Safety Group meetings;
- ward and departmental checklists, departmental fire procedures, fire incident reports, and training records.

5.4 Auditing of CTMUHB Fire Safety by External Agencies

The organisations fire safety compliance is monitored externally by:

- National Health Wales Shared Services Partnership (NWSSP) - Facilities Services on behalf of the Welsh Government (WG), by means of the annual NWSSP on-line Fire Audit;
- South Wales Fire and Rescue Service by means of audit and inspection visits to sites and departments, inspecting the physical condition of the property or area, records of maintenance, tests, training and questioning staff. The Fire Authority have the powers to inspect at ANY time. Formal audits are arranged giving the HB formal notification of where they wish to audit. Informal audits will be on a NO formal notice approach and will normally be out of normal working hours.

5.5 Department / Building / Site Compliance

Each Site / Department Manager is responsible for maintaining workplace fire safety requirements. This can be achieved by utilising a management checklist for fire safety; reporting and chasing up of any defects that

compromises the safety from fire of the users and cooperating with other departments where shared or common areas exist.

5.6 New build or alteration to any part of a CTMUHB owned or head leased / managed building should be undertaken without prior consultation with the Fire Safety Manager and/or the Senior Fire Officer / Fire Officers, where requested a Fire Build Form MUST be completed and sent to the relevant fire officer.

When any changes are planned either through capital, virement or any other means the Fire Build Form (available via Fire web page) MUST be completed by the Manager requesting the change or alteration etc and forwarded to the site relevant Fire Officer for comments / advise / information on fire requirements that must be met. This Fire Build Form should then accompany the SON, virement or another request. This will allow the CTMUHB Fire Officers to provide the necessary fire relative information for the build or alteration to those involved.

All building provisions such as fixed electrical, lightning protection, fire hydrants, compartmentation, fire safety provisions, should be maintained and checked in accordance with relevant standards and manufacturers recommendations (this list is not exhaustive). Responsibility for this lies with the Head of Estates for CTMUHB owned properties and Primary Care lead for head leased buildings.

Should the CTMUHB enter into any contract for managing a building e.g. Primary care, the Fire Safety Manager should be consulted prior to undertaking any fire responsibilities for the building. Copies of the agreement detailing all the fire safety provisions and arrangements for testing and maintaining must be provided prior to becoming the lead / head lease.

5.7 Guidance for Compliance

Housekeeping: It is essential that all areas are kept free from clutter which will reduce the risk of an incident or could affect or impede a fire evacuation such as slips, trips and falls. This can be avoided by regular and frequent workplace inspections by the relevant Manager and ensure issues such as waste collection, cable management, storage etc are addressed. Responsibility for this lies with those responsible persons who have control over the ward, area and/or department, this includes common or shared accommodation such as corridors directly adjacent to their ward or department.

Means of Escape: It is essential that all escape routes are always maintained clear of obstructions and available for use. All staff must familiarise themselves

with the location and operation of fire exits and ensure routes to these exits are maintained clear for use. Responsibility for this lies with those 'responsible persons' having control of the ward, area, department and/or process, consideration to where the escape route leads must be considered.

Fire Safety Systems (Fire Alarms): It is essential the organisation has an adequate means of raising the alarm suitable for the building and risks. All staff should be aware of the location of the fire safety systems within their working environment. It is essential that these are maintained, clear of obstruction, and available for use always, also that they can be heard where sounder alerts are provided or seen where visual indicators are provided. This responsibility lies with the 'responsible persons' for the ward, area and/or department.

Whilst the Head of Estates is responsible for the maintenance of the fire alarm system(s) this may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site, they are responsible for in order to meet the British Standards requirements.

Emergency Lighting: Provision of emergency or escape lighting provided and maintained to the relevant BS/WHTM and as required or identified by the Fire Risk Assessment (FRA). Provision and testing of emergency lighting lies with the Head of Estates. *(This may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site they are responsible for to meet the British standards requirements).*

Fire Fighting Equipment: First aid firefighting equipment provided in the form of handheld fire extinguishers suitable for the risks. The type will be in accordance with the relevant British/EU Standards. All extinguishers display operating instructions and application. Suitable suppression systems will be provided where a hazard exists, or fire risk assessment identifies the need. All staff must familiarise themselves with the location, operation and application of all. It is essential that these are maintained, clear of obstruction and available for use always. Responsibility for this lies with the 'responsible person' for the area having control of the ward, area, department and/or process. Responsibility for the provision and maintenance of firefighting equipment lies with the Fire Safety Manager and Head of Estates respectfully. *(This may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site they are responsible for to meet the British standards requirements).*

Fire Action Notices / Signs: Fire action notices should be displayed as near as practically possible to each break glass call point, and where necessary

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additional areas of high population. These will inform all patients, visitors and staff of the correct action to take on discovering or suspecting a fire, and what action should be undertaken. Directional and exit signage shall be displayed accordingly. These should always be visible and not obscured. Fire related notices and signs must conform to WHTM and European standards. Provision of Fire Action notices lies with the Head of Estates. *(This may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site they are responsible for to meet the British standards requirements).*

Ensuring they are in position and contain the relevant information it is the responsibility of the 'responsible person' having control of the ward, area, department and/or process that they are located in.

Flammable Substances / Compressed Gasses: All flammable substances / compressed gasses shall be stored and used in accordance with the relevant substance storage and use instructions and disposed of in the correct manner. Only minimal quantities should be kept within the working area such as required on a day-to-day basis, relevant signage to indicate flammable substances / compressed gas should be displayed. Under no circumstances should flammable substances or pressurised containers be disposed of through the general waste disposal system. Responsibility for ensuring there is a risk assessment, safe system of work or protocol, and relevant hazard signage is in place, and the substances and gases are stored and used correctly and safely lies with the 'responsible person' having control of the ward, area, department and/or process.

Dangerous Substances Explosive Atmosphere Regulations (DSEAR): Managers are responsible to ensure all areas within their responsibility that contain or carry out a process which use dangerous substances, or create an explosive atmosphere, a DSEAR risk assessment is in place, and that they have undertaken or have in place the recommendations from the risk assessment. Responsibility for ensuring there is a DSEAR risk assessment is in place lies with the "responsible person" having control of the ward, area, department and/or process. Responsibility for ensuring the DSEAR assessment is undertaken lies with Head of Health, Safety and Fire.

Medical Gases: All medical gases should be stored and used in accordance with the relevant British Standard / WHTM 02. Medical gas cylinders within buildings should be stored in fire rated rooms with adequate ventilation direct to outside of the building *(to prevent the build-up of gases and explosive atmosphere).* Responsibility for ensuring medical gases is used and stored correctly lies with

the 'responsible person' having control of the ward, area, department and/or process.

Electrical Equipment: All electrical equipment must be tested by the Estates Department before use. No extension leads should be used without the Estates Department inspecting the area and determining the reason for use. Departments should attempt to minimise the number of leads in use where possible. During the festive season all festive lighting and electrical equipment must be of low voltage type and tested prior to use and display the PAT certificate. The use of cuboids multi plug adaptors is forbidden, these create strain on the plug sockets leading to damage and possible shorting. Responsibility for ensuring electrical items is checked lies with the 'responsible person' having control of the ward, area, department and/or process. Responsibility for the PAT testing of the items lies with the Head of Estates and the Department Managers.

Lithium-Ion Batteries: Rechargeable equipment such as E-Scooters, E-Bikes are not permitted within CTM UHB premises, these items must be located within the secure cycle shelters provided. It is not permissible to charge these items within the workplace. The Lithium-Ion Batteries pose a great fire risk to the environment and the safety of staff, patients and visitors. Other rechargeable items such as personal phones, laptops etc pose a fire risk whilst charging and must not be left unattended or in a location where spontaneous ignition may occur.

Please seek advice from your local Fire Officer or Senior Fire Officer.

Donated and/or Purchased Equipment: Donated or purchased equipment for use within the organisation should be certified as safe before use i.e. electrical equipment should be tested by Estates before any use. Any furnishings must be of fire-resistant material and comply with the current relevant WHTM/BS, and display the furnishings fire safety label indicating its standard of fire resistance, have no signs of damage or internal fillings being open to view or open to ignition sources thus reducing the fire rating. Any items showing inner foam should be repaired or removed from the workplace. All items of furniture and fittings must comply with the current WHTM for furniture and fittings and should be purchased through the CTMUHB procurement process. Responsibility for ensuring donated or purchased equipment and furnishings lies with the 'responsible person' having control of the ward, area, department and/or process. Responsibility for the procurement of suitable items lies with the Lead for Procurement.

Patients Sleepwear: Patients being admitted should be advised to bring flame retardant nightwear and dressing gowns. Visitors should also be advised where

replacement sleepwear is brought in to ensure they are flame resistant wherever possible.

Access Routes for Emergency Vehicles: All access routes within CTMUHB sites should be maintained clear of vehicles or items that would impede emergency vehicle access. Staff should observe the no parking areas and abide by the site restrictions. These will either be marked with double yellow lines, hatched area or be a recognised no parking area. Responsibility for ensuring access routes is clear lies with the 'responsible person' having control of the parking, area or site.

Lightning Protection: Lightning protection shall be installed and maintained as recommended by the relevant British Standard/WHTM. Responsibility for ensuring lightning protection is provided and maintained lies with the Head of Estates.

Maintenance and Testing: All maintenance and testing of fire related equipment must be undertaken by a competent person. This will either be through direct labour (Estates Department employee) or an authorised supplier or engineer for the product. Responsibility for ensuring fire related equipment is maintained lies with the Head of Estates.

Smoking: The organisation is bound to current legislation regarding smoking and full guidance is contained within the Smoke Free Environmental Policy. Responsibility for ensuring the Smoke Free Environmental Policy is adhered to lies with the 'responsible person' having control of the ward, area, department, process and/or site, and smoking policy lead.

Arson reduction: all staff in all areas must be aware of the potential for arson and take steps to prevent the occurrence. Such as minimising or controlling the availability of combustibles and flammables or items that would assist a fire etc, ensuring storerooms are locked, combustible and flammable materials are controlled etc. External skips should not be sited within 6 metres of any building or overhang to prevent arsonists utilising the CTMUHB waste as fuel. Responsibility for ensuring wards, areas and departments reduce the possibility of arson lies with the 'responsible person' having control of the ward, area, department, process and/or site.

Shared or Common Areas: Where areas are shared or there are common areas all must cooperate to achieve a fire safe environment.

Shared accommodation is areas used by several departments or staff within an area such as a corridor between two departments or a number of

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departments. This can extend into a common area where rooms used by departments or staff are utilised e.g. disposal hold or rooms in the main hospital street or corridor. Responsibility for this would lie with the users and the Service Group responsible for emptying).

A common area would be somewhere like a main 'hospital corridor or street', or a shared area when primarily used by staff such as in a small building e.g. 'Department link corridor'.

Cooking: any form of cooking whether microwave, toaster, gas or electric cooker must be in the recognised purpose built (fire rated) room or designated cooking areas only. Under no circumstances should cooking be undertaken in any room other than the approved designated rooms for cooking (refer to fire site specific documents for accepted areas for cooking). Where cooking is undertaken the process should not be left unattended not even for short periods. Safe systems of work / use should be displayed close to the cooking equipment. Any alarm activation caused by cooking left unattended or the fire door being wedged open could result in the cooking facility being removed. Responsibility for ensuring areas and departments maintain a safe and controlled cooking environment lies with the 'responsible person' having control of the ward, area, department, process and/or site.

Personal Emergency Evacuation Plans(PEEPS) PEEPS are required to be in place for any staff who are disabled, mobility impaired or have special needs, such as pregnant, hearing, sight, mobility restricted or impaired that may require assistance in leaving the building in an emergency. They are to be compiled in conjunction with the individual concerned and based on the knowledge of the building and location of the workplace location within the building. They must explain what methods; routes of escape and assistance is to be in place. Once completed they must be kept in the staff member's or department's confidential file. Where the use of a buddy system is highlighted or the individual is not allowed to work alone or any other issue highlighted requires assistance or the person to carry out a specific role then other members of staff must be made aware of their roles and responsibilities as well as the needs of the individual. Responsibility for ensuring PEEPS is in place lies with the 'responsible person' having control of the ward, area, department, process and/or site.

Note: The PEEP procedure can be utilised for patients in our care or have regular treatment whose condition requires additional non-standard equipment or planning. e.g. bariatric.

5.8 Contractors, Non-Organisation Employees, Voluntary Agencies and Any Other Users of Organisations Premises

Any person using CTMUHB property must comply with the organisations Fire Policy and be familiar with protocols and procedures the organisation employs. This includes the requirement to attend specific fire training or briefings on fire safety relevant to the site or department. The organising department is responsible for ensuring the contractor is briefed in fire safety matters appertaining to the area prior to commencement of work in their area (where the area is still operationally occupied by CTMUHB). Where the area is handed over to the contractor it is the project leads responsibility to ensure fire information has been given to the contractor.

Under RR(FS)O article 5(3) & (4) the contractor is then responsible for ensuring that the work they undertake relating to fire safety matters within their control are carried out in good order. Therefore, any contractor undertaking work must be aware of the working environment and the requirement to maintain the fire safety provisions by liaising with the Estates Department and the Department Manager where the work is to be undertaken. To ensure they are aware of any restrictions measures required before being granted a permit to work (especially where hot work is to be undertaken, or there is to be any interruption or work on the fire alarm system. Emphasis must be made to the need to prevent unwanted fire signals - false alarms). (Refer to the organisations Control of Operational Estates Maintenance Contractors Procedure).

5.9 New Builds and Alterations

Where new builds or alterations are to be made to existing sites or departments the WHTM 05 Firecode documents provide advice on achieving compliance and must be used for inpatient properties and other relevant guidance as appropriate for non-inpatient properties. Whilst there may be alternative ways of achieving compliance or the same objectives, where an alternative approach is to be taken the designers must demonstrate that the approach taken does not result in a lower standard of fire safety than if Firecode had been applied. In all cases the CTMUHB Fire Officers must be consulted from conception to completion including sign off.

The HB utilises a Fire Build form, this must be completed and forwarded to the site relevant Fire Officer prior to any commencement of design or building works. This allows the required fire information to be provided to the user/designer/project lead.

Forms are available via the Fire website on the HB intranet.

Life safety sprinklers in buildings offer several trade-offs and structural relaxations and should be considered and decisions recorded at the outset of design. Close liaison between the Fire Safety Team, Estates (especially where alarm and detection will be affected) from conception through to completion must be maintained and the development formally discussed and recorded to ensure fire safety is not compromised. Responsibility for this lies with the Director of Finance and the delegated project leads.

6. Information, Instruction and Training

6.1 Training Implications

Fire Safety training is a STATUTORY requirement under the:

- Regulatory Reform Fire Safety Order 2005;
- Health and Safety at Work etc Act 1974;
- Management of Health and Safety at Work Regulations 1999.

It is mandated under WHTM 05-01 Firecode management of Fire Safety and the organisations Knowledge Skills and Framework.

CTMUHB fire training needs analysis highlights all staff need to understand fire risks, fire prevention, and fire/evacuation procedures, for within their areas of employment and that no person should exceed a two-year period between face-to-face training by a HB Fire Officer. It is the responsibility of those identified as having responsibility for managing staff under them to ensure their staff / volunteers attend and undertake the relevant training.

6.2 Induction

All staff / volunteers should receive fire induction training on or before their first day of employment or as close to their start date as possible, (not to exceed 1 month from their start date).

CTMUHB fire induction is in two parts 'corporate' and 'local' (ward / departmental). Corporate training is carried out as face to face by a CTMUHB Fire Officer on the corporate induction program.

Corporate induction must be supplemented by ward or departmental fire / evacuation procedures on commencement of employment in the workplace, by the 'responsible person' for that ward, department or role. This includes CTMUHB staff working in non CTMUHB properties; the CTMUHB manager for the staff working in non CTMUHB property is responsible for ensuring their staff receive local induction. The Ward / Department manager must maintain records

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of local inductions and update the ESR records.

Non CTMUHB departments, staff or volunteers working in CTMUHB properties must also comply with CTMUHB's protocols of local induction training relative to the department and site. Where staff are employed that cannot immediately on starting attend the corporate induction, local induction relating to fire and evacuation procedures must be carried out and recorded and ESR updated by the Line / Ward manager on the first day of commencing work.

Staff that are employed where there are specific risks, hazards or specialist equipment (i.e. DSEAR, evacuation lifts, evacuation aids etc) or they have a specific role in a fire incident the corporate induction must be supplemented with specific Ward, Department, equipment and role training. It is the responsibility of the Line / Ward Manager to ensure this is carried out and recorded. It is the Line / Ward Managers responsibility to ensure that staff are familiar with their roles and responsibilities in relation to fire safety within their workplace environment.

6.3 Update / Refresher Fire Training

All staff, volunteers and frequent users of the organisation's premises must attend update / refresher fire training. This is a statutory requirement under the Regulatory Reform Fire Safety Order and WHTM 05-01. This must be undertaken periodically ensuring no staff member exceeds a Two-year period without formal face to face fire training from a CTMUHB Fire Officer.

Additionally, where there are specific fire risks, evacuation equipment is provided, or staff have a specific fire role, training is to be undertaken periodically in line with manufacturer's instructions. Where no defined time scales exist from the manufacturer it is recommended the training frequency follows the CTMUHB fire training timescales of not exceeding a Two-year period without this specialist training being undertaken, this training should form part of the local ward / department refresher training.

Local departmental training should be carried out in between the face to face by a CTMUHB Fire Officer. The Ward / Line Manager is responsible for ensuring this training is carried out and recorded both within the fire file and on ESR.

Departmental Fire Procedures and information should be reviewed and updated by managers of wards and departments annually or when a change occurs or a change is made to the physical structure of the area, changes to the operational running of the area or process, or an incident highlights deficiencies or issues. The Manager must consult with the site relative Fire Officer when reviewing the procedure, where changes to the existing procedure are to be made.

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The review requirements should be recorded, and any changes should be made known to staff.

6.4 Responsible Person / Manager / Senior Person Fire Training

Any person who has management responsibility for staff or areas must undertake this training. It is designed to meet the requirements of management responsibilities for fire within their workplace. This is a statutory requirement under the Regulatory Reform Fire Safety Order and WHTM 05-01. This must be undertaken periodically ensuring no manager exceeds a Two-year period without this fire training. Note: The Responsible Person, Manager, Senior Person training is provided instead of the update / refresher training and is not additional but counts as attending refresher / update and awards that competency.

Note: Where evacuation equipment is provided for the evacuation of patients, the ward/dept managers must undertake the training in addition to the managers course to understand the requirements and process.

Note: Video and computer-based fire training should not be used in isolation or as a sole means of induction but can be used to enhance other forms of fire training (*RRFSO/WHTM 05*). Where the organisations staff are employed in other NHS / private facilities they must adhere to the host organisations policy in relation to training. Any records of training undertaken at these locations must be forwarded to the employing organisations training database holder. Where the host organisations standard or frequency of training is to a lower standard or a frequency exceeding two yearly (i.e. e-learning only as a means of training) then face to face training with a CTMUHB Fire Officer must be undertaken not exceeding two years, and departmental training undertaken in between.

6.5 Records of Fire Training

Irrespective of how training records are maintained (locally or centrally) Managers must have access to or keep training records of all their staff (and any volunteers that work within their areas) that they are responsible for as having attended fire training, including specialist site or local ward or departmental training and specialist equipment for fire purposes i.e. evacuation lifts, evacuation aids. These records must be readily available for inspection when requested by the CTMUHB Fire Officer when undertaking Fire Risk Assessments (FRA) or any inspecting authorities (e.g. Fire Service audit). It is therefore recommended these staff attendance records are kept within the fire file for the area.

Failure to provide information at the time of a Fire Service formal audit could result in enforcement action being imposed on the ward or department for failing to provide the required information.

6.6 Review, Monitoring and Audit Arrangements

The FSM will ensure that the Policy and Procedures are reviewed in accordance with the timescale specified at the time of approval. Staff who become aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local / national directives that affect, or could potentially affect, the organisations policies and procedures should advise the Fire Safety Manager as soon as possible who will then consider the need to review the Policy or procedure outside of the agreed timescale for revision.

7. Equality and Welsh Language Impact Assessment Outcome

This Policy has been subject to a full equality assessment, and no impact has been identified.

8. Main Relevant Legislation

Fire safety legislation is regulated by the Regulatory Reform Fire Safety Order 2005 RR(FS)O and the associated guidance documents. The NHS has supplementary documents to the Regulatory Reform Fire Safety Order to assist in fire safety within Healthcare, Health Technical Memorandum 05 series - Firecode (within CTMUHB the Welsh editions WHTM shall be applied). Reference may be made to other statutory, legislated and guidance documents where necessary.

All NHS organisations in Wales must comply with legislation relating to fire safety and the Welsh Government policy. All NHS organisations in Wales who commission and or lease buildings or occupy buildings under a PPP/PFI contract must be satisfied that they comply with legislation relating to fire safety. Any Service Group undertaking such a commission or lease etc should inform the fire safety manager in writing providing full details of the arrangements prior to completing.

The Department for Health and Social Services will ensure that appropriate advice and guidance on all matters related to fire safety will be available to NHS organisations in Wales through the Firecode suite of documents.

The Government expects that all contracts for health services placed by commissioners will contain clauses to ensure that premises comply with, and will continue to comply with, all statutory fire safety provisions and, where appropriate, Firecode.

Fire safety is a responsibility for all employees, and a duty for all managers to maintain a high standard of fire safety.

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CTMUHB is compelled to ensuring the safety of its users (relevant persons) by complying with the statutory fire safety legislation, relevant EU/British standards, WHTM guidance notes and codes of practice.

9. References

9.1 Statutory Documents

Regulatory Reform (Fire Safety) Order 2005;
Building Regulations;
The National Health Service and Community Care Act (current edition);
Health and Safety at Work etc Act (current edition);
Management of Health and Safety at Work Regulations 1999 (current edition);
Registered Homes Act (current edition);
The Housing Act (current edition);
Furniture and Furnishings Fire Safety Regulations (current edition).

9.2 Mandatory Documents

Welsh Health Technical Memorandum (WHTM) 05 – suite of documents – Firecode.

9.3 Legislative Documents

There are several WHTMs that have fire implications that relate to fire contained within them. Care should be taken ensure that the fire safety is not compromised by other WHTM guidance's.

9.4 Internal Health Board Fire Documents

Fire False Alarm incident reporting form;
Site Specific operational documents;
FRA/INO/ENO Procedure;
Building Alteration / Development Procedure.

This list is not exhaustive, and other legislation may apply in varying circumstances. Internal documentation will be developed as and when identified as being required.

10. Getting Help

10.1 Major Emergencies

For any fire related major emergency the Senior CTMUHB manager in charge should follow the major incident procedure and contact those listed on the major incident action card.

For interpretation, resolution of problems or other special situations, specific information is available via the [health and safety web pages](#), with general information available through the [CTM home page](#).

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11. Related Policies

CTMUHB Policies with a potential health and safety content (non- exhaustive list) may be found on the:

- Corporate/non-clinical policy section of the UHB Intranet;
- On the Fire Safety department website.



Quality, Safety & Experience Committee

Pharmaceutical Needs Assessment 2026

Eitem yr Agenda / Agenda Item	6.1.3
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Jason Carroll, Principal Pharmacist Community Services
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:	Endorse for Board Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Review the 2026 Pharmaceutical Needs Assessment (PNA) note the key findings and endorse for Board approval.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> Strategic Context: <i>This report aligns to the following Strategic Pillars</i>	Sustaining Our Future
	If more than one applies please list below: Improving Care
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhai'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 Pharmaceutical Needs Assessment (PNA) for 2026-2031 assesses the pharmaceutical service needs of the Cwm Taf Morgannwg population and evaluates whether existing pharmacy provision meets current and future demand.

The PNA is a statutory requirement under the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and must be published at least every five years. It considers population demographics, health needs, pharmaceutical service provision, stakeholder engagement and future demand for services

Key findings within the 2026 PNA include:

- CTMUHB serves a population of approximately 449,000 residents.
- There are 109 community pharmacies and three dispensing GP practices operating within the Health Board area.
- 95.2% of GP prescriptions generated within CTM are dispensed by pharmacies within the Health Board area.
- Access to pharmaceutical services is generally good, with most residents able to reach a pharmacy within 20 minutes.
- No current gaps in pharmaceutical services have been identified.
- Future population growth and an ageing population are expected to increase demand for pharmaceutical services.
- A future need has been identified for a pharmacy within the Llanilid development once housing development reaches specified thresholds.

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)

The PNA concludes that current pharmaceutical provision is adequate across all eight clusters and supports delivery of essential, national and locally commissioned pharmacy services.

The population continues to experience significant health inequalities, higher levels of deprivation than the Welsh average, higher prevalence of several long-term conditions and poorer health outcomes in



So, what (<i>provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these</i>)	some communities. Community pharmacy will continue to play an important role in prevention, medicines optimisation and provision of independent prescribing services. Failure to maintain an up-to-date PNA would present regulatory and governance risks and could affect decision-making regarding pharmacy applications and service planning. The PNA provides the statutory framework which supports these decisions.
Beth Nesaf (<i>crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud</i>) What Next (<i>summary of intended action and benefits supporting the choices and recommendation(s) being made</i>)	• Endorse for Board Approval the 2026 PNA • Publish the PNA by 1 October 2026. • Use the PNA to support decisions on pharmacy applications, relocations, opening hours and commissioning priorities. • Continue development of clinical community pharmacy services, including pharmacist independent prescribing and clinical service delivery
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Committee is asked to: 1. Note the findings of the 2026 Pharmaceutical Needs Assessment. 2. Note that no current pharmaceutical service gaps have been identified. 3. Endorse for Board Approval the PNA for publication, completing the statutory process.

1. Background / Context

The PNA is the Health Board's statutory assessment of pharmaceutical service needs and provision across its population.

The assessment covers the period 1 October 2026 to 30 September 2031 and represents CTMUHB's second PNA, following publication of the first assessment in October 2021. It has been developed by a multi-agency steering group and informed by public, contractor and stakeholder engagement.

2. Strategic Insights

- Population expected to continue growing across the Health Board area.
- Significant ageing population projected across all local authority areas.
- Higher prevalence of chronic disease, obesity, smoking and deprivation than Welsh averages.
- Community pharmacy network demonstrates strong accessibility and capacity.
- Increasing role for community pharmacies in prevention, independent prescribing and reducing pressures on GP services.

3. Risks and Opportunities

Risks

- Increased demand arising from demographic change.
- Workforce pressures within primary care.
- Potential future loss of pharmaceutical services in individual localities.
- Reliance on maintaining adequate community pharmacy capacity.

Opportunities

- Expansion of pharmacist independent prescribing.
- Increased delivery of clinical services through community pharmacies.
- Improved prevention and early intervention.
- Enhanced access for patients through community-based care.

4. Compliance and Governance

The draft PNA has been prepared in accordance with the requirements of the NHS (Pharmaceutical Services) (Wales) Regulations 2020. It has undergone a statutory 60-day consultation process and been updated accordingly. The final document must be published no later than 1 October 2026 and will remain valid for up to five years unless significant changes require earlier revision.

5. Benchmarks

Compared with Wales overall:

- CTM has higher prevalence of several long-term conditions.
- Deprivation levels exceed the Wales average in many communities.
- Access to community pharmacy services remains strong.
- No current access gaps have been identified.
- Community pharmacy provision compares favourably with assessed population need.

6. Conclusion

The draft PNA demonstrates that current pharmaceutical services are meeting the needs of the CTMUHB population. While future demographic and health challenges are expected to increase demand, the existing network is considered capable of meeting current needs and no significant service gaps have been identified. The PNA provides an important statutory and strategic framework for future service planning and decision-making.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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 Service Transformation & Outcomes	
	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	Not Applicable	
	If more than one applies please list below:	
Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i> Equality & Welsh Language Impact Assessment Outcome	Outcome for Equality (delete as appropriate): POSITIVE Summary of impact: The PNA specifically considers protected characteristics, deprivation, disability,	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:



(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	geography and service accessibility. Outcome for Welsh Language (delete as appropriate): POSITIVE Summary of impact: Assessment considers Welsh language needs and pharmacy workforce language capability. The consultation was available in Welsh and the final PNA will be published in Welsh.	
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)	The report was written by an externally commissioned partners so a Quality Impact Assessment has not been undertaken	
Cyfreithiol / Legal	Yes (Include further detail below) The PNA supports compliance with statutory requirements under the NHS (Pharmaceutical Services) (Wales) Regulations 2020	
Enw da / Reputational	Yes (include further detail below) Demonstrates compliance with statutory duties and proactive service planning	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (include further detail below) Existing staffing and service planning requirements. No immediate financial consequence from approval of the PNA. Future commissioning decisions may have resource implications.	

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



Executive Leadership Group	14/09/2026	For approval
QSEC	03/06/2026	Approval of PNA draft for consultation
PNA Steering Group	2025/26	Draft PNA developed
Community Pharmacy Wales	Ongoing	Stakeholder input
Local Medical Committee	Ongoing	Stakeholder input
Llais	Ongoing	Stakeholder input
Public Engagement Survey	Mar-Apr 2026	286 Responses received
Community Pharmacy Contractor Survey	Mar-Apr 2026	78 responses received

Acronyms / Glossary of Terms	
PNA	Pharmaceutical Needs Assessment



Quality, Safety & Experience Committee

Water Safety, Infection and Risk Prevention Policy

Eitem yr Agenda / Agenda Item	6.1.4
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Cyflwynydd yr Adroddiad / Report Presenter:	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance
Diben yr Adroddiad / Report Purpose:	For Approval
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The QSEC are asked to approve the policy.

1. Situation / Background

- 1.1 The purpose of the policy is to assess, prevent and control risks associated with bacterial or chemical contamination and subsequent development of disease from work activities and water systems on the Health Board's premises.
- 1.2 This Policy has been developed to introduce a structured procedure for the Management and Control of water systems in compliance with current guidelines and regulations (The Health and Safety at Work etc. Act 1974, COSHH 2002, HSE Approved Code of Practice Legionnaires' Disease L8 – the control of legionella bacteria in water systems, the Welsh Health Technical Memorandum 04-01 – 'Safe Water in Healthcare Premises' and associated UK regulations and guidance, WHBN 00-09)

2. Specific Matters for Consideration

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

Name Title	Date Consulted / Completed
Equality Impact Assessment	Completed 22/07/2026
Informal Consultation with interested parties	Water Safety Group completed 02/06/2026
Formal Consultation	Available on Sharepoint policies page – closed 03/08/26
Committee – For approval	Approved at OMB on 05/08/26

- 2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
- 2.3 The membership of the CTM Water Safety Group have been engaged in the consultation and review process.
- 2.4 Organisational values and behaviours have been reflected within the policy.





3. Key Risks / Matters for Escalation

3.1 In response to the consultation the following amendments have been made:

- Only minor typographical amendments were made as a result of the various consultation stages.
- Latest CTM policy template used.

4. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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 6	
	If more than one applies please list below: Risk 6 Risk 10	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	
	If more than one applies please list below:	
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 <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhwch reswm o'r</i>	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact:	If no, please select a reason below. Choose an item.



<i> rhestr ostwng a llofnodwch y Weithrediaeth.)</i> Equality & Welsh Language Impact Assessment Outcome (Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	Outcome for Welsh Language (delete as appropriate): NEUTRAL Summary of impact:	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 impact	
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
Water Safety Group - Approved	02/06/2026	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	29/07/2026	ENDORSED FOR APPROVAL
Operational Management Board	05/08/2026	ENDORSED FOR APPROVAL

Acronyms / Glossary of Terms	
WHTM	Welsh Health Technical Memorandum
WHBN	Welsh Health Building Note
IPC	Infection Prevention and Control

5. Recommendation

- 5.1 The QSEC are asked APPROVE the Water Safety, Infection and Risk Prevention Policy
- 5.2 Next Steps - Once approval is obtained the author will proceed to publication on SharePoint and the Health Board Internet Site

Water Safety, Infection and Risk Prevention Policy

Document Type:	Policy
Indicate Clinical or Non-Clinical:	Non-Clinical
Document Reference:	EST WSP
Document Author (Title Only):	Head of Operational Estates
Document Executive Director Sponsor	Executive Director of Finance
Date Equality and Welsh Language Impact Assessment Completed:	22/07/2026
Freedom of Information Act Status (For Policies Only)	Open
	If indicated as closed please indicate exemption that has been applied: ()
Approving Forum:	(If you are not sure this is available from: ctm.qualityassurancecompliance@wales.nhs.uk)
Approval / Effective from Date:	Initial 27/02/2020.
	Reviewed 26/05/26
Review date due by:	Formal – 25/05/29
	Informal – 25/05/27
Document Version:	2
Target Audience	All Staff

Disclaimers

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

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



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Cwm Taf Morgannwg
University Health Board



Components

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

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

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non-Clinical Policy Development please contact:

ctm.qualityassurancecompliance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint.

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APPENDIX 1: WATER SAFETY GROUP

1. Purpose

- 1.1 CTMUHB is aware of and supports the contents, requirements and intentions of The Health and Safety at Work etc. Act 1974, COSHH 2002, HSE Approved Code of Practice Legionnaires' Disease L8 – the control of legionella bacteria in water systems, the Welsh Health Technical Memorandum 04-01 – 'Safe Water in Healthcare Premises and associated UK regulations and guidance, WHBN 00-09.
- 1.2 To assess, prevent and control risks associated with bacterial or chemical contamination and subsequent development of disease from work activities and water systems on the Health Board's premises.

2. Policy Statement

- 2.1 Cwm Taf Morgannwg University Health Board (thereafter referred to as CTMUHB) attaches the greatest importance to the health, safety and welfare of staff, patients and visitors. As part of this commitment, it is our aim to work closely together as an organisation to achieve properties free of infection from bacterial and chemical contamination associated with water systems. It also has a commitment to general water safety, by preventing scalding events, promoting good housekeeping, and adding resilience to the management of water systems.

3. Principles

- 3.1 This policy seeks to ensure the following principle:
 - CTMUHB through its Chief Executive, will ensure that its duties and responsibilities for the management of water systems within healthcare facilities are fully met.

4. Scope

- 4.1 The policy applies to all service users, visitors and staff associated with the Health board and should be read in association with the current water safety plan and implemented whenever water hygiene risk management advice is required. This water safety policy will be implemented throughout all premises, or parts of premises, that the Health Board owns or occupies, or for which the Health board is responsible.
- 4.2 In the event of an infection outbreak, flu pandemic or major incident, the Health Boards recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety.

5. Legislative and NHS Requirements.

5.1 This policy is based on good practice principles and guidelines and accords with legal and Agenda for Change obligations. the principal guidance documents to provide the necessary strategy for CTMUHB are:-

- Health & Safety Executive (HSE) Approved Code of Practice Legionnaires' Disease (ACoP L8) : The control of Legionella bacteria in water systems
- Health & Safety Executive (HSE) – Health & Safety Guidance (HSG) 274 Part 1 : The control of Legionella bacteria in evaporative cooling systems (N.B – It is recognised by the health board & Water Safety Group (WSG) its estate does not include any buildings where systems such as this are used and is only included for information and reference material purposes only)
- HSE - HSG 274 Part 2: The control of legionella bacteria in hot & cold water systems
- HSE - HSG 274 Part 3: The control of legionella bacteria in other risk systems
- HSE – HSG 282: The control of legionella and other infectious agents in spa-pool systems
- PWTAG: code of practice for swimming pool water 2016
- The Welsh Health Technical Memorandum WHTM 04-01: Safe Water in Healthcare Premises - Part A Design, Installation and Commissioning.
- The Welsh Health Technical Memorandum WHTM 04-01: Safe Water in Healthcare Premises - Part B Operational Management.
- The Welsh Health Technical Memorandum WHTM 04-01: Safe Water in Healthcare Premises - Part C Pseudomonas Aeruginosa - Advice for Augmented Care Units.
- The Welsh Health Technical Memorandum WHTM 04-01 Supplement. Performance specification D 08 thermostatic mixing valves (healthcare premises) 2017 edition
- World Health Organisation Water Safety in Buildings (March 2011).
- Health and Safety at Work Act 1974
- Control of Substances Hazardous to Health Regulations 2002
- Public Health (Infectious Diseases) Regulations 1988
- Water Supply (Water Quality) Regulations 2010
- Private Water Supplies (Wales) Regulations 2010 (as amended)
- Food Safety Act 1990
- Water Supply (Water Fittings) Regulations 1999

5.2 It is accepted that CTMUHB staff at all levels must do all that is reasonably practicable to achieve compliance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH 2002), Health and Safety Executive (HSE), NHS and other recognised guidance with regard to the prevention of infection within the Health Board and, where appropriate, relevant training and information will be provided by CTMUHB.

5.3 It is the intention of CTMUHB to ensure the effective implementation of this policy and to keep it under consideration in all aspects of health practice and decision making.

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Policy Title: Water Safety, Infection and Risk Prevention Policy

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6 Duties and responsibilities of staff.

A person intending to fulfil any of the following staff functions should be able to prove that they possess sufficient skill, knowledge and experience to be able to perform safely the designated tasks. Where required, such as AE, RP, DRP duties they will be requested to accept the responsibilities in writing. All staff have a duty to assist in water safety management.

6.1 Duty Holder

The Duty Holder has overall responsibility for the Health Board, (CEO of the Health Board. The Duty Holder must ensure that staff with designated roles have the resources to fulfil those roles.

6.2 Designated Person.

The Designated Person (DP) Director of Finance, Capital and Estates is the senior executive board level member, with assigned responsibility for the service, acting on behalf of the Duty Holder. They will appoint in writing the Authorising Engineer (AE), and are responsible for appointing in writing the Responsible Persons (RP) and Deputy Responsible Persons (DRP) following specialist assessment and advice given by the Authorising Engineer. They are responsible for requesting the independent annual audit carried out by the Independent AE, or any other associated auditors.

6.3 Authorising Engineer

The Authorising Engineer (AE (W)) is an independent appointee to the Health Board, reporting directly to the Designated Person (DP). They will be a person with the appropriate experience and qualifications in line with WHTM 00 and WHTM 04-01. Their role is to provide independent technical advice on all aspects of water safety. The AE (W) also assesses the suitability of and recommends the appointment of Responsible Persons. The AE (W) shall be appointed by the Designated Person with a brief to provide services in accordance with Welsh Health Technical Memoranda guidance for Water.

The AE (W) shall monitor the performance of the WSG and provide an annual governance audit to the Designated Person. To carry out this role effectively, particularly with regard to audit, the AE (W) shall remain independent of the operational structure of the HB Trust.

The Authorising Engineer (AE) will be invited to attend the Water Safety Group (WSG), where they will give expert advice and guidance to the group. They will witness tests and carryout checks where required to do so, and deliver to the DP audits as requested, to provide assurances on the management of water systems within CTMUHB. The person must have specialist knowledge, training and experience of all water systems

6.4 Responsible Persons (Water) – RP (W)

RP (W) are the individuals possessing sufficient technical knowledge and having received appropriate training to manage water systems on a specific site or group of sites. They will have a good knowledge of the systems for which they are appointed and have a level of authority to make decisions about the system. They will be appointed in writing by the Designated Person (DP) following assessment by the AE (W). They also fulfil the role of Responsible Persons as defined in HSE ACOP L8, and noted in WHTM 04. The RP (W) will assess and appoint Competent Persons to work on the water systems. They may be either Health board employed staff or external contractors.

6.5 Competent Persons CP (Water) – CP (W)

CP (W) are individuals assessed and appointed by the Responsible Person as having sufficient technical knowledge and experience to carry out work on a Water System. They will include maintenance personnel and water samplers. They may be either the HB employed staff or external contractors.

6.6 Estates Management

The Estates Management team are tasked with managing water maintenance, through the designated Planned Preventative Maintenance (PPM) electronic control system. They will ensure that water related maintenance is distributed to relevant trained and qualified engineering staff or appointed contractors with the necessary skills, accreditations and qualifications to undertake maintenance at the required timescales as noted in WHTM04-01. They will provide a helpdesk where remedial work can be requested and will ensure timely distribution to qualified in-house or external contractors. They will ensure that staff are trained, and that refresher training is carried out when required. The Head of Operational Estates will Chair the WSG.

6.7 Facilities Management

The Facilities Manager is the person nominated by management to advise on control measures to prevent the spread of water pathogens. This includes management of cleaning safe systems of work (ssow), disinfection, and outlet flushing measures where required as identified within the risk assessment, and in the delivery of housekeeping duties. They will ensure that staff have adequate hygiene training, and that staff are fully aware of their responsibilities to prevent microbiological contamination of plumbing components, and adherence to relevant legislation. They will form part of the quorum as a main lead on the Water Safety Group. The person must have specialist knowledge, training and experience of water systems.

6.8 Infection Control Doctor for the Health Board

The Infection Control Doctor for the Health Board (or consultant microbiologist, if not the same person) is the person nominated by the management to advise on monitoring the infection control policy and microbiological performance of the HB Water Systems in line with WHTM 04-01 and WHBN 00-09 and any associated water policies and procedures.

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6.9 Infection Prevention Lead & Control Team (IPCT)

The IPCT is responsible for working in conjunction with those responsible for delivering maintenance and construction projects and those ensuring the estate is fit for purpose in line with WHTM 04-01 and WHBN 00-09 and any associated water policies and procedures. They will provide clinical advice, mentoring for maintenance staff on infection control and minimising HCAIs, advice on risk assessments regarding the built environment, identify the priorities for the action plan and will assist in monitoring this policy.

6.10 Capital Project Managers / Officers

Capital Project officers are responsible for ensuring any work meets the requirements of legislation, WHTM 04-01, and to work in conjunction with IPC colleagues to meet WHBN 00-09 and the specifications for each individual project they are assigned to. They need to have an understanding of the operation and requirements associated with water devices and supplies.

Capital project managers / officers will also be responsible for reporting any works associated with water systems within their projects / schemes to the Water Safety Group (WSG), detailing the scope of works, what has been asked of the contractors in terms of competencies, is the system to be chlorinated after works, how the contractor will manage, control and ensure water quality throughout the works etc so that the WSG can consider and confirm the requirements as appropriate to each individual project / scheme.

Designs should be in accordance with WHTM 04 – 01, and in particular Part A. They are responsible for supplying correct manuals, documentation, pre-handover training and the familiarisation to operational personnel. Capital / Major Projects, Project Managers are responsible for ensuring final certification on satisfactory completion of building construction, including any required sampling & sampling results, that will be presented to the Microbiologist / IPC as the combined sign off of the project prior to occupation in line with WHBN 00-09.

6.11 Architects / Design Engineers / Design Consultants / Consultants / Principal Contractors / Contractors

Architects / Design Engineers / Design Consultants / Consultants / Principal Contractors / Contractors are responsible for the design of buildings and need to have an understanding of the operation and requirements associated with water devices and supplies in accordance with WHTM 04-01, WHBN 00-09 and any other water regulations. Project and construction engineers are responsible for the installation of water systems. When buildings are being constructed, renovated or modified, engineers provide a key role in establishing risk-management plans to minimise risks to people using the building. These risk-management plans should include instructions on how they will actively manage the water system during the active works, how to deal with potential problems, disruptions to services, and they should ensure that technical standards and regulations are met.

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Risk- management plans should include how education of maintenance and construction workers on the task will be undertaken, and ongoing assurances that the standards laid out in the RA are followed, monitored, and addressed should a failure in the plan be found.

6.12 Site Managers

Have joint responsibility for the monitoring, cleanliness and reporting maintenance requirements in patient care environments within their service areas. They will work closely with the Estates team, the IPCT, and the relevant support services to ensure delivery of WHTM 04-01 and the Water Safety Plan.

6.13 Ward or Department Managers

Have a responsibility to adhere to WHTM 04-01, and health board water safety plans. They will identify little-used is something missing here. Once identified these outlets must be flushed by departmental staff in accordance with the flushing requirements of the water safety plan.

6.14 Clinical Staff / All Staff

Have a joint responsibility for ensuring water safety in accordance with WHTM04-01, and the water safety plan, within their clinical areas, or the areas they operate and work within any health board site. They are responsible for reporting any maintenance defects relating to the end user water systems to the Estates Maintenance helpdesk.

7. Water Safety Group

The Water Safety Group will be chaired by either the Head of Operational Estates or nominated RP. The nature of this chair and representation will be determined in the Terms of Reference for the group. With the aid of Infection Control, Microbiology, Facilities, RP's and Estate leads, capital project managers / officers, deputies of the Responsible Person, appropriate maintenance staff and contractors, the WSG has the following roles, and has direct accountability to the DP:

- to work with and support the IPC team;
- to ensure effective ownership of water quality management for all uses;
- to determine the particular vulnerabilities of the at-risk population;
- to review the risk assessments;
- to ensure the WSP is kept under review including risk assessments and other associated documentation;
- to ensure all tasks indicated by the risk assessments have been allocated and accepted;
- to ensure new builds, refurbishments, modifications and equipment are designed, installed, commissioned and maintained to the required water standards;
- to ensure maintenance and monitoring procedures are in place;
- to review clinical and environmental monitoring data;

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- to agree and review remedial measures and actions, and ensure an action plan is in place, with agreed deadlines, to ensure any health risks pertaining to water quality and safety are addressed;
- to determine best use of available resources;
- to be responsible for training and communication on water-related issues
- to oversee water treatment with operational control monitoring and to provide an appropriate response to out-of-target parameters (that is, failure to dose or overdosing of the system);
- to oversee adequate supervision, training and competency of all staff;
- To ensure surveillance of both clinical and environmental monitoring.
- Agree operational microbiological testing regime, when samples should be taken, at what frequency & from what locations and to also consider regimes for capital and major project schemes.

Appendix 1 shows the structure of the WSG and direct accountability to the DP.

7.1 Minutes of Meetings

Detailed minutes of the group meetings should be recorded, distributed promptly and retained in accordance with the management policy to demonstrate good management, appropriate and timely actions and good governance.

7.2 Reporting

The Water Safety Group reports to the Capital and Estates Health, Safety and Risk Committee, which in turn reports to the Capital and Estates Governance Board. It also reports to the Infection Prevention Control Committee, which reports to the Corporate Risk Committee. All the roles listed above have legal responsibilities.

8. Water Safety Plan

8.1 The Water Safety Group must ensure that there is an operational water safety plan and written scheme for which the Health Board is responsible. The document will be a living document and as such will be reviewed and updated at appropriate intervals. This WSP will assist with understanding and mitigating risk associated with waterborne hazards in distribution, supply & waste systems and associated equipment. It will provide a risk managed approach to the safety of water and establishes good practice in local water usage, distribution, supply and waste.

8.2 The Water Safety Plan must contain the following elements:

- Assess the risks that may be posed to patients (including those with particular susceptibility), staff and visitors;
- Put into place appropriate management systems to ensure the risks are adequately controlled;
- Ensure there are supporting programmes, including communication, training and competency checks.

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- A clinical risk assessment to identify those settings where patients are at significant risk from waterborne pathogens;
- An engineering and bacterial risk assessment of all water systems;
- Operational monitoring of control measures and record-keeping methodology;
- Information on the age and condition of the water distribution system and materials of construction (as different materials hold differing risks and react differently to chemicals);
- Links to clinical surveillance;
- Early warnings of poor or unsuitable water quality (for example, taste, odour, flavour and appearance if intended for drinking);
- Plans for the sampling and microbiological testing of water in identified at-risk units
- Adequate supervision, training and competency for all levels of staff including housekeeping staff and those employed by facilities management organisations;
- Appropriate design, installation, commissioning and maintenance of all components and equipment;
- Remedial actions to be taken to remedy high counts for *P. aeruginosa* and *Legionella* and other relevant pathogens where appropriate;
- Adjustments to clinical practice until remedial actions have been demonstrated to be effective;
- Regular removal/cleaning/descaling or replacement of the water outlets, hoses and thermostatic mixing valves (TMVs) and other components where risk assessment states;
- Amendments when changes are carried out including new builds, refurbishments and recently decommissioned clinical departments or units;
- Amendments made when changes are made at the annual review.
- The WSP should identify potential alert organisms and microbiological hazards caused by *Legionella*, *P. aeruginosa* and other relevant pathogens, consider practical aspects and detail appropriate control measures.
- Schematic diagrams and descriptions of all the supply, storage and distribution systems within Health Board premises and a statement to enable authorised persons to locate the up-to-date as-fitted drawings.
- Step-by-step instructions to operate, maintain, control and shut down the water supply, storage and distribution systems within Health board premises.
- A schedule of possible emergency incidents causing loss of the water supply from the water undertaker. Each item in the emergency incident schedule should include guidance on operational procedures to re-establish a stable wholesome water supply.

9. Risk Assessments

9.1 CTMUHB commissions written risk assessments in accordance with the requirements of BS8520/2010 and WHTM 04-01, with accurate schematic diagrams and photographic evidence, to identify potential hazards, and assess the risk of exposure to bacteria from water systems on the premises and any

precautionary measures necessary. Specialist contractors will be engaged for this purpose.

9.2 Risk assessments will be available for existing buildings, and required water carrying equipment, plant, structures. They will also be completed/updated for new building works, new installations or alterations to existing water supply and distribution systems. They will also include water treatment, air conditioning, water outlets, vending, chilled-water, ice making machines, humidifiers, birthing pools, garden sprinklers, vehicle washing points, decorative water features, wet fire and automatic sprinkler systems, patient contact equipment e.g. nebulisers, heater cooler units, flowers and plants, buried pipelines, showers, spa pools and hydrotherapy pools etc.. Risk assessments should include anything which may contribute to legionella risk, *Pseudomonas aeruginosa* or any other hazardous waterborne bacteria.

9.3 Audits or assessments of risks are undertaken regularly in accordance with WHTM 04-01 and ACop L8 2013.

9.4 Risk assessments, audits and records of water safety control activities are reviewed and monitored by the Water Safety Group, which meets quarterly.

10. Preventative measures

10.1 CTMUHB takes all reasonable measures to minimise the risk of exposure of staff, patients and visitors to infection in accordance with existing guidance. The Water Safety Plan makes reference to all managers, staff and disciplines responsibilities, including estates detailed schedule of preventative maintenance procedures, monitoring of water quality and record keeping, which is audited annually and as required by other external agencies.

10.2 Cleaning of water outlets / sinks and appliances is routinely undertaken by the HB domestic services, where staff undergo specific cleaning, hygiene and water understanding training.

11. Retention or Archiving arrangements

11.1 Copies of this Policy will be archived and stored in line with the Organisation's Records Management Policy

12. Process for monitoring compliance with the effectiveness of the policy.

12.1 In order to monitor compliance with this policy, the WSG will regularly carryout scrutiny of the policy for accuracy and suitability, and will review and ratify at least every 3 years, or when any significant change arises if sooner.

12.2 The Policy will also be subjected to scrutiny in the Annual Shared Services Independent annual compliance audit, present to the DP.

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13. Non Conformance

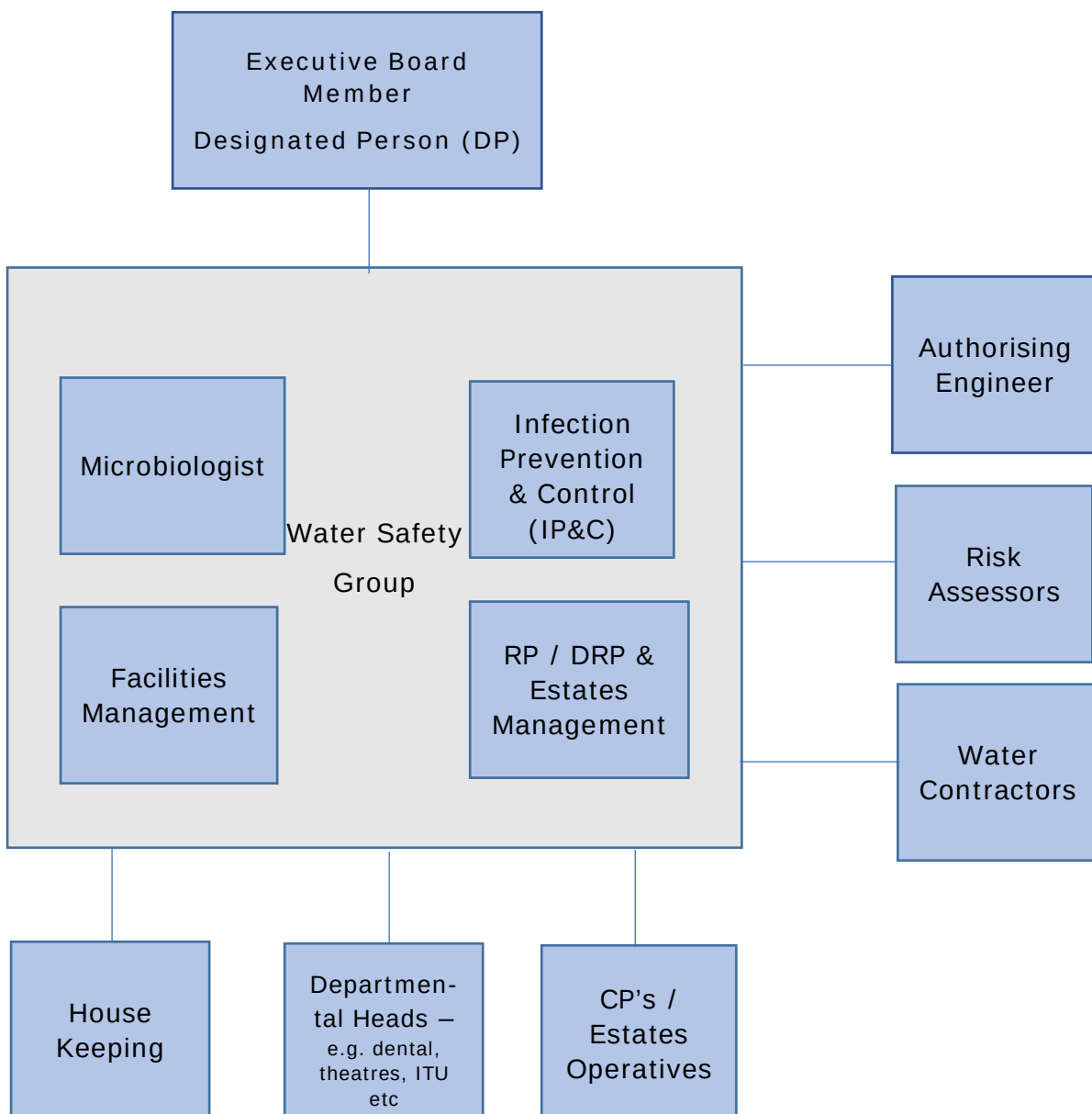
- 13.1 There is a requirement for all staff to comply with this Policy, and where requested, to demonstrate such compliance. Failure to comply will be regarded as a disciplinary incident, and will be dealt with under the appropriate Health Board Workforce and Organisational Development Policy.
- 13.2 Security information and regular security bulletins are provided on the organisations share point intranet news and where appropriate are also displayed throughout the Health Board to encourage members of the public to comply with this Policy.

14. Equality & Welsh Language Impact Assessment Statement

- 14.1 This Policy has been subject to a full equality & Welsh language impact assessment and no impact has been identified.



Appendix 1 : Water Safety Group





Quality, Safety & Experience Committee

Policy and Procedure for the Prevention and Management of Adult Inpatient Falls

Eitem yr Agenda / Agenda Item	6.1.5
Dyddiad y Cyfarfod / Date of Meeting:	22/09/26
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Lead Nurse, Corporate Nursing
Cyflwynydd yr Adroddiad / Report Presenter:	Hayley Ellis-Evans, Lead Nurse Corporate Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Approval
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Quality, Safety & Experience Committee are asked to APPROVE the Policy and Procedure for the Prevention and Management of Adult Inpatient Falls and to support its implementation across Cwm Taf Morgannwg University Health Board.



1. Situation / Background

- 1.1 The Policy and Procedure for the Prevention and Management of Adult Inpatient Falls sets out the Health Board's approach to reducing falls and falls-related harm through the consistent assessment, prevention, management and review of falls risks.

It applies to all staff and all clinical settings within Cwm Taf Morgannwg University Health Board where patient care is delivered, ensuring a standardised and evidence-based approach to falls prevention and patient safety.

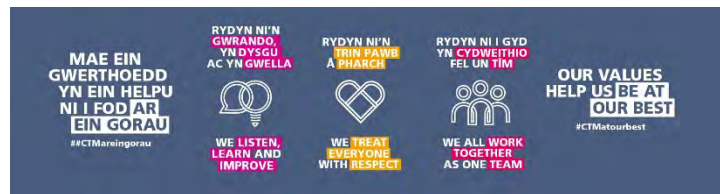
2. Specific Matters for Consideration

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

Name Title	Date Consulted / Completed
Equality Impact Assessment	July 6 th 2026, submitted
Informal Consultation with interested parties	Informal consultation has been undertaken with the Falls Prevention Group, all Senior Nurses, Allied Health Professional Leads, and relevant clinical stakeholders across CTM UHB to ensure the policy reflects current practice and national guidance
Formal Consultation	Formal consultation has been undertaken with relevant professional leads for falls prevention, including the Patient Safety Group, Therapies Forum, and Quality and Safety Leads. Harm Free Care – Falls Steering Group 17/6/2026
Committee	Quality, Safety & Experience Committee for Approval following Operational Management Board (OMB) and contact with the Medical Directors Office who will notify the Assistant Medical Director of the outcome from the Operational Management Board.

- 2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

- 2.3 All Health Care Professionals have been engaged in the consultation.
- 2.4 Organisational values and behaviours have been reflected within the policy.



3. Key Risks / Matters for Escalation

- 3.1 In response to the consultation the following amendments have been made:
- 3.1.1 Streamlined the document - 30/7/26
- 3.1.2 Clarified safeguarding escalation processes – 29/07/2026
- 3.1.3 Adapted changes to reporting criteria within National Audit of Inpatient Falls 7/7/26
- 3.1.4 Clarity of roles and responsibilities within Allied Health Professionals– 16/6/26 and 19/6/26
- 3.1.5 Patient Care and Safety feedback in relation to escalation of incidents and roles-9/6/26

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) 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 Service Transformation & Outcomes
	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	Culture & Valuing People	
	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)	Positive impact anticipated. The policy supports improved patient care and safety by promoting the prevention and management of falls, reducing avoidable harm, improving patient outcomes, and assuring a consistent, evidence-based approach to care across CTM UHB.	
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
Falls Steering Group Falls Collaborative MDT Leads for Falls within Allied Health Professionals Governance Harm Free Care Operational Management Board		Approved with some comments and late amendments April 2026 June 2026 June 17 th 2026

Acronyms / Glossary of Terms	

5. Recommendation

- 5.1 The Quality, Safety & Experience Committee are asked APPROVE the Policy and Procedure for the Prevention and Management of Adult Inpatient Falls

6. Next Steps

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

Policy and Procedure for the Prevention and Management of Adult Inpatient Falls

Document Type:	Policy
Indicate Clinical or Non-Clinical:	Clinical
Document Reference:	(If you are not sure this is available from: ctm.qualityassurancecompliance@wales.nhs.uk)
Document Author (Title Only):	Lead Nurse Corporate Nursing
Document Executive Director Sponsor	Executive Director of Nursing, Midwifery & Patient Care
Date Equality and Welsh Language Impact Assessment Completed:	
Freedom of Information Act Status (For Policies Only)	Open
	If indicated as closed please indicate exemption that has been applied: N/A
Approving Forum:	(If you are not sure this is available from: ctm.qualityassurancecompliance@wales.nhs.uk)
Approval / Effective from Date:	22/09/26 (if Approved by QSEC)
Review date due by:	March 2027
Document Version:	2.5.1
Target Audience	All Staff

Disclaimers

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

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



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Cwm Taf Morgannwg
University Health Board



Components

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

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

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Or visit the Policy Author Page on SharePoint.

Policy Reference Number:

Policy Title: Policy and Procedure for the Prevention and Management of Adult Inpatient Falls

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1. Introduction

- 1.1 Cwm Taf Morgannwg University Health Board is committed to reducing avoidable harm from adult inpatient falls while supporting safe mobility, independence, dignity and person-centred care. Falls are among the most reported inpatient safety incidents and may result in no harm, minor injury, significant harm or, rarely, catastrophic injury. Effective falls prevention therefore requires consistent assessment, timely intervention, clear communication and multidisciplinary review.

2. Policy Statement

- 2.1 CTMUHB will ensure that adult inpatients who are at risk of falling receive proportionate, evidence-informed assessment, care planning and intervention.
- 2.2 Falls prevention and post-fall management will be delivered through multidisciplinary working, patient and carer involvement, timely documentation, incident reporting and learning from harm.
- 2.3 The policy supports compliance with legal, regulatory and professional requirements, including health and safety duties, safeguarding duties, the Nurse Staffing Levels (Wales) Act where applicable, Duty of Candour requirements and national falls guidance.

3. Scope of Policy

- 3.1. This policy applies to all CTMUHB staff, students, temporary staff, locums, contractors and others working in inpatient settings who contribute to the care, safety or environment of adult inpatients.
- 3.2. It applies to adult inpatient areas across acute, community, mental health and learning disability settings, recognising that local pathways, documentation and escalation routes may vary by service.
- 3.3. It covers falls prevention, multifactorial assessment, standard and targeted interventions, immediate post-fall actions, reporting, investigation, assurance, learning and discharge considerations.
- 3.4. Falls occurring in community settings outside inpatient care are outside the scope of this policy and should be managed under the relevant community pathway or service procedure.

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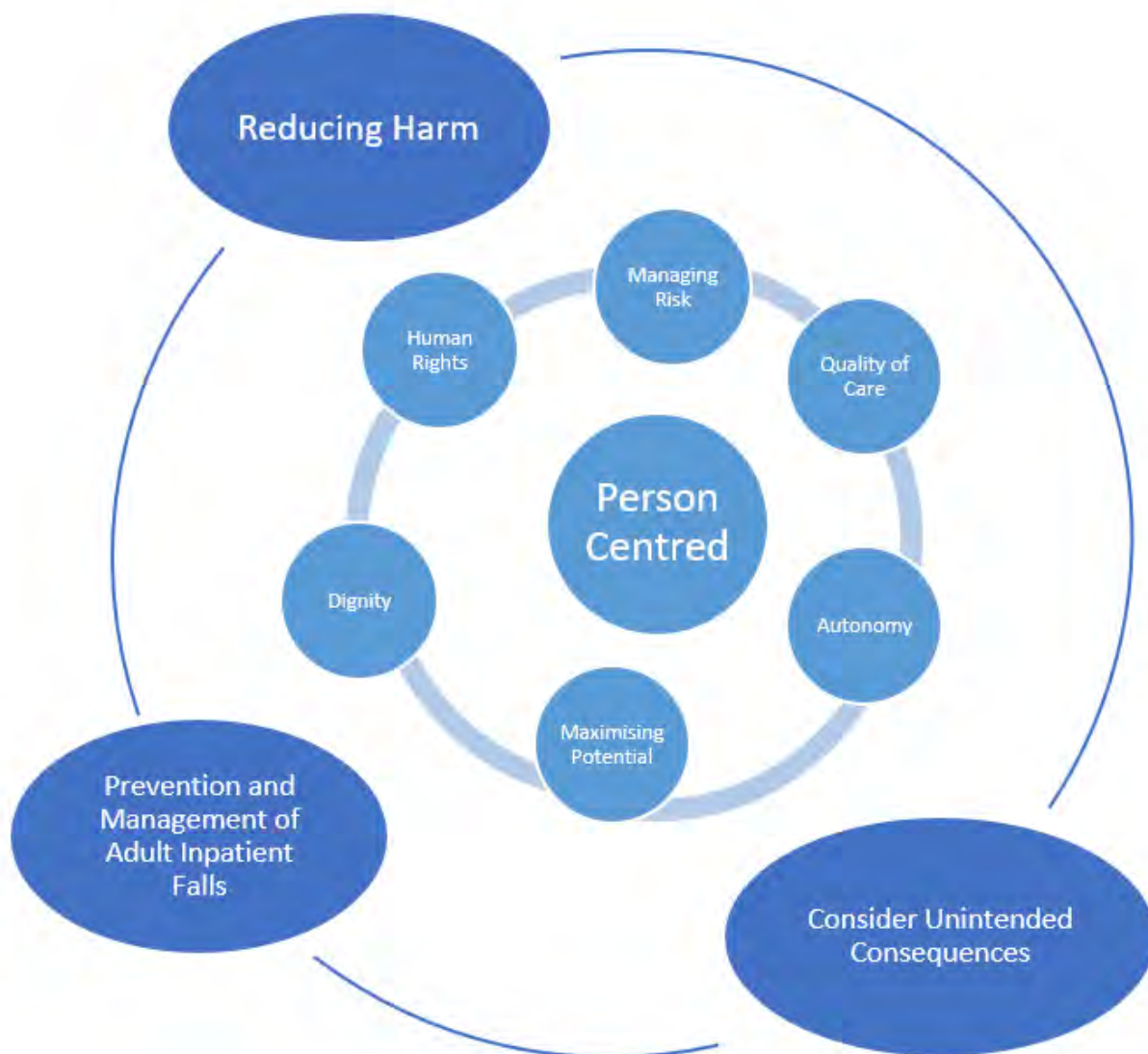
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4. Aims and Objectives

- 4.1. To provide a clear and consistent framework for preventing and managing adult inpatient falls.
- 4.2. To ensure patients are assessed using the Multifactorial Assessment to Optimise Safe Activity and receive an individualised falls prevention care plan where required.
- 4.3. To support safe activity and reduce deconditioning while balancing risk, autonomy, dignity and patient choice.
- 4.4. To ensure all falls are reported, reviewed and investigated proportionately, with learning shared and actions monitored through established governance arrangements.
- 4.5. To clarify responsibilities for staff, managers, clinical teams, Care Groups and Health Board governance forums.



5. Underpinning Key Principles



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6. Responsibilities

- 6.1. All staff working in inpatient areas must understand and follow this policy, maintain a safe environment, complete or contribute to falls risk assessment and care planning within their role, communicate identified risks, and respond promptly when a fall occurs.
- 6.2. Registered nurses are responsible for ensuring the required falls assessment and care planning processes are completed, reviewed and updated, including following admission, transfer, change in condition, near miss or fall.
- 6.3. Medical staff are responsible for assessing and treating clinical causes or consequences of falls, reviewing relevant medical conditions and medicines, and contributing to post-fall management and secondary prevention.
- 6.4. Allied health professionals, including physiotherapy, occupational therapy, dietetics, pharmacy and psychology where appropriate, contribute specialist assessment and interventions relating to mobility, function, nutrition, medication, cognition, behaviour and safe discharge planning.
- 6.5. Ward managers, team leaders and clinical managers are responsible for ensuring staff awareness, local implementation, environmental safety checks, audit participation, documentation standards and escalation of risks.
- 6.6. Heads of Nursing, Senior Nurses, Lead Nurses and Care Group leadership teams are responsible for oversight of implementation, incident review, assurance, improvement actions and escalation through governance arrangements.
- 6.7. The Quality and Safety teams support incident management, analysis, reporting, Duty of Candour requirements, learning outputs and improvement monitoring in line with CTMUHB frameworks.
- 6.8. The CTMUHB Inpatient Falls and Deconditioning Steering Group provides strategic oversight of falls prevention, deconditioning improvement, audit findings, incident themes, training needs and shared learning.
- 6.9. Estates and Facilities teams are responsible for responding to escalated environmental risks that may contribute to falls, including issues relating to flooring, lighting, handrails, equipment hazards and unsafe physical conditions.

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7. Definitions

Term	Definition
Fall	An event in which a person comes to rest inadvertently on the ground, floor or other lower level.
Slip	An involuntary slide causing loss of balance or foothold.
Trip	An accidental misstep that threatens or causes a fall.
Unexplained fall	A fall that was not witnessed, where the cause is unclear, or where the person cannot explain how or why they fell.
MASA	Multifactorial Assessment to Optimise Safe Activity; the CTMUHB assessment used to identify falls risk factors and inform individualised care planning.
Falls prevention care plan	An individualised plan setting out actions to reduce falls risk while supporting safe activity, independence and dignity.
Post-fall review	The immediate and multidisciplinary review undertaken after a fall to assess injury, identify contributory factors and agree actions to reduce further risk.
Nationally Reportable Incident	A patient safety incident meeting national reporting criteria, including specified falls resulting in severe harm or death.

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8. Implementation / policy compliance
 - 8.1. This policy will be implemented through Care Group governance arrangements, ward assurance processes, the CTMUHB Inpatient Falls and Deconditioning Steering Group, and relevant quality and safety forums.
 - 8.2. All adult inpatients must receive routine falls prevention measures. Patients identified as being at higher risk of falling must receive MASA assessment and an individualised falls prevention care plan.
 - 8.3. MASA and care plans must be reviewed following admission, transfer, significant change in condition, near miss, fall, or where new risk factors are identified.
 - 8.4. All inpatient falls must be recorded in DATIX as soon as possible and normally within 24 hours. Documentation must also be completed in the patient record, including assessment findings, actions taken, communication with the patient or representative, and any changes to the care plan.
 - 8.5. Falls resulting in moderate or severe harm, repeated falls, unexplained falls or safeguarding concerns must be escalated in line with CTMUHB incident management, safeguarding and governance procedures.
 - 8.6. Compliance will be monitored through MASA documentation audits, falls incident trend analysis, ward assurance, accreditation activity, training data and review of action plans arising from incident learning.
9. Information, Instruction and Training
 - 9.1. All clinical staff involved in inpatient care must receive appropriate information, instruction and training on falls prevention and post-fall management.
 - 9.2. Training must include completion and review of MASA, individualised falls prevention care planning, standard falls prevention measures, safe mobility, post-fall assessment, escalation, DATIX reporting, documentation and safeguarding considerations.
 - 9.3. Relevant staff must complete required manual handling training, including safe management of a falling or fallen person, and any ESR or local falls modules identified by CTMUHB.
 - 9.4. Managers must monitor training compliance and address gaps through local action plans, supervision, induction, refresher training and escalation where required.

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- 9.5. Learning from falls incidents, audits, assurance visits and panel reviews must inform education updates, safety briefings and improvement activity.
10. Equality and Welsh language impact assessment outcome
 - 10.1. This policy must be considered through the CTMUHB Equality and Welsh Language Impact Assessment process before approval.
 - 10.2. Falls prevention and post-fall care must be delivered in a way that respects dignity, human rights, communication needs, mental capacity, cultural needs, language preference and reasonable adjustments.
 - 10.3. Information for patients, relatives and carers should be available in accessible formats and Welsh where required, in line with organisational requirements and Welsh Language Standards.
 - 10.4. Where a patient may lack capacity to make decisions about falls prevention interventions, staff must follow the Mental Capacity Act and relevant CTMUHB procedures, including best-interest decision-making where appropriate.
11. Main Relevant Legislation
 - 11.1. Health and Safety at Work etc. Act 1974.
 - 11.2. Management of Health and Safety at Work Regulations 1999.
 - 11.3. Workplace (Health, Safety and Welfare) Regulations 1992.
 - 11.4. Mental Capacity Act 2005 and Mental Capacity (Amendment) Act 2019.
 - 11.5. Social Services and Well-being (Wales) Act 2014.
 - 11.6. Health and Social Care (Quality and Engagement) (Wales) Act 2020, including Duty of Candour requirements.
 - 11.7. Nurse Staffing Levels (Wales) Act 2016.
 - 11.8. All Wales Safeguarding Procedures.
 - 11.9. Relevant national falls guidance, including NICE guidance and National Audit of Inpatient Falls requirements.
12. References
 - 12.1. National Institute for Health and Care Excellence. Falls guidance and quality standards.
 - 12.2. Royal College of Physicians. National Audit of Inpatient Falls reports and resources.
 - 12.3. Welsh Government. Principles, framework and national indicators for adult inpatient falls.

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- 12.4. All Wales NHS Manual Handling Training, Passport and Information Scheme.
- 12.5. UK Government guidance on bed rails: management and safe use.
- 12.6. CTMUHB incident management, concerns, safeguarding, mental capacity, enhanced supervision, manual handling, health and safety, and learning and development policies.
13. Getting Help
 - 13.1. Staff should seek immediate advice from a senior clinician, nurse in charge, site manager, medical team, allied health professional or patient safety colleague where there is uncertainty about falls risk, post-fall care, escalation or documentation.
 - 13.2. Specialist advice may be sought from physiotherapy, occupational therapy, pharmacy, dietetics, psychology, tissue viability, safeguarding, manual handling, estates or the aligned Quality and Patient Safety team depending on the risks identified.
 - 13.3. For urgent patient safety concerns, staff must follow local escalation procedures and ensure any immediate risk to the patient, other patients, staff or visitors is addressed without delay.
 - 13.4. For policy interpretation, audit, governance or training queries, staff should contact their line manager, Care Group governance route or the CTMUHB Inpatient Falls and Deconditioning Steering Group route as appropriate.
14. Related Policies
 - 14.1. CTMUHB Incident Management Framework.
 - 14.2. CTMUHB Concerns Policy and Procedures / Listening to People arrangements.
 - 14.3. CTMUHB Safeguarding Adults Policy and associated procedures.
 - 14.4. CTMUHB Mental Capacity Act and Deprivation of Liberty Safeguards procedures.
 - 14.5. CTMUHB Enhanced Supervision or Safe and Supportive Observation guidance.
 - 14.6. CTMUHB Manual Handling Policy and training requirements.
 - 14.7. CTMUHB Health and Safety Policy and environmental risk assessment procedures.
 - 14.8. CTMUHB Learning and Development Policy.
 - 14.9. CTMUHB Bedrails guidance and associated risk assessment documentation.

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14.10. Relevant patient information leaflets and appendices supporting falls prevention, post-fall care, deconditioning and discharge planning.

15. Appendices

Appendix 1	Fall and Bone Health Multifactorial Assessment, actions, and interventions for all adults (MFA) and continuation sheet.	
Appendix 2	Adult inpatient bedrail risk assessment	
Appendix 3	Pre-fall patient information leaflet	
Appendix 3a	Pre-fall information leaflet for relatives/carers	
Appendix 3b	Post-fall patient information leaflet	
Appendix 4	Immediate actions following adult inpatient fall: Prevention and management of falls flowchart.	
Appendix 4a	Immediate actions following adult inpatient fall: Prevention and management of falls flowchart (YCC and YCR Hospitals only)	
Appendix 4b	Immediate actions following adult inpatient fall: Prevention and management of falls flowchart (Mental Health & Learning Disabilities only)	
Appendix 5	Falls Alert	
Appendix 5a	Falls Alert (Community Hospital only)	

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Appendix 5b	Post Falls Assessment (Mental Health & Learning Disabilities)	
Appendix 6	Bed Rails Poster	
Appendix 7	Enhanced Supervision Policy	
Appendix 8	NAIF Resources	NAIF resource repository RCP Audit guidance, documents, and files (ffap.org.uk)
Appendix 9	In-Patient Falls Learning and Assurance Panel SOP	
Appendix 9a	Assurance Panel Chair Template	
Appendix 10	Age UK Falls Leaflet 10.1 English 10.2 Welsh	
Appendix 11	CTM Delirium Policy	
Appendix 12	Discontinue the routine of movement sensors	
Appendix 13	Mandatory Training Requirements	
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Appendix 15	(1) Deconditioning Poster (2) Deconditioning: Your Guide to Staying Well at Home and Preventing Falls and Pressure Ulcers	

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	(3) Deconditioning: YOUR GUIDE TO STAYING WELL AT HOME AND PREVENTING FALLS & PRESSURE ULCERS	
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Quality, Safety & Experience Committee

Water Cooler & Ice Machine Policy

Eitem yr Agenda / Agenda Item	6.1.6
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Cyflwynydd yr Adroddiad / Report Presenter:	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance
Diben yr Adroddiad / Report Purpose:	For Approval
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The QSEC are asked to approve the policy.

1. Situation / Background

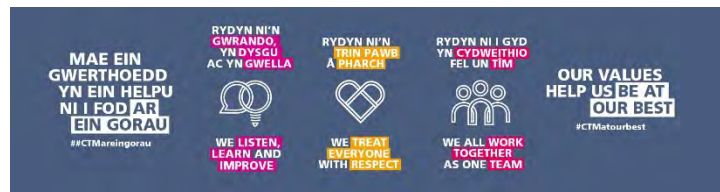
- 1.1 The purpose of this procedure is to set out the process prior to installation of any water coolers or icemaking equipment, and subsequent actions once authority has been given, in order to prevent the risk of infection and to ensure compliance with current guidelines and regulations.

2 Specific Matters for Consideration

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

Name Title	Date Consulted / Completed
Equality Impact Assessment	22/07/2026
Informal Consultation with interested parties	Water Safety Group completed 02/06/2026
Formal Consultation	Available on Sharepoint policies page – closed 03/08/26
Committee – For approval	Approved at OMB on 05/08/26

- 2.1 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
- 2.2 The membership of the CTM Water Safety Group have been engaged in the consultation and review process.
- 2.3 Authorisation must be gained prior to any installation via the Water Safety Group. Without the authority of the Water Safety Group, no authority to purchase, install or proceed is granted.
- 2.4 Organisational values and behaviours have been reflected within the policy.



3 Key Risks / Matters for Escalation

- 3.1 In response to the consultation the following amendments have been made:
- Minor text adjustments made to clarify and tighten procedures where required



- Latest CTM policy template used.

4 Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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 6	
	If more than one applies please list below: Risk 6 Risk 10	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	
	If more than one applies please list below:	
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 (<i>Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhwch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.</i>) Equality & Welsh Language Impact Assessment Outcome (<i>Please write summary statement, if not undertaken provide reason</i>)	Outcome for Equality (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:
	Outcome for Welsh Language (delete as appropriate): NEUTRAL Summary of impact:	



from dropdown and Executive sign off.)		
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 impact	
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
Water Safety Group - Approved	02/06/2026	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	29/07/2026	ENDORSED FOR APPROVAL
Operational Management Board	05/08/2026	ENDORSED FOR APPROVAL

Acronyms / Glossary of Terms	
WHTM	Welsh Health Technical Memorandum
WHBN	Welsh Health Building Note
IPC	Infection Prevention and Control

5 Recommendation

5.1 The QSEC are asked APPROVE the Water Cooler & Ice Machine Policy

5.2 Next Steps - Once approval is obtained the author will proceed to publication on SharePoint and the Health Board Internet Site

Water Cooler & Ice Machine Policy

Document Type:	Policy
Indicate Clinical or Non-Clinical:	Non-Clinical
Document Reference:	EST 011
Document Author (Title Only):	Alan Martin Head of Operational Estates. Supported by the IPCC team and Water Safety Group.
Document Executive Director Sponsor	Executive Director of Finance
Date Equality and Welsh Language Impact Assessment Completed:	22/07/2026
Freedom of Information Act Status (For Policies Only)	Open
	If indicated as closed please indicate exemption that has been applied: ()
Approving Forum:	Quality, Safety & Experience Committee
Approval / Effective from Date:	26/05/2026
Review date due by:	25/05/2029
Document Version:	1
Target Audience	All Staff

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Introduction

1. Policy Statement

- 1.1 The purpose of this policy is to set out the process prior to any installation of water coolers or icemaking equipment and actions once authority has been given to prevent the risk of infection. Authorisation must be gained prior to any installation via the Water Safety Group. Without the authority of the Water Safety Group, no authority to purchase, install or proceed is granted. It is the responsibility of departments, to make the request by following this policy. As part of this authority to proceed the department is required to state the clinical need for chilled water where no other water source is available and put in place suitable maintenance with the designated company stipulated by the Water Safety Group and Procurement supplying the equipment. As part of any authority, the department must implement a daily cleaning regime in line with manufacturers recommendations, or those advised at time of installation by IPC teams. This must be documented and available for inspection at any time by those approved by the Water Safety Group, that includes, members of the IPCC team, microbiology, Health Board Water Responsible Persons and Shared Services Authorising Engineers, to prevent infection within the Cwm Taf Morgannwg University Health Board.
- 1.2 The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of water cooler and icemaking systems. Cwm Taf Morgannwg University Health Board will ensure that all water coolers and ice making equipment are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Welsh Health Technical Memoranda (WHTM) or similar, to ensure that such equipment does not pose a health or operational risk to either, staff, patients or members of the public.

2. Scope of Policy

- 2.1 The policy applies to all properties owned and maintained by the Health Board, including properties leased, rented or occupied under lease or any other occupancy agreement. The policy covers the requirement to seek authority to proceed, the requirements of installation in accordance with WHTM 04-01, Part A, 9.24 – 9.27, maintenance contracts to be set up of all water cooler and icemaking equipment, and the requirement for departmental daily cleaning of equipment, in line with WHBN 00-09:2016 Infection control in the built environment, including the obligation to ensure correct billing is carried out to prevent contracts being placed on stop, within Cwm Taf Morgannwg University Health Board, to ensure a safe environment for both patients, staff and the public.
- 2.2 This policy also applies to any new installations undertaken under a capital programme, redesign of an area, new build. No new water coolers or ice making machines will be installed without prior WSG approval, with the requirement following process of approval. For these machines to be included within project scopes, they must have the WSG approval first, and agreement that the occupying users are aware of their responsibilities under this policy.

- 2.3 For those approved by the WSG, it will be taken that the process is applied. It will then be the occupying departments responsibility to ensure this policy is followed. If not, they will be subject to the same process and costs for removal.
- 2.4 Chilled water from cooling machines is prohibited in augmented care locations in accordance with WHTM 04-01, Part A, 9.24 and WHTM 04-01 Part C, 3.1
- 2.5 Ice makers are prohibited in any augmented care location in accordance with WHTM 04-01, Part A, 9.24, WHTM-04-01 Part B, 8.6, and WHTM 04-01, Part C, 3.1

3. Definitions

- 3.1 For the purpose of this document the following definitions apply:
- 3.2 The Environment - Relates to the total space of an occupier's surroundings when in a healthcare premises, whether they are a patient, member of staff or a visitor. This includes the fabric of the building and related fixtures, fittings and services such as water supplies.
- 3.3 Water cooling - Is a means of delivering water via the use of a suppliers specially designed equipment that reduces the temperature of mains water to that of refrigerated water. In terms of this policy, it must be plumbed into the main water system and dispensed to the end user through a designated outlet.
- 3.4 Ice Machines – An icemaker, ice generator, or ice machine may refer to either a consumer device for making ice, found inside a home freezer, a stand-alone appliance for making ice, or an industrial machine for making ice on a large scale. The term "ice machine" usually refers to the stand-alone appliance.
- 3.5 Water Safety – Clinical and non-clinical areas within a healthcare establishment are considered critical to its ability to provide healthcare.
- 3.6 WHTM 04-01 Part B sets a requirement for water safety within a healthcare environment. The Water Safety Group (WSG) is a requirement of this WHTM and is in place to govern water safety within CTMUHB. As water is a critical utility to delivering services this clearly meets the definition that "a loss of service from such a system would seriously degrade the ability of the premises to deliver optimal healthcare"
- 3.7 Annual Authorising Engineers (AE) Report - A summary of annual verification progress and standards met, which will take into consideration the health boards approach to water safety management in relation to water coolers and ice machines.

4. Aims and Objectives

- 4.1 The policy has been developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all water systems used within the organisation. The policy will not only ensure the organisation complies with the law, it also fosters confidence amongst both public and staff that the organisation takes its responsibilities regarding the installation, maintenance and daily cleaning of these systems seriously.
- 4.2 Implementation of this policy will:
- 4.3 Contribute to the overall Infection Prevention and Control agenda within the Health Board;

- 4.4 Comply with Health and Safety legislation requirements;
- 4.5 Maintain the health, comfort and environment for all patients, staff and public, by ensuring any equipment contained within this policy is installed with the appropriate authority, maintained, cleaned and is fully functional with the risk of infection reduced.
- 4.6 Information.
 - 4.6.1 Dangers from incorrectly installed, maintained or cleaned hospital water coolers and ice machines, increase the risk of hospital-acquired infections from bacteria and fungi like Legionella, pseudomonas or Aspergillus etc, especially for immunocompromised patients, and place a high risk of infection, to other patients, staff and visitors.
- 4.7 Infection risks
 - 4.7.1 Microbial growth: Water coolers can be a breeding ground for bacteria and fungi, including Legionella, pseudomonas and opportunistic pathogens like Acremonium and Aspergillus, which can pose a significant risk to patients, staff and visitors.
 - 4.7.2 Cross-contamination: Germs can spread through touch transmission on the machines, especially with high footfall in hospitals. Cross-contamination can also occur from drinking directly from the tap or using a saliva-tainted bottle.
 - 4.7.3 Waterborne illnesses: The presence of viruses and other waterborne pathogens can lead to waterborne illnesses, especially in vulnerable patients.
- 4.8 Maintenance and water quality issues
 - 4.8.1 Poor maintenance: Irregular cleaning and maintenance can lead to poor water quality and increase the risk of microbial contamination.
 - 4.8.2 Inadequate usage: Infrequent use can cause water stagnation, creating an environment where bacteria can multiply.
 - 4.8.3 Poor quality: The water quality can deteriorate quickly in plumbed-in units that require regular filter changes to maintain quality where servicing has been neglected.
 - 4.8.4 Placement: Placing water coolers in inappropriate areas, such as near toilets, can increase the risk of cross-contamination and infection spread.

5. Disclaimer.

- 5.1 Due to the significant risk of infection, Machines Water chiller or Ice Machines WILL ONLY be considered by the WSG if there is a clinical / patient need, and there is no other provision of offering drinking water possible. And only on the proviso that the policy is followed and continues to pass any associated audits. Failure to follow the process will result in the equipment being removed without notice.
- 5.2 The Health board have encountered multiple issues, with departments / offices / wards etc not following the process for the installations and ensuring continued maintenance and cleaning of equipment relating to this document was carried out, that has significantly increased the risk of infection. Following this, numerous water coolers have been removed from service.

- 5.3 Any Department which has cooled water or an ice machine currently in use before the implementation of this new policy will be required to re-submit a formal request for approval APPENDIX C, with full supporting information. If refusal is then given by the WSG, the water cooler or ice maker will be removed from service.
- 5.4 No New machines can be bought, leased, installed or new contracts entered into without submitting the relevant forms for approval by the Water Safety Group. Any found to be in place without authority of the WSG will be removed from service. If a water cooler is found to be installed, the department will be responsible for the cost of removal.
- 5.5 The only consideration given for a request for a water cooler will be a machine that is directly plumbed into the mains water system and fitted with a check valve to prevent feed back into the main water source. No consideration will be given to any bottle reservoir dispensing equipment, or equipment with direct drinking nozzle capacity.
- 5.6 Ice Making Machines
 - 5.6.1 Ice making machines must only be used in areas of clinical need (e.g. Orthopaedics to reduce swelling). The application for an ice machine must clearly outline the clinical need to the area. Ice must NOT be used for consumption. Display sign: 'not for human consumption' should be in place.
 - 5.6.2 Ice machines shall have a regular maintenance contract, records of which must be kept. The responsible person for this will be documented on the application form (Appendix A) and have documented evidence of the cleaning undertaken. These records must be produced at the request of the Infection Prevention and Control Team or Estates.
 - 5.6.3 All ice machines must not have a reservoir collecting ice outside of the machine i.e. the machine must dispense ice upon request.
 - 5.6.4 **** DO NOT HANDLE ICE **** A dedicated scoop must be provided. The scoop should be washed with hot water daily and dried thoroughly as part of the department's responsibility as part of the cleaning routine.
 - 5.6.5 Installation requirements are set out in WHTM 04-01, backflow protection and location requirements. The RP or DRP will have final say on whether the requested unit/s should be installed. The RP / DRP will be consulted when the request is submitted, and the WSG will take the advice of the RP on making its decision

6. Procedure for requesting a Water Chiller or Ice Machine.

- 6.1 Any Directorate that requires the installation of a water cooler must complete the documentation at APPENDIX A and submit for consideration to the Water Safety Group. No authority to proceed is given until this is signed and returned.
- 6.2 Any Directorate that requires the installation of an Ice machine must complete the documentation at APPENDIX B and submit for consideration to the Water Safety Group. No authority to proceed is given until this is signed and returned.
- 6.3 Water coolers can only be leased via procurement on production of the appropriate signed appendix submission signed by the WSG. Lease will be from pre-approved suppliers who are covered by official Health Board Contracts and stipulated by the WSG. Prior to any lease arrangement the process outlined in this guidance must be

followed. Any supply water coolers purchased from a non-contracted supplier is non-compliant with this guidance.

- 6.4 The WSG will also stipulate the model that has been approved for installation, and this is the only model that will be permitted, which has been scrutinized by IPC requirements to minimize infections. As part of this agreement minimum service visits will be specified, and the directorate will follow the service frequencies agreed with the supplier.
- 6.5 Any Directorate that requires a water cooler or ice making machine, will be expected once authority to proceed is given, to meet the costs of installing the plumbed in water cooler and ongoing associated costs including:
- Agreement via the procurement process to engage with the chosen single supplier of equipment for all costs.
 - Maintenance contract set up with the chosen single supplier of equipment.
 - Regular maintenance contract as agreed with the single supplier of equipment.
 - Running costs (electricity etc).
 - Agreement to ensure billing is met by the directorate through financial processes.
 - Removal and repair of any Estate work required (including any relevant asbestos issues)

7. Maintenance contracts.

- 7.1 Any Directorate that has approval to install after following the above, will also be expected to ensure that as part of the lease agreement the service contract is in place, and adhered to. It is the directorates responsibility to ensure those visits are undertaken at the agreed frequency, and that service visit sheets are maintained within the department for inspection at any time by those delegated by the WSG to audit.

8. Cleaning of Water Coolers / Ice Machines:

- 8.1 It is the responsibility of the manager of the Department in which the machine exists to ensure the cleaning is completed and undertaken. Should a machine be placed in a public area, it's the responsibility of the manager making the request to ensure cleaning is maintained. It is NOT the responsibility of domestic cleaning staff to undertake any cleaning on water coolers or ice machines.
- 8.2 Cleaning of water coolers – The exterior of the equipment, including the dispensing taps, must be cleaned at least daily by a designated person using only approved IPC products. – If the cooler is fitted with a drip tray, this should be emptied and cleaned daily. Manufactures instructions on daily cleaning should be followed, which will include any nozzle, outlet that can be removed by the end user for sanitation purposes. Any ambiguities on the routine can be clarified through your local IPC team.
- 8.3 Daily cleaning must occur and be documented. Documentation must be retained within the department the equipment has been leased by and provided immediately

for inspection at the request of the Infection Prevention and Control Team, Estates or those designated to act on behalf of the WSG. Documentation must contain the name of the person who completed the daily clean, signed and dated.

- 8.4 Operation of water coolers – Water coolers should never be switched off. – If the water cooler is left unused for a period (for example, over the weekend), the tap should be run for 20-30 seconds prior to being used for drinking. This should be carried out by the department as would be expected for a little used outlet.
- 8.5 Disposable drinking cups should be kept wrapped and stored in a clean dry place until placed in the cup dispenser.
- 8.6 Cleaning of Ice Machines - Ice machines should be cleaned and sanitised regularly in accordance with the manufacturer's instructions to ensure safe operation and hygiene. Typically, this involves isolating the machine, removing any ice, and dismantling accessible components such as bins, filters, and water distribution parts. Approved food-safe cleaning and sanitising chemicals should be used at the correct concentrations, following the specified contact times, and all surfaces must be thoroughly rinsed with clean water before reassembly. Frequency of cleaning should align with manufacturer guidance and local risk factors (e.g., water quality, usage levels), and all maintenance should be recorded to demonstrate compliance and ensure consistent performance.
- 8.7 Any defect must be reported immediately to the company and an engineer called to rectify. Notification of defects must also be reported to the Estates Team Authorised Person for Water for the site via the onsite estates team or CTMUHB estates helpdesk

9. Audit

An annual audit will be conducted between Procurement, the supplier of equipment and the WSG to ensure that service contracts have been put in place, and to report on completed service visits, and ensure payment of rental agreements has been made. Any equipment found to not have a service agreement in place, continual missed service visits, or billing not undertaken, that possess a significant risk of infection to the health board, will have the equipment disconnected and the agreement to install a water removed.

IP&C undertake regular audits on wards / departments where water cooler and ice making machines will fall be audited. Checking of machine cleanliness and ensuring maintenance has been conducted at the correct intervals ensures good water quality and should form part of the environmental audits. Findings from will be reported to WSG under this process.

Appendix A –

Statement of Need for a Plumbed in Water Cooler

This form is to be used for the request to enter a hire agreement of a single mains fed water cooler. When completed please return to Water Safety Group via email:

CTT_EstatesAdmin@wales.nhs.uk

Authorisation needs to be given by the Water Safety Group before any water coolers can be leased. If agreement is given the only route to hire is via the dedicated CTMUHB procurement service, through the authorised supplier. Without a signed copy of this document by the members of the WSG procurement will not authorise any hire agreement.

There will be a cost of installation and ongoing service maintenance, and a requirement for daily cleaning which will have to be met by the Directorate.

APPLICANT:

Name

Department

Hospital

Directorate

Contact email.....

Reasons for application. The application should highlight the clinical / patient requirements for the equipment to be installed i.e. how this is required as part of treatment, care etc. It should highlight why there is no other source of drinking water available, and that all other sources of water have been considered, and that this is the last option available. (continue on another page if needed)

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ACCOUNTABILITY

Contact should be made with your procurement lead to confirm the cost of rental, and ongoing service maintenance visits (inc any repair fees). This cost will be the responsibility of the directorate.

Rental cost / annual service fee

Number of service visits per year:.....

Lease agreement length.....

Person responsible for maintenance contract.....

Responsible person for daily cleaning.....

In some circumstances there may be additional estates costs in order to accommodate new equipment. Please make contact with your local Estates team. The water responsible person will confirm if additional cost is required as part of this process. The cost of any associated Estates Work will be the responsibility of the directorate

Estates Costs.....(virement process)

Directorate Manager Signature:

Date Submitted

(approval will not be considered unless the Directorate/General Manager has given approval, by signing you agree to follow the full content of this procedure)

Once all sections above are complete please send to the WSG for consideration

Approved / not approved (reasons to be stated)

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.....

Signed Chair Water Safety Group.....

Date

Signed IPC Lead Water Safety Group.....

Date

Signed site Water responsible Person.....

Date.....

If approved, please provide procurement with a signed copy of this appendix to proceed with the hire agreement. If this document is unsigned by the WSG no authority to proceed is given.

Appendix B –

Statement of Need for an Ice making machine

This form is to be used for the request to purchase or hire an Ice making machine. When completed please return to Water Safety Group via email: CTT_EstatesAdmin@wales.nhs.uk

Authorisation needs to be given by the Water Safety Group before any ice making machines to be hired or purchased. If agreement is given the only route to hire is via the dedicated CTMUHB, NWSSP procurement service, through the authorised supplier. Without a signed copy of this document by the members of the WSG procurement will not authorise any hire agreement or purchase of such equipment.

Should there be a cost of installation and ongoing service maintenance, and a requirement for daily cleaning this will have to be met by the Directorate.

APPLICANT:

Name

Department

Hospital

Directorate

Contact email.....

Reasons for application. The application should highlight the clinical / patient requirements for the equipment to be installed i.e. how this is required as part of treatment, care etc. (continue on another page if needed)

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ACCOUNTABILITY

Contact should be made with your procurement lead to confirm the cost of purchase, rental, and ongoing service maintenance visits (inc any repair fees). This cost will be the responsibility of the directorate.

Rental cost / annual service fee / purchase cost.....

Number of service visits per year:.....

Lease agreement length.....

Responsible person for daily cleaning.....

Directorate Manager Signature:

Date Submitted

(approval will not be considered unless the Directorate/General Manager has given approval, by signing you agree to follow the full content of this procedure)

Once all sections above are complete please send to the WSG for consideration

Approved / not approved (reasons to be stated)

.....

Signed Chair Water Safety Group.....

Date

Signed IPC Lead Water Safety Group.....

Date

Signed site Water responsible person.....

Date.....

If approved, please provide procurement NWSSP.Cwm.Taf.Procurement@wales.nhs.uk with a signed copy of this appendix to proceed with the hire agreement or purchase. If this document is unsigned by the WSG no authority to proceed is given.

Appendix C

Water /ice Machines in existence prior to guidance implementation

This form is to be used to highlight to the WSG, current Water Cooler or Ice making machine within CTMUHB, and for a decision to be made to continue the use of the equipment or request the submission of a new statement of need. When completed please return to Water Safety Group via email: CTT_EstatesAdmin@wales.nhs.uk

Name

Department

Hospital

Directorate Manager.....

Contact email.....

Date of Submission:

In existence:

Ice Machine / Water Cooler (delete as appropriate)

Hired / Purchased?.....

Who is the hire with?.....

Date installed (approx year):

Model Number?

Condition of equipment? New / Good / Average / Poor

Is the water cooler bottle fed or mains fed?.....

If ice machine, is a scoop used? Yes / No

Is ice dispensed on demand? Yes / No.

Location of equipment?.....

Usage

Please described what it is used for:

.....

.....

.....

.....

.....

Do patients consume this?

Cleaning / Maintenance

Maintenance contract in place: YES / NO

If so who with?

Date of last service?.....

Are service sheets available?.....

Regular cleaning (daily) undertaken:

Name person responsible for above:

Documentation of maintenance/cleaning completed?

Form Completed By:

Name:

Position

Dept. & Hospital

Contact No:

Policy Reference Number:

Policy Title:

APPENDIX D

Month.....Year.....

Daily Cleaning Department Signature Form

Daily Cleaning sheet of Water Cooler / Ice making machine in accordance with manufactures recommendations. Daily cleaning must however cover general cleaning of external surfaces, trays that hold or catch water, push buttons, and dispensing taps. Any items that can be removed as part of general cleaning should be carried out in line with IPC guidelines for infection control.

Equipment type..... Serial

Number.....

Directorate..... Responsible

Person.....

Day	Cleaning complete YES / NO	Print Name	Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
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31			

This document must be produced on request by the WSG, IPC or Estates
Water responsible person

Policy Reference Number:

Policy Title:

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Quality, Safety & Experience Committee

Authorised External Personnel Policy (PCS09)

Eitem yr Agenda / Agenda Item	6.1.7
Dyddiad y Cyfarfod / Date of Meeting:	22/09/26
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter:	Head of People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Approval
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Quality Safety & Experience Committee is asked to APPROVE the Authorised External Personnel Policy (PCS09) for implementation across CTMUHB.



1. Situation / Background

1.1 The policy has been developed to provide clear governance arrangements for the attendance of external or internal organisations on Health Board premises for non-clinical experience, engagement, information or stall-based activity. It applies to activity that may take place in clinical and non-clinical areas and is intended to support safe, appropriate partnership and engagement activity while minimising disruption to services and protecting patients, staff and external personnel.

1.2 The policy confirms that applicants must submit a completed application and comply with any conditions identified. A hosting service single point of contact must be identified and will work with site leads to process and agree the application. Final approval rests with the relevant Hospital Site Manager, supported by appropriate risk assessment and secure documentation arrangements.

2. Specific Matters for Consideration

Strategic Insights

2.1 The policy strengthens strategic oversight of non-clinical external personnel activity by setting out consistent standards for approval, supervision and compliance. It supports a proportionate approach to safeguarding, recognising that a standard DBS check will not routinely be required for one-off supervised visits, while allowing the Health Board to request assurance of appropriate checks where the risk profile indicates this is required.

2.2 The policy also reinforces that external organisations cannot undertake filming, recording or photography during visits, and that Health Board staff must manage any photography or recording in line with relevant Health Board policy and consent requirements.

3. Risks and Opportunities

Key risks addressed by the policy include safeguarding risks, exposure of vulnerable patients or confidential locations, infection prevention and control concerns, health and fire safety, information governance, reputational impact, commercial influence, conflicts of interest, non-compliant sales or fundraising activity, and disruption to clinical services.

The policy mitigates these risks through mandatory application and approval arrangements, pre-visit risk assessment, site manager approval, 24-hour confirmation by the host area, visitor identification, supervision requirements, clear safeguarding boundaries, incident reporting and secure retention of documentation.

The policy also creates an opportunity to support appropriate partnership, community, wellbeing and engagement activity where safeguards are in place and the activity is aligned with Health Board requirements.

4. Compliance and Governance

4.1 Compliance requirements include submission of applications at least four weeks in advance, proportionate governance review, public liability insurance requested by the single point of contact, site manager approval, sign-in and visitor badge arrangements, fire procedure briefing, agreement to comply with visitor expectations, and clear escalation of incidents or concerns.

4.2 Specific controls are included for charitable fundraising, conflicts of interest and commercial neutrality, trading standards and the sale of goods, photography/filming/consent, food and drink, health and safety risk assessment, safeguarding supervision and boundaries, confidentiality and visibility risk, equipment training/assurance and record retention.

4.3 The policy also references relevant legal and policy requirements, including the Health and Safety at Work etc. Act 1974, Regulatory Reform (Fire Safety) Order 2005, Non-Clinical Photography, Video & Audio Recording Procedure, All-Wales Social Media Policy, and related Health Board policies.

5. Benchmarks

5.1 No external benchmarking information has been identified within the policy. This section is therefore not applicable for comparative performance purposes. The focus of the report is approval of a local governance policy to support consistent practice across CTMUHB sites.

6. Conclusion

6.1 The policy provides a clear, proportionate and consistent governance framework for external personnel activity on Health Board premises. It supports safe engagement, protects patients and staff, and clarifies roles and responsibilities for applicants, hosting services, site leads and Hospital Site Managers.

6.2 QSEC Approval of the policy will enable implementation of a standard approach to application, risk assessment, approval, supervision, visitor expectations and documentation. QSEC is asked to Approve the policy for implementation across all of CTM UHB sites.



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- 6.3 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
- 6.4 Organisational values and behaviours have been reflected within the policy.



7. Key Risks / Matters for Escalation

- 7.1 In response to the consultation the following amendments have been made:
- Request to include medical reps within this process at Operational management Board. Policy has been updated to reflect this.

8. 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) 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 4 Community & Partner Engagement
	The policy mitigates strategic risks associated with patient safety, safeguarding, information governance, infection prevention and control, legal compliance, reputational impact and inconsistent site arrangements for external personnel activity.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	The policy supports safe engagement with patients, carers, visitors and communities, with additional consideration for vulnerable individuals, bilingual information and appropriate partnership activity.
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective



	The policy supports quality by ensuring appropriate governance, proportionality, risk assessment, safeguarding, consent, infection prevention and control, and clarity of staff responsibilities
--	--

Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	Neutral / Low impact The policy does not identify a direct environmental sustainability impact. Local arrangements should consider waste management, access, parking and environmental factors where relevant to individual activities.

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 Equality: EWLIA completed on 07/07/2026. Summary outcome to be inserted from the approved EWLIA record. Outcome for Welsh Language: EWLIA completed on 07/07/2026. The policy notes Welsh language requirements, including bilingual information/displays and arrangements where the Health Board is bound by Welsh Language Standards	If no, please select a reason below. Does not impact peopleDoes not impact people
Canlyniad Asesiad Effaith Ansawdd (Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)	Quality Impact Assessment Outcome: Positive / mitigating.	



Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	The policy strengthens safe management of external personnel activity through governance review, risk assessment, safeguarding, supervision, information governance, IPC and incident reporting requirements.
Cyfreithiol / Legal	Yes (Include further detail below) This policy outlines the requirements needed to ensure safe and effective governance requirements are in place to support this activity.
Enw da / Reputational	Yes (include further detail below) This policy supports staff and external personnel to ensure awareness of guidance and protocol to protect patients, staff and visitors supporting the HB through these engagement opportunities.
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
Equality and Welsh Impact Assessment	07/07/2026	Yes completed 07/07/2026
Informal Consultation with interested parties Relevant corporate specialist leads / services	Drafts socialised across: People's Experience Forum – June 2026 Senior Nurse & Lead Nurse Forum – July 2026 Director of Nursing Forum – August 2026 QSRE Forums – June/July 2026	The policy has been developed with input from relevant corporate specialist functions and incorporates clear escalation and advice pathways to ensure appropriate oversight of external visitor activity. This approach provides assurance that specialist considerations, including safety,



		safeguarding, information governance, equality, Welsh language standards and environmental factors, are identified and addressed proportionately, supporting consistent decision-making and robust governance arrangements across the Health Board
Formal Consultation Endorsed By		Operational Management Board (OMB) on 5 th August 2026
QSEC Committee – For approval		September 2026

Acronyms / Glossary of Terms	
DBS	Disclosure and Barring Service
IPC	Infection Prevention and Control
IG	Information Governance
EWLIA	Equality and Welsh Language Impact Assessment
PCS09	Authorised External Personnel Policy reference
FBO	Food Business Operator
SPoC	Single Point of Contact
OMB	Operational Management Board
QSEC	Quality Safety & Experience Committee

9. Recommendation

9.1 Quality, Safety and Experience Committee are asked to APPROVE the Authorised External Personnel Policy (PCS09).

10. Next Steps

- 10.1 Following Approval the author will update the policy with the required information, will share the Policy with the relevant team for uploading onto the Health Board Internet Site.

Authorised External Personnel Policy

Document Type:	Policy
Indicate Clinical or Non-Clinical:	Non-Clinical
Document Reference:	PCS09
Document Author (Title Only):	Head of People's Experience
Document Executive Director Sponsor	Executive Director of Nursing and Midwifery
Date Equality and Welsh Language Impact Assessment Completed:	07/07/2026
Freedom of Information Act Status (For Policies Only)	Open
	If indicated as closed please indicate exemption that has been applied: ()
Approving Forum:	(If you are not sure this is available from: ctm.qualityassurancecompliance@wales.nhs.uk)
Approval / Effective from Date:	05/08/2026
Review date due by:	10/06/2027
Document Version:	006
Target Audience	All Staff

Disclaimers

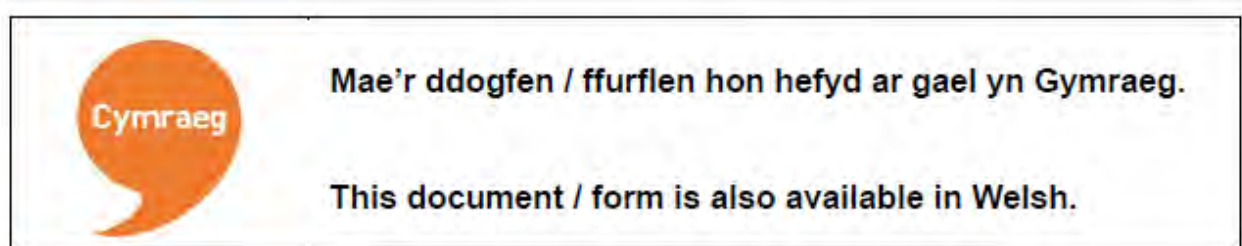
CTMUHB Policies, Procedures and other Written Control Documents can only be considered valid and up to date if viewed on the SharePoint Pages, which is considered as the master library: LINK

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



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Components

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

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

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non-Clinical Policy Development please contact:

ctm.qualityassurancecompliance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint.

Policy Reference Number: PCS09

Policy Title: Authorised External Personnel Policy

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Introduction

2. Policy Statement

This policy outlines the governance arrangements for any external or internal organisation wishing to attend Health Board premises to provide a non-clinical experience, engagement activity, information or stall. Also inclusive of medical representatives attending Health Board premises to provide training, educational sessions, lunch talks or similar activities.

The policy ensures that activities are safe, appropriate, and aligned to safeguarding, information governance, infection prevention and control, commercial neutrality, legal compliance and the management of personnel.

All external personnel activity must operate within a clear safeguarding framework that prioritises the safety, dignity and rights of patients, particularly children and adults at risk. A proportionate approach will be taken to assessing safeguarding risk, including consideration of the level of contact with patients, supervision arrangements, and whether individuals are operating in a position of trust. Safeguarding principles will underpin all decisions regarding approval, access and oversight of external personnel.

3. Scope of Policy

This policy recognises that many visits are organised as single, one-off events and therefore a standard Disclosure and Barring Service (DBS) check will not routinely be required. However, a proportionate safeguarding risk assessment must be undertaken in all cases

This will consider:

- the nature, frequency and duration of the visit
- the level of contact with patients (direct, indirect or none)
- whether the activity places the individual in a position of trust
- whether visits occur in clinical environments or areas with vulnerable patients

Where external personnel are:

- attending frequently or on a recurring basis,
- engaging directly with patients, or
- working in settings where patients may be particularly vulnerable, the Health Board may request assurance of appropriate pre-employment checks, including DBS where applicable to their employing organisation.

Policy Reference Number: PCS09

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- External personnel will not be permitted unsupervised access to patients under any circumstances

4. Aims and Objectives

The purpose of this policy is to provide a consistent approach to approving activities on CTM premises, ensuring safety of patients, staff and external personnel. Minimising disruption to services and supporting appropriate partnership and engagement activities.

Build awareness amongst employees of their responsibilities in ensuring that visits are handled properly.

Ensure appropriate safeguarding arrangements are in place for vulnerable patients and implemented by employees.

This policy requires that one-off or short-term external personnel are always accompanied throughout their visit to any Health Board site.

CTM has clear responsibilities under the Non-Clinical Photography, Video & Audio Recording Procedure (2024) and the All-Wales Social Media Policy (2016). These policies outline that all photography/recording of staff, patients or the public for non-clinical purposes must follow explicit, informed consent processes, including additional safeguards where patients lack capacity and those that are vulnerable. These requirements apply to CTM staff only.

External organisations are unable to take any filming/recording or photographs during their visits due to risks associated with consent (particularly vulnerable patients, children and those whose location should remain unknown due to risks associated with them).

5. Responsibilities

Applicants must submit a completed application (appendix 1) and comply with any conditions identified.

A single point of contact needs to be identified by the service hosting the experience/ activity who will work with the site leads to process and agree the application.

The hosting service (Single Point of Contact) is responsible for:

- ensuring an appropriate risk assessment is completed prior to approval and attendance.

- ensuring external personnel are escorted at all times within clinical areas or areas where patients are present
- ensuring external personnel are never left alone with patients
- briefing external personnel on safeguarding expectations and boundaries prior to the visit
- Undertake identification checks, ensuring copies of individual ID is copied and stored securely

Site Leads and Premise Managers must ensure activities do not impact clinical care. To ensure Governance and Compliance please note points of contact for relative areas. For any queries, please refer to table below:

Infection Prevention and Control	Felipe Leitaó, Head of Nursing for IPC	CTT_InfectionControlNurses@wales.nhs.uk
Health and Safety	Chris Beadle, Ass. Director Health Safety & Fire	CTM_Health_and_Safety_Queries@wales.nhs.uk
Safeguarding	Claire O'Keefe, Head of Safeguarding	CTHB_SafeguardingTeam@wales.nhs.uk
Catering	Rhiannon Facey-Richards, Catering & Compliance Manager	Rhiannon.Facey-richards@wales.nhs.uk
Security	Russell Hoare, Ass. Director, Facilities	CTM.Security@wales.nhs.uk
Estates	Alan Martin, Head of Operational estates	<u>CTT_EstatesAdmin@wales.nhs.uk</u>
Facilities	Russell Hoare, Ass Director, Facilities	<u>ctt_facilitiesadmin@wales.nhs.uk</u>
Communications	Alex Harden, Head of Comms & Media	<u>ctm.commsandengteam@wales.nhs.uk</u>



Information Governance		CTM.IGTeam@wales.nhs.uk
Charitable fundraising	Abe Sampson, Head of Charity	Ctm.charity@wales.nhs.uk
EQIA		ctm.equality.welshlanguageimpact@wales.nhs.uk

6. Risk

Final approval rests with the Hospital Site Manager for each Site, who will need to complete a risk assessment for each visit. Hospital Site Manager will need to ensure that all documents and annual review documentation are stored securely on a shared drive.

Visits will need to be confirmed by host area 24 hours prior to attendance to ensure there are no issues regarding Infection, Prevention & Control, Fire/Health and Safety reasons that may impact the visit.

External personnel should ensure they make contact with the single point of contact to confirm this but also awareness this could also be subject to change on the day due to infection, prevention control and service considerations.

7. Definitions

Experience: Non-clinical observational or engagement activity.

Stall: Static or mobile information point including signposting and selling of goods.

Applicant: Organisation or individual requesting attendance at premises.

Medical representative: Attending Health Board premises to provide training, educational sessions, lunch talks or similar activities.

Single Point of Contact: Person who has received the request and will be hosting the visit.

8. Implementation / Policy Compliance

Applications must be submitted a minimum of four weeks in advance (utilise page 3-5). A proportionate governance review will be undertaken including health and fire safety, infection prevention and control, safeguarding, and data protection considerations. Hospital Site Managers will confirm approval prior to attendance outlining any conditions of visit. There will be a leaflet outlining expectations of the attendee's compliance with Health Board policies and procedures. Agreement to adhere to these must be signed and dated prior to the visit commencing.

Policy Reference Number: PCS09

Policy Title: Authorised External Personnel Policy

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Public Liability Insurance will be requested as part of the visit application process by the Health and Safety Team

Charitable Fundraising

- Any proposed charitable fundraising activity taking place on Health Board premises must be notified in advance to the Charitable Funds team via the generic mailbox: ctm.charity@wales.nhs.uk.
- This is to enable appropriate oversight, coordination and alignment with existing charitable activity across the Health Board.
- Consideration should be given to the purpose and intended beneficiaries of fundraising activity, including whether funds will directly benefit local populations served by the Health Board.
- Staff and external organisations should be made aware of the Health Board's official charity as one of a number of potential options for fundraising, particularly where the intention is to support local patients and communities.
- Approval of fundraising activity may be subject to additional consideration to ensure fairness, transparency and to mitigate risks associated with fraud, reputational impact or duplication of effort.

Conflicts of Interest and Commercial Neutrality

All staff involved in arranging or approving external personnel activity must ensure that any actual, potential or perceived conflicts of interest are identified and managed in accordance with the Health Board's Conflicts of Interest, Gifts and Hospitality policies.

- A proportionate approach should be taken, reflecting the nature, scale and purpose of the activity. Low-risk, community or wellbeing-focused activities should not be subject to unnecessary restriction, provided appropriate safeguards are in place.
- The provision of free or voluntary activities (e.g. wellbeing sessions, performances or demonstrations) as part of an approved visit will not normally be considered a gift. However, staff must not accept any personal gifts, hospitality or incentives beyond that which is incidental to the approved activity.

- External activities must not be offered, accepted or used as an inducement to influence decision-making, procurement, or future commercial relationships.
- External personnel activity must be managed in a way that preserves the Health Board's commercial neutrality. Care must be taken to avoid creating any actual or perceived advantage for an individual or organisation, particularly in relation to current or future procurement opportunities.
- Participation in external personnel activity does not confer any advantage in current or future procurement processes and must not influence commissioning, purchasing or contracting decisions.
- External visits must not be used as a platform for targeted promotion, marketing or endorsement of specific products or services. Any reference to products or services should be incidental, relevant to the activity, and must not create pressure or expectation to purchase, adopt or engage commercially.
- Activities must not include the collection of personal data for marketing purposes, or create routes for follow-up commercial engagement, without explicit prior approval.
- Staff must remain alert to any attempt to inappropriately influence decisions or secure advantage and must declare and escalate any concerns promptly.
- Where there is any uncertainty or concern regarding conflicts of interest, commercial influence, or potential fraud, bribery or corruption risk, this must be escalated to the appropriate governance lead and/or Local Counter Fraud Specialist for advice prior to approval.

Trading Standards/ Sale of Goods

- Where activities involve the sale or distribution of goods (including craft items), applicants must ensure that all items comply with relevant legal and regulatory requirements, including product safety and consumer protection legislation.
- The Health Board reserves the right to decline or withdraw approval for any activity where there are concerns regarding counterfeit, unsafe or non-compliant goods.
- Applicants may be required to confirm, as part of the application process, that goods supplied are genuine, appropriately sourced and compliant with applicable standards.

Photography, Filming and Consent

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This can only be undertaken by Health Board employees and utilised by the Health Board. CTMUHB staff are responsible for ensuring that photography and recording during any visit/activity is appropriately authorised and managed in line with Health Board policy.

Staff cannot share any images/recording with external personnel/organisations.

Staff responsibilities include in respect of the above:

- Staff need to ensure that within the consent process extra consideration is given to those patients who are vulnerable (adults/children i.e. those whose location should remain unknown due to risks associated with them, medical conditions, mental capacity, protected characteristics).

Selling of food and drink:

- All Food Business Operators (FBOs) supplying food or drink within CTM UHB—whether for patient feeding or commercial sale—must operate through an approved and compliant route to market. The sale of food and drink on Health Board premises is not permitted under any circumstances outside of these arrangements.

Anyone wishing to sell these must contact Head of Catering - Rhiannon Facey-Richards: email: Rhiannon.Facey-richards@wales.nhs.uk

Health and Safety Risk Assessment

- The team or service organising the activity is responsible for undertaking a proportionate, written health and safety risk assessment prior to the event or visit. For further information regarding undertaking a risk assessment click on link below:

[Undertaking Risk Assessments](#)

- The risk assessment should identify foreseeable hazards and set out appropriate control measures, considering the nature, scale and location of the activity. This may include (but is not limited to):
 - ✓ equipment, stands or temporary structures (e.g. stalls, marquees or displays)

- ✓ activities involving members of the public, including children or vulnerable individuals
 - ✓ fire safety arrangements, including access to and visibility of fire exits
 - ✓ capacity and safe movement of people within the space
 - ✓ first aid provision appropriate to the activity
 - ✓ waste management and housekeeping arrangements
 - ✓ access, egress and parking considerations
 - ✓ environmental factors such as weather (where relevant)
- Where external organisations or participants are involved, appropriate risk assessments must be obtained and reviewed as part of the approval process.
 - Control measures identified within the risk assessment must be implemented and monitored for the duration of the activity. Any concerns should be escalated to the person in charge of the event.
 - Advice and support on risk assessment and safety arrangements can be sought from the Health, Safety and Fire team; however, accountability for the assessment and associated risks remains with the organising team/staff member or service.
 - Safeguarding risks, including level of contact with patients, supervision arrangements, and risks relating to vulnerable individuals or concealed locations.

Safeguarding Requirements for External Personnel

A proportionate safeguarding approach must be applied to all visits. The following minimum standards apply:

Access and Supervision

- External personnel must be always accompanied in any clinical area or area where patients may be present
- External personnel must not be left unsupervised with patients, including during informal interactions
- Access to wards/clinical areas must be restricted to what is necessary for the approved activity only

Contact with Patients

- Activities involving direct patient interaction must be explicitly approved as part of the application process
- External personnel must not undertake any activity that could be perceived as care, advice, advocacy or support, unless formally commissioned and appropriately vetted

- Third-party organisations are encouraged to ensure all of their displays and information are bilingual in Welsh and English, and where those organisations are subject to the Welsh Language Standards, that they have due regard to them to ensure a bilingual experience for CTMUHB patients.
- Where an activity is externally led but partly funded by the Health Board by at least 50%, CTMUHB is bound by the Welsh Language Standards in terms of publicity, displays and events.

DBS and Workforce Assurance (Proportionate Approach)

- DBS checks are not routinely required for one-off, supervised visits
- Where external personnel are working:
 - ✓ in a position of trust,
 - ✓ with regular or repeated access, or
 - ✓ in settings involving vulnerable groups,
 the Health Board may request assurance that appropriate checks (including DBS) are in place through their employing organisation
- The Health Board will not routinely retain DBS certificates, but may seek written confirmation of compliance where risk indicates

When and how to check DBS status

- The applicant has provided consent for the status check to be completed.
- The Health Board is legally entitled to request a DBS check for the role being applied for.
- The existing DBS certificate is at the appropriate level and relates to the same workforce required for the post.

For further information, please refer to the DBS Update Service guidance on GOV.UK, [DBS Update Service guidance](#) which provides detailed information on status checks, service limitations, and safer recruitment considerations. Additional advice and support can be obtained from the DBS Regional Outreach Team dbsregionaloutreach@dbs.gov.uk

Safeguarding Boundaries

- External personnel must:

- ✓ not seek personal information from patients
- ✓ not share contact details or initiate contact outside the visit
- ✓ not provide gifts, advice, or services to individuals

Confidentiality and Visibility Risk

- Additional controls must be applied to protect:
 - ✓ patients whose location must remain undisclosed
 - ✓ individuals subject to safeguarding plans
- Staff must ensure that external personnel are not exposed to identifiable information or locations where risk is present

9. Information, Instruction and Training

On arrival those in attendance should be informed of the procedures undertaken in event of fire and appropriate fire exits and assembly points.

If Health Board equipment is being used, assurance that individuals have received instruction, training and supervision to meet Health Board requirements will need to be recorded.

This will need to be documented and stored on a shared drive to accompany the application for access by Hospital Site Manager and Care Group hosting. If a longer team visit agreement is in place an annual review date agreed to ensure compliance and alignment to Health Board policies.

All attendees must display their Visitor Identification Badge for the duration of their agreed visit and be provided with an Information Leaflet.

All attendees must sign in at the General Office for the site they are visiting to receive a Visitor Identification Badge. Every badge will define the length of stay that has been agreed. The badges must be returned to General Office on completion of visit. If this is outside of General Office opening times on each site then the single point of contact must ensure these are returned.

However, if the visit has not fulfilled all criteria and authorised, the visit cannot take place. The responsibility for this remains with the Health Board single point of contact for each visit.

Lack of compliance with Health Board policies and procedures, as detailed in the general information leaflet and agreed stipulations of attendance will lead to termination of the visit.

Any incidents or concerns arising from the activity must be reported to the single point of contact/service hosting and managed in line with the organisation's incident reporting procedures.

All documentation will be retained in accordance with CTMUHB records management policies and may be subject to audit or review.

10. Personal Property & Equipment

The Health Board will not accept responsibility for the receipt or safe custody of goods or materials delivered to the site by external personnel as well as personal possessions. External personnel must make their own security arrangements for assets brought onto sites.

11. Equality and Welsh Language Impact Assessment Outcome

A summary of the outcome of the EIA must be present on the front cover of the document.

Either

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

Or

This policy has been subject to a full equality impact assessment, and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

Either statement needs to be approved by a member of the Equality team (CTM_Equality@wales.nhs.uk), and the date this was done noted.

Under Welsh Language Standard 82 policies which cover the following areas need to be made available in Welsh:

- (a) a policy relating to behaviour in the workplace;
- (b) a policy relating to health and well-being at work;
- (c) a policy relating to salaries or workplace benefits;
- (d) a policy relating to performance management;
- (e) a policy relating to absence from work;
- (f) a policy relating to working conditions;
- (g) a policy relating to work patterns.

If one or more of the above apply, this should be indicated on the template, and the policy (once approved) should be made available in Welsh. A Welsh version of a health board policy has equal status and authority to any

English version. It should be published at the same time and it is vital that any changes made to either version is reflected immediately in the other.

Translations can be sent to ctt_welsh_translation@wales.nhs.uk.

12. Relevant Legislation

[Health and Safety at Work etc Act 1974 - HSE](#)

[The Regulatory Reform \(Fire Safety\) Order 2005](#)

13. References

14. Getting Help

Please see table in Section 5.

15. Related Policies

[MANAGING VIPS PROTOCOL.DOCX](#)

[PRC_EST05_CODEOFCONDUCT&SAFETYRULESCONTRACTORS_FINAL.DOCX](#)

[SECURITY POLICY.DOCX](#)

[POL_COMMS04_AWSOCIALMEDIA_FINALV1.DOC](#)

[National Infection Prevention and Control Manual: Home](#)

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

16. Appendices

Quality, Safety & Experience Committee

Healthcare Inspectorate Wales Improvement Plan Tracker Report

Eitem yr Agenda / Agenda Item	6.2.1
Dyddiad y Cyfarfod / Date of Meeting:	22 nd September 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Claire Jones- Head of Quality Assurance and Compliance
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:	No action/decision required, for noting only
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	Improving Care
	If more than one applies, please list below:

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Executive Summary of what the report is describing:

Beth What	The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker (Appendix 1) of the accepted Improvement Plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 11 th May 2026 to 3 rd August 2026.
Felly, beth So, what	The report shows that there has been pro-active intention to complete and close off recommendations' actions arising from new inspections particularly in the Mental Health and Learning Disabilities care group.

Beth Nesaf	All Care groups are encouraged to take action to update and complete/close off any historic actions. All users are reminded that it is important to continually refer back to the original recommendation action to evaluate progress for updating.
What Next	
Argymhelliaid	For noting
Recommendation	

1. Background / Context

- 1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker (Appendix 1) of the accepted Improvement Plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 11th May 2026 to 3rd August 2026.

2. Strategic Insights

- 2.1 There are currently 217 open recommendation actions across the six care groups. 65 actions are currently overdue in total.
- 2.2 There has been positive engagement with the Mental Health and Learning Disabilities Care Group showing 99 actions fully complete awaiting approval as evidenced in *Graph 4*.
- 2.3 This period there has been 100 actions fully complete awaiting approval overall.
- 2.4 There have been 2 new inspections resulting in an added 148 new inspection actions.

3. Risks and Opportunities

- 3.1 The HIW tracker continues to utilise the AMaT system to track, manage and update actions. Engagement with teams and demonstrating how to use the system for governance purposes continues to be a priority for the Quality Assurance and Compliance team and each care group.
- 3.2 Timely reminders to update recommendations actions are sent out to users ahead of the call for updates and users are reminded that these actions can be updated at any time. Users are encouraged to update actions periodically throughout the month to ensure updates are being captured ahead of committee meetings.

4. Compliance and Governance

- 4.1 Users are regularly reminded that when considering an update of a recommendation action to always check back to the original recommendation action rather than using previous updates. The Quality

Assurance and Compliance team note that there may be times whereby the original action has been superseded as the Health Board's strategic plans evolve and so updates should reflect this and a review as to whether the original action can now be marked as complete.

5. Benchmarks

- 5.1 Graph 5 shows the progress on a month-by-month basis which shows steady progression each month. This last period shows the highest number of fully complete since March 2025. This could be down to the slightly extended period between QSEC updates this period which has allowed the data to capture more updates.
- 5.2 Many of the updates for closure have arisen from the Care groups' swift completion and closure of actions from the 2 newest reports. This shows a proactive approach of the care groups in taking prompt action to resolve recommendations arising from more recent inspections
- 5.3 Care groups are encouraged to continue to cleanse their older and more historic actions.

6. Conclusion

- 6.1 The HIW actions tracker continues to use the live AMaT system with a continued targeted focus on actions where the action agreed due by date has passed or no update has been received. Sustained effort to reduce the number of partially complete overdue actions is required.
- 6.2 The Quality Assurance and Compliance team note that there may be times whereby the original action has been superseded as the Health Board's strategic plans evolve and so updates should reflect this and a review as to whether the original action can now be marked as complete.
- 6.3 The Quality Assurance and Compliance team continue to encourage Care group leads to engage in the AMaT process for Audits and Inspections whereby the approval process differs slightly to the AMaT programme used in the clinical setting allowing for more robust governance and assurance.

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)	No - Not Applicable	
	If more than one applies please list below:	
Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhwch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	Outcome for Equality (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:
Equality & Welsh Language Impact Assessment Outcome <i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i>	Efficient, Equitable, Safe, Timely	
Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>		
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i>	There is no direct impact on resources as a result of the activity outlined in this report	



Resource Impact
(People / Financial)

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

Committee / Group / Individuals	Date	Outcome
Quality, Safety and Experience Committee	22/09/2026	

Acronyms / Glossary of Terms

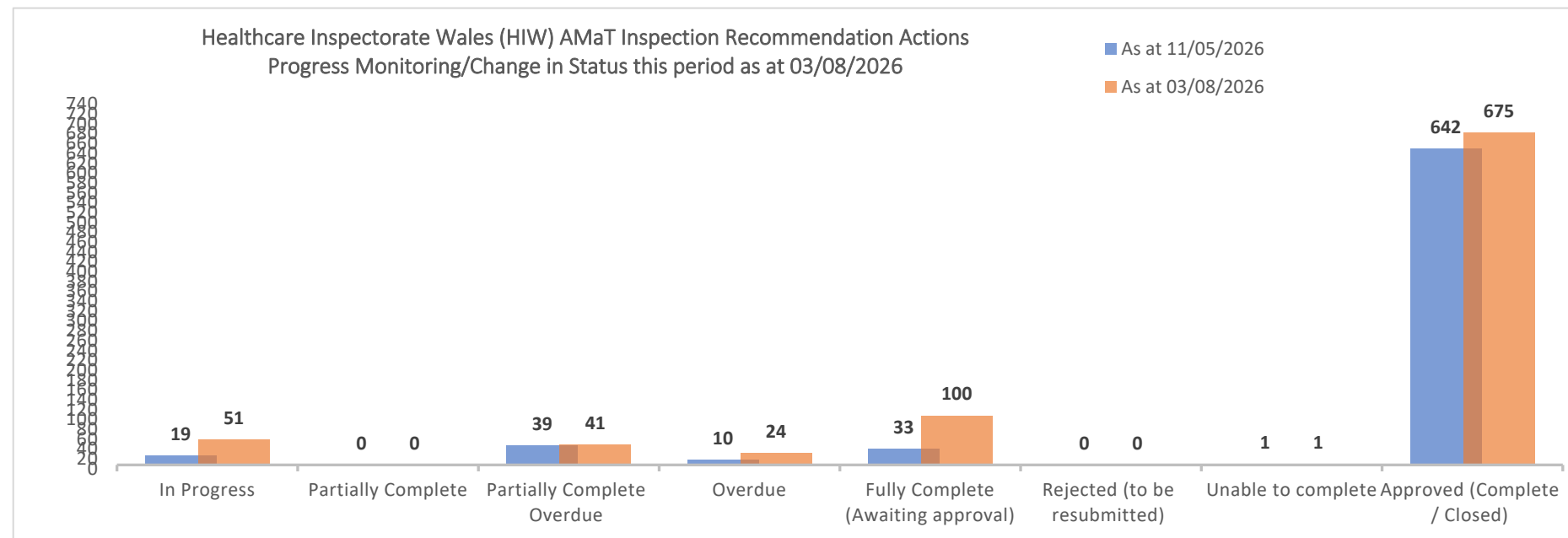
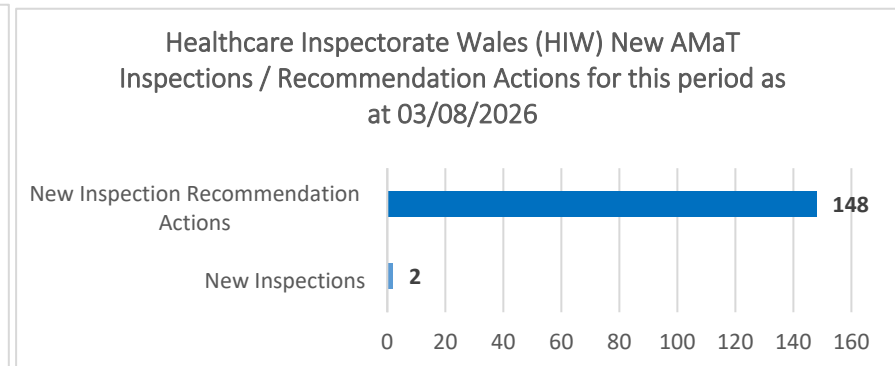
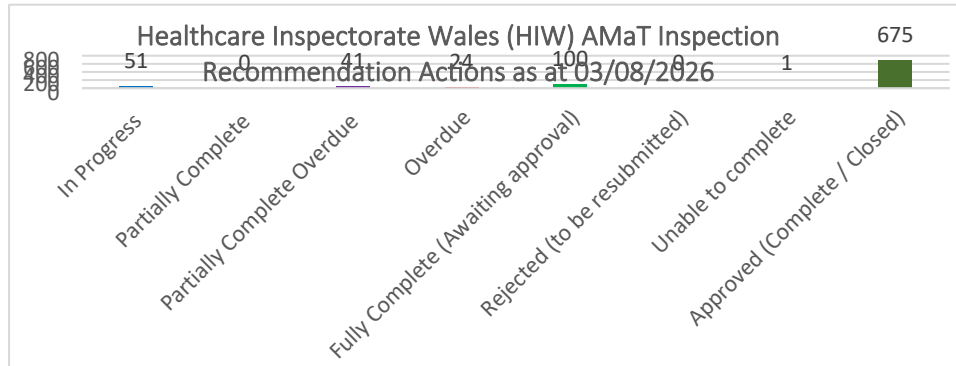
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking (system)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Compliance Dashboard

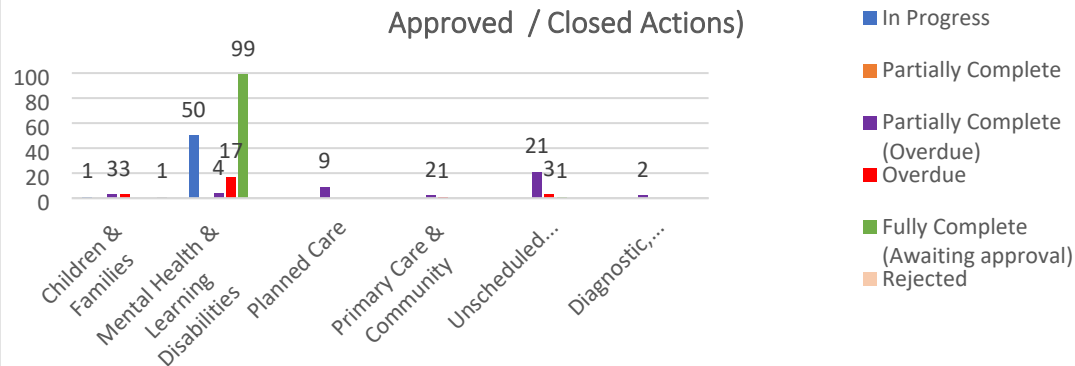




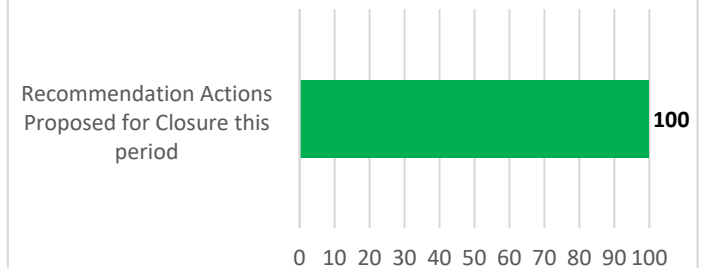
GIG
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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

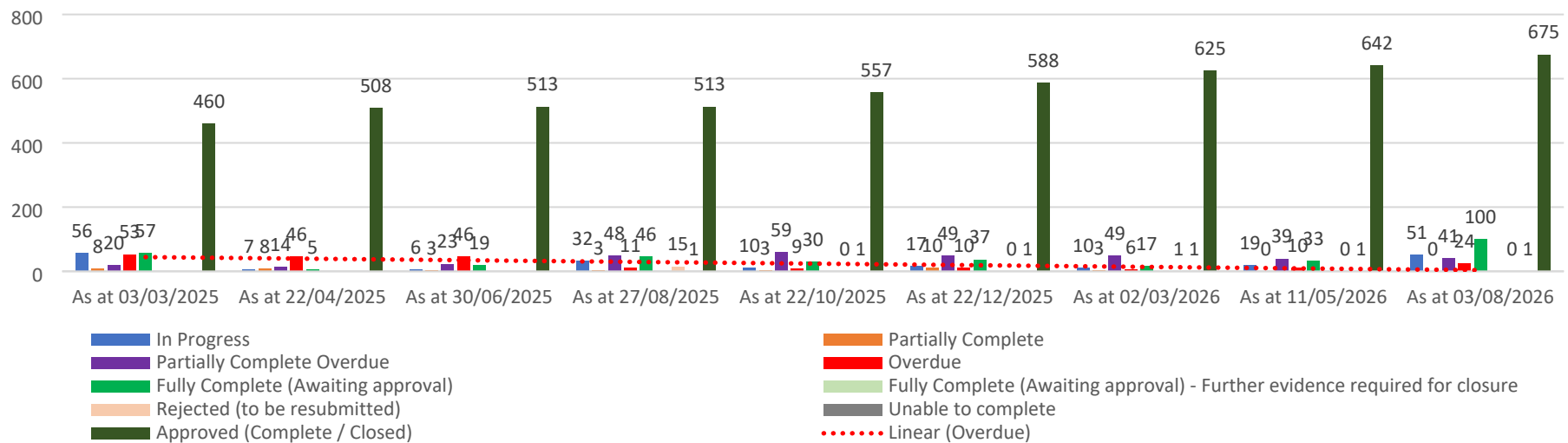
Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions by Care Group as at 03/08/2026 (excluding Approved / Closed Actions)



Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions Proposed for Closure this period as at 03/08/2026



Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions Progress Monitoring / Change in Status this period as at 03/08/2026



Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	22	22	Planned Care Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda - Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)	08/09/2020	2	2	Primary Care & Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	17	18	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	2	2	Unscheduled Care Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	7	7	Primary Care & Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	50	50	Unscheduled Care Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	31	36	Unscheduled Care Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	14	36	Children & Families Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13.11.2024	27	46	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	27.01.2025	13	14	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing
Healthcare Inspectorate Wales (HIW)/2025/261	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	20.05.2025	4	8	Diagnostic, Therapies, Pharmacy and Specialities Carl Verrecchia, Service Director
Healthcare Inspectorate Wales (HIW)/2025/264	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20.05.2025	24	59	Diagnostic, Therapies, Pharmacy and Specialities Carl Verrecchia, Service Director
Healthcare Inspectorate Wales (HIW)/2025/276	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	18.08.2025	16	24	Children & Families Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2025/277	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	05.08.2025	19	19	Unscheduled Care Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2026/289	Appendix C - Improvement Plan_Ty Lliard_12, 13 & 14 January 2026 (Ref: 03944)	12.01.2026	11	32	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing
Healthcare Inspectorate Wales (HIW)/2026/304	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	13.01.2026	39	75	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing
Healthcare Inspectorate Wales (HIW)/2026/307	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	13.04.2026	32	73	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing

AMaT Recommendation Actions - Status Key

In progress	Inspection action is in the process of being completed and has not yet reached the deadline.
Partially complete	Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.
Partially complete (Overdue)	Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.
Overdue	Inspection action deadline has been reached and no recommendations have been completed.
Fully complete (Awaiting approval)	Inspection actions have been fully completed and are waiting to be approved to be closed.
Rejected (To be resubmitted)	This Inspection action was submitted as Fully complete (Awaiting Approval) however more narrative is required to satisfy closure of the action and to provide assurance it has been completed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.
Unable to Complete	This action is unable to be completed.

HIW Inspections Recommendation Actions Tracker as at 03/08/2026 (for Quality, Safety and Experience Committee 22/09/2026)											
Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the LHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	31.12.2025	Partially complete (Overdue)	April, July 2026 Update - No update against this recommendation action has been received on these occasions. February 2026 Update - Escalated to Executive Director of Nursing, Midwifery & Patient Care and to Care Group DoH for an urgent update on the outstanding action, whilst noting that the roll out is expected to end March 2026.	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD8/1	The implementation of Open Eyes will provide optometrists with access to patient information that will promote, simplify and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024	31.12.2025	Partially complete (Overdue)	March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - Working group established. Implemented for Glaucoma. Next phase cataracts. On target for end of March 2026.	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Healthcare Inspectorate Wales (HIW)/2017/141/MD10/1	Documents and resource related to FUNB patients are shared between the business informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PIFU Patients with appointments canceled	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25). FUNB list known. CIN recommendation agreed for those on PIFU / SOS. Retrospective application of CIN PIFU / SOS agreed for FUNB list. Awaiting start date from medical records.	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Healthcare Inspectorate Wales (HIW)/2017/141/MD12/1	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - All outcome forms from OP clinics have PIFU / SOS option included. No option for patients to be put on FUNB list. Agreed PIFU / SOS pathways which will be applied retrospectively to FUNB list.	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	Healthcare Inspectorate Wales (HIW)/2017/141/MD13/1	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - FUNB strategy agreed through PIT programme. Retrospective application of PIFU and SOS CIN pathways to be implemented. Awaiting start date	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment – Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HIW)/2017/141/MD15/1	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CARROS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete (Overdue)	March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - Ongoing discussions	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment – Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/141/MD17/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025, January, March, June, September 2026 Updates - No update against this recommendation action has been received on these occasions. August 2025 Update (27/8/25) - as of today we are still waiting WG decision re further advice / shared learning.	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to be implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	December 2025, January, March, June, September 2026 Updates - No update against this recommendation action has been received on these occasions.	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDB) example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HIW)/2017/141/MD21/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include iPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - Extended 3 part time optometrists whilst workforce review and BC approval.	
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HIW)/2020/139/MD2/1	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care and Community	01.10.2020	01.10.2020	Overdue	March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. November 2025 Update (27/11/25) - Head of Quality Assurance and Compliance email to Head of Nursing Primary Care & Community.	
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MD3/1	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete (Overdue)	July 2026 Update - a meeting is planned to address this action with new medic cover at end of July 26. April 2026 Update -Delay remains with regards to medic provision , we are in process of appointing and the aim is to ensure this is completed by end of July 2026.	
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Healthcare Inspectorate Wales (HIW)/2022/131/MD1/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Unable to complete	June, September 2026 Update - No update against this recommendation action has been received on these occasions. February 2026 Update - Escalated to Executive Director of Nursing, Midwifery & Patient Care for review and guidance to ensure required action is completed.	

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Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales (HIW)/2023/134/MD2/1	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance:- ED •Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. •An Ba Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. •A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCSWs Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ILS and PILS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	June, September 2025 Update - No update against this recommendation action has been received on these occasions. February 2026 Update (19/02/26) -Update, improving trajectory-require a further summary for 24th February 2026.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken. To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October, December 2025, March, June, September 2026 - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MD7/1	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October, December 2025, March, June, September 2026 - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales (HIW)/2023/155/MD6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of Whiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026)- no dedicated stroke specialist Pharmacist, however an allocated Pharmacist available on stroke daily- Senior Principal Pharmacist oversight for USC CSG (RC), who responds proactively to the needs of the service. RAG rate amber
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD14/1	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below "table removed for AMaT purposes"), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	June, September 2026 Update - No update against this recommendation action has been received on these occasions. February 2026 Update-Improvement in Stroke flow and creating sufficient ring fenced capacity including weekends/out of hours
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - actions completed, escalation policy in place and monitored via ED Huddles/Conference calls etc. Close and finally approve.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - currently have a 6 day service, working towards 7 days. Rag rate Amber.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update - ACP currently 6 day service. Working on 7 day service as part of the transformation work.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion April 2026 Update (01/04/2026) - no change, however a TEAMS communication channel in place that is MDT supports this action and is working effectively to ensure timely transfer to the ASU. Amber rate.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HIW)/2023/155/MD19/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - this work is ongoing in line with Stroke Transformation.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - no change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD25/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - this action is nearing completion-awaiting neurologist to commence employment. RAG Rate amber.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, ingested into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025, March, June, September 2026 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - inpatient stroke services currently centralised at Royal Glamorgan Hospital. Agreement that confirmed strokes only will be admitted to the Acute Stroke Unit to prevent medical outliers occupying stroke capacity. Daily aim to ensure ringfenced stroke bed to support flow and stroke pathway. Stroke demand on all three sites discussed at Safe to Start meetings twice daily and at HB conference calls. Ring fenced beds and ASU capacity continues to form part of the out of hours and weekend planning cycle of the HB.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD31/1	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 (01/04/2026) - No change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - No change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) -actioned progressed 6 day working, plan to move to 7 day as part of transformation work. RAG Rate Amber

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Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - No change, RAG Rate Amber.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the D2RA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - No change but RAG rating is AMBER with training compliance to date Stroke Unit.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase uptake for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) -action progressing, increase in bed availability due to increase trend in discharge/transfer out of Stroke Unit. RAG Rating AMBER.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD41/1	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026)- progressing as below, RAG Rating AMBER, data evident.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - CTM UHB Escalation policy approved, RGH Ward 1 can be used flexibly as a surge area to support patient flow-following escalation and agreement of CSG.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (01/04/2026) - there are no further plans to support construction works in ED PCH. The ambulatory area has been updated including plans to update the Mental Health room in line with legislation-amber rating.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (27/4/26) - Business case being developed in response to the birthrate report 2025, currently in draft. Regular finance meetings are in place with Directorate leadership team, the director of finance and the care group directors.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. April 2026 Update (27/4/26) - MatNCo SMOc attended the site escalation meetings - daily and during weekends and out of hours, Internal acute and community safe to start ad safety huddles in place, to review Site safe to start process with the senior team as not currently workable for maternity to ensure appropriate communication and escalation between site and maternity.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Colty Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	5. The health board must develop a policy in line with best practice guidelines that ensures the safety, privacy, dignity and rights of patients can be maintained throughout the mixed gender wards as well as keeping patients of the same gender safe in dormitories.	Healthcare Inspectorate Wales (HIW)/2024/235/MD5/2	The Health Board has developed a Single Sex accommodation policy. The draft version is currently going through the Health Board's ratification process.	Mental Health & Learning Disabilities	30.04.2025	30.09.2026	In progress	July 2026 Update - New revised date 30th September 2026. February 2026 Update - New Revised date for completion is 31-05-2026.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Colty Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	7. The health board must develop a policy to provide guidance to staff regarding patients' use of electronic equipment, mobile phone devices and access to the internet.	Healthcare Inspectorate Wales (HIW)/2024/235/MD7/1	There is an all Wales Social Media Policy and a Health Board policy that supports use of mobile phones within hospital settings. Both policies are out of date. A request has been made to update the Health Boards policy.	Mental Health & Learning Disabilities	30.06.2025	30.09.2026	In progress	July 2026 Update - Revised date of completion 30-09-26. April 2026 Update -Revised date for completion 31-05-2026.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	11. The health board must ensure that a dietician is allocated to the ward to support staff and meet the needs of the patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD11/1	Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. Mitigation includes; all patients have a risk assessment which determines the level of risk. There is a scoring mechanism in place from 0-7+ based on nutritional risk. If the score is 7+ then the patient requires referral to Dietetic service. In this scenario the Advanced Nurse Practitioner (ANP) or Doctor also prescribe supplements, advise on diet plan and nursing staff would complete weekly weights.	Mental Health & Learning Disabilities	31.12.2025	31.03.2027	In progress	July 2026 Update - The inpatient redesign work has started but completion aimed for 31st March 2027. April 2026 Update - revised date to 31-05-26.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	12. The health board must ensure that policies are reviewed to ensure they are current.	Healthcare Inspectorate Wales (HIW)/2025/241/MD12/1	The policies identified within the inspection that were; Mental Health policies • Management of violence and behaviours that challenge, no review date (this has been completed) Corporate / Health Board policies • Health and safety policy, review date August 2024 • Consent to examination or treatment, review May 2024 • Policy for safe support and supervision of patients, review date October 2018 • PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents, however, at appropriate intervals there will be engagement with the Assistant Medical Director Quality & Clinical Effectiveness, who leads on Clinical Written Control Documents to ensure consistency and flow. Project Objectives: 1. To establish a baseline compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. 4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents. To review the "Policy on Policies" and develop a simplified document supported with clear process maps.	Mental Health & Learning Disabilities	31.12.2025	31.08.2026	In progress	July 2026 Update - Revised completion date 31-8-26. April 2026 Update -revised completed date 31-05-26.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	13. The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HIW)/2025/241/MD13/1	It has been agreed that a priority for the Older Adult Mental Health Directorate is to complete a pan CTM inpatient redesign review which will scope a widespread multi-disciplinary establishment review.	Mental Health & Learning Disabilities	31.12.2025	31.03.2027	In progress	July 2026 Update - redesign in progress new completion date 31st March 27. April 2026 Update - Revised completion date 31-05-2026.
Healthcare Inspectorate Wales (HIW)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/3	CTM DRL group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRLs. The DRL group will feed into CTM image optimisation team and radiation safety committee.	Diagnostic, Therapies, Pharmacy and Specialities	05.06.2025	05.06.2025	Partially complete (Overdue)	October, December 2025, March, June, September 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	13. The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HIW)/2025/264/MD13/3	Observation and referral form audit will be added to AMaT system to ensure action plans in place, robust analysis and re-audit in an appropriate time frame. Ongoing	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	Partially complete (Overdue)	October, December 2025, March, June, September 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	2. Ensure timely pain relief is available postnatally.	Healthcare Inspectorate Wales (HIW)/2025/276/MD2/1	All Wales self-administration policy is currently distributed for comment, once ratification the organisation will support implementation.	Children & Families	30.04.2026	30.04.2026	Overdue	December 2025, March, June, September 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	4. Improve signage to the department.	Healthcare Inspectorate Wales (HIW)/2025/276/MD4/1	Videos to be developed to support women and their families how to find maternity departments. Ensure clear signage is displayed to help women and families locate the maternity unit. Estates to review signage across the site to ensure easy access to maternity.	Children & Families	28.02.2026	30.04.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. May 2026 Update (12/05/2026) - Videos currently being filmed and edited by medical illustrators.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	11. Review, evaluate and improve communication and engagement between senior management and staff.	Healthcare Inspectorate Wales (HIW)/2025/276/MD11/2	Create a Maternity specific Share-point page to support staff to access key information.	Children & Families	28.02.2026	30.08.2026	In progress	July 2026 Update (27/07/26) - unable to complete due to the implementation of Badgernet. Phased go live including phase 1 go live 17/3/26 and phase 2 go live 10/06/26 - digital priority remains on stabilisation of Badgernet currently therefore propose due date extended.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	12. Ensure that established investigation processes are implemented consistently when needed.	Healthcare Inspectorate Wales (HIW)/2025/276/MD12/1	The Maternity Governance team to undertake an engagement event to celebrate the rebranded title of – quality assurance team.	Children & Families	31.01.2026	04.05.2026	Overdue	June, September 2026 Update - No update against this recommendation action has been received on these occasions. March 2026 Update (02/03/2026) Update - Quality assurance team have reviewed team structure and core responsibilities and presented at unit meetings. International day of the midwife and well-being event has been scheduled to take place within CTM on 4th May. Quality assurance team due to present the at this session, various stakeholder engagement have taken place, posters have been developed and disseminated throughout the maternity departments. NOTE - due date changed 4/5/26 in line with well-being event.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	12. Ensure that established investigation processes are implemented consistently when needed.	Healthcare Inspectorate Wales (HIW)/2025/276/MD12/2	Develop an assist me pack which is specific to maternity and neonatal staff to support staff who maybe involved in an incident and the process	Children & Families	31.01.2026	31.01.2026	Partially complete (Overdue)	June, September 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	4. The health board must continue to be highly cognisant of the footprint of the department and its ability to remain fit for purpose in the context of current demand, capacity and usage.	Healthcare Inspectorate Wales (HIW)/2025/277/MD4/1	CTMUHB recognises the requirement to continually the ED footprint and its ability to remain fit for purpose in the context of current demand and capacity. Following service reconfiguration as a result of the Critical Incident in Princess of Wales Hospital, a comprehensive review of the current ED footprint will be required to ensure it aligns with evolving service needs. This review should consider patient flow, workforce requirements, infrastructure limitations, and future growth projections to ensure the department remains responsive, safe, and sustainable.	Unscheduled Care	31.03.2026	31.03.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. 1st April 2026, as part of Unscheduled Care transformation work (UNITE)-STAMP has now been implemented in POWH 29/03/26-this facilitates the flow out of ED into AMU/SECC in line with RGH and PCH. Corridor care removed from POWH and an Ambulatory Area configured in November 2025-thus supporting 6 Goals initiative and ED's remaining fit for purpose in the context of current demand and capacity. This is in progress (amber rating)
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	6. The health board must consider the recommendations of RCEM (December 2020) regarding security and restraint and ensure that ED staff can access a consistent site security presence.	Healthcare Inspectorate Wales (HIW)/2025/277/MD6/1	CTMUHB acknowledges the findings regarding the requirement to ensure consistent access to on site security presence. The ED regularly receive Violence and Aggression (V&A) Modules B - Personal Safety & De-escalation and Module C - Breakaway & Escape Techniques. Historically CTMUHB Emergency Departments have not been trained in Module D - Physical Restraint Techniques (PMVA) and the onsite security team are trained to assist with restraint. Since the introduction of Right Care Right Person by South Wales Police, ED staff cannot guarantee support from South Wales Police to attend incidents of violence. Datix incident analysis over the past few years shows security porters have been required to manage restraint incidents without back up support from South Wales Police. There are two security porters available to manage violence at any given time and this is to support the hospital site. Next steps: The facilities team are currently undertaking a review of the security team establishment and a training needs analysis to support the increase of security availability at the hospital site. The facilities team are undergoing improvement work to review the current establishment of the security team and implement a training plan for PMVA training.	Unscheduled Care	31.03.2026	31.03.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. 1st April 2026-no change from January update. RAG rated Amber
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	11. The health board should re-audit the paediatric department against the RCPCH standards, with particular focus on paediatric workforce capacity.	Healthcare Inspectorate Wales (HIW)/2025/277/MD11/1	CTMUHB recognises the importance to audit and revisit the RCPCH audit following the implementation of a designated paediatric area in the ED. The ED has developed a Paediatric Emergency Medicine (PEM) group who are currently undertaking a review of the RCPCH standards to benchmark against previous audits prior to implementing the designated paediatric area. Current workforce establishment: 1.6 WTE PEM consultants covering a 6-hour period, 5 days a week. x 1.0 WTE Band 7 Paediatric Lead x 2.0 WTE Band 6 Paediatric nurses x 4.0 WTE Band 5 Paediatric Nurses Additional Information: • Focus on workforce capacity • The RGH ED PEM group will complete benchmarking exercise within the next 3 months.	Unscheduled Care	31.12.2025	31.12.2025	Partially complete (Overdue)	September 2026 Update - No update against this recommendation action has been received on this occasion. 1st April 2026-no change-amber rating as 3 ED's have appropriate separate Paediatric Areas. Await update as described in January 2026
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	17. The health board should consider the training suggestions provided by staff in response to our survey, such as, Advanced Life Support, Paediatric Advanced Life Support, and Advanced Trauma Life Support.	Healthcare Inspectorate Wales (HIW)/2025/277/MD17/1	CTMUHB acknowledges that compliance for mandatory resuscitation training is not where we want it to be. The ED currently has 46 staff booked on various resuscitation courses, compromising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTL5 = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An 8a Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all RNs and HCSW which will align across the 3 ED's. • The PDN across the 3 EDs are currently working towards instructor potential to enable and facilitate inhouse training to support training compliance improvements. A trajectory improvement action plan has been made to improve compliance to 100%.	Unscheduled Care	31.03.2026	31.03.2026	Partially complete (Overdue)	June, September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	18. The health board must review staff compliance with all immediate and Advanced Life Support training for both adult and paediatric patients, ensuring that improvements are made promptly.	Healthcare Inspectorate Wales (HIW)/2025/277/MD18/1	CTMUHB acknowledges that compliance for mandatory resuscitation training is not where we want it to be. The ED currently has 46 staff booked on various resuscitation courses, compromising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTL5 = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An 8a Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all RNs and HCSW which will align across the 3 ED's. The Practice Development Nurses (PDN) across the 3 EDs are currently working towards instructor potential to enable and facilitate inhouse training to support training compliance improvements. A trajectory improvement action plan has been made to improve compliance to 100%.	Unscheduled Care	31.03.2026	31.03.2026	Partially complete (Overdue)	June, September 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	1. The health board must ensure all observation panels work as intended to support safe and appropriate observations.	Healthcare Inspectorate Wales (HIW)/2026/289/MD1/4	A spot check against this audit will be completed on a monthly basis over a six month period. This will be reported into Quality, Safety and Experience Group (QSE).	Mental Health & Learning Disabilities	16.09.2026	16.09.2026	In progress	July 2026 Update - In progress estimated date of completion 16th September 2026.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	2. The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.	Healthcare Inspectorate Wales (HIW)/2026/289/MD2/3	A spot check against this process will be completed on a monthly basis over a six month period. This will be reported into QSE.	Mental Health & Learning Disabilities	16.09.2026	16.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	2. The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.	Healthcare Inspectorate Wales (HIW)/2026/289/MD2/4	The phase 2 Capital works to improve the Enhanced Care Area (ECA) is in progress.	Mental Health & Learning Disabilities	31.07.2026	31.07.2026	Overdue	July 2026 Update - In progress estimated to be completed 31st July 2026.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	4. The health board must ensure that key risk management information is clearly and consistently reflected across all relevant documents, including MySafety Plans, to reduce the risk of important details being missed and to support safe, consistent care delivery.	Healthcare Inspectorate Wales (HIW)/2026/289/MD4/2	Monthly WARRN and care-plan audit to be implemented and subject to a six month review, to ensure that YP who are identified to require restrictive practice, have clear risk management actions within the WARRN and a co-produced restraint reduction goal within the care-plan. My Safety Plan is embedded into the care-plan document and specific to what the young person feels best helps them in managing their mental health and any crisis.	Mental Health & Learning Disabilities	16.09.2026	16.09.2026	In progress	July 2026 Update - In progress estimated date of completion 16th September 2026.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	4. The health board must ensure that key risk management information is clearly and consistently reflected across all relevant documents, including MySafety Plans, to reduce the risk of important details being missed and to support safe, consistent care delivery.	Healthcare Inspectorate Wales (HIW)/2026/289/MD4/3	Audit findings will be reported via Directorate QSE to ensure that the required level of improvement has been met/ agree if the audit needs to be extended for assurance.	Mental Health & Learning Disabilities	16.09.2026	16.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	5. The health board must ensure that enhanced observation records are completed in full to provide an accurate account of each young person's presentation and to ensure that no safeguarding concerns or changes in risk are missed.	Healthcare Inspectorate Wales (HIW)/2026/289/MD5/3	NIC checklist to be audited monthly and subject to six month review to further strengthen improvements in this area. Findings will be reported via Directorate QSE.	Mental Health & Learning Disabilities	16.09.2026	16.09.2026	In progress	July 2026 Update - In progress estimated date of completion 16th September 2026
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	6. The health board must: •Review the current paper record system and implement improvements to ensure information is easy to navigate and in a timely manner. •Consider moving to an electronic patient record system to improve accessibility, enhance consistency and reduce the challenges experienced when reviewing and cross-checking information.	Healthcare Inspectorate Wales (HIW)/2026/289/MD6/2	MHLD to award contract for electronic record.	Mental Health & Learning Disabilities	01.05.2026	01.05.2026	Fully complete (Awaiting approval)	July 2026 Update - completed in June, see evidence attached. May 2026 Update - MHSCB procurement process has been delayed. The HB is presently awaiting confirmation by Welsh Government of agreed system supplier. It is likely that this will take place by end of 26/27 Q1 (30 June 2026).
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	6. The health board must: •Review the current paper record system and implement improvements to ensure information is easy to navigate and in a timely manner. •Consider moving to an electronic patient record system to improve accessibility, enhance consistency and reduce the challenges experienced when reviewing and cross-checking information.	Healthcare Inspectorate Wales (HIW)/2026/289/MD6/3	The MHLD Care Group will implement a single electronic record for patient notes.	Mental Health & Learning Disabilities	31.05.2028	31.05.2028	In progress	July 2026 Update - In progress estimated date of completion 21st May 2028.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	7. The health board must ensure that all care and treatment plans fully address the relevant domains of the Mental Health (Wales) Measure, and that these are routinely explored, recorded and translated into clear, measurable actions.	Healthcare Inspectorate Wales (HIW)/2026/289/MD7/2	A snap shot audit of all CTMUHB patients admitted over the last 12 months will take place to review compliance to the MHM and the results of this audit will be shared widely with the CTMUHB community teams to support any learning identified.	Mental Health & Learning Disabilities	20.05.2026	20.05.2026	Fully complete (Awaiting approval)	July 2026 Update - completed 20th May , see evidence attached.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Lliardd_12, 13 & 14 January 2026 (Ref: 03944)	7. The health board must ensure that all care and treatment plans fully address the relevant domains of the Mental Health (Wales) Measure, and that these are routinely explored, recorded and translated into clear, measurable actions.	Healthcare Inspectorate Wales (HIW)/2026/289/MD7/3	The findings of the CTMUHB audit and AMAT will be reported into Directorate QSE. This will then form part of regular AMAT audit reporting into QSE.	Mental Health & Learning Disabilities	20.05.2026	20.05.2026	Fully complete (Awaiting approval)	July 2026 Update - completed, see evidence attached.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Lliardd_12, 13 & 14 January 2026 (Ref: 03944)	9. The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.	Healthcare Inspectorate Wales (HIW)/2026/289/MD9/1	The training identified was regarding meal support. Full Day Meal Support Training is presently being rolled out by the regional Eating Disorder Outreach Service, training compliance is presently 35% and will rise to 53% May 2026 and 85% by December 2026. This will remain a training requirement for all substantive and new MDT staff working in Ty Lliardd.	Mental Health & Learning Disabilities	31.12.2026	31.12.2026	In progress	July 2026 Update - in progress estimated completion 31st Dec 2026.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Lliardd_12, 13 & 14 January 2026 (Ref: 03944)	9. The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.	Healthcare Inspectorate Wales (HIW)/2026/289/MD9/2	Compliance will be reported and monitored via Directorate QSE	Mental Health & Learning Disabilities	31.12.2026	31.12.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Lliardd_12, 13 & 14 January 2026 (Ref: 03944)	9. The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.	Healthcare Inspectorate Wales (HIW)/2026/289/MD9/3	Speciality specific training needs analysis to be completed and considered in line with QNIC standards. Once agreed and embedded, compliance will be reported and monitored via Directorate QSE.	Mental Health & Learning Disabilities	01.07.2026	01.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Lliardd_12, 13 & 14 January 2026 (Ref: 03944)	10. The health board must ensure that the electronic patient information boards are consistently maintained and accurately reflects real-time clinical information.	Healthcare Inspectorate Wales (HIW)/2026/289/MD10/3	Audit to be developed to ensure factual completeness of the electronic patient information board. This will be completed monthly over a 6-month period, learning will be disseminated and reported via Care Group QSE for assurance.	Mental Health & Learning Disabilities	30.09.2026	30.09.2026	In progress	Note: Due Dates - 1st July 2026 completion of analysis. Update on progress in QSE 20th May 2026 and final report in QSE 15th July 2026. September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Lliardd_12, 13 & 14 January 2026 (Ref: 03944)	11. The health board must strengthen incident-reporting processes and ensure the remaining open incidents are addressed promptly. Additionally, ensure all future incidents are logged in a timely manner, that Datix entries contain accurate and complete information, and that incidents are reviewed and closed promptly to improve oversight and support learning.	Healthcare Inspectorate Wales (HIW)/2026/289/MD11/2	A weekly check by the Senior Nurse has been implemented to ensure timely investigation and closure of incidents. And a reminder for timely investigation and closure forms part of daily NIC check list.	Mental Health & Learning Disabilities	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	July 2026 Update - completed see evidence attached.
Healthcare Inspectorate Wales (HIW)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Lliardd_12, 13 & 14 January 2026 (Ref: 03944)	11. The health board must strengthen incident-reporting processes and ensure the remaining open incidents are addressed promptly. Additionally, ensure all future incidents are logged in a timely manner, that Datix entries contain accurate and complete information, and that incidents are reviewed and closed promptly to improve oversight and support learning.	Healthcare Inspectorate Wales (HIW)/2026/289/MD11/3	The above checks will be implemented in order to review the timeliness of incident reporting with a monthly review for six months into QSE meetings, to monitor the quality. This will also include a review of: • Open Incidents • Incidents under investigation • Incidents awaiting closure This will provide assurance around adherence to the Incident Management Framework.	Mental Health & Learning Disabilities	16.09.2026	16.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Ensure consistent monitoring and recording of medication refrigerator and medication storage room temperatures, with clear accountability for compliance.	Healthcare Inspectorate Wales (HIW)/2026/304/MD1/1	1.1 A refrigerator and clinic room temperature checklist and process, which includes clear accountability for staff, have been developed and are in use daily.	Mental Health & Learning Disabilities	16.01.2026	16.01.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 16/01/2026. See Appendix 1.1 + 1.2' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Implement robust governance oversight and audit processes to ensure medications are safely stored.	Healthcare Inspectorate Wales (HIW)/2026/304/MD2/1	1.2 The daily refrigerator and clinic room temperature monitoring checklist includes a weekly team leader audit and a monthly senior nurse audit. This will be monitored through the monthly adult community mental health Quality, Safety, Risk and Experience meeting.	Mental Health & Learning Disabilities	16.01.2026	16.01.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 16/01/2026. See Appendix 1.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Provide staff with appropriate training, guidance and oversight to improve awareness and understanding of medicines storage and management processes.	Healthcare Inspectorate Wales (HIW)/2026/304/MD3/1	1.3.1 The CTMUHB medication storage procedure has been re-shared by email and verbally with the team.	Mental Health & Learning Disabilities	21.01.2026	21.01.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 21/01/2026. See Appendix 1.3 + 1.3.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Provide staff with appropriate training, guidance and oversight to improve awareness and understanding of medicines storage and management processes.	Healthcare Inspectorate Wales (HIW)/2026/304/MD3/2	1.3.2 Pharmacy team will provide dedicated training to Taff Ely CMHT to ensure awareness of temperature monitoring requirements and the risks associated with non-compliance. Training is scheduled for 30/01/2026.	Mental Health & Learning Disabilities	30.01.2026	30.01.2026	Fully complete (Awaiting approval)	July 2026 Update - Completed and evidence uploaded, signed off QSE Jan 26. Added to tracker June 2026; In Progress. Estimated Date of Completion 30/01/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Ensure depot medication is prescribed and administered at the correct intervals.	Healthcare Inspectorate Wales (HIW)/2026/304/MD4/1	2.1.1 The 3 depot charts highlighted have been reviewed and are now prescribed as per licence dosing.	Mental Health & Learning Disabilities	16.01.2026	16.01.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 16/01/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Ensure depot medication is prescribed and administered at the correct intervals.	Healthcare Inspectorate Wales (HIW)/2026/304/MD4/2	2.1.2 All depot charts in Taff Ely CMHT are under review to ensure that there are no other prescribing ambiguities. As there is no pharmacy resource within CMHTs, this will be undertaken by the medical team.	Mental Health & Learning Disabilities	30.01.2026	30.01.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and signed at QSE in June, evidence attached. Added to tracker June 2026; In Progress. Estimated Date of Completion 30/01/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Introduce safeguards within the prescribing process so depot medication is always recorded correctly.	Healthcare Inspectorate Wales (HIW)/2026/304/MD5/1	2.2.1 A review of current processes for depot chart screening and supply of depot medication to CMHT to be undertaken by pharmacy dept.	Mental Health & Learning Disabilities	30.01.2026	30.01.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and signed in QSE in June, evidence attached. Added to tracker June 2026; In Progress. Estimated Date of Completion 30/01/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Introduce safeguards within the prescribing process so depot medication is always recorded correctly.	Healthcare Inspectorate Wales (HIW)/2026/304/MD5/2	2.2.2 A safe standardised approach to chart screening and supply is to be implemented HB-wide.	Mental Health & Learning Disabilities	28.02.2026	28.02.2026	Partially complete (Overdue)	July 2026 Update - Review completed and draft SOP in place 24/04/2026 See Appendix 2.2 and 2.2.1 Policy to be ratified and process implemented by 30/06/2026 Email shared with all CMHT CPN staff reminding of process whilst policy awaiting ratification Added to tracker June 2026; Estimated Date of Completion 28/02/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Introduce safeguards within the prescribing process so depot medication is always recorded correctly.	Healthcare Inspectorate Wales (HIW)/2026/304/MD5/3	2.2.3 A wider depot service review will be undertaken by Meds Management MH Team.	Mental Health & Learning Disabilities	31.03.2026	31.03.2026	Fully complete (Awaiting approval)	July 2026 Update - completed signed off in QSE in June, evidence attached. Added to tracker June 2026; In Progress. Estimated Date of Completion 31/03/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Standardise and improve depot charts, ensuring essential clinical details are consistently recorded.	Healthcare Inspectorate Wales (HIW)/2026/304/MD6/1	2.3.1 The CMHT is transitioning to the use of All Wales standardised inpatient mental health medication charts, as they contain a dedicated section for depot medications. All depot charts will be reviewed to ensure that they are written on the All Wales charts and include relevant clinical information.	Mental Health & Learning Disabilities	30.03.2026	30.03.2026	Fully complete (Awaiting approval)	July 2026 Update - completed signed off at QSE in March evidence attached. Added to tracker June 2026; In Progress. Estimated Date of Completion 30/03/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Standardise and improve depot charts, ensuring essential clinical details are consistently recorded.	Healthcare Inspectorate Wales (HIW)/2026/304/MD6/2	2.3.2 An audit of the presence of relevant clinical information standards will be added to the existing CMHT depot audit (Appendix 2.3.2) and implemented on completion of the review of depot charts. This will be monitored through the monthly adult community mental health Quality, Safety, Risk and Experience meeting.	Mental Health & Learning Disabilities	30.03.2026	30.03.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and signed off in QSE in Feb, evidence attached. Added to tracker June 2026; In Progress. Estimated Date of Completion 30/03/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Provide clear guidance and training to staff to remove ambiguity surrounding administration intervals and improve the accuracy of depot prescribing and documentation.	Healthcare Inspectorate Wales (HIW)/2026/304/MD7/1	2.4.1 Pharmacy team will provide dedicated training to Taff Ely CMHT to ensure awareness of prescribing and recording standards of all depot medications. Training is in place for 30/01/2026.	Mental Health & Learning Disabilities	30.01.2026	30.01.2026	Fully complete (Awaiting approval)	July 2026 - Completed evidence attached, signed off at QSE Feb 26. Added to tracker June 2026; In Progress. Estimated Date of Completion 30/01/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Strengthen pharmacy support to the CMHT, ensuring staff have access to timely advice, oversight and professional guidance relating to safe medicines management.	Healthcare Inspectorate Wales (HIW)/2026/304/MD8/1	2.5.1 Contact details for the Medicines Management MH Team have been re-circulated to the wider MHLd team to support timely access to advice.	Mental Health & Learning Disabilities	20.01.2026	20.01.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed 20/01/2026 See Appendix 2.5.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix B - Immediate improvement plan The health board must: Strengthen pharmacy support to the CMHT, ensuring staff have access to timely advice, oversight and professional guidance relating to safe medicines management.	Healthcare Inspectorate Wales (HIW)/2026/304/MD8/2	2.5.2 A review will be undertaken of high-risk prescribing areas within CMHT and resource allocation of Medication Management team with MHLd directorate.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Partially complete (Overdue)	July 2026 Update - Review completed and x0.2 WTE community MH pharmacist appointed to support high risk prescribing areas (Clozapine, lithium, depot medication). Estimated start date 31/07/2026. Added to tracker June 2026; In Progress.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan 1. The health board and local authority must ensure that physical health monitoring is consistently recorded, monitored and reviewed for all service users, and particularly those identified as being at increased risk.	Healthcare Inspectorate Wales (HIW)/2026/304/MD9/1	All CMHT clinical staff have been reminded by email that where patients are identified as requiring weight monitoring as part of physical health monitoring standards, this should be consistently recorded as per physical health monitoring policies. Where the patient does not wish to be weighed this should be clearly recorded and actioned as necessary.	Mental Health & Learning Disabilities	12.03.2026	12.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed 12/03/2026 Evidence 1.1 email to CMHT' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan 1. The health board and local authority must ensure that physical health monitoring is consistently recorded, monitored and reviewed for all service users, and particularly those identified as being at increased risk.	Healthcare Inspectorate Wales (HIW)/2026/304/MD9/2	This action has been discussed as a reflective point within the TECMHT team meeting on 25/03/2026 to ensure that all care coordinators understand their responsibilities in terms of care planning and offering physical health monitoring.	Mental Health & Learning Disabilities	25.03.2026	25.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed 25/03/2026 Evidence 1.2' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan 1. The health board and local authority must ensure that physical health monitoring is consistently recorded, monitored and reviewed for all service users, and particularly those identified as being at increased risk.	Healthcare Inspectorate Wales (HIW)/2026/304/MD9/3	A standardised physical health monitoring audit will be developed and implemented against the standards contained within mental health physical health monitoring policies and monitored through the directorate QSE meeting. This will be monitored monthly for 6 months and become part of standard reporting if consistent high compliance is achieved.	Mental Health & Learning Disabilities	31.10.2026	31.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/10/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan The local authority should: 2.1 Offer and complete a carers' assessment where it appears a carer may have support needs, in line with the Social Services and Wellbeing (Wales) Act. 2.2 Record carers' assessments and outcomes clearly to demonstrate how carers' needs are identified and supported.	Healthcare Inspectorate Wales (HIW)/2026/304/MD10/1	2.1 and 2.2 All local authority staff across the RCT CMHTs have been reminded of the Carers conversation and guidance via email 27/03/26 to ensure all areas are aware of offer and need to complete carers assessment and record on the system where it appears a carer may have support needs in line with legislations.	Mental Health & Learning Disabilities	27.03.2026	27.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 27/03/2026 See evidence 2.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan The local authority should: 2.3 Strengthen support arrangements for carers and assure practice quality through routine oversight.	Healthcare Inspectorate Wales (HIW)/2026/304/MD11/1	2.3 RCT MH&LD Service manager to undertake quality assurance audit of the offer and recording of carers assessment and outcomes. The findings of the audit will be shared through the RCTCBC staff forum and adult services performance and quality assurance forum meeting . Any further actions required as an outcome of the audit to be considered as part of the service evaluation for 2026/2027 and managed through the business/service planning process.	Mental Health & Learning Disabilities	30.09.2026	30.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 30/09/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan The local authority should: 2.4 Consider whether individuals have difficulties engaging in assessment or decision making and provide advocacy where required.	Healthcare Inspectorate Wales (HIW)/2026/304/MD12/1	2.3 and 2.4 RCTCBC will review arrangements for unpaid carers to ensure compliance with the Ombudsman review and the WG Carers strategy expected in 2026/2027. RCTCBC will support the Implementation of the agreed carers Information, Advice, Assistance (IAA) model of service	Mental Health & Learning Disabilities	31.03.2027	31.03.2027	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/03/2027.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan 3. The health board must review and strengthen the process for managing ADHD referrals to ensure timely assessment and reduce pressure on wider CMHT functions.	Healthcare Inspectorate Wales (HIW)/2026/304/MD13/1	Improvement and sustainability in the management of ADHD assessment and treatment including shared care with primary care and the 3rd sector is a workstream within the community mental health services redesign programme. There is a clear action plan dedicated to this work with timescales for action and improvement. Monitoring of improvements is through monthly care group Improving Care Board (ICB).	Mental Health & Learning Disabilities	31.05.2026	31.05.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and signed off at QSE in April. Added to tracker June 2026; In Progress Estimated date of completion 31/05/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C - Improvement plan The health board and local authority must ensure: 4.1 Service users' entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept. 4.2 Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.	Healthcare Inspectorate Wales (HIW)/2026/304/MD14/1	The CMHT will arrange to invite Advocacy services in to meet with care co-ordinators to explain their role and how to refer to advocacy.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed, signed off QSE April, evidence attached. Added to tracker June 2026; In Progress.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must ensure: 4.1 Service users’ entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept. 4.2 Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.	Healthcare Inspectorate Wales (HIW)/2026/304/MD14/2	4.2 Advocacy rights is included within MHM training including details of how to refer and this will be reiterated by CTP Leads, both in training and during team visits. All standard appointment letters to CMHT service users will be reviewed to ensure that they contain relevant advocacy information.	Mental Health & Learning Disabilities	30.06.2026	30.06.2026	Fully complete (Awaiting approval)	July 2026 Update - completed evidence attached signed off QSE April. Added to tracker June 2026; In Progress Estimated date of completion 30/06/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must ensure: 4.1 Service users’ entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept. 4.2 Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.	Healthcare Inspectorate Wales (HIW)/2026/304/MD14/3	A Lunch and learn session will be organised by RCTCBC to relaunch the RCTCBC Advocacy Policy.	Mental Health & Learning Disabilities	30.05.2026	30.05.2026	Fully complete (Awaiting approval)	July 2026 Update - completed evidence attached, signed off QSE in May. Added to tracker June 2026; In Progress Estimated date of completion 30/05/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must ensure: 4.1 Service users’ entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept. 4.2 Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.	Healthcare Inspectorate Wales (HIW)/2026/304/MD14/4	This offer of advocacy is monitored in the bi-monthly CTP audit (AMAT). On review of the audit tool, team leaders are not accurately recording this element of the audit tool. The CTP leads will provide a training session on completion to all CMHT team leaders and following this, improvements or further development needs with regards to the offer of advocacy will be monitored through CTP audit and themes and reported through the MHM operational group which is attended by health and LA partners.	Mental Health & Learning Disabilities	30.06.2026	30.06.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and evidence attached signed off at QSE. Added to tracker June 2026; In Progress Estimated date of completion 30/06/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must ensure: 4.1 Service users’ entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept. 4.2 Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.	Healthcare Inspectorate Wales (HIW)/2026/304/MD14/5	CTP Leads oversee any required actions and feedback at the MHM Operational Group for shared action and learning. The CTP leads will work with the LA team managers to develop a process to ensure that all LA audit actions and themes are jointly reviewed and fed through the MHM operational group to ensure shared learning and governance.	Mental Health & Learning Disabilities	02.04.2026	02.04.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 02/04/26 Evidence 4.2.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must ensure: 4.1 Service users’ entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept. 4.2 Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.	Healthcare Inspectorate Wales (HIW)/2026/304/MD14/6	All RCT Service managers will complete a quality assurance audit of the use of advocacy across adult social services. This will be fed back and learning shared through the service manager joint work programme.	Mental Health & Learning Disabilities	31.10.2026	31.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress. Estimated date of completion 31/10/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 5. The health board must ensure comprehensive ligature risk assessments are maintained and ensure mitigations are regularly reviewed to support service user safety.	Healthcare Inspectorate Wales (HIW)/2026/304/MD15/1	Anti – ligature assessment completed; these are monitored, and mitigations discussed via escalation panel, held bi-monthly. The assessment will be reviewed annually as per policy. Renewal dates of assessment are held within our service improvement team.	Mental Health & Learning Disabilities	17.06.2026	17.06.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed Evidence 5.1 Evidence 5.2 Evidence 5.3' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 6. The health board must ensure that fire safety checks are completed and documented in line with required frequency.	Healthcare Inspectorate Wales (HIW)/2026/304/MD16/1	Fire checks have been completed and documented in line with requirements since the inspection and there is now a weekly rota of responsible person for fire checks.	Mental Health & Learning Disabilities	17.06.2026	17.06.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed Evidence 6.1.1 and 6.1.2 Evidence 6.2' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 6. The health board must ensure that fire safety checks are completed and documented in line with required frequency.	Healthcare Inspectorate Wales (HIW)/2026/304/MD16/2	A monthly audit of compliance will be developed to ensure compliance with the standards and reported monthly for 6 months in QSE. This will form standard reporting if consistent compliance is achieved.	Mental Health & Learning Disabilities	30.10.2026	30.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 30/10/2026
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 7. The health board must urgently review the hospital’s security arrangements and ensure that effective access control measures are implemented, supported by interim measures to reduce risks while longer term solutions are implemented.	Healthcare Inspectorate Wales (HIW)/2026/304/MD17/1	The Adult Mental Health Directorate Manager will meet with the Assistant Director of Facilities to determine any access control measures that can be implemented in the short term whilst the wider capital funding bid progresses. This will be reported through the monthly Care group Quality, Safety and Experience meeting. To reduce risk in the interim there is a daily team of staff dedicated to support any escalating or aggressive behaviour in the mental health department. There is also a lone working procedure which gives clear instruction around personal safety in the building.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed singed off QSE in June, evidence attached. Added to tracker June 2026; In Progress Estimated date of completion 30/04/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 8. The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.	Healthcare Inspectorate Wales (HIW)/2026/304/MD18/1	A Lone Working lunch and learn for all local authority social work staff has been completed, this included the reporting duties and process to follow to report incidents.	Mental Health & Learning Disabilities	24.03.2026	24.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed 24/03/2026 evidence 8.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 8. The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.	Healthcare Inspectorate Wales (HIW)/2026/304/MD18/2	RCTCBC will redistribute all policies related to unscheduled care and the interface with CMHT to ensure that all social work staff are aware of process and procedure.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed, evidence attached and signed off at QSE in June. Added to tracker June 2026; In Progress Estimated date of completion 30/04/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 8. The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.	Healthcare Inspectorate Wales (HIW)/2026/304/MD18/3	RCTCBC will arrange for health board policies to be included on local authority Intranet to ensure ease of access.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and evidence attached signed off at QSE June 26. Added to tracker June 2026; In Progress Estimated date of completion 30/04/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 8. The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.	Healthcare Inspectorate Wales (HIW)/2026/304/MD18/4	RCTCBC has a Staff forum embedded in the service area. The forum will address how to escalate concerns via line management and reporting of safeguarding concerns in addition to policy.	Mental Health & Learning Disabilities	14.04.2026	14.04.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete Next forum 14/04/2026 Evidence 8.2' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 8. The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.	Healthcare Inspectorate Wales (HIW)/2026/304/MD18/5	RCTCBC Head of service has distributed Safeguarding Training Standards for RCTCBC staff and has included a recording sheet for team practice and performance managers to ensure that all relevant staff are aware.	Mental Health & Learning Disabilities	27.03.2026	27.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 27/03/2026 Evidence 8.3' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 8. The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.	Healthcare Inspectorate Wales (HIW)/2026/304/MD18/6	Standard Agenda Item added to team meetings to include Safeguarding training, Themes and issues for escalation, and learning across Adult Social Services issues.	Mental Health & Learning Disabilities	01.04.2026	01.04.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed 01/04/26 Evidence 8.4' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must: 9.1 Strengthen information-sharing arrangements to ensure staff have timely access to complete and accurate records across all CMHT systems.	Healthcare Inspectorate Wales (HIW)/2026/304/MD19/1	9.1The MH&LD Directorate has recently appointed a Nursing Information Officer to assist the Digital transformation of MH services. This is a Senior leadership role who will work as a Subject matter expert for all aspects of development and implementation of the Mental Health Single Clinical Record (MHSCR), with a particular focus on minimising system variation in conjunction with Local Authority partners, patient safety issues and delivery of effective care across community and inpatient services.	Mental Health & Learning Disabilities	31.05.2028	31.05.2028	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/05/28.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must: 9.1 Strengthen information-sharing arrangements to ensure staff have timely access to complete and accurate records across all CMHT systems.	Healthcare Inspectorate Wales (HIW)/2026/304/MD19/2	In mitigation whilst the MHSCR is under development the Mental Health Directorate will ensure that there is a mechanism in place to ensure that there is available access for all CMHT staff to both LA and HB clinical systems.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - Completed and signed off in QSE in July evidence attached. Added to tracker June 2026; In Progress Estimated date of completion 31/04/26.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must: 9.2 Ensure all staff understand and follow escalation processes when safety concerns arise.	Healthcare Inspectorate Wales (HIW)/2026/304/MD20/1	9.2 Adult Mental Health have a daily darised huddle attended by unscheduled care senior nurse, ward managers and CMHT team leaders designed to share live information and action plan in real time around patients at risk of deterioration or hospital admission. Details of the huddle and attendance will be reshared to all staff and LA staff will be reinvised to this huddle. If unable to attend they share information with health leads around cases of concern.	Mental Health & Learning Disabilities	17.06.2026	17.06.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed Evidence 9.2, 9.2.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan The health board and local authority must: 9.3 Review and address the communication gaps that have resulted in missed information at key points and ensure learning is shared and embedded to prevent recurrence.	Healthcare Inspectorate Wales (HIW)/2026/304/MD21/1	9.3 There have been no incidents raised to the CMHT team leaders of avoidable hospital admissions due to gaps in information sharing. Therefore, to fully understand and reflect on this point the recommendation has been added to the next CMHT team meeting on 25/03/2026 for team discussion, any learning identified will be taken forward from the discussion.	Mental Health & Learning Disabilities	25.03.2026	25.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 25/03/2026 Evidence 1.2' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 10. The health board and local authority must reflect on staff feedback about CMHT crisis cover and engage with staff to ensure timely access to medical advice.	Healthcare Inspectorate Wales (HIW)/2026/304/MD22/1	The Health Board acknowledges that there have been inconsistencies in medical staffing cover across community mental health services. The adult mental health directorate is currently redesigning its community medical model to ensure that there is robust and consistent medical staffing in all localities. This redesign model is expected to be completed by 31/05/2026.	Mental Health & Learning Disabilities	31.05.2026	31.05.2026	Fully complete (Awaiting approval)	July 2026 Update - Completed and evidence attached , signed of at QSE in June 26. Added to tracker June 2026; In Progress Estimated date of completion 31/05/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 10. The health board and local authority must reflect on staff feedback about CMHT crisis cover and engage with staff to ensure timely access to medical advice.	Healthcare Inspectorate Wales (HIW)/2026/304/MD22/2	To mitigate against any shortfall in medical staffing the directorate holds a daily medical staffing rota which is accessible to all staff through CMHT leads or the medical rota coordinator which gives clear direction as to contacts for any urgent work.	Mental Health & Learning Disabilities	17.06.2026	17.06.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed – Evidence 10.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 11. The health board must strengthen and stabilise the psychology workforce and ensure the CMHT has sufficient psychological support to: 11.1 Restore timely access to psychological therapies. 11.2 Prevent future backlogs and service pauses. 11.3 Support care coordinators managing complex and high risk cases. 11.4 Provide consistent psychological leadership within the MDT.	Healthcare Inspectorate Wales (HIW)/2026/304/MD23/1	11.1 Plan to clear backlog of those waiting over 26 weeks (as of beginning of March) by funding additional hours for health board staff has been formulated and is awaiting final finance sign off. It is anticipated that the wait for psychology will be under 26 weeks by end Jul 2026. 11.2 Band 8a psychologist currently being authorised on TRAC. This is being re-advertised as previous attempt to recruit in November 2025 was unsuccessful. This post will add additional clinical input alongside the current 0.8 band 7 psychologist to prevent future backlogs. 11.3/11.4 It is also a senior psychologist post which can provide extra support to care co-ordinators managing complex cases and provide psychological leadership within the team. In the event of failure to recruit plans and finance are in place to restructure the post to make it more attractive to applicants. Improvements in recruitment and retention will be monitored via monthly reporting of vacancy rates at the Integrated Performance Meeting. Sustained improvement will be monitored through robust job planning, PDR process and CPD opportunities.	Mental Health & Learning Disabilities	31.07.2026	31.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/07/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 12. The health board must strengthen Occupational Therapy (OT) capacity and ensure the CMHT has sufficient OT support to maintain safe, timely and effective care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD24/1	Recruitment to 2 wte Band 6 registered Occupational Therapist posts (Community Mental Health) was in progress at the time of the inspection. After being extended due to limited interest initially, the advert eventually closed on 26.02.2026. Shortlisting was completed immediately and interviews were held on 18.03.26. There was one successful candidate, the remaining post will be re-advertised by end of March 26 with the aim of recruitment and postholders in post by end July 26.	Mental Health & Learning Disabilities	31.07.2026	31.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/07/26.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 12. The health board must strengthen Occupational Therapy (OT) capacity and ensure the CMHT has sufficient OT support to maintain safe, timely and effective care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD24/2	There are 1.6 wte OT support staff posts vacant in Adult Community Mental. The posts are being redesigned into OT Assistant Practitioner roles and new Job Description (JD) has been developed. Band 4 JD sent for matching on 18.03.2026. Once job matched Band 4 vacancies will be placed onto Trac immediately for financial approval, estimated by 31.03.2026. Once vacancies approved, they will be advertised throughout April, and applicants shortlisted by 08.05.2026. Band 4 interviews are estimated to be scheduled for week commencing 25.05.2026. If conditional offers are made by the end of May 2026 then Band 4 postholders should commence employment by end of July 2026.	Mental Health & Learning Disabilities	31.07.2026	31.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/07/2026.

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Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 13. The health board and local authority must review administrative staffing levels to ensure adequate support for essential CMHT functions.	Healthcare Inspectorate Wales (HIW)/2026/304/MD25/1	Since the HIW inspection all CMHT administrative roles have been recruited to – there are no currently no admin vacancies within the CMHT's. The staff member who was supporting another team has returned to Taff Ely CMHT full time and there is a full-time admin team leader in post covering all CMHT's in RCT.	Mental Health & Learning Disabilities	01.04.2026	01.04.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed 01/04/26' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 14. The health board should engage with staff to ensure they have access to effective IT solutions, including appropriate dictation software, and provide clear guidance to support consistent practice.	Healthcare Inspectorate Wales (HIW)/2026/304/MD26/1	The MH&LD Directorate is presently undertaking a pilot exercise within specialised services to understand the effectiveness of a third-party software package that enable staff to digitally transcribe interviews and conversations. The outcomes from this pilot will be reported through the Improving Care Board and used to inform future service delivery. The MH&LD Directorate has recently appointed a Nursing Information Officer to assist the Digital transformation of MH services. A subsidiary part of that role will be the coordination and alignment of all digital initiatives including use of AI products, thereby allowing clear engagement with and communication to all staff of the opportunity that arise because of wider service improvement.	Mental Health & Learning Disabilities	31.05.2026	30.09.2026	In progress	July 2026 Update - this has been extended to complete 30/09/26. Added to tracker June 2026; In Progress Estimated date of completion 31/05/26.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 15. The health board and local authority must address the risks created by multiple recording systems and ensure that key clinical information is recorded and shared consistently, to support timely, safe and effective care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD27/1	The MH&LD Directorate has recently appointed a Nursing Information Officer to assist the Digital transformation of MH services. This is a Senior leadership role who will work as a Subject matter expert for all aspects of development and implementation of the Mental Health Single Clinical Record (MHSCR), with a particular focus on minimising system variation in conjunction with Local Authority partners, patient safety issues and delivery of effective care across community and inpatient services.	Mental Health & Learning Disabilities	31.05.2028	31.05.2028	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/05/28.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 15. The health board and local authority must address the risks created by multiple recording systems and ensure that key clinical information is recorded and shared consistently, to support timely, safe and effective care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD27/2	In mitigation whilst the MHSCR is under development the Mental Health Directorate will ensure that there is a mechanism in place to ensure that there is available access for all CMHT staff to both LA and HB clinical systems.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 30/04/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 16. The health board must: 16.1 Ensure hospital managers' hearing minutes are completed accurately, to avoid inconsistencies within service users' records. 16.2 Provide additional training to MHA administrative staff to prevent future errors and maintain consistent, reliable documentation.	Healthcare Inspectorate Wales (HIW)/2026/304/MD28/1	The Mental Health Act Team Leader has spoken with the MHA team to ensure that the whole team understand the requirement and is aware of the correct date to complete on the decision. This will be included within the regular MHA documentation audit going forward and findings reported through the MHA operational group.	Mental Health & Learning Disabilities	31.07.2026	31.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/07/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 17. The health board and local authority must ensure multidisciplinary discussions, decision making and key updates are consistently captured within service user records and are accessible to all relevant staff.	Healthcare Inspectorate Wales (HIW)/2026/304/MD29/1	A Mental Health Case recording policy is in the process of ratification with an expected ratification date of 31/04/2026. This includes standards for MDT case recordings.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 - completed evidence attached, signed off at QSE IN June. Added to tracker June 2026; In Progress
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 17. The health board and local authority must ensure multidisciplinary discussions, decision making and key updates are consistently captured within service user records and are accessible to all relevant staff.	Healthcare Inspectorate Wales (HIW)/2026/304/MD29/2	On ratification, the policy will be shared with all staff and an audit tool against the standards will be developed and a regular audit (Recommendation 27) completed to ensure compliance with the standards.	Mental Health & Learning Disabilities	31.10.2026	31.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 17. The health board and local authority must ensure multidisciplinary discussions, decision making and key updates are consistently captured within service user records and are accessible to all relevant staff.	Healthcare Inspectorate Wales (HIW)/2026/304/MD29/3	The Terms of Reference for the Weekly MDT meeting will be amended to include a specific standard ensuring decisions made are added to citizen's WCCS record for RCTCBC	Mental Health & Learning Disabilities	30.06.2026	31.07.2026	Overdue	Added to tracker June 2026; In Progress Estimated date of completion 31/10/2026. July 2026 Update - extended to 31st July 26. Added to tracker June 2026; In Progress Estimated date of completion 31/06/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 18. The health board and local authority must ensure that all records consistently use person centred language that reflects the individual's voice and involvement in planning their care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD30/1	CTP Leads currently provide MHM training that includes a detailed section on service users' voice and involvement.	Mental Health & Learning Disabilities	17.06.2026	17.06.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed Evidence 18.1 Slide and audit compliance' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 18. The health board and local authority must ensure that all records consistently use person centred language that reflects the individual's voice and involvement in planning their care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD30/2	CTP Leads routinely visit teams to review documentation, provide focused feedback and support This action is monitored in the bi-monthly CTP audit (AMaT). Audit compliance for both TECMHT and adult MH services is consistently strong in this area. However, the CTP audit has highlighted need for greater understanding of 1st person, 3rd person and service lead outcomes.	Mental Health & Learning Disabilities	17.06.2026	17.06.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed Evidence 18.2 MHM training schedule' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 18. The health board and local authority must ensure that all records consistently use person centred language that reflects the individual's voice and involvement in planning their care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD30/3	The CTP leads will provide dedicated training to team leads in April 2026 to aid their understanding with an aim to improve compliance in this area to over 80% by September 2026.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed, evidence attached and signed off at QSE JUNE. Added to tracker June 2026; In Progress.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 18. The health board and local authority must ensure that all records consistently use person centred language that reflects the individual's voice and involvement in planning their care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD30/4	CTP Leads oversee any required actions and feedback at the MHM Operational Group for shared action and learning. The CTP leads will work with the LA team managers to develop a process to ensure that all LA audit actions and themes are jointly reviewed and fed through the MHM operational group to ensure shared learning and governance.	Mental Health & Learning Disabilities	30.09.2026	30.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 30/09/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 18. The health board and local authority must ensure that all records consistently use person centred language that reflects the individual's voice and involvement in planning their care.	Healthcare Inspectorate Wales (HIW)/2026/304/MD30/5	RCTCBC line managers check compliance during CTP file audit as part of QA framework.	Mental Health & Learning Disabilities	30.06.2026	30.06.2026	Partially complete (Overdue)	July 2026 Update - Partially completed awaiting evidence to be submitted. Added to tracker June 2026; In Progress Estimated date of completion 30/06/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 19. The health board and local authority must strengthen arrangements for evidencing service users' involvement in care planning, rather than relying on non-response as assumed agreement.	Healthcare Inspectorate Wales (HIW)/2026/304/MD31/1	This will be discussed with the TECMHT at their team meeting on 29/04/2026 and emphasised by the CTP leads during MHM training. Going forward, relevant patients will be supported in person to document their agreement, or disagreement with the CTP, or any aspect of it and this will be evidenced through an in-person signature or through email agreement where appropriate. Where it has not been possible to obtain a signature or reflect agreement then this will be documented with a clear rationale.	Mental Health & Learning Disabilities	29.04.2026	29.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed , evidence attached and QSE signed off in June. Added to tracker June 2026; In Progress Estimated date of completion 29/04/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 19. The health board and local authority must strengthen arrangements for evidencing service users' involvement in care planning, rather than relying on non-response as assumed agreement.	Healthcare Inspectorate Wales (HIW)/2026/304/MD31/2	CTP Leads will support and monitor through team visits and review of documentation. This action is monitored in the bi-monthly CTP audit (AMaT) CTP Leads oversee any required actions and feedback at the MHM Operational Group for shared action and learning. The current Taff Ely CMHT compliance for the signing of CTP's is 80% with the overall care group being 72% with a target of above 80% across the care group by September 2026. The evidencing of agreement with the CTP is stronger with 80% or above across the care group.	Mental Health & Learning Disabilities	30.09.2026	30.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 30/09/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 19. The health board and local authority must strengthen arrangements for evidencing service users' involvement in care planning, rather than relying on non-response as assumed agreement.	Healthcare Inspectorate Wales (HIW)/2026/304/MD31/3	The CTP leads will work with the LA team managers to develop a process to ensure that all LA audit actions and themes are jointly reviewed and fed through the MHM operational group to ensure shared learning and governance.	Mental Health & Learning Disabilities	30.06.2026	31.08.2026	In progress	July 2026 Update - extended for completion August 26. Added to tracker June 2026; In Progress Estimated date of completion 30/06/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 20. The health board and local authority should reflect on the staff feedback provided throughout this report and consider opportunities to strengthen the capacity and effectiveness of the service.	Healthcare Inspectorate Wales (HIW)/2026/304/MD32/1	Please see response to recommendations 9,11,12, and 13	Mental Health & Learning Disabilities	31.07.2027	31.07.2027	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026. See target dates for recommendations 9,11,12, and 13.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 21. The health board and local authority must strengthen joint communication, engagement and information sharing to support coordinated operational and strategic decision making.	Healthcare Inspectorate Wales (HIW)/2026/304/MD33/1	The adult mental health directorate holds a bi-monthly improving care meeting and a bi-monthly strategic partnership forum to improve communication, shared decision making and information sharing. A regional bi-monthly meeting will be established with the Care Group Senior Leadership and Heads/Directors of Adult Services from each LA within CTMUHB to strengthen partnership strategic decision making, communication and shared learning. This will provide partnership escalation and information sharing for the existing.	Mental Health & Learning Disabilities	30.06.2026	30.06.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and evidence attached and signed off at QSE. Added to tracker June 2026; In Progress. Estimated date of completion 30/06/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 22. The health board should co-produce its review of community services and pathways to care with the local authority and service users, to ensure improvements are robust, informed and delivered in a timely way.	Healthcare Inspectorate Wales (HIW)/2026/304/MD34/1	A community mental health service review launch day was held on 26/01/2026 involving all local authority partners. LA partners are engaged within several CMHT improvement workstreams and partnership working with both LA and 3rd sector is a distinct workstream within the redesign. LA partners have been invited to the monthly community redesign forum in order to ensure co-production . The 3 Community Voluntary Council service user engagement officers in CTM are engaged in conversation around how we meaningfully co-produce the work with CMHT service users going forward with a dedicated meeting in place for 03/04/26 to progress the work.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 03/04/26 Evidence 22.1, 22.1.1, 22.2+22.3' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 23. The health board and local authority must: • Undertake a review of staffing capacity across the CMHT and prioritise recruitment to vacant posts. • Engage with staff to discuss how the team's resources can be used more effectively. • Review support worker capacity within the CMHT to ensure that staff can focus on their core professional roles.	Healthcare Inspectorate Wales (HIW)/2026/304/MD35/1	A co-occurring support worker employed in partnership with BAROD a 3rd sector organisation is commencing post on 1st April 2026 Proactive measures are being taken by the HB to employ into identified areas (please see recommendations 11,12,13).	Mental Health & Learning Disabilities	20.03.2026	20.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 20/03/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 23. The health board and local authority must: • Undertake a review of staffing capacity across the CMHT and prioritise recruitment to vacant posts. • Engage with staff to discuss how the team's resources can be used more effectively. • Review support worker capacity within the CMHT to ensure that staff can focus on their core professional roles.	Healthcare Inspectorate Wales (HIW)/2026/304/MD35/2	The RCTCBC AMHP lead has met with team practice and performance managers to discuss review of resources across the RCT area considering use of current resources across the region. An action plan will be developed by end April 2026 and fully implemented with evaluation measures included by end October 2026.	Mental Health & Learning Disabilities	31.10.2026	31.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/10/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 23. The health board and local authority must: • Undertake a review of staffing capacity across the CMHT and prioritise recruitment to vacant posts. • Engage with staff to discuss how the team's resources can be used more effectively. • Review support worker capacity within the CMHT to ensure that staff can focus on their core professional roles.	Healthcare Inspectorate Wales (HIW)/2026/304/MD35/3	DoLS - A Court of Protection prioritisation tool for RCTCBC was created in February 2026 to prioritise community deprivation of liberty applications based on urgency and risk factors, so that people most in need receive a timely response. It provides a framework to categorise cases into high, medium and low priority levels, depending on the severity of the situation and the individual's circumstances. This will be shared with CMHT teams via CMHT team meetings.	Mental Health & Learning Disabilities	31.05.2026	31.05.2026	Fully complete (Awaiting approval)	July 2026 Update - this is fully completed signed off at QSE in July and evidence attached. Added to tracker June 2026; In Progress Estimated date of completion 31/05/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 23. The health board and local authority must: • Undertake a review of staffing capacity across the CMHT and prioritise recruitment to vacant posts. • Engage with staff to discuss how the team's resources can be used more effectively. • Review support worker capacity within the CMHT to ensure that staff can focus on their core professional roles.	Healthcare Inspectorate Wales (HIW)/2026/304/MD35/4	RCTCBC Legal and Social Work Café peer support group has been implemented, this group includes education around the COP flowchart, and quality assurance and governance arrangements.	Mental Health & Learning Disabilities	25.02.2026	25.02.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Complete 25/02/2026 Evidence 23.1' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 23. The health board and local authority must: • Undertake a review of staffing capacity across the CMHT and prioritise recruitment to vacant posts. • Engage with staff to discuss how the team's resources can be used more effectively. • Review support worker capacity within the CMHT to ensure that staff can focus on their core professional roles.	Healthcare Inspectorate Wales (HIW)/2026/304/MD35/5	The Independent Living Support Worker service has referral capacity, information and referral details will be redistributed to all CMHT staff. The Independent Living Support Manager will be invited to all CMHT meetings to remind all staff of the service offer.	Mental Health & Learning Disabilities	30.06.2026	30.06.2026	Fully complete (Awaiting approval)	July 2026 Update - Completed, evidence attached and signed off at QSE in June. Added to tracker June 2026; In Progress. Estimated date of completion 30/06/2026,

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 24. The health board must ensure all outstanding mandatory training is completed and that sufficient training courses, particularly for resuscitation, are made available to support staff compliance and maintain staff and service user safety.	Healthcare Inspectorate Wales (HIW)/2026/304/MD36/1	TECMHT moving and handling compliance is currently 70%, DOLS compliance is 80% and CPR training is 60%. There is availability for HB wide CPR training, though a bespoke training session has been arranged for TECMHT for 10/04/2026, meaning that compliance with CPR training will then be 100%. Moving and handling training is also booked for all, meaning that compliance will be 100% by the end of April. Mandatory training compliance is monitored monthly by senior nurse and directorate manager during team and directorate performance meetings. All outstanding training is addressed through targeted supervision. Current training compliance within TECMHT is 81% and community MH services mandatory training compliance is 82% with an overall improvement trajectory of above 85% by 30/04/2026.	Mental Health & Learning Disabilities	30.04.2026	31.07.2026	Overdue	July 2026 Update - Revised date 31st July 2026. Added to tracker June 2026; In Progress Estimated date of completion 30/04/26.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 25. The local authority should ensure that supervisions and reflective practice are consistently recorded and documented to an appropriate standard.	Healthcare Inspectorate Wales (HIW)/2026/304/MD37/1	The RCTCBC Quality assurance framework which includes supervision and practice standards will be reshared with all Team practice and performance managers. Head of service will address areas of learning from this improvement plan in Team manager forum including: Writing summary of reflective supervision in the supervision document and recording in folders. Requirement for decisions made to be identified as action for recording in Citizen's case notes and by who. Peer supervision record to be formally added to supervision folder.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and signed off QSE in July, evidence attached. Added to tracker June 2026; In Progress Estimated date of completion 30/04/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 25. The local authority should ensure that supervisions and reflective practice are consistently recorded and documented to an appropriate standard.	Healthcare Inspectorate Wales (HIW)/2026/304/MD37/2	Improvements following these actions will be monitored by the Service manager through quarterly supervision audit.	Mental Health & Learning Disabilities	31.07.2026	31.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress. Estimated date of completion 31/07/2026.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 26. The health board and local authority must ensure that records are stored securely in accordance with information governance requirements, and that staff remain vigilant in maintaining safe record handling practices.	Healthcare Inspectorate Wales (HIW)/2026/304/MD38/1	This incident has been investigated and found to be isolated due to human error. All areas have been checked with no other incidents of this type found. Admin staff have been reminded of their responsibilities in regard to Information Governance. All admin staff within TECMHT are in compliance with mandatory information governance training and the overall CMHT admin compliance rate is strong at 92%. This will continue to be monitored through monthly performance meetings.	Mental Health & Learning Disabilities	24.03.2026	24.03.2026	Fully complete (Awaiting approval)	Added to tracker June 2026; this action is marked as 'Completed 24/03/2026 Evidence 26' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/304	13.01.2026	Community Mental Health Team Inspection (Announced) Taff Ely Community Mental Health Team_13 and 14 January 2026	Appendix C – Improvement plan 27. The health board and local authority must work together to establish a robust joint auditing and reporting framework, ensuring both agencies can fully participate in joint assurance processes and strengthen integrated governance arrangements.	Healthcare Inspectorate Wales (HIW)/2026/304/MD39/1	A joint audit framework will be developed across the CMHTs to include CTP audit, case documentation standards and physical health monitoring standards. Findings will be monitored through the MHM operational group and the bimonthly Adult Community MH Quality, Safety and Experience meeting. Any actions will be tracked and implemented through the adult community MH action and learning group which is a joint forum.	Mental Health & Learning Disabilities	31.10.2026	31.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker June 2026; In Progress Estimated date of completion 31/10/2026.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/1	ILS - Ward 21, Ward 22 and PICU are on a trajectory of 85% ILS compliance by 26/05/2026. Training dates have been arranged, and staff have been booked. BLS - Ward 21, Ward 22 and PICU are on a trajectory of 85% BLS compliance by 26/05/2026. All training has been booked.	Mental Health & Learning Disabilities	26.05.2026	26.05.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and signed off at QSE in June, evidence attached. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/2	PMVA - Ward 21, Ward 22 and PICU are on a trajectory of 85% PMVA compliance by 11/05/2026. All training has been booked.	Mental Health & Learning Disabilities	11.05.2026	20.08.2026	In progress	July 2026 Update - PICU and Ward 21 Complete See Evidence 1A(1) Revised Date for Completion for Ward 22 20/08/2026 Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/3	MANUAL HANDLING - Ward 21, Ward 22 and PICU are on a trajectory of 85% Manual Handling compliance by 30/07/2026. Training dates have been arranged, and staff have been booked.	Mental Health & Learning Disabilities	30.07.2026	30.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/4	FIRE TRAINING - Ward 21, Ward 22 and PICU are on a trajectory of 85% Fire training compliance by 24/06/2026. Training dates have been arranged, and staff have been booked.	Mental Health & Learning Disabilities	24.06.2026	28.08.2026	In progress	July 2026 Update - Added to tracker July 2026- Ward 21 and PICU complete See Evidence 1C(1) Revised Date for completion for Ward 22 28/08/2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/5	RAPID TRANQ - Ward 21, Ward 22 and PICU are on a trajectory of 85% Rapid Tranq compliance by 26/04/2026 Training dates have been arranged, and staff have been booked.	Mental Health & Learning Disabilities	26.04.2026	26.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed, evidence attached and signed off at QSE in May. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/6	The ongoing training compliance will be monitored on a weekly basis, the Ward Manager and Senior Nurse will scrutinise the rosters weekly to ensure suitably trained numbers of staff are on duty, this will be subject to a six-month review. This will be shared and overseen in Directorate and Care Group Quality, Safety and Experience (QSE) meetings.	Mental Health & Learning Disabilities	23.10.2026	23.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/7	Ward Managers review all incidents reported on the Datix system daily. Incidents involving restraint are reviewed within the DATIX system and subsequently investigated by the Ward Manager and Senior Nurse. This investigation includes the training compliance of the staff involved. The MHLD Care Group has Datix dashboards that enable staff to easily review themes and trends in Datix incident reporting. Any identified themes, concerns, or issues are escalated through the Directorate QSE meeting to the Care Group QSE to ensure appropriate assurance, awareness, and assurance. Examples of the reports are included in Evidence 1B and 1C(1). Training compliance for all staff is monitored through Directorate and Care Group Integrated Performance Meetings (IPM).	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed and evidence attached and signed off at QSE in May. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/8	Following a review of current processes, the Directorate has implemented amendments to strengthen the quality of information around staff trained in PMVA captured during the daily safe to start huddle, so any identified risks or gaps are addressed, and appropriate mitigations implemented to ensure both staff and patient safety. This ensures the collection of more robust information capture that aligns with the DATIX system, enabling reliable and effective audit processes to be undertaken.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed evidence attached and signed off at QSE in May. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 1. The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety. • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Healthcare Inspectorate Wales (HIW)/2026/307/MD1/9	A sample audit of 20 restraint incidents over a four-month period will be undertaken to ensure that mitigation measures align with the information collected within the daily huddle. Should any shortfalls be identified through the audit process, a repeat audit will be conducted to provide assurance and monitor improvement.	Mental Health & Learning Disabilities	24.05.2026	24.05.2026	Fully complete (Awaiting approval)	July 2026 Update - completed evidence attached and signed off at QSE in May. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 2. The health board must ensure that all staff who use portable BOC oxygen cylinders receive competency-based training on their safe use across all health board services.	Healthcare Inspectorate Wales (HIW)/2026/307/MD2/1	The Health Board has urgently reviewed options to rapidly increase staff compliance in Medical Gas Training which includes BOC oxygen competencies. An email has been cascaded to all staff on the wards to remind them of the medical gases policy for awareness. The Policy has also been added to the agenda of all upcoming Ward Meetings.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed, evidence attached signed off in QSE in June. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 2. The health board must ensure that all staff who use portable BOC oxygen cylinders receive competency-based training on their safe use across all health board services.	Healthcare Inspectorate Wales (HIW)/2026/307/MD2/2	The Adult Unscheduled Care Directorate will rapidly improve staff compliance with Medical Gas Safety Training delivered via the ESR module, strengthening Care Group assurance and reducing risk related to the safe use, storage, and set-up of medical gases and cylinders with a trajectory to complete by 09/05/2026.	Mental Health & Learning Disabilities	09.05.2026	09.05.2026	Fully complete (Awaiting approval)	July 2026- completed evidence attached signed off at QSE in June. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 2. The health board must ensure that all staff who use portable BOC oxygen cylinders receive competency-based training on their safe use across all health board services.	Healthcare Inspectorate Wales (HIW)/2026/307/MD2/3	This will be monitored through the Directorate Quality, Safety and Experience (QSE) meeting. Any identified themes, concerns, or issues are escalated to the CARE Group QSE to ensure appropriate governance, oversight, and assurance.	Mental Health & Learning Disabilities	04.06.2026	04.08.2026	In progress	July 2026 Update - Revised Date for Completion 04/08/2026. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment's inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/1	On 16/04/26, inpatient ward managers were issued with estates logs for their respective ward areas and undertook a comprehensive baseline review to confirm that all environmental, ligature and IPC issues were accurately captured. Ward staff remain responsible for promptly identifying and recording hazards or faults.	Mental Health & Learning Disabilities	16.04.2026	16.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 16/04/2026 See Evidence 3A (1) ' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/2	Ongoing monitoring and assurance of estates and environmental risks will be undertaken through directorate Integrated Performance Meeting (IPM), to support shared ownership and visibility. Directorate reporting is supported by a detailed estates risk appendix, detailing risk status, mitigation, escalation points and outstanding actions, supplemented by a concise summary narrative. This ensures oversight extends beyond high-level metrics and supports effective prioritisation and decision-making.	Mental Health & Learning Disabilities	27.04.2026	27.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed evidence attached and signed off at QSE in June. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/3	Following receipt of the validated report of outstanding maintenance issues, Estates and Facilities teams commenced immediate remedial action from 17/04/26. A total of 167 maintenance issues were identified across Ward 21, Ward 22 and the PICU.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/04/2026 See Evidence 3C' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/4	To strengthen oversight and ensure that mitigation actions are robust and sufficient, an extraordinary risk register meeting has been scheduled for 27/04/26, specifically focusing on inpatient environmental risks, in direct response to the HIW Immediate Action. The purpose of this meeting is to undertake a detailed review of existing risk register entries, identify any risks not currently captured, and agree a clear and strengthened action plan to mitigate risk pending full resolution.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/04/2026 See Evidence 3B' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/5	Quotes for replacement curtain rails and window blinds for areas without appropriate curtains were obtained, and orders placed 23/04/26.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/04/2026 See Evidence 3D' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/6	Existing curtains have been replaced by the Facilities team where required and a curtain monitoring schedule implemented by Facilities management.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/04/2026 See Evidence 3E' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/7	Hand soap dispensers have been ordered for all patient bedrooms and communal water closets. As an immediate interim measure, the directorate procured hand soap directly and distributed it to these areas to ensure continuity of IPC controls.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/04/2026 See Evidence 3F' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/8	Estates works have progressed, to enable out-of-order bathroom and toilet facilities to be returned to full service, with actions monitored through special estates and clinical governance arrangements. All wards have both female and male bathrooms open.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/04/2026 See Evidence 3G' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/9	The MH&LD Care Group has committed to revise and formally approve the Maintenance of Mental Health Premises policy by the end of May 2026. This revision will specifically reflect enhanced escalation procedures, assurance requirements and clarified responsibilities in relation to the management of environmental and estates risks within mental health inpatient settings.	Mental Health & Learning Disabilities	30.05.2026	01.09.2026	In progress	July 2026 Update - Revised Date for Completion 01/09/2026. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/10	A safe system of work has been implemented to strengthen governance and oversight. This includes clearer assurance reporting, enhanced monitoring of long-standing and unresolved estates risks and defined senior management oversight through established directorate and Health Board governance routes. Together, these actions strengthen both the immediate operational controls and the longer-term policy framework, supporting sustained oversight.	Mental Health & Learning Disabilities	23.04.2026	23.04.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/04/2026 See Evidence 3H' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/11	A meeting was held 23/04/26 attended by the MHLD Senior Leadership team and senior Estates colleagues where it was agreed to instigate a review of estates resources and capacity.	Mental Health & Learning Disabilities	30.07.2026	30.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/12	Arrangements have been put in place to review and strengthen controls associated with the mental health inpatient environment risk held on the Health Board risk register since 2018. An extraordinary risk register meeting has been scheduled for 27/04/26 to focus specifically on inpatient environmental risks, in direct response to the HIW immediate Action. The purpose of this meeting is to undertake a detailed review of existing risk register entries relating to the inpatient environment, to identify any risks that are not currently captured, and to agree a clear and strengthened action plan to mitigate the risk. This will include reviewing the adequacy of current controls, clarifying ownership, and establishing actions and timescales sufficient to support risk reduction and, where appropriate, risk closure. The outcomes of the meeting will be reflected through updated risk register entries and strengthened governance arrangements, ensuring that longstanding environmental risks are subject to sustained senior oversight, clear escalation, and ongoing monitoring until effectively mitigated.	Mental Health & Learning Disabilities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	July 2026 Update - completed evidence attached and signed of in QSE in June. Added to tracker 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix B – Immediate improvement plan 3. The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment’s inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk.	Healthcare Inspectorate Wales (HIW)/2026/307/MD3/13	This will be shared within the Directorate Quality, Safety and Experience (QSE) meeting. Any identified themes, concerns, or issues are escalated to the CARE Group QSE to ensure appropriate governance, oversight, and assurance.	Mental Health & Learning Disabilities	17.06.2026	17.06.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 1. The health board must ensure the patient experience feedback is reviewed and used to implement timely and sustained improvements.	Healthcare Inspectorate Wales (HIW)/2026/307/MD4/1	The Adult Directorate will review and update the current patient feedback questionnaire, and develop a consistent feedback form and mechanism, incorporating a “You Said, together we” format.	Mental Health & Learning Disabilities	06.07.2026	30.08.2026	In progress	July 2026 Update - Revised Estimated Date of Completion 30/08/2026. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 1. The health board must ensure the patient experience feedback is reviewed and used to implement timely and sustained improvements.	Healthcare Inspectorate Wales (HIW)/2026/307/MD4/2	This will be shared within the Ward Managers’ monthly report and shared within the Directorate Quality, Safety and Experience (QSE) group.	Mental Health & Learning Disabilities	30.08.2026	30.08.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 2. The health board must ensure consistent access to outdoor space for all patients, supported by appropriate staffing and timely completion of environmental works.	Healthcare Inspectorate Wales (HIW)/2026/307/MD5/1	Within the Royal Glamorgan Hospital, patients have unrestricted access to outdoor areas between 07:00 and midnight. Access outside of these hours is available upon request, dependent on risk. Patient information notices outlining this access are displayed across all wards. At the time of the HIW inspection, the PICU outside area was unavailable due to ongoing refurbishment and maintenance works, requiring patients to use the outdoor space on Ward 22. These works were completed on 28th May 2026, and unrestricted access to the PICU patio has since been fully reinstated.	Mental Health & Learning Disabilities	15.06.2026	15.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as ‘Complete 15/06/2026 Appendix 2 Appendix 2a’ as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 3. There was no structured programme of therapeutic activities in place across the three wards.	Healthcare Inspectorate Wales (HIW)/2026/307/MD6/1	Whilst recruitment to the Activity Worker post is ongoing, interim measures have been implemented to ensure patients continue to receive meaningful therapeutic engagement. These include assigning a named HCA from a ward within the unit for each shift to coordinate and facilitate activities, ensuring consistent delivery. To develop and introduce a structured weekly activity timetable across the acute wards.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as ‘Complete 22/06/2026 Appendix 3 Appendix 3a Appendix 3b’ as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 4. The health board must continue robust recruitment to the vacant activities coordinator post to support the planning and delivery of therapeutic activities.	Healthcare Inspectorate Wales (HIW)/2026/307/MD7/1	The Mental Health Directorate has re-advertised the post and placed the vacant Activity Coordinator position out for advert. Anticipated to recruit by end September 2026.	Mental Health & Learning Disabilities	30.09.2026	30.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 5. The health board must review the Occupational Therapy provision for the PICU to ensure patients have equitable access to therapeutic input in line with recovery-focused care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD8/1	The Health Board will undertake a review of Occupational Therapy provision within PICU to determine how equitable access for patients can be achieved. This will include jointly scoping the feasibility of the current 0.6 WTE Band 6 Occupational Therapist post working across both PICUs/sites. It is recommended that this work is jointly led by the Senior Nurse and the Principal Occupational Therapist.	Mental Health & Learning Disabilities	13.07.2026	31.08.2026	In progress	July 2026 Update - revised date 31st August 2026. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 5. The health board must review the Occupational Therapy provision for the PICU to ensure patients have equitable access to therapeutic input in line with recovery-focused care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD8/2	Should the scoping exercise determine that it is not feasible for the current part-time PICU Occupational Therapist post to deliver a service across two sites, a broader review of Occupational Therapy provision within Adult Mental Health services will be required. This should be undertaken jointly by the AMH Directorate and the Occupational Therapy Service to explore opportunities for redistribution of existing posts or consideration of skill mix within current or forthcoming vacancies.	Mental Health & Learning Disabilities	01.12.2026	01.12.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 6. The health board must ensure Patient Status ‘at a Glance board’ are consistently kept closed when not in use, to protect patient confidentiality.	Healthcare Inspectorate Wales (HIW)/2026/307/MD9/1	Risk currently sitline within the Health Board Risk Register 6297. The health board must ensure Patient Status ‘at a Glance board’ are consistently kept closed when not in use, to protect patient confidentiality. The Status ‘at a Glance board’ is now covered when not in use.	Mental Health & Learning Disabilities	13.06.2026	13.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as ‘Complete 13/06/2026 Appendix 6 Appendix 6b’ as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 6. The health board must ensure Patient Status ‘at a Glance board’ are consistently kept closed when not in use, to protect patient confidentiality.	Healthcare Inspectorate Wales (HIW)/2026/307/MD9/2	In addition, ongoing monitoring will be undertaken through a monthly Senior Nurse spot-check audit, with findings reviewed over a three month period and reported via the Directorate Quality, Safety and Experience (QSE) meeting.	Mental Health & Learning Disabilities	30.08.2026	30.08.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 7. The health board must review shared bedrooms and mixed-gender accommodation on Wards 21 and 22 to ensure patients’ privacy and dignity are supported and aligned with modern mental health care provision.	Healthcare Inspectorate Wales (HIW)/2026/307/MD10/1	On Ward 21 and 22 there are multi occupancy bedrooms, but these are never mixed sex. Ward 21 and 22 also have separate male and female toilets. A Safe System of work has been implemented across the inpatient service and this process is being adhered to	Mental Health & Learning Disabilities	12.06.2026	12.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as ‘Complete 12/06/2026 Appendix 7’ as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 8. The health board must ensure that clear, accessible and up-to-date patient information is consistently available and clearly displayed across all wards.	Healthcare Inspectorate Wales (HIW)/2026/307/MD11/1	All signage has been reviewed, and notice boards are updated.	Mental Health & Learning Disabilities	06.07.2026	31.08.2026	In progress	July 2026 Update - revised date 31st August 2026. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 8. The health board must ensure that clear, accessible and up-to-date patient information is consistently available and clearly displayed across all wards.	Healthcare Inspectorate Wales (HIW)/2026/307/MD11/2	This will be monitored via the monthly Ward Manager and Senior Nurse audit which will be reviewed over a 3-month period and be reported via the Directorate Quality, Safety and Experience (QSE) meeting.	Mental Health & Learning Disabilities	01.10.2026	01.10.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 9. The health board must provide appropriate facilities, equipment and support to ensure equitable access to care for patients with mobility difficulties.	Healthcare Inspectorate Wales (HIW)/2026/307/MD12/1	All acute inpatient wards are equipped with assisted en-suite shower facilities to support patients with mobility needs. Due to the existing footprint and configuration of Ward 21, it is not feasible to provide a designated assisted bathroom within this area. Patients with mobility needs are rarely admitted; however, should such a requirement arise, a risk assessment and appropriate care plan would be completed. The patient would then be transferred to the most suitable ward to ensure their needs are met safely and effectively.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as ‘Complete 22/06/2026 Appendix 9’ as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 10. The health board must: • Strengthen governance oversight and quality assurance processes to ensure environmental checklists are fully, accurately and consistently completed on all wards. • Implement clear processes to ensure issues identified through the checklists are escalated and addressed; • Implement and maintain a formal, embedded senior manager quality walk-round process to provide regular oversight and assurance of environmental safety.	Healthcare Inspectorate Wales (HIW)/2026/307/MD13/1	July - revised completion date 31st August A single checklist proforma will be shared across all the adult inpatient wards.	Mental Health & Learning Disabilities	10.07.2026	10.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 10. The health board must: • Strengthen governance oversight and quality assurance processes to ensure environmental checklists are fully, accurately and consistently completed on all wards. • Implement clear processes to ensure issues identified through the checklists are escalated and addressed; • Implement and maintain a formal, embedded senior manager quality walk-round process to provide regular oversight and assurance of environmental safety.	Healthcare Inspectorate Wales (HIW)/2026/307/MD13/2	A reminder email has been circulated to all staff to remind them to complete the current checklist proforma. This message will also be reinforced through the ward safety brief during daily handovers and at team meetings to ensure consistent communication and awareness across all staff groups. A clear and structured escalation and assurance process has been implemented in line with the Mental Health Premises SOP. All environmental issues identified through ward checklists are recorded via a standardised process, with defects logged onto the central Mh&LD Care Group Estates Log to ensure a single, auditable record of all environmental risks.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as ‘Complete 22/06/2026 Appendix 10a Appendix 10b’ as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 10. The health board must: • Strengthen governance oversight and quality assurance processes to ensure environmental checklists are fully, accurately and consistently completed on all wards. • Implement clear processes to ensure issues identified through the checklists are escalated and addressed; • Implement and maintain a formal, embedded senior manager quality walk-round process to provide regular oversight and assurance of environmental safety.	Healthcare Inspectorate Wales (HIW)/2026/307/MD13/3	A formal monthly senior manager environmental walk-round process has been implemented across all adult inpatient wards. These walk-rounds are jointly undertaken by the Senior Nurse and Operational/Support Manager and recorded within the MH Estates log and the Adult Acute H&S, IP&C, FRA Action Log, which is discussed in Directorate Quality, Safety & Experience (QSE) Meeting. A defined escalation pathway has been embedded captured within the SOP, to ensure issues are actively progressed and resolved. Where works are not completed within agreed timeframes, these are escalated through a formal route to ensure timely resolution and oversight of risk. These are shared within the Care Group Integrated Performance Meeting (IPM).	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 10c Appendix 10d Appendix 10e Appendix 10f' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 11. The health board must review the ward configuration to ensure that access arrangements minimise through-traffic and mitigate the impact on patient privacy, dignity and safety, supporting a safe and therapeutic ward environment.	Healthcare Inspectorate Wales (HIW)/2026/307/MD14/1	This risk is recorded on the Health Board Risk Register (ID 6611) and relates to the use of Ward 21 as a through-route to other wards within the inpatient environment. A controlled access system remains in place, with all entry and exit managed by staff to maintain oversight of movement through the ward. When risks increase staff deployment has been adapted to ensure a consistent presence within key areas of the ward, supporting patient observation, managing access, and enabling early identification and de-escalation of risk behaviours. Environmental mitigation measures continue to be progressed, including improvements to line of sight (e.g. installation of observation mirrors). Patient flow and access arrangements are actively managed on a day-to-day basis, with use of alternative ward space, escorted movement where appropriate, and clear staff oversight to minimise disruption and maintain a safe and therapeutic environment. This position is supported through ongoing monitoring via the risk register and senior management oversight to ensure the risk is actively managed and remains under review.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 12. The health board must strengthen leadership and governance arrangements to ensure all ward areas are effectively cleaned and monitored. This must include providing clear guidance to nursing and housekeeping staff to ensure a shared understanding of roles, responsibilities and accountability for maintaining IPC standards.	Healthcare Inspectorate Wales (HIW)/2026/307/MD15/1	The Facilities Manager within the Royal Glamorgan Hospital has reported that at present the update of The Health Board's Cleanliness Standard Roles, Responsibilities and Audit Tool Procedure is on hold until the publication of the New National Standards for Cleaning in NHS Wales. The current policy is still appropriate at this time based on current funding /standards. The Cleanliness Standard Roles, Responsibilities and Audit Tool Procedure has been shared with all staff via email and will be reinforced via the ward safety brief at daily handovers and team meetings. A monthly cleaning audit is currently conducted by the Housekeeping Supervisor. To enhance this process, the audit will now be carried out jointly with the Ward Manager. Audit results will be shared with staff and displayed on the ward for patient/carer information. Planned quarterly interface meeting between housekeeping services and Senior Nurse for Inpatient teams has been agreed.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 12 Appendix 12a, 12b Appendix 12c A' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 13. The health board must ensure that staff have consistent access to suitable cleaning and decontamination equipment to support safe and effective cleaning of the wards.	Healthcare Inspectorate Wales (HIW)/2026/307/MD16/1	Access to out-of-hours housekeeping services is available when required. Details on how to access this service have been communicated to all staff via email. This information will be reinforced during daily safety briefings at handover, as well as in staff meetings. Access to appropriate cleaning and decontamination equipment outside of standard housekeeping hours is now available to staff as required. Guidance on how to access these items has been communicated to all staff via email. This information will be reinforced through the ward safety brief at daily handovers and in team meetings. Out of hours contact numbers are on displayed on the ward.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 13 and 13a Appendix 13b' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 14. The health board must ensure clear arrangements for the decontamination of shared equipment and facilities, including appropriate labelling to indicate when items are clean and safe for use.	Healthcare Inspectorate Wales (HIW)/2026/307/MD17/1	An email reminder has been issued to all staff outlining the expected standards. This will be reinforced through the ward safety brief during daily handovers, as well as in team meetings.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 14, 14a' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 14. The health board must ensure clear arrangements for the decontamination of shared equipment and facilities, including appropriate labelling to indicate when items are clean and safe for use.	Healthcare Inspectorate Wales (HIW)/2026/307/MD17/2	Senior Nurse will complete a monthly audit and report any concerns or issues through Quality, Safety & Experience Meeting (QSE). This will be reviewed within 3 months.	Mental Health & Learning Disabilities	30.09.2026	30.09.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 15. The health board must ensure annual IPC audits are completed at the required frequency and used to monitor, review and improve IPC practice across all wards.	Healthcare Inspectorate Wales (HIW)/2026/307/MD18/2	Following discussion with the Infection Prevention and Control (IPC) team within the Health Board, annual audits are not routinely undertaken. Instead, audits are completed in line with AMAT scores as part of the ward manager's monthly schedule, including environmental audits. In addition, spot-check audits are carried out. A date had been scheduled for an IPC audit to be carried out on the Ward 22, following HIW inspection, action plan given to Senior Nurse.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 15 Appendix 15a' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 16. The health board must ensure all staff complete and remain compliant with mandatory IPC training to support consistent practice across all wards.	Healthcare Inspectorate Wales (HIW)/2026/307/MD19/1	Mandatory IPC Training compliance Ward 21 – 92.8% Ward 22 – 94.1% PCU RGH – 100% This will be reported via the Directorate Quality, Safety and Experience (QSE) meeting.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 16 Appendix 16a Appendix 16b' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 17. The health board must review laundry arrangements on Wards 21 and 22 to support IPC, timely access to clean clothing and patient dignity.	Healthcare Inspectorate Wales (HIW)/2026/307/MD20/1	The Directorate has commissioned the upgrade of laundry facilities for patient use, including the installation of 2 washing machines and 2 tumble dryers. A purchase order has been raised for the required electrical infrastructure works, with Estates progressing installation of the necessary sockets to enable commissioning of the equipment. Installation is dependent on contractor mobilisation, with Estates currently confirming a start date. Once electrical works are complete, the equipment will be installed and brought into use, restoring on-ward laundry provision and improving patient access and dignity. Additionally, mitigation measures are in place where washing facilities are available on alternative area within the MH unit.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 17' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 18. The health board must review the emergency medication storage arrangements on Ward 21 to ensure emergency drugs are readily accessible and can be accessed without delay.	Healthcare Inspectorate Wales (HIW)/2026/307/MD21/1	The storage of emergency medication on Ward 21 has now been lowered and is readily accessible for staff use.	Mental Health & Learning Disabilities	15.06.2026	15.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 15/06/2026 Appendix 18' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 19. The health board must ensure ward food and drink equipment is fit for purpose to support patients' nutritional and hydration needs and reduce avoidable pressure on staff.	Healthcare Inspectorate Wales (HIW)/2026/307/MD22/1	Following the HIW inspection the tea trolley on Ward 21 has since been repaired.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 19' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 19. The health board must ensure ward food and drink equipment is fit for purpose to support patients' nutritional and hydration needs and reduce avoidable pressure on staff.	Healthcare Inspectorate Wales (HIW)/2026/307/MD22/2	Arrangements are in place for the replacement of the hot water dispenser on Ward 22. Ward 22 have access to a tea trolley which is in use on the ward.	Mental Health & Learning Disabilities	31.07.2026	31.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 20. The health board must reflect on the staff feedback outlined in this report and identify improvements to support staff experience and sustain high-quality patient care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD23/1	The findings from the staff questionnaire will be escalated to the Senior Management Team (SMT) for review and discussion. An action plan will be developed in response to the feedback, focusing on addressing key areas of concern, improving staff experience, and supporting the delivery of high quality patient care. In addition to this, all furniture has now been ordered. Compassionate Leadership sessions have been delivered, and implementing Safe Wards training has been completed across all wards. We have seen significant improvement through staff participation in the Compassionate Leadership sessions, which focus on ensuring all staff feel valued, supported, and understood. This approach promotes empathy and strengthens teamwork, ultimately helping to ensure patients receive exceptional care. Furthermore, Safe Wards training has been implemented. This is an evidence-based model for inpatient settings that aims to reduce conflict between staff and patients, contributing to a safer and more therapeutic environment.	Mental Health & Learning Disabilities	30.07.2026	30.07.2026	Overdue	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 20. The health board must reflect on the staff feedback outlined in this report and identify improvements to support staff experience and sustain high-quality patient care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD23/2	In addition, the CTM Speak Up Safety Initiative has been shared through team briefings and the Adult Directorate Staff Newsletter, providing staff with a clear and accessible route to raise queries and concerns.	Mental Health & Learning Disabilities	03.06.2026	03.06.2026	Fully complete (Awaiting approval)	July 2026 Update - completed, evidence attached and signed off at QSE in July. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 21. The health board must consider the feedback regarding senior management visibility and communication and implement improvements to foster a more collaborative approach to patient care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD24/1	A joint Senior Nurse/ Operational manager visit is undertaken weekly.	Mental Health & Learning Disabilities	09.06.2026	09.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 9/06/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 21. The health board must consider the feedback regarding senior management visibility and communication and implement improvements to foster a more collaborative approach to patient care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD24/2	A Monthly 'Cuppa and a Chat' staff drop-in sessions have been implemented and will be facilitated by the Senior Nurse. In addition, the MHLd Care Group host a monthly Q&A session, which has been circulated within the Care Group via the Business Support Team.	Mental Health & Learning Disabilities	23.06.2026	23.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/06/2026 Appendix 21 Appendix 21b' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 21. The health board must consider the feedback regarding senior management visibility and communication and implement improvements to foster a more collaborative approach to patient care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD24/3	A Lead Nurse monthly visiting schedule (rolling programme) has been implemented any concerns and recurring themes will be escalated and discussed within the Senior Management Team (SMT).	Mental Health & Learning Disabilities	23.06.2026	23.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 23/06/2026 Appendix 21a' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 22. The health board must continue robust recruitment to vacant posts to strengthen staffing stability, reduce workforce pressures and support safe, effective patient care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD25/1	The below are the current vacancies within the inpatient wards of Royal Glamorgan Hospital: Ward 21 1 x Band 6. 0.5 Band 5 RMN. 0.4 Band 2 HCA 1 Activity Worker. Ward 22 6 x Band 5 RMN. 2 on Trac 4 x Streamlining for September intake. PICU No vacancies The Health Board has an agreed arrangement for a streamlining process, with these posts currently being progressed for the September intake to support newly qualified staff nurses. All remaining vacancies have been advertised on Trac and are progressing through the recruitment process. It is anticipated that all vacant posts will be filled by October 2026. All vacancies are reported through the Directorate Integrated Performance Meeting.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 23. The health board must engage with staff to review the impact of service reconfiguration and ensure staffing levels and support arrangements meet patient needs and promote staff wellbeing, team cohesion and the consistent delivery of effective care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD26/1	A meeting has been arranged 29/07/2026 with the Senior Nurse and Lead Nurse and Operational Manager to engage with staff and discuss the impact of the service reconfiguration on workload, staffing and morale. In addition, Leadership visibility will be strengthened through regular Senior Nurse, Operational Manager walkarounds and Lead Nurse visits.	Mental Health & Learning Disabilities	23.06.2026	23.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 23' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 23. The health board must engage with staff to review the impact of service reconfiguration and ensure staffing levels and support arrangements meet patient needs and promote staff wellbeing, team cohesion and the consistent delivery of effective care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD26/2	Concerns and recurring themes will be escalated and discussed within the Senior Management Team (SMT). Concerns and recurring themes will be escalated and discussed within the Senior Management Team (SMT). Feedback and agreed actions will be communicated through the Acute Senior Leadership Team (SLT), cascaded to Ward Manager forums, and shared with staff through local ward team meetings and staff briefings to ensure visibility of actions taken and ongoing improvements.	Mental Health & Learning Disabilities	17.08.2026	17.08.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 24. The health board must review staffing levels and access to psychology and occupational therapy services across mental health wards to ensure the consistent delivery of effective, person centred care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD27/1	A Nursing establishment review was completed and monitored through the Nursing workforce meeting.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 24. The health board must review staffing levels and access to psychology and occupational therapy services across mental health wards to ensure the consistent delivery of effective, person centred care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD27/2	Staffing requirements are determined on a day-by-day basis and when additional staff are required to meet the needs of the patients then additional staffing requests are submitted. All requests since the implementation of the new staffing establishment have been approved.	Mental Health & Learning Disabilities	24.06.2026	24.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 24/06/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 24. The health board must review staffing levels and access to psychology and occupational therapy services across mental health wards to ensure the consistent delivery of effective, person centred care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD27/3	OT The Senior Nurse and Principal Occupational Therapist will jointly lead a scoping exercise to assess the feasibility of the current 0.6 WTE Band 6 Occupational Therapist post operating across two PICU sites. Should the outcome indicate that it is not feasible for the existing part time PICU OT role to deliver a service across both sites, a wider review of OT provision within Adult Mental Health services will be undertaken. This will be a collaborative review between the AMH Directorate and the OT Service to explore opportunities for redistribution of existing posts or consideration of skill mix adjustments in relation to any vacancies within the Directorate	Mental Health & Learning Disabilities	01.12.2026	01.12.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 24. The health board must review staffing levels and access to psychology and occupational therapy services across mental health wards to ensure the consistent delivery of effective, person centred care.	Healthcare Inspectorate Wales (HIW)/2026/307/MD27/4	Psychology At present, our service is operating with a reduced establishment, which has impacted our capacity to fully meet demand. We have conducted a review of staffing levels and service needs and have put mitigations in place to support continuity of care and maintain service delivery as safely and effectively as possible. Vacancies for an Art Psychotherapist and maternity cover for a Band 7 CAAPs roles have now been placed on Trac, and we are prioritising these appointments to stabilise the workforce and improve resilience within the service going forward. In the interim, we are continuing to utilise available resources flexibly, alongside prioritisation processes, to ensure that risk is managed appropriately and that service users receive the most urgent care required. In addition, training had been provided to frontline acute staff over the last 12 months in regard to a relational model of psychological care, with team formulations and reflective practice utilising this model in place to ensure a safe psychological environment. This will continue to be built on through the next year with the addition of training available to acute staff to further develop a psychologically skilled and trauma-informed workforce across acute services in Cwm Taf Morgannwg.	Mental Health & Learning Disabilities	31.08.2026	31.08.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 25. The health board must implement robust measures to ensure that all outstanding mandatory training is completed, regularly monitored, and that staff receive appropriate support to complete training in a timely manner.	Healthcare Inspectorate Wales (HIW)/2026/307/MD28/1	All Ward Managers are responsible for actively monitoring, supporting, and evidencing staff compliance with mandatory training requirements. To support improvement, targeted measures have been implemented, including the provision of protected time to enable staff to complete training and improve access and overall compliance. This is shared within the Ward Managers report following monthly audit. Additionally, to further strengthen compliance monitoring and governance, an automated reminder system has been implemented for Ward Managers. A bi-weekly reminder is issued via the Adult Mental Health Business Support calendar, prompting Ward Managers to review and update their mandatory training compliance and trajectory data. The communication includes a direct link to the live SharePoint compliance documents, ensuring timely access to the most up-to-date information and supporting accurate reporting and oversight. This automated approach reinforces accountability and promotes consistent updating of compliance records across all wards. Compliance is regularly monitored and reviewed through Care Group Integrated Performance Meetings (IPM) to ensure sustained oversight and accountability.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 26, 36a and 36b, Appendix 26c' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 27. The health board must ensure that policies and procedures are reviewed and updated in a timely manner to provide clear, current and reliable guidance for staff.	Healthcare Inspectorate Wales (HIW)/2026/307/MD29/1	All Mental Health policies are monitored by the Mental Health Learning Disability (MHLd) Policy Review Group which has an operational scope to: •Review & RAG of all existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review When due for renewal, policies are assigned to an expert group for update, review, and completion, before being sent back to the MHLd Policy Group for ratification. At the time of the HIW inspection, eight policies were identified as out of date or in draft, comprising two Mental Health-specific policies and six Health Board-wide policies.	Mental Health & Learning Disabilities	01.12.2026	01.12.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 27. The health board must ensure that policies and procedures are reviewed and updated in a timely manner to provide clear, current and reliable guidance for staff.	Healthcare Inspectorate Wales (HIW)/2026/307/MD29/2	HB wide policies are the responsibility of the policy authors to ensure timely reviews of written control documents within their areas. This is set out in the Policy for the Development, Review and Approval of Organisational Wide Policies. The policy programme is currently under review and aims to introduce an additional step where reminders will be issued to the policy leads ahead of the policy passing its review period.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Overdue	July 2026 Update - estimated completion date 1st Dec 2026. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 28. The health board must ensure that staff meetings are regularly held on the PICU and that records are maintained to evidence regular staff engagement and communication.	Healthcare Inspectorate Wales (HIW)/2026/307/MD30/1	Within PICU RGH, monthly staff meetings are now in place. Following every meeting minutes will be shared with all staff.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 28' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 29. The health board must: • Display clear information about how patients can provide feedback and raise concerns. • Ensure regular patient meetings are held on all wards and are consistently documented. • Strengthen systems to record, address and provide feedback about actions taken in response to issues raised. • Provide governance oversight to assure patient and family/carer feedback is used to inform service improvement.	Healthcare Inspectorate Wales (HIW)/2026/307/MD31/1	Information has been displayed within our notice boards on how patients can provide feedback and raise concerns.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 29' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 29. The health board must: • Display clear information about how patients can provide feedback and raise concerns. • Ensure regular patient meetings are held on all wards and are consistently documented. • Strengthen systems to record, address and provide feedback about actions taken in response to issues raised. • Provide governance oversight to assure patient and family/carer feedback is used to inform service improvement.	Healthcare Inspectorate Wales (HIW)/2026/307/MD31/2	Weekly patient meetings are in place across the inpatient ward with notices displayed for patient awareness.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026 Appendix 29a' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 29. The health board must: • Display clear information about how patients can provide feedback and raise concerns. • Ensure regular patient meetings are held on all wards and are consistently documented. • Strengthen systems to record, address and provide feedback about actions taken in response to issues raised. • Provide governance oversight to assure patient and family/carer feedback is used to inform service improvement.	Healthcare Inspectorate Wales (HIW)/2026/307/MD31/3	"You said we did" board will be implemented across the inpatient wards to provide feedback to patient.	Mental Health & Learning Disabilities	31.08.2026	31.08.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 29. The health board must: • Display clear information about how patients can provide feedback and raise concerns. • Ensure regular patient meetings are held on all wards and are consistently documented. • Strengthen systems to record, address and provide feedback about actions taken in response to issues raised. • Provide governance oversight to assure patient and family/carer feedback is used to inform service improvement.	Healthcare Inspectorate Wales (HIW)/2026/307/MD31/4	Following feedback from patient meetings, this will be reviewed on a monthly basis, reported within the Ward Manager's report, and used within the 'You Said, We Did' approach to inform service improvement, with outcomes shared at Senior Management Team (SMT) and Quality, Safety and Experience (QSE) meeting.	Mental Health & Learning Disabilities	31.08.2026	31.08.2026	In progress	September 2026 Update - No update against this recommendation action has been received on this occasion. Added to tracker July 2026
Healthcare Inspectorate Wales (HIW)/2026/307	13.04.2026	Hospital Inspection Report (Unannounced)_Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital_13, 14 and 15 April 2026 (ref: 03925)	Appendix C – Improvement plan 30. The health board must take robust action to implement the recommendations set out in this report and ensure that improvements are embedded and sustained.	Healthcare Inspectorate Wales (HIW)/2026/307/MD32/1	The Care Group has developed a governance framework to ensure all recommendations from the inspection are actioned, monitored and sustained. A centralised improvement plan tracker has been established, with named responsible leads, clear timescales and RAG-rated progress updates. Performance against the plan will be reviewed monthly through the Directorate Quality, Safety and Risk Meeting and escalated through Care Group governance structures as required.	Mental Health & Learning Disabilities	22.06.2026	22.06.2026	Fully complete (Awaiting approval)	Added to tracker July 2026; this action is marked as 'Complete 22/06/2026' as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 22nd September 2026 as completed.



Quality, Safety & Experience Committee

CTMUHB IPFR Annual Report 2025-26

Eitem yr Agenda / Agenda Item	6.2.2
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Commissioning Support Officer, Commissioning Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Philip Daniels, Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	N/A
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	Improving Care
	If more than one applies, please list below: Creating Health
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	The All-Wales IPFR Policy supports Health Boards statutory obligation to ensure the population of Wales has access to healthcare that meets their needs.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhwylu'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)

Provide an annual update on the All-Wales IPFR Policy in relation to CTMUHB residents accessing health care via the policy.

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 assurance that CTMUHB is fulfilling it's statutory obligation and provides activity trend details.

We have seen a slight decrease in applications submitted in 2025/26 compared to the previous year. It is not known at present whether this trend is similar to that in other health boards across Wales. The AWTTC IPFR Annual report (2025/26) is due for publication later this year, when an assessment will be undertaken to understand if there has been any change in the number of IPFR cases at an All-Wales level.

Please note, even though there was a slight decrease in applications, the PAR and IPFR budget has consistently overspent in the last two years. Please refer to 2.5.2.

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

This report is for noting.

made)

Argymhelliad (Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).

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

This report is for noting.

1 Background / Context

1.1 This report briefs Board members of the decisions made by the Cwm Taf Morgannwg University Health Board (CTM) Individual Patient Funding Request (IPFR) panel during 2025/26.

1.2 The All Wales IPFR Policy was introduced in 2011 and revised in 2015 and 2017 following Ministerial reviews. It was further reviewed in 2025. The aim is to ensure there is a fair, transparent and consistent approach to decision making across Wales for medicine and non-medicine treatments not routinely commissioned on the NHS as they are new, novel or experimental. Where a medicine or treatment has not been appraised or approved for use in the NHS in Wales, a clinician can apply for it to be made available under the IPFR process. This process allows access to treatments where there is clear evidence a patient will derive significant clinical benefit from the treatment compared to other patients and that there is evidence that the treatment will be clinically effective and represents a cost effective use of NHS resources.

1.3 The membership of health boards IPFR panel is outlined in the All Wales IPFR policy. Within CTM, the panel membership is as follows:

- Assistant Medical Director (Chair- under delegated authority from the Medical Director)
- Public Health Consultant (Deputy Chair - under delegated authority from the Director of Public Health)
- Head of Medicine Management
- Executive Director of Nursing, Midwifery and Patient Care
- Executive Director of AHPs and Health Science
- Assistant Director of Transformation
- Lay representative (2 vacant posts)

Each member now has a delegated deputy.

1.4 The CTM IPFR panel is scheduled to meet every fortnight to ensure applications are considered in line with the required timescales requested. The IPFR panel will be cancelled if there are no IPFR applications to consider. There is also an established mechanism to consider urgent applications within 24-48 hours. For urgent/life threatening applications and when a panel cannot be convened or discussion facilitated virtually within 24-48 hours, the Chair of the IPFR panel can undertake Chairs Action. During

2025/26, the CTM IPFR panel was convened on 22 occasions, while Chair's Action was undertaken for 2 cases.

2 Strategic Insights

2.1 IPFR panel Quoracy

Ensuring that IPFR Panel meetings are quorate is key to ensuring that the scheduled meetings proceed to discuss the cases in line with their clinical urgency. The local process for reviewing attendees for upcoming meetings and planning for periods of annual leave continues. Clinical representation from each directorate (in line with the Terms of reference) is encouraged to ensure sufficient attendees, not only for quoracy but to strengthen the robust discussions that take place during IPFR panels.

Table 1: Attendance from each directorate for 2025/26

	Total number of meetings	22	%
Meeting attended by at least one representative from:	Medical	20	90.9
	Nursing	14	63.6
	AHP & HCS	18	81.8
	Pharmacy	19	86.4
	Public Health	22	100
	Public Health (Clinical reps)	16	72.7

*Please note a representative from the Commissioning Team is included in panel membership, however, they are not included as part of the quoracy.

Consideration is requested from each directorate as to how they are being represented in IPFR Panel meetings. Should each directorate aim for 90% attendance, it is estimated that quoracy would be achieved at all meetings.

2.2 IPFR data 2025/26

The requests submitted to the CTM IPFR panel vary in terms of complexity. The majority of applications relate to non-NICE approved/unlicensed drugs. The number of non-medicine requests received has been historically low, however an increase in the number of requests was noted in 2024/25 which has been demonstrated again in 2025/26. Themes identified for interventions discussed at IPFR panel in 2025/26 include:

- Papillon contact brachytherapy for rectal adenocarcinoma
- Complex Abdominal Wall Surgery

Following discussion with the IPFR Chair and IPFR Deputy Chair on how such applications are progressed, a new approach has been implemented: the 1st application for an intervention where a potential cohort has been indicated is considered via IPFR and if deemed appropriate by the IPFR Panel, agreement is given that any future requests can be considered via PAR. This approach ensures things like economic case are considered as an initial baseline. All IPFR decisions are recorded centrally on the All Wales IPFR database.

Table 2: Requests submitted to the CTM IPFR panel 2025/26

2025/26	Approved	Not Approved	Deferred	Total
Medicine	23	4	4	31
Non medicine	11	0	4	15
Total	34	4	8	46

Of the 34 IPFR's approved, 26 were for treatment within NHS Wales, with 8 for treatment in English providers

Table 3: Requests submitted to the CTM IPFR panel 2024/25

<i>2024/25</i>	<i>Approved</i>	<i>Not Approved</i>	<i>Total</i>
<i>Medicine</i>	<i>31</i>	<i>10</i>	<i>41</i>
<i>Non medicine</i>	<i>8</i>	<i>3</i>	<i>11</i>
<i>Total</i>	<i>39</i>	<i>13</i>	<i>52</i>

Table 4: IPFR applications considered by the CTM panel by year.

	Approved	Not approved	Total
2021/22	21	7	28
2022/23	17	6	23
2023/24	29	13	42
2024/25	39	13	52
2025/26	34	12*	46

*Total of no. applications not approved (4) and no. applications deferred (8).

The number of IPFR applications the Health Board has considered in 2025/26 has totalled 46. It is not known at present whether this figure is similar to that in other health boards across Wales. The AWTTTC IPFR Annual report (2025/26) is due for publication later this year, when an assessment will be undertaken to understand if there has been any increase in the number of IPFR cases at an All Wales level.

2.5 Financial Commitment

2.5.1 The very nature of IPFR spend is unpredictable and will vary year by year due to the requests received. The table below highlights an increase in committed spend when compared to previous years, with the number of applications approved by the CTM IPFR panel. The committed spend for 2025/26 is slightly lower than 2024/25 which is in line with the number of applications considered:

Table 5: IPFR financial commitment by year, based on approvals issued.

Year	Total approved (£)
2021/22	£178k
2022/23	£228k
2023/24	£243k
2024/25	£374k
2025/26	£319k

It is noted that the majority of requests approved at IPFR panel are for drugs/ interventions less than £15,000. In 2025/26, there were a handful of drug requests approved that were over this value, including;

- Pembrolizumab, lung cancer (Velindre)
- Dupilimab, Bullous pemphigoid (CTMUHB)
- Daratumumab, On-going chronic active antibody-mediated rejection of kidney transplant (outside of 100 days), (C&VUHB)

Usually, in such instances of approval are issued for a short period of time (e.g. 3 / 4 months) to review. This is to ensure a review on response is provided back to panel and also enables financial control. In 2025/26, the highest value request approved was for £26,000 / set period.

2.5.2 The PAR and IPFR spend is reported against the same budget and so we are unable to split out the financial performance for IPFR spend versus budget however, below shows the reported position for 24/25 and 25/26:

Table 6: IPFR & PAR Spend vs Budget

	Budget	Actual Spend	Variance
2024-25	£282,297	£324,741	£42,444
2025-26	£345,488	£605,979	£260,491

- Please note that the above spend may also include funding approvals relating to other financial years depending on how long the CTM resident was on the provider waiting list.

2.6 Amendment to Directions concerning Cross Border Directive (2011/24/EC) and the S2 funding route process

2.6.1 Following the UK's withdrawal from the European Union (EU) on 31st December 2020, the EU Directive funding route ceased. Welsh Government issued the Welsh Health Circular (2021/005) instructing Health Boards that the EEA Directive can no longer be used by UK citizens to access healthcare treatment in the EU.

2.6.2 Whilst the EU Directive funding route has ceased, S2 arrangements will continue as part of agreed post Brexit reciprocal healthcare arrangements with the EU. The S2 route enables CTM patients to apply to have their planned treatment in another EEA country at the expense of their home state. This can be in state provider or private healthcare provider that accepts an S2 certificate for which treatment will be provided under the same conditions and payment as for a resident of the country of treatment.

2.6.3 For the period of 2025/26 CTMUHB considered less than 5 S2 requests. For information governance purposes and due to the low number of requests considered; the true number of requests is generally not reported due to being potentially patient identifiable. The Commissioning team will continue to closely monitor the number of S2 applications in 2026/27 and escalate appropriately if the number of requests increase.

2.7 Top Up Policy

In August 2008, the Minister for Health and Social Services commissioned Professor Philip Routledge, Chair of the All Wales Medicines Strategy Group (AWMSG), to review ways of improving access to medicines for patients in Wales. Professor Routledge convened an Expert Group, and its findings were published in March 2009 as '*The Routledge Report*.' The Minister established an Implementation Group to deliver the report's 11 recommendations. The Minister tasked the group with examining the legal and ethical framework for top-up payments and clarifying the implications for patients in Wales.

The Health Board is required to adopt the procedure for introducing top-up Payments as set out in the Implementation Group (IG) Report (February 2011). Failure to implement the revised top-up Payment to Medicine Policy and Procedure (2025) would leave the Health Board misaligned with Welsh Government expectations and failing to adhere to clinical and corporate governance. There was previously inequity in terms of accessing Top-Up within Cwm Taf Morgannwg University Health Board (CTMUHB) as the Top Up Policy and Procedure was never adopted or implemented for use within the health board. Therefore, CTMUHB patients were disadvantaged by not being able to access medicines via the Top-Up. A top-up is a payment made by a patient for a medicine and any related care that is not approved or funded by the NHS. This means that the patient pays privately for a specific medicine while continuing to receive the rest of their care from the NHS.

This applies to medicines and associated activity and not to full private treatment packages.

The All-Wales IPFR Network and Policy Implementation Group (IPFR PIG) recently undertook a review of the Top Up Payment to Medicine Policy (2016). During the review, All NHS Wales Health Boards and Trusts mutually agreed revisions to the policy that enabled the policy and procedure to be streamlined.

CTM UHB recently endorsed the use of the Top Up payment policy in March 2026. As this represents a new function within CTM UHB, the health board has aligned its internal administration of the process to that of other health boards across Wales; where this function sits alongside the Individual Patient Funding Request (IPFR), Prior Approval Request (PAR) and S2 funding requests. Within CTM UHB, the administration of the process will therefore fall within the responsibility of the Commissioning Team, with appropriate input and governance from both clinical and medicine management colleagues. The annual reporting on Top Up activity will be via the IPFR annual report.

3. Risks and Opportunities

3.1 CTMUHB IPFR panel membership

Following the retirement of The IPFR Chair in December 2025 (Deputy Medical Director), the Assistant Medical Director Quality and Governance is now the formal chair of the IPFR Panel. The clinical representative from the Public Health team continues as Deputy Chair. Discussions are ongoing as to how to further strengthen clinical representation on the IPFR Panel.

3.2 Lay Representation on the CTM IPFR panel

CTMUHB is required to recruit two lay representatives to the local IPFR panel as per the IPFR terms of reference (TOR). There has been great difficulty in attracting suitable candidates to the role for a number of years across Wales. Renewed efforts will be made to link with external stakeholders to recruit suitable lay members.

4 Compliance and Governance

4.1 All Wales IPFR policy update

An IPFR request considered by the JCC was subject to a judicial review in 2021 as due process had not been followed. The JCC were tasked with undertaking a '*di minimis*' review to address the recommendations made by the QC at the time. Following a prolonged process, the revised IPFR policy was agreed and implemented throughout NHS Wales; all health boards obtained the relevant endorsement and approval via their respective internal governance channels. The revised IPFR Policy was implemented as of 01/02/2026, ensuring that IPFR applications adhere to the correct policy consistently across Wales.

4.2 CTMUHB representation on the All Wales IPFR panel

In the revised All Wales IPFR Policy (2025), the JCC updated their TOR for the All Wales IPFR Panel to strengthen clinical representation from health boards.

4.3 Quality Assurance Panel

Following the independent review of the IPFR process in Wales in 2017, a key recommendation was to 'establish a national IPFR quality function to support IPFR panels to ensure quality and consistency in decision making'. This includes facilitation, advice training and auditing of the IPFR process and has an obligation to report on the quality of processes, highlighting any concerns through the existing quality and clinical governance processes in Wales. The QA panel was therefore established to undertake this function and is hosted by The All Wales Therapeutics and Toxicology Centre (AWTTC).

4.4 The governance structure for the established QA panel is clearly laid out in the terms of reference which were approved as part of the IPFR review through existing health board governance structures, including Joint Commissioning Committee (JCC) and by the Deputy Chief Medical Officer for Wales to whom the group reports. The group's role is to scrutinise a randomly selected IPFR case from each IPFR panel to ensure the process had been followed in line with the All Wales IPFR Policy.

4.5 There are strict process and timescales for IPFR case management for which the health board is audited, on a quarterly basis by the Quality Assurance panel. The QA selects an IPFR case chosen at random from the All Wales IPFR database. After each QA panel, the health board will receive a formal update. For 2025/26, the health board has performed well and has been consistent in its approach in terms of process and timelines. It is consistently commended for the excellent IPFR service it provides.

5. Benchmarks

5.1 The AWTCC plays a pivotal role in supporting IPFR panels, ensuring consistency in approach via the QA group, establishing an All Wales IPFR database which seeks to identify any cohorts thus enabling a rapid review of the evidence and possible early access to treatment, for both medicines and non-medicines, and supporting the requirement for ongoing IPFR training events. When a patient cohort is identified through cases submitted to the All- Wales IPFR database, this links with the One Wales Commissioning Process.

5.2 Health Technology Wales (HTW) forms part of the QA group and are alerted to any non-medicine cohorts identified via the All Wales database thus enabling them to carry out an evidence appraisal. They also provide support for rapid evidence appraisals to IPFR panels when required. During 2025/26, CTM requested *10 rapid appraisals* to assist the IPFR panel decision making process. Individual clinicians can also submit a topic for consideration.

5.3 One Wales Medicine Assessment process

The IPFR cases considered by the CTM IPFR panel and other health boards across NHS Wales including JCC, are also used to inform other aspects of the AWTTC work programme, in particular the One Wales Medicines Assessment process (OWMAG). This process has been developed to facilitate one single agreed decision for NHS Wales on access to particular medicines for a group of patients (a patient 'cohort'). Medicines and patient cohorts are identified for consideration by the OWMAG by signals from activity in the IPFR Panels, from JCC, the Chief Pharmacist Peer Group or clinicians.

- 5.4 Ongoing monitoring of the IPFR data has shown that soon after publication of a OWMAG positive decision, applications are no longer submitted for these indications. This positively demonstrates that the process effectively reduces the burden on IPFR panels and encourages equity of access to these medicines across Wales. During 2025/26, there was a single One Wales appraisal completed that was identified as an IPFR cohort in 2024-2025; venetoclax in combination with azacitidine for treatment of relapsed or refractory acute myeloid leukaemia (OW32). Seven requests for encorafenib in combination with cetuximab for the first-line treatment of metastatic colorectal cancer with a BRAF mutation were recorded in 2025-2026. This has been flagged to the AWTTC One Wales team who are monitoring the situation.
- 5.5 This demonstrates that overall, the IPFR route is being correctly used by clinicians; for those individual patients who may have clinical presentations that are different to the general patient cohort. The majority of the assessments are being triggered by requests from the service or individual clinicians rather than through collection of IPFR cohort data. This may in part be due to the diversity of requests coming through IPFR but it also shows more awareness by the service of the One Wales Medicines process.

In 2025-26 there were 6 new medicines assessed:

- ipilimumab with nivolumab for neoadjuvant treatment of stage 3 melanoma;
- panitumumab for treatment of metastatic colorectal cancer;
- trametinib for treatment of recurrent or progressive low grade serous ovarian cancer;
- venetoclax with azacitidine for relapsed / refractory acute myeloid leukaemia
- infliximab for treatment of immune checkpoint inhibitor (ICI) induced myocarditis;
- infliximab for treatment of immune checkpoint inhibitor (ICI) induced pneumonitis;

There are currently 26 positive One Wales decisions enabling access to medicines for the treatment of patients with conditions where there is unmet clinical need. All of these medicines are off-label (not licensed for the indication specified).

5.6 All Wales IPFR Workshop

AWTTC hosted the eighth annual IPFR workshop in January 2026, which was held virtually via MS Teams. The workshop was open to IPFR panel members, IPFR teams, clinicians who complete IPFR applications and those interested in learning more about the IPFR process. A total of 84 attendees were present and all health boards were represented. CTMUHB were well represented with 10 colleagues attending from Corporate Services, Pharmacy, Commissioning, IPFR Panel and wider clinical colleagues.

The event provided delegates the opportunity to network and develop links across health boards. A series of presentations were made to delegates and topics covered included:

- Welcome/ roundup on IPFR over the last year
- What's new: Changes to the IPFR policy
- IPFR Panel cases; giving delegates the opportunity to form 'panels' to consider examples of IPFR cases.
- Undertaking an IPFR review (IPFR panel members and associated staff) OR IPFR database – how to submit an IPFR application (session for clinicians submitting IPFRs)
- Quick guide on how to interpret a systematic review or network meta-analysis

6. Conclusion

6.1 The Quality, Safety & Experience Committee are asked to NOTE:

- The contents of this report; and
- The need to recruit lay representation to the CTM IPFR panel;

6.2 Note the increased financial risk on the IPFR/ PAR budget as the last two years have overspent, with 2025-26 having seen a significant overspend on IPFR and PAR applications.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (<i>Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg</i>) 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 1a
	1b, 2,8.



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	Data to Knowledge
	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.)	N/A	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	EQIA undertaken on an All Wales basis.	



<i>rationale for why it was not required)</i>	
Cyfreithiol / Legal	Yes (Include further detail below)
	CTMUHB has a statutory obligation to ensure its population has access to healthcare that meets their needs
Enw da / Reputational	Yes (include further detail below)
	Activity where performance falls short of the Health Board's statutory requirement to provide access for it's population may result in impact to the trust and confidence in the Health Boards service provision.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (include further detail below)
	Workforce and financial resources are required to process and approve IPFR applications within the Health Board.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Elizabeth Beadle	17/08/2026	Supported
IPFR Panel Members	17/08/2026	Supported
Claire Thompson	17/08/2026	Supported
Philip Daniels	17/08/2026	Supported

Acronyms / Glossary of Terms	
AWTTC	All Wales Toxicology and Therapeutic Committee
EU	European Union
HTW	Health Technology Wales
IPFR	Individual Patient Funding Request
JCC	Joint Commissioning Committee
NICE	National Institute of Clinical Effectiveness
PIG	Policy Implementation Group
QA	Quality Assurance
TOR	Terms of Reference
OWMAG	One Wales Medicines Assessment Group



Quality, Safety & Experience Committee

Annual Report of the Decision – Making and Consent Working Group

Eitem yr Agenda / Agenda Item	6.2.3
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Miss Tehmina Riaz, Speciality Doctor. Decision Making and Consent Working Group Chair
Cyflwynydd yr Adroddiad / Report Presenter:	Dr David Deekollu, Assistant Medical Director for Governance & Quality 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
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> <i>Strategic Context: This report aligns to the following Strategic Pillars</i>	Not applicable
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol (<i>Cyfeiriad blaenoriaeth berthnasol</i>) Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (<i>Reference relevant priority</i>)	Not applicable

1. Background / Context

- 1.1 The CTMUHB Consent Working Group was formed in 2020. The Group reported directly to the Medical Director. The governance structure of the group was formally introduced in April 2025 and approved in November 2025. This report is the first annual report submitted to the QSEC and covers the period from April 2025 – April 2026.
- 1.2 Terms of Reference for the group were formulated in September 2020 and updated in April 2024. The process of approval was not clear and was highlighted. The final draft was approved by the EMB in November 2025 and is available upon request.
- 1.3 Group organisation/representation – the HB group is led by the Chair and a panel of representatives from all major HB care groups and specialities.
- 1.4 Role of the Chairperson is to provide leadership and direction to the group. Consent remains a complex and demanding clinical area in the NHS with limited resources and time deficient clinical environment.
- 1.5 Aims of the group are to promote training and learning in the standards of the consent process, arrange peer review audit for the Welsh Risk Pool, respond to Datix and complaints involving consent, updating the local policies around the consent process and provide any help and guidance to clinicians and service users in the context of consent.
- 1.6 Standing agenda template of the group – a standardised format was introduced in 2024 and the reporting of the minutes of the meetings are available to view on share-point.
- 1.7 Reporting and monitoring structure – the Chair of the DMacSWG has monthly update meetings with the Assistant Medical Director for Governance and Quality and reports directly to the Medical Director. The DMacSWG reports annually to the QSEC, with quarterly highlight reports to Executive Management Board.

2. Strategic Insights

- 2.1 National Decision Making & Consent Group and Welsh Risk Pool Meetings occur quarterly and are well attended by the leads from all the HBs in Wales. This central body confers the standards and safeguards to be maintained by Welsh HBs.
- 2.2 Bi-annual Peer Review Audit of the consent process is mandated by the Welsh Risk Pool. The 2024-2025 HB audit has been completed and presented widely. A copy of the report is available upon request. This audit was developed with the participation of the Audit and Clinical Effectiveness Department. There were various challenges in initiation of the audit, sick leave in the audit department team, recruitment of consent takers, resource facilities, notes acquisition, etc. Some specialities did not meet the deadline for data collection. The overall compliance with standards based on scored questions had improved to 77% when compared to the previous audit.

- 2.3 From the conclusions of the audit, it is clear from that clinicians are particularly good at completing consent forms and explaining the relevant risks and benefits of a proposed treatment. There is also good evidence of two-stage consenting and improving dialogue with patients. The use of EIDO information leaflets has improved from previous audits.

However, from the number of reviewers ticking 'Unclear' for answers, this would imply that documentation is not of the standard the health board would expect from the consenting process.

The recommendations of the Audit are tabulated in Table below:

Issue identified	Improvement Action	Timescale	Lead
EIDO forms not always being used when available for a given procedure.	Communication to all clinicians to remind them of the WRP standard to use an EIDO information leaflet when available. Provide clear documentation EIDO information leaflets were provided e.g. on consent forms or in clinic letters when recording consent discussions.	3 months	CTMUHB Consent Lead
Consent documentation not to the standard expected in the patient's case notes.	Communication to all clinician to remind them of the importance of good documentation in the patient's notes.	3 months	CTMUHB Consent Lead
The clinic letter detailing the procedure, risks and shared decision to proceed needs to be shared/mailed to the patient.	Documentation of communication with the patient of shared decision-making was difficult to validate and this simple task will benefit the patient and the Health Board.	3 months	Leads of all Surgical Specialities

The Welsh Risk Pool has introduced Webinars that have been populated by the HB communication and were well attended. These include 'Decision making and consent - No decision about me without me' on 20th June 2024, 'End of life decision making' on 10th December 2024 and 'Challenges of best interest decision-making in clinical practice' on 26th Feb 2026.

The Introductory Video on Decision Making and Consent was produced in March 2026. This short training video summarises the legal framework for decision-making and consent and its application in clinical practice. It provides practical guidance for all patient facing clinicians. It does not replace the need to complete the full e-learning package or approved face-to-face training on

decision-making and consent. It would be suitable for use as part of induction programmes. It can also provide a focus for a wider interactive training session on decision-making and consent within postgraduate training programmes or clinical governance meetings.

- 2.4 The Report on National Review of Decision Making and Consent to Examination & Treatment Standards in NHS Wales by Welsh Risk Safety and Learning Team was issued to CTMUHB on 31st March 2026 (copy available upon request). Extensive evidence for this review was submitted by the HB in March 2025. The CTMUHB achieved an assurance rating of 'Reasonable Assurance.' The recommendations for the HB to achieve 'Substantial Assurance' were outlined. An action plan for achieving these was submitted by the HB on 27/04/2026.
- 2.5 DMACWG Summary: The MoM have been maintained since 2023 and are available to view on the dedicated share-point page.
- 2.6 Quarterly meetings of the DMCWG have taken place on 26.06.2024, 09.08.2024, 01.11.2024, 24.01.2025, 02.05.2025, 01.08.2025, 07.11.2025 and 06.02.2026.
- 2.7 There is very good representation from the different Health Board departments but very limited representation from the different surgical and medical specialities. Efforts have been initiated by contacting different leads to consider sending representatives. Even when reps have been identified by the leads, they do not attend or interact. When asked as to the reason, a few members have mentioned that they have clinical commitments and do not receive any time to attend these meetings in their job plan.
- 2.8 Training in decision making and consent process. The 110 e-Learning Certification - Consent & Decision Making in Clinical Practice (Wales) is a 90 minute e-learning course that is designed to give clinicians the information they need to help patients make truly informed decisions. Welsh HBs standard is for 85% of Medical & Dental, Nursing & Midwifery and AHPs to have completed the course on ESR. The course is renewable every three years. Five of seven HBs in Wales have mandated the training for these three staff groups. However, CTMUHB is one of the 2 HBs where this is still not mandated. Efforts to have the training mandated continue. All HBs that have mandated this training have seen a significant increase in compliance. The National Team are now presenting data on compliance, twice a year, by the Welsh HBs. The table below provides proof that CTMUHB has very low compliance rates as of November 2025.



Name of HB	Mandated (Yes/No)	Report date	Total staff to be trained in three categories	Total staff trained in three categories	%	Total Medical and Dental staff to be trained	Total Medical and Dental staff trained	Total Nursing and Midwifery registered staff to be trained	Total Nursing and Midwifery registered staff trained	Total Allied and Health Care Professionals to be trained	Total Allied and Health Care Professionals trained
	Yes	30/11	9170	8027	87.5	820	363	4880	4509	1033	943
	Yes	30/11	9794	8386	85.6	1320	902	6929	6173	1545	1311
	Yes	0/11	7620	6058	79.5	1214	590	5071	4273	1335	1195
CTMU HB	No	30/11	6154	260	4.2	943	19	4330	205	881	36
	Yes	30/11	5660	4790	84.6	798	380	3993	3629	869	781
	No	30/11	7024	2009	28.6	1072	247	4812	1132	1140	630
	Yes	30/11	1014	964	92	66	49	781	730	194	185
	Yes	30/11	119	119	100	9	9	37	37	73	73
	Yes	30/11	503	430	85.5 %	99	65	194	170	210	195

However, the most recent data reported to the CTMUHB DMACWG in May 2026, shows an overall increase of 50% and 8.4% of all staff have completed the ESR training. This is encouraging and has involved concerted efforts from the team. Various strategies have been implemented which include reminders in Medical Directors Newsletter and reminders in the Education and Learning Newsletter and Share-point page.

- 2.9 Alternate routes to achieve compliance that have been explored by the HB include delivering the training in group sessions. The process of logging this training delivered in group sessions is being finalised with the help of the Executive Administration Support and the Learning Team.
- 2.10 Ad-hoc training in Consent delivered by recognised bodies/programmes is also encouraged. The procedure to log the training in ESR has been communicated to staff via the share point page. However, it is not clear how this information is gathered and included by the ESR team.
- 2.11 Learning to be included at Induction of all new staff and essential for induction of the three major staff groups who take consent. Introductory video has been circulated to all Education Leads and recommendation to include in Induction teaching has been welcomed by the leads.
- 2.12 Communication with clinicians and service users is of paramount importance in achieving the standards of care. The foremost need was for a dedicated site on the intranet where all essential information and links are on clearly visible.
- 2.13 Share point Consent Webpage was introduced in 2025. All the recent communication/news around decision-making and consent is updated and archived on this site. The links to all the sites including MCA/DoLs and safeguarding links and email contacts of the team are uploaded on the site. This has proved valuable in putting consent and decision-making information



easily available and accessible to busy, front-line staff and providing a support network within the HB.

- 2.14 The promotion of dedicated Consenting Clinics or dedicated slots in clinics for consenting patients at least 2 – 4 weeks prior to the date of treatment/surgery is advised for all surgical specialities. This ensures that the at-least a two-tiered approach to the discussion around consent has taken place. The consent taking formally on the day of surgery is sub-standard practice and is to be discouraged for all elective/planned treatments.
- 2.15 NICE Guideline NG197 1.2.20 recommends 'When writing clinical letters after a discussion, write them to the patient rather than to their healthcare professional ... Send a copy of the letter to the patient (unless they say they do not want a copy) and to the relevant healthcare professional.' This practice is variable in CTMUHB and is implemented by one or two clinicians in each surgical speciality. The recent peer-review audit high-lighted this and has included in its recommendation.
- 2.16 The National Team has been discussing digital consent for over ten years. At present there are two ongoing pilots in Wales. The surgical department has approached the DMAcWG about doing a pilot in CTMUHB and is in the discussion phase. Digital consent has obvious advantages in reducing need for clinic space and reducing did not attend rates. However, there are significant IT issues and integration into existing digital facilities that have been a stumbling block in previous pilots in Wales.
- 2.17 Procedure Specific Patient Information Leaflets – All Welsh HBs are mandated to use the EIDO inform library database to provide PSPILs to service users. There have been issues with the website and now this facility is under the umbrella of Digital Healthcare Wales (DHCW). However, the national team recognise PSPILs from professional bodies. There are some procedures where neither EIDO nor Professional body PSPILs are not available. In these situations, departments have used locally made PSPILs. There was no formal policy on patient information material used in CTMUHB. The DMAcWG highlighted the issue and we now have a policy in place. However, the governance around the specific pathway for locally produced or locally used procedure specific PILS still needs some clarification, and ongoing work is in progress.
- 2.18 Procedure Specific Consent Forms – Consent form 1, 2 and 4 are national Consent forms. These are blank forms and need to be filled in by hand. This occasionally leads to difficulty in deciphering the writing and relies on the clinician not forgetting to write all the risks associated with the procedure. Pre-filled Consent forms have been used in HBs across UK. The National Team has provided guidance for the development of these forms. The DMAcWG have now produced a local document that is in the draft stage and has received three forms for consideration.
- 2.19 The involvement with Datixes and Complaints involving the Consent process has been limited. The group is not directly involved with these and all are internally resolved. However, the Group has asked for all Consent related complaints and themes are picked up. The group has advised that any

incident that involves consent, the Lead Investigator must ensure that all concerned staff provide evidence of completing the ESR Consent Module.

3. Risks and Opportunities

- 3.1 Implement the recommendations of the 2024/25 peer review audit. The recommendation for clinicians to share the written information around the proposed treatment or procedure needs to be widely implemented by the HB. The aim is to increase the compliance and achieve the standard of 95% for the future audit.
- 3.2 The formal Consent prior to a treatment or procedure should be at least a two-stage process. All Surgical Specialities Care Groups need to implement consenting clinics or some slots in the out-patient clinics for formal consent taking.
- 3.3 The in-progress actions from the Action Plan submitted in response to recommendations from the 2025/206 National Review of Consent Standards need to be completed. This includes update of the existing policy that expired in May 2026, Welsh translation of the CTMUHBs policy on Procedure Specific Consent Forms, database of Local Procedure Specific Consent Forms and formal procedure to log ad-hoc training on consent to be included in the HB data. This evidence will need to be submitted by the HB to WRP in the future.
- 3.4 Continue efforts to improve representation from surgical specialities including obstetrics and gynaecology, trauma & orthopaedics, endoscopy, ophthalmology, ENT, rheumatology, medical oncology, urology and cardiology. Representatives need to have time allotted in job plan to attend meetings.
- 3.5 Consent ESR learning – The required standard for HBs compliance is not met by a long percentage. Although we have doubled the number of staff attaining the competency we need to reach 85%.
- 3.6 Introduce Group ESR training sessions – the first one took place on 10/03/26. However, the process to input this onto ESR is with the Learning and Development Team and need to be finalised.
- 3.7 The ESR Consent module needs to be mandated for the three staff groups as advised by Welsh Risk Pool. In all the other Welsh HBs that have mandated the ESR training, a significant improvement in compliance has been reported.
- 3.8 Include the Introductory Video on Decision Making and Consent for NHS Wales in all induction programmes for new staff especially Medical & Dental, Nursing & Midwifery and AHPs.
- 3.9 Attain evidence of inclusion of Introductory Video on Consent in all HB induction teaching programmes.
- 3.10 Ensure outpatient clinic appointment slots for consent for planned treatments and procedures.

- 3.11 Ensure shared decision making by copying all clinical letters with the patient/service user and the health professional.
- 3.12 Alternate training on Consent – process developed to enable staff attendance to be captured onto the training matrix and captured as compliance for WRP.
- 3.13 Admin support for uploading on the intranet share-point page needs to be standardised and confirmed.
- 3.14 Local guidance for developing PSCFs other than EIDO or professionally recognised bodies to be completed and approved.
- 3.15 The CTMUHB needs to provide evidence of a database of locally produced and approved PSPILs used in the consent process.

4. Compliance and Governance

4.1 The Quality, Safety & Experience Committee are asked to note the contents of this report.

5. Conclusion – Next Steps

- 5.1 Priorities for 2026 – 2027
- 5.2 Continue efforts to increase the compliance rate of training.
- 5.3 Complete the in-progress actions in order to achieve full compliance with All Wales Standards.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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 Service Transformation & Outcomes
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Not Applicable
	If more than one applies please list below:



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

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.)	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Does not impact people
Equality & Welsh Language Impact Assessment Outcome (Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable	Named Executive/Board member sign off for no EWLIA completion: Dom Hurford
Canlyniad Asesiad Effaith Ansawdd (Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)	Not applicable	
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
Decision-Making and Consent Working Group	01/05/2026	Approved



Executive Leadership Group	10/08/2026	Noted
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Acronyms / Glossary of Terms	
AHP	Allied Health Professional
CTMUHB	Cwm Taf Morgannwg University Health Board
DMACWG	Decision Making and Consent Working Group
DH&CW	Digital Health & Care Wales
EMB	Executive Management Board
HB	Health Board
HEIW	Health Education and Improvement Wales
MDT	Multi-Disciplinary Team
MoM	Minutes of Meeting
Nursing and Midwifery Staff	N&WS
OPA	Outpatient Appointment
PILs	Patient Information Leaflets
PSPILs	Procedure Specific Patient Information leaflets
PSCFs	Procedure Specific Consent Form
QSEC	Quality, Safety and Experience Committee
WRP	Welsh Risk Pool
MCA	Mental Capacity Act
DoLS	Deprivation of Liberty Safeguarding

Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	21/07/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Chair of Sub-Committee and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Assurance
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards	Various	Noted

1. SITUATION / BACKGROUND

This report had been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSOC) Sub-Committee at its public meeting on 29 June 2026.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted – [June 2026](#))

Status	Update
Alert / Escalate	Fragile Specialised Services and Workforce Pressures – Members discussed continued fragility across a number of specialised services, including cardiac surgery, neurosurgery, intestinal failure services, thrombectomy pathways and renal dialysis capacity. Workforce sustainability, capacity constraints and service resilience were highlighted as recurring themes. Members requested that these issues be escalated to the Joint Committee and considered through the emerging Joint Committee Assurance Framework. JACIE Accreditation Risks – Risks relating to Bone Marrow Transplant and CAR-T services continue to be highlighted. Loss of accreditation would have significant implications for patient pathways and service delivery across Wales. Assurance continues to be sought regarding contingency planning. Caswell Clinic – Caswell Clinic remains in escalation, although significant progress has been made since escalation commenced. The Committee noted ongoing work towards de-escalation and requested a further lay member visit to review progress. Continued reliance on independent sector placements due to unavailable medium secure beds remains a concern. Cardiac Surgery – Members were advised that cardiac surgery services in Cardiff had moved to Level 2 escalation following the reporting period. Concerns remain regarding data quality, the absence of sufficient improvement plans and limited visibility of progress. See <i>Appendix 1</i> for the Escalation Trajectories of the services currently in escalation and the actions being undertaken to manage these. All Wales Individual Patient Funding Request (IPFR) Panel – Members welcomed improved health board attendance and panel resilience. Continued concerns regarding Powys Teaching Health Board attendance were highlighted and will be raised through appropriate forums and reflected in this highlight report.
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed. Director of Commissioning for Specialised Services Services were generally stable during the reporting period with no new escalations reported at time of publication.

Status	Update
	Members discussed quality and sustainability risks across cardiac surgery, neurosurgery, intestinal failure, thrombectomy, dialysis services and PET-CT demand growth. The Committee requested enhanced future reporting on specific quality impacts. Welsh Kidney Network (WKN) Report - Members received assurance that there had been no significant changes to risks during the reporting period. Four Nationally Reportable Incidents are expected to close shortly, with learning and closure reports to be brought to a future meeting. The Committee welcomed continued development of governance reporting arrangements following integration of the WKN into NWJCC. Director of Commissioning for Ambulance Services and National Programmes - Members discussed ongoing demand and capacity challenges across Emergency Ambulance Services, NHS 111 Wales and Non-Emergency Patient Transport Services (NEPTS). Ambulance handover delays remain a significant quality and safety concern. Improvements to NHS 111 digital services and roster redesigns are planned. A further update on the NEPTS Improvement Board will be requested. Director of Commissioning for MHLDVG Report - The Committee received updates regarding St Andrew's Healthcare repatriation arrangements, the Adult Welsh Gender Service review, Cygnet Bury concerns and Caswell Clinic. Members noted continued progress in reducing the number of Welsh patients remaining at St Andrew's Healthcare and were assured that patient safety issues continue to be actively monitored. The Incident and Concerns Report highlighted - Members noted 12 new Nationally Reportable Incidents, 6 complaints, 1 Ombudsman referral and 19 closure reports. Particular attention was given to strengthening thematic analysis, organisational learning and assurance regarding how learning from WAST incidents is embedded across services. A Regulation 28 review regarding a Cardiac Incident is underway and the outcome will be reported back to QSOC.

Status	Update
	A development session looking into incidents and NRI reporting has been scheduled to better understand NWJCC processes.
Assure	The Committee received the QSOC sub-committee's assigned risks from the NWJCC Operational Risk Register as of 31 May 2026. After QSOC scrutiny and review, the JCC will receive the May 2026 risk register at its July 2026 meeting. The following were highlighted; Whilst the reported risks were mostly unchanged, Members noted emerging neurosurgery risks and welcomed work to strengthen strategic risk oversight through the Joint Committee Assurance Framework. The positive de-escalation of the hereditary anaemia service risk was also noted. Risk Management and Assurance Framework – The Committee endorsed the Risk Management Procedure, Joint Committee Assurance Framework (JAF), Risk Appetite Statement and strategic risk reporting arrangements for onward consideration by the Joint Committee. Members welcomed the strengthened approach to strategic risk management and assurance and were pleased with the progress made to strengthen Risk Management. The Escalation Trajectories Report was received and is attached at Appendix 1. The Committee received assurance regarding services currently in escalation and noted that updates had been considered through the Director reports. The Regulator Report was received. The Committee reviewed Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) activity and received assurance regarding ongoing monitoring and follow-up arrangements. Particular attention was drawn to the forthcoming Caswell Clinic inspection findings.
Inform	Patient Story – QSOC received a Welsh language patient story on chronic renal disease and home dialysis, highlighting the benefits of home therapies, the importance of early patient engagement, Welsh language accessibility and strong clinical support. The patient raised concerns about extended transport times and the suitability of food provision for dialysis patients. QSOC agreed that these issues should be reviewed, with further work to gather and analyse patient travel experiences, review transport coordination with WAST, and consider food provision feedback.

Status	Update
	The patient story and associated follow-up actions will be escalated to the Joint Commissioning Committee for awareness and assurance. Blueteq Governance Arrangements – Members approved the new Standard Operating Procedure for Blueteq form, strengthening governance controls around high-cost medicines commissioned by NWJCC. Policy Validation Group – Members received assurance regarding ongoing work to maintain and review commissioning policies, recognising both the importance of this work and the workforce constraints affecting delivery. Forward Plan of Business – The Committee reviewed and noted the 2026–27 Forward Plan.
Appendices	Appendix 1 - Escalation Trajectories.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality	Effective
	Efficient; Equitable; Person-centred; Timely; Safe

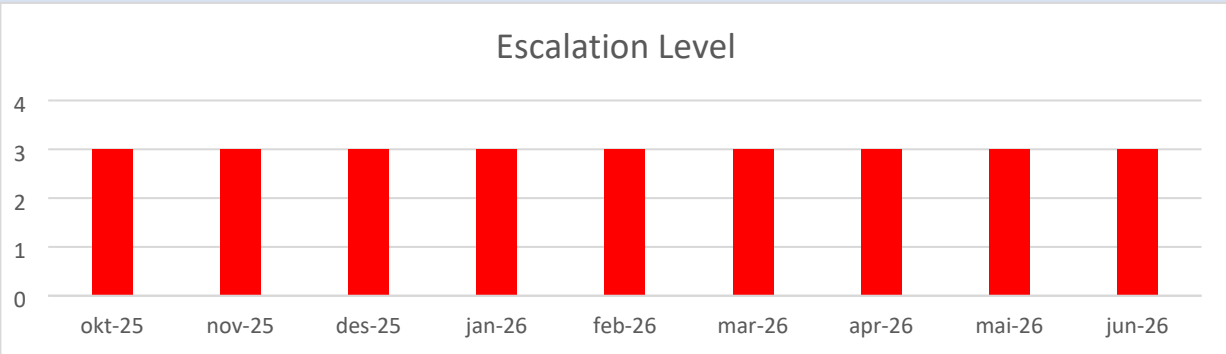
(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental / Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Commissioning Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	The performance of the services will be used to develop the Plan and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Joint Commissioning Committee is asked to:

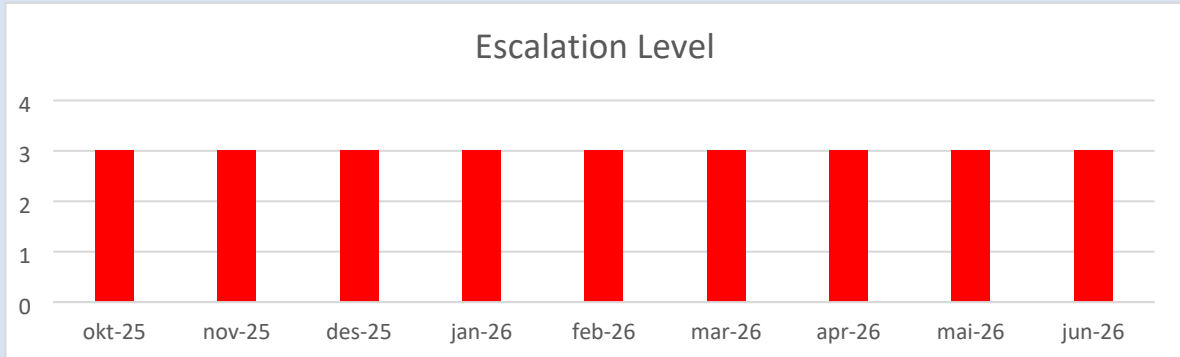
- Note the highlights outlined in Section 3 of this report; and
- Receive the report as assurance.

Executive Director Lead: Melanie Wilkey		Service in Escalation: Specialist Auditory Implant Device Service		Escalation Trend Level														
Commissioning Lead: Krysta Hallewell				Trend	Rationale	Current Trend Level												
Commissioning Team: Neuro-Sciences				↓	Escalation level lowered	↔ June 26												
Date of Escalation Meetings: 28/04/2026				↔	Escalation remains the same													
Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026		Current Escalation Level 3		↑	Escalation level escalated													
Escalation Trajectory:				Escalation History:														
Escalation Level 				<table><tr><th>Date</th><th>Escalation Level</th></tr><tr><td>October 2025</td><td>3</td></tr></table>			Date	Escalation Level	October 2025	3								
Date	Escalation Level																	
October 2025	3																	
Background Information: The escalation of the Cardiff and Vale Specialist Auditory Implant Device Service to Level 3 of the NWJCC Escalation Framework was initiated in October 2025 and endorsed by the NWJCC Senior Leadership Team. The NWJCC assurance and confidence rating remains Low. A formal escalation letter was issued to Cardiff and Vale UHB on 6 October 2025. However, delays in confirming a named Executive Lead and Health Board availability resulted in a postponement of the initial escalation meeting. The first formal escalation meeting was subsequently held on 22 January 2026.				Rationale for Escalation Status: Due to insufficient progress against agreed improvement actions monitored through the quarterly Service Performance Management meetings since January 2024, and continued underperformance against the RTT position relative to the specific ministerial target for this patient cohort, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends escalation to Level 3 – Escalated Measures.														
				The service now requires significant and sustained improvement, with Executive-level oversight and intervention necessary to address performance risks and secure recovery against agreed standards.														
				<table><tr><th>Action (NWJCC Lead: Director of Commissioning):</th><th>Action Due Date</th><th>Completion Date</th></tr><tr><td>Escalation endorsed by SLT</td><td>Oct 25</td><td>Oct 25</td></tr><tr><td>Escalation letter sent to CVUHB</td><td>Oct 25</td><td>Oct 25</td></tr><tr><td>Escalation meeting to discuss detail and progress against action plan (every 4 weeks)</td><td>Ongoing</td><td>Ongoing</td></tr></table>			Action (NWJCC Lead: Director of Commissioning):	Action Due Date	Completion Date	Escalation endorsed by SLT	Oct 25	Oct 25	Escalation letter sent to CVUHB	Oct 25	Oct 25	Escalation meeting to discuss detail and progress against action plan (every 4 weeks)	Ongoing	Ongoing
				Action (NWJCC Lead: Director of Commissioning):	Action Due Date	Completion Date												
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Escalation letter sent to CVUHB	Oct 25	Oct 25																
Escalation meeting to discuss detail and progress against action plan (every 4 weeks)	Ongoing	Ongoing																
Issues/Risks:																		

February 2026 Update – Commissioning and provider teams to jointly clarify: Historic and current commissioning expectations for CT scans, where clinical interpretation of scans should take place and whether pathway changes created unintended delays.

April 2026 update the pre-surgical CT scan pathway remains an open action. Progress has been made on the Long-Term Agreement (LTA), and the service will share the draft in due course. The service has highlighted the impact of additional activity undertaken to reduce backlog pressures, noting a decline in staff morale. There is a recognised risk that ongoing pressures on staff wellbeing may contribute to increased sickness absence. Escalation meeting planned for the 16th April has been moved to the 28th of April at the request of the service.

June 2026 – There has been significant progress in addressing the 52 week waits in the service and there are no patients currently at 52 weeks working towards a 36-week target. Work ongoing with the review and rebasing of the LTA. The pre surgical scan pathway is still an open action with an SOP in draft. An operational manager has been moved into the service for support but there are still some concerns around stress wellbeing with the service being stretched due to increased activity to reduce the longest waiters.

Executive Director Lead: Sue O’Leary Commissioning Lead: Sue O’Leary Commissioning Team: Mental Health Date of Escalation Meetings: 30/04/2026 Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026		Service in Escalation: Caswell Current Escalation Level 3		Escalation Trend Level <table><tr><th>Trend</th><th>Rationale</th><th>Current Trend Level</th></tr><tr><td>↓</td><td>Escalation level lowered</td><td rowspan="3">June 2026</td></tr><tr><td>↔</td><td>Escalation remains the same</td></tr><tr><td>↑</td><td>Escalation level escalated</td></tr></table>			Trend	Rationale	Current Trend Level	↓	Escalation level lowered	June 2026	↔	Escalation remains the same	↑	Escalation level escalated													
Trend	Rationale	Current Trend Level																											
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Escalation Trajectory: Escalation Level <table><caption>Escalation Level Data</caption><tr><th>Month</th><th>Escalation Level</th></tr><tr><td>okt-25</td><td>3</td></tr><tr><td>nov-25</td><td>3</td></tr><tr><td>des-25</td><td>3</td></tr><tr><td>jan-26</td><td>3</td></tr><tr><td>feb-26</td><td>3</td></tr><tr><td>mar-26</td><td>3</td></tr><tr><td>apr-26</td><td>3</td></tr><tr><td>mai-26</td><td>3</td></tr><tr><td>jun-26</td><td>3</td></tr></table>		Month	Escalation Level	okt-25	3	nov-25	3	des-25	3	jan-26	3	feb-26	3	mar-26	3	apr-26	3	mai-26	3	jun-26	3	Escalation History: <table><tr><th>Date</th><th>Escalation Level</th></tr><tr><td>January 25</td><td>3</td></tr></table> Rationale for Escalation Status: The service has been placed under formal escalation due to sustained concerns relating to safety and quality within the facility. A site visit by NWJCC representatives in July 2025 identified significant safety and quality concerns. These were reported to the JC in September 2025, which commissioned a full-service review. The review, undertaken between 15 September and 3 October 2025, assessed compliance with recognised Medium Secure Unit standards and included patient-level review. It identified serious safety and quality issues requiring urgent action. Similar concerns had been raised in a 2022 NCCU review and were echoed in a June 2025 independent report on Swansea Bay University Health Board’s Mental Health and Learning Disability services, which highlighted compromised care standards and weaknesses in leadership and oversight. The findings indicate systemic governance and safety risks requiring immediate improvement action and strengthened executive oversight.				Date	Escalation Level	January 25	3
Month	Escalation Level																												
okt-25	3																												
nov-25	3																												
des-25	3																												
jan-26	3																												
feb-26	3																												
mar-26	3																												
apr-26	3																												
mai-26	3																												
jun-26	3																												
Date	Escalation Level																												
January 25	3																												
Background Information: The escalation of the Caswell Clinic Service to Level 3 of the NWJCC Escalation Framework was initiated and endorsed by the NWJCC Senior Leadership Team in October 2025, following significant safety and governance concerns. Following engagement with the Swansea Bay Executive Team, the service was placed in Level 3 escalation, with weekly improvement meetings established with Caswell senior leaders and monthly oversight meetings with the Health Board Executive. A detailed improvement plan		<table><tr><th>Action (NWJCC Lead- Director of Mental Health AC)</th><th>Action Due Date</th><th>Completion Date</th></tr><tr><td>In Committee update to JCC members</td><td>October 2025</td><td>October 2025</td></tr><tr><td>Letter to SBUHB Executive team</td><td>October 2025</td><td>October 2025</td></tr></table>			Action (NWJCC Lead- Director of Mental Health AC)	Action Due Date	Completion Date	In Committee update to JCC members	October 2025	October 2025	Letter to SBUHB Executive team	October 2025	October 2025																
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In Committee update to JCC members	October 2025	October 2025																											
Letter to SBUHB Executive team	October 2025	October 2025																											

aligned to recognised standards was developed, with a number of urgent actions identified. Admissions were paused pending assurance that immediate safety risks had been addressed.

February 2026 Update

Admissions were suspended in September 2025 due to significant staff and patient safety concerns. Immediate risk mitigation actions were implemented over a three-month period. Assurance was received in January 2026, and admissions recommenced on 9 January 2026.

Robust oversight remains in place, including:

- Weekly meetings between MHLDVG and Caswell senior leadership to monitor delivery of the action plan, with independent verification of completed actions.
- Fortnightly meetings between the MHLDVG Director and Swansea Bay Executive Team to seek further assurance and address delivery risks.

The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.

JCC to meet with Caswell SLT on a weekly basis	Complete	Complete
Suspension for new admissions to the clinic	Complete	Complete
JCC to meet with Caswell SLT on a fortnightly basis	Complete	Complete
Clinic reopen to admissions	January 2026	January 2026
JCC to meet with Caswell Team and Executive Lead monthly	April 2026	ongoing

Issues/Risks:

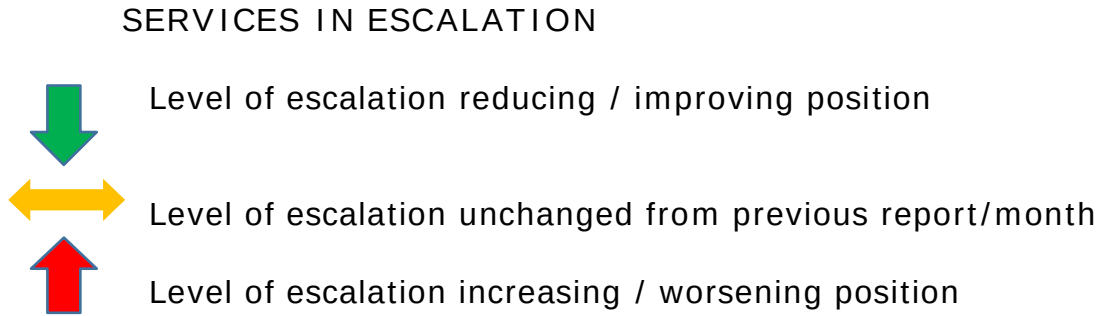
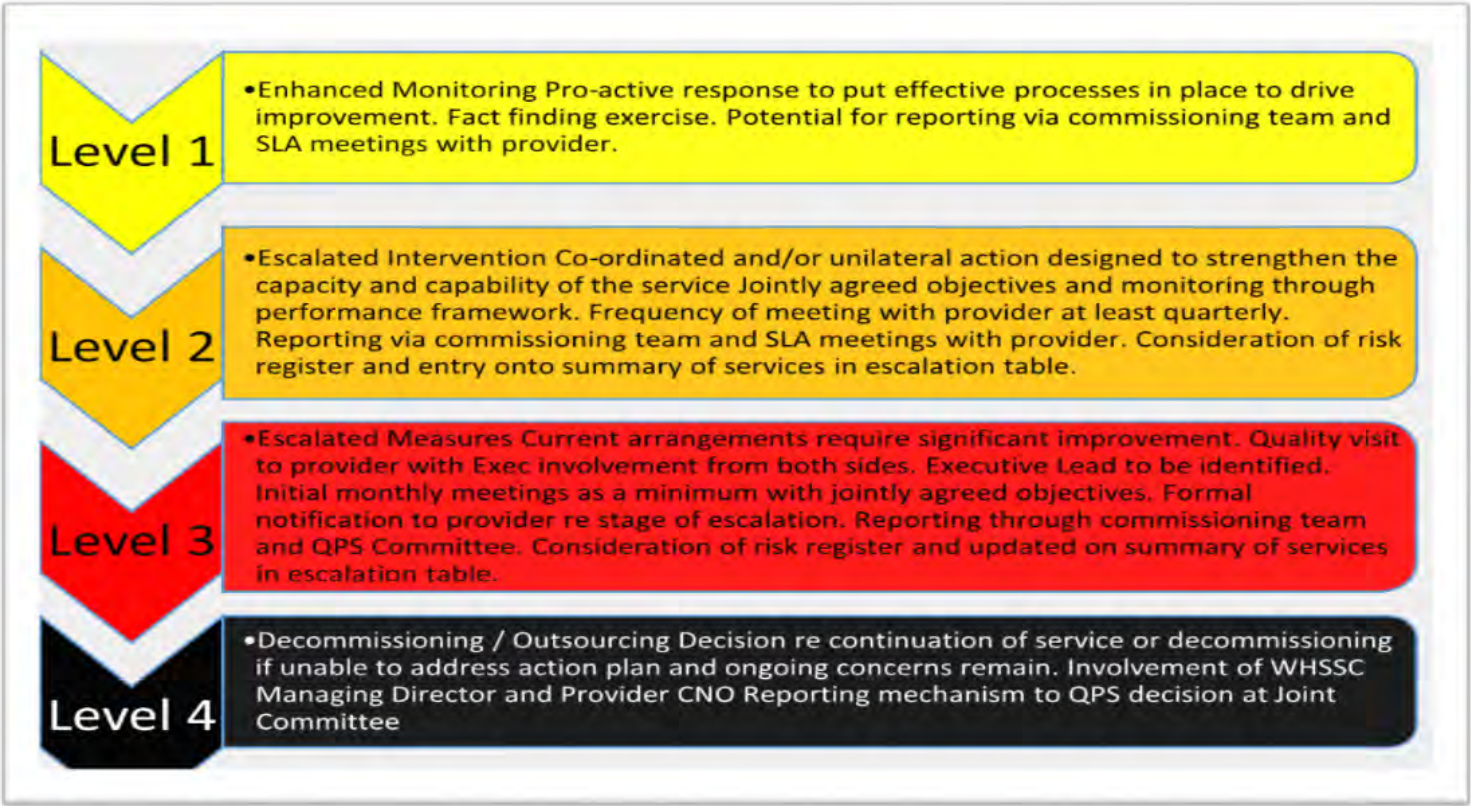
The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.

Caswell Clinic remain in Level 3 escalation. Discussions have been held within JCC to establish what needs to be done in order to reduce the level of escalation in the future. Caswell Clinic have been asked to complete the evidence section of the MHLDVG action plan. This will give the JCC a description of what the service has done in order to resolve or mitigate the issues raised at the time of the initial review. Once that has been received by the MHLDVG division, each action will be reviewed against the evidence supplied with a view to understanding what level of progress has been made and what the ongoing escalation level will be. The current series of meetings between the MHLDVG and SBUHB have been suspended and will be rearranged following receipt of the updated action plan from the service in order to ensure that the ongoing meetings are relevant, with the appropriate personnel, and discuss relevant points of the action plan”.

June 2026 – Following receipt of a consolidated report in late April 2026 evidencing significant progress against the original review findings, commissioning, quality safety and medical teams have undertaken a detailed assessment to identify the remaining actions required for de-escalation to level 2 monitoring. More integrated oversight arrangements are in place, via monthly escalation meetings from April 2026, with ongoing engagement with the service to support delivery. A clear set of outstanding actions are in place with the health board, with a commitment to review and sign off evidence on a rolling basis.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level 1 Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum: • Chair (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress, then further escalation will be required to Level 4. On the other hand, if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level DECOMISSIONING / OUTSOURCING	4 Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered, and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified, and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.
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Quality, Safety & Experience Committee

CTM Carers Programme – End of Year Progress Report
2025/26

Eitem yr Agenda / Agenda Item	6.2.5
Dyddiad y Cyfarfod / Date of Meeting:	22.09.26
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	David Watkins – Corporate Carers Lead
Cyflwynydd yr Adroddiad / Report Presenter:	Jenny Oliver, Head of Peoples Experience
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 Quality, Safety & Experience Committee is asked to: - NOTE the progress made during 2025/26 in strengthening the recognition, involvement and support of unpaid carers across CTMUHB. - RECEIVE LIMITED ASSURANCE that the programme is informed by lived experience, partnership working and organisational learning, while recognising that implementation remains variable and programme-wide outcome measures are still being developed. - NOTE the remaining challenges identified within the report, including variation in practice, workforce capacity, accessibility of support and the need to strengthen outcome measurement.



	SUPPORT the continued embedding of unpaid carer-inclusive practice into routine Health Board activity.
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> Strategic Context: <i>This report aligns to the following Strategic Pillars</i>	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)	The CTM Carers Programme supports delivery of CTMUHB priorities relating to person-centred care, quality, prevention, safe discharge and integrated community support. Through strengthening unpaid carer identification, involvement and access to information and support, the programme is intended to contribute to improved patient and carer experience, reduced variation in care and a more coordinated whole-system approach. The programme also supports the implementation of CTM 2030, the All-Wales People Experience Framework and the Health Board's strategic commitment to embedding lived experience within service improvement, quality assurance and organisational learning.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhofi'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

The CTM Carers Programme has continued to strengthen the recognition, involvement and support of unpaid carers across CTMUHB during 2025/26. The year has seen the programme move beyond awareness raising towards the development of a broader and more coordinated approach to unpaid carer support, informed by lived experience,



evidence to support that position etc)

partnership working and engagement across hospital, community and professional settings.

Key achievements during 2025/26 have included:

- development of the CTM Carers Passport and associated work to strengthen the identification and recognition of unpaid carers;
- development of an AI-supported chatbot to improve access to Information, Advice and Assistance, progressed in partnership with the University of South Wales and third sector colleagues;
- increased community engagement and unpaid carer voice, including Carers Week activity, carers cafés, community groups, Veterans engagement and direct conversations with patients, families and unpaid carers;
- strengthening of workforce awareness and education, including engagement with newly qualified nurses, district and community nursing teams, clinical services and professional groups;
- greater integration of unpaid carer perspectives into wider service improvement, including Stroke, dementia, Palliative and End of Life Care, Learning Disabilities, Falls and Pressure Ulcer prevention and other clinical pathways;
- continued development of partnership working with local authorities, County Voluntary Councils, third-sector organisations and regional partners;
- development of the Staff Carers Café, providing support, information and peer connection for CTMUHB employees with unpaid caring responsibilities; and
- increased visibility of lived experience within organisational governance and decision-making, helping ensure that the views of unpaid carers and families inform wider improvement activity.

Together, these developments indicate that unpaid carer support is beginning to be incorporated across a wider range of services and settings rather than being progressed solely through a standalone initiative. However, implementation is not yet consistent, and further evidence is required to demonstrate sustained change and impact.

Felly, beth (darparu dadansoddiad ystyrlon gan

The work undertaken during 2025/26 has moved the CTM Carers Programme towards a more coordinated



*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)*

*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)*

Health Board approach to recognising and supporting unpaid carers. Progress remains uneven, however: identification and recording are not yet consistent across services, workforce capacity may affect implementation, digital and non-digital access must be maintained, and programme-wide outcome measures are still being developed. The evidence therefore supports assurance on programme direction, engagement and planned controls, but not yet on consistent implementation or sustained impact.

Importantly, engagement has increasingly led to action. Lived experience from unpaid carers and families has informed practical developments, service improvement and workforce activity. For example, learning from a stroke patient and family story was subsequently used to support recruitment within stroke services, providing a clear example of how unpaid carer and family experience can influence practice beyond the original engagement. The programme has widened consideration of unpaid carers across community, clinical, workforce and governance settings. This provides evidence of increased reach and organisational attention; however, evidence is not yet sufficient to confirm consistent changes in practice or improved outcomes for unpaid carers across all services.

While programme-wide outcome measures are still being developed, the progress made during 2025/26 provides a strong foundation for evaluating whether these developments lead to more consistent identification, involvement, experience and access to support over time.

The next phase will focus on consolidating progress while addressing the remaining challenges of variation in practice, workforce capacity, accessibility and incomplete outcome evidence. Priorities will include implementing and evaluating the Carers Passport, testing the AI-supported information platform within the Bridgend pilot, progressing the Carer Identifier/Icon, maintaining non-digital routes to support, strengthening partnership and workforce engagement, and establishing proportionate measures and governance arrangements to assess impact and escalate implementation risks.

This will include continuing implementation of key developments, progressing the Carer Identifier/Icon, maintaining community and



	workforce engagement, strengthening links with partner organisations, and ensuring that unpaid carer voice continues to inform service improvement and organisational decision-making. A further priority will be to develop and agree a proportionate outcome framework. Measures will distinguish implementation from impact and will include, where feasible, reach and uptake; consistency of unpaid carer identification and recording; staff and carer experience; appropriate involvement in care and discharge planning; access to information and support; accessibility and equity; and evidence of service improvement arising from lived experience. Baselines, reporting frequency, ownership and escalation arrangements will be established as implementation progresses so that future assurance is based on trend and outcome evidence rather than activity alone.
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: • NOTE the achievements made during 2025/26 and the increasing integration of unpaid carer considerations across clinical, workforce, community and governance activity. • RECEIVE LIMITED ASSURANCE that engagement with unpaid carers and families is informing programme development, service improvement and organisational learning, while noting that the consistency and impact of resulting changes have not yet been fully evaluated. • ENDORSE the continued development of a coordinated Health Board approach to recognising and supporting unpaid carers. • SUPPORT the development of proportionate outcome measures to strengthen future assurance on impact.

1. Background / Context

1.1.

The CTM Carers Programme has developed in response to the need for a more consistent approach to recognising, involving and supporting unpaid carers across Cwm Taf Morgannwg University Health Board.

Unpaid carers can play a significant role throughout a person's health and care journey, including before admission, during periods of illness, throughout hospital care and following discharge. Their knowledge of the person they support can be valuable to clinical teams, while their own circumstances, confidence and access to appropriate support can influence both their experience and the sustainability of ongoing care.

Lived experience has consistently highlighted that people may not immediately recognise themselves as an unpaid carer and can move into significant caring responsibilities with little preparation. Recurring themes include the importance of early recognition, clear and compassionate communication, meaningful involvement in care and discharge planning, appropriate preparation and timely access to information, advice and support. Importantly, involvement should always reflect the individual unpaid carer's circumstances and choices and should not be assumed.

The programme has therefore sought to connect lived experience, service improvement, workforce development and partnership working, ensuring that unpaid carer support is considered across hospital, community and wider organisational activity rather than through isolated initiatives.

The following sections describe the key areas of work progressed during 2025/26 and, importantly, the learning and changes arising from that activity.

2. Strategic Insights

2.1. Carers Passport

During 2025/26, the CTM Carers Passport was developed as a practical approach to improving the recognition and involvement of unpaid carers during a patient's hospital stay.

The Passport was designed to support earlier conversations between staff and unpaid carers, clarify how an unpaid carer may wish to remain involved in the person's care, and provide a more consistent way of recognising their knowledge, circumstances and support needs. Importantly, involvement is based on individual choice and should not be assumed simply because someone has a caring role.

Development of the Passport was informed by lived experience and engagement with clinical teams, unpaid carers and families. Feedback reinforced the need for

the approach to be simple, practical and flexible enough to reflect different caring situations, including circumstances where hospital admission may provide important respite for the unpaid carer.

The work undertaken during 2025/26 established the foundations for a more structured and consistent approach to recognising unpaid carers as partners in care, while also highlighting the importance of clear staff communication and appropriate safeguards around choice and expectations.

Learning from phased implementation will inform further rollout during 2026/27. Brief ward-based training will support implementation, reflecting ward manager feedback. Post-launch monitoring and a three-month evaluation will assess reach and uptake, staff and unpaid carer experience, implementation barriers, consistency of identification and recording, and whether the Passport supports earlier recognition and more appropriate involvement in care. Findings will be reviewed through programme governance and used to refine the approach, target additional support and inform decisions on further rollout. As outcome measures are still being developed, early findings will be treated as indicative rather than conclusive evidence of impact.

2.2 AI Chatbot – Information, Advice and Assistance

During 2025/26, significant progress was made in developing an AI-supported chatbot to improve access to Information, Advice and Assistance for unpaid carers.

The project was developed in partnership with the University of South Wales and third-sector colleagues, with a total project value of £50,000. This included £25,000 secured through third-sector organisations, of which £10,000 was provided through the CTM Regional Partnership, alongside £25,000 match funding from the University of South Wales.

The funding supported a dedicated researcher role to develop and programme the chatbot and populate it with relevant service information. The initial pilot is focused on the Bridgend locality, allowing the approach to be tested on a limited basis before any consideration of wider rollout.

By the end of March 2026, the project had established the funding, researcher capacity and technical foundations required to develop and populate the chatbot. The chatbot is now in the final stages of development and will be trialled with unpaid carers groups in Bridgend during 2026/27, allowing feedback on usability, accessibility and usefulness to inform the approach before wider use within the pilot locality.

The AI Chatbot Implementation Group will engage with unpaid carers groups in Bridgend prior to launch, allowing carers to trial the chatbot and provide feedback on its usability, accessibility and usefulness. Following launch, the Regional Partnership will undertake outreach and engagement with unpaid carers and voluntary organisations, both to support people to make effective use of the chatbot and to gather qualitative feedback on their experience.

Evaluation will also draw on anonymised usage data collected by the University of South Wales, including information such as site visits, levels of use and broad themes in the information being sought. No personally identifiable data will be collected for this purpose. The same carers groups engaged before launch will be revisited approximately three months after launch, and findings from the different sources will be brought together to evaluate the usability, accessibility, relevance and overall value of the chatbot before any wider rollout is considered.

This phased approach is intended to reduce implementation risk, ensure that the chatbot is informed by unpaid carer experience, and provide a stronger evidence base for decisions about any future expansion.

2.3 Community Engagement and Unpaid Carer Voice

During 2025/26, the CTM Carers Programme significantly expanded opportunities to engage with unpaid carers, families and community partners across a range of settings.

Engagement activity included Carers Week events, carers cafés, community groups, Veterans engagement, ward-based conversations, primary care engagement and participation in wider health, social care and wellbeing forums. These opportunities provided different routes for unpaid carers to share their experiences and highlighted recurring themes around identification, communication, involvement in care and discharge planning, access to information and the need for timely support.

A key development has been the increasing use of this feedback to inform practical change rather than engagement being undertaken in isolation. Learning from unpaid carers has helped shape programme development, service improvement activity and workforce awareness, while also strengthening links with community and third sector support.

This work has also helped broaden the reach of the programme beyond hospital settings, recognising that many unpaid carers require support within their local communities and may not identify themselves through traditional health service routes.

The breadth of engagement undertaken during 2025/26 is set out in Appendix 1, which summarises the activity, who was involved, what was heard and how the learning informed subsequent action.

2.4 Workforce Awareness and Training

During 2025/26, work continued to strengthen workforce awareness of unpaid carers across a range of clinical and professional groups.

Engagement and training activity included newly qualified nurses, district and community nursing teams, Band 7 community managers and wider clinical and professional staff. The aim was to improve understanding of how unpaid carers can be identified, appropriately involved and connected to information and support as part of routine care.

A consistent theme throughout this work has been that unpaid carer recognition should not sit solely with specialist services. Staff across hospital and community settings have opportunities to identify caring roles, understand the impact that caring may have on an individual, and ensure that involvement in care is offered appropriately rather than assumed.

This activity has helped broaden unpaid carer awareness across the workforce and has supported the longer-term aim of embedding unpaid carer recognition within everyday practice rather than relying on individual champions or isolated initiatives.

The work undertaken during 2025/26 also provided a foundation for continued integration of unpaid carer awareness within staff education, professional development and service-specific learning.

2.5 Service Integration and Wider Clinical Work

During 2025/26, unpaid carer considerations were increasingly incorporated into wider clinical and service improvement activity across CTMUHB.

Work with Stroke services provided a particularly strong example of lived experience influencing wider improvement. Patient and family feedback highlighted the importance of communication, involvement, dignity and compassionate care. This learning was subsequently used within the Stroke service, including to support recruitment activity, demonstrating how patient and family experience can influence both service development and workforce activity.

Unpaid carer perspectives were also incorporated into Palliative and End of Life Care, recognising the significant role that family members and unpaid carers can play throughout serious illness, end-of-life care and bereavement. This helped ensure that unpaid carer needs were considered as part of wider service development rather than as a separate issue.

Engagement also extended into areas including Learning Disabilities, Dementia, Falls and Pressure Ulcer prevention, Mouthcare Improvement and other clinical and professional forums. These opportunities helped raise awareness of the contribution unpaid carers can make to prevention, continuity of care and recognising deterioration, while reinforcing that any involvement must remain appropriate, agreed and responsive to individual circumstances.

Taken together, this work demonstrates a broader shift towards embedding unpaid carer awareness within existing clinical pathways and improvement activity, helping to ensure that learning from unpaid carers and families influences services beyond the core Carers Programme.

2.6 Partnership Working and Governance

During 2025/26, partnership working continued to strengthen across the CTM region, helping to connect Health Board activity with wider statutory, voluntary and community support for unpaid carers.

The programme has worked closely with the Regional Partnership, Local Authority unpaid carers leads, County Voluntary Councils, Third sector organisations and other regional partners. These relationships have supported shared learning, improved awareness of available community-based support and helped create clearer links between Health Board services and wider information, advice and assistance.

Partnership activity has also provided opportunities to hear from unpaid carers in a range of settings and to ensure that local experience informs programme development. This has been particularly important in recognising that many of the challenges faced by unpaid carers extend beyond the hospital environment and require coordinated responses across health, social care and the voluntary sector.

Within CTMUHB, unpaid carer experience has increasingly been incorporated into wider People Experience and governance arrangements, helping to ensure that lived experience contributes to organisational learning, service improvement and senior oversight.

The work undertaken during 2025/26 has therefore helped strengthen the infrastructure around the programme, creating a more connected approach in which unpaid carer voice, service learning and partnership intelligence can be brought together to inform improvement across organisational boundaries.

The planned re-establishment of the regional Carers Steering Group will provide a further opportunity to build on this foundation by bringing together unpaid carers, statutory partners and third sector organisations within a dedicated forum for shared priorities and coordinated improvement.

2.7 Staff Carers Café

During 2025/26, the Staff Carers Café was developed to provide a dedicated space for CTMUHB employees who also have unpaid caring responsibilities.

Initial attendance was encouraging, and staff who attended valued the opportunity to connect with colleagues in similar circumstances, share experiences and access information and signposting to relevant support. The Café also helped raise awareness of the additional pressures that can arise when individuals are balancing employment alongside an unpaid caring role.

However, attendance reduced over time and some sessions had to be cancelled due to low numbers. This highlighted that, while the offer was valued by those who attended, the timing and accessibility of sessions may not have suited the wider staff carer population.

This learning has informed a review of the current approach, including consideration of different days and times to determine whether this improves accessibility and participation.

The Staff Carers Café therefore remains a useful mechanism for peer support and staff engagement, but the experience during 2025/26 has also demonstrated the importance of adapting the model in response to attendance and feedback to ensure it is sustainable and meets the needs of staff carers.

2.8 Unpaid Carer Identification and Recording

During 2025/26, work continued to strengthen the identification and recording of unpaid carers across CTMUHB.

Consistent identification is important because unpaid carers may not always recognise themselves as having a caring role, and staff may not routinely identify or record this information unless there is a clear process for doing so. Earlier recognition creates an opportunity for meaningful conversation, appropriate involvement in care and discharge planning, and access to relevant information and support.

The work undertaken during the year has helped reinforce that identification should not be viewed simply as an administrative exercise. Its value lies in what follows: recognising the knowledge and circumstances of the unpaid carer, understanding whether and how they wish to be involved, and connecting them with appropriate support where required.

Progress during 2025/26 has therefore focused on strengthening the visibility of unpaid carers within existing systems and promoting more consistent approaches to recognition across clinical settings.

Further work will be required to improve consistency of recording and to develop proportionate measures that demonstrate whether unpaid carers are being identified earlier and supported more effectively as a result.

3. Risks and Opportunities

3.1 Key Risks and Mitigations

The principal strategic risk is that inconsistent identification, involvement and support of unpaid carers may contribute to avoidable variation in experience, discharge planning and access to timely support, limiting progress against Strategic Risk 8: Prevention and Early Intervention and the Health Board's person-centred care priorities. Current mitigations include phased implementation, practical ward-based training, partnership working, continued non-digital access routes, monitoring and time-limited evaluation. These controls reduce implementation risk but do not yet provide assurance of consistent practice or improved outcomes across CTMUHB. Although significant progress was made during 2025/26, several risks remain as the programme continues to develop. These are being addressed through phased implementation, engagement, monitoring and evaluation.

- Variation in identification and involvement of unpaid carers. Practice is not yet consistent across all services and settings, creating a risk that unpaid carers may experience different levels of recognition, involvement and access to support. This is being mitigated through phased implementation, learning from earlier testing, and workforce engagement. For the Carers Passport, ward managers have informed the training approach, with short face-to-face ward-based sessions identified as the preferred method for supporting staff implementation.

- Demonstrating impact

Current information does not yet provide a complete picture of programme outcomes. Outcome measures are therefore being developed alongside implementation, with evaluation focused on whether key initiatives improve identification, involvement, experience and access to support. This will enable future assurance to move increasingly from reporting activity and engagement towards demonstrating outcomes and impact.

- Workforce capacity and sustainability.

Competing operational pressures may limit the ability of teams to adopt and sustain new approaches, creating a risk that implementation remains dependent on local capacity and individual leadership. Mitigation includes brief ward-based training, integration with existing education and governance arrangements, and a practical implementation model. Uptake and barriers should be monitored so that areas requiring additional support can be identified and escalated.

- Accessibility, digital inclusion and information quality.

The AI-supported information platform may not meet the needs of all unpaid carers, and inaccurate, outdated or inaccessible information could reduce trust or delay access to appropriate support. Mitigation includes a limited Bridgend pilot, pre- and post-launch testing with unpaid carers, outreach through the Regional Partnership and voluntary organisations, anonymised usage monitoring, continued non-digital routes, and review of content quality and accessibility before any wider rollout is considered.

3.2 Evaluation and Learning

Evaluation will form an important part of the next phase of the programme.

For the Carers Passport, implementation will be supported by post-launch monitoring and a three-month evaluation, drawing on learning from the phased approach and feedback from staff and unpaid carers. This will help assess uptake, implementation experience, barriers and whether the Passport is supporting earlier identification and more appropriate involvement of unpaid carers.

Evaluation will combine anonymised usage data collected by the University of South Wales with qualitative engagement undertaken by the Regional Partnership and feedback from unpaid carers in Bridgend. Carers groups will trial the platform before launch and will be revisited approximately three months afterwards. Findings will assess reach, repeat use, accessibility, usability, relevance and accuracy of information, broad themes in enquiries, user confidence and any unintended barriers or inequalities. The Implementation Group will review the combined evidence, identify required changes and make a documented recommendation on whether the pilot should continue, be refined or be considered

for wider rollout. Early findings will inform decision-making but will not, in isolation, demonstrate longer-term impact.

3.3 Opportunities

The work undertaken during 2025/26 provides an opportunity to embed unpaid carer recognition more consistently across clinical and community services, strengthen the use of lived experience within service improvement, and improve connections between Health Board and community-based support.

The combination of phased implementation, engagement and planned evaluation also provides a stronger foundation for developing proportionate outcome measures and demonstrating more clearly, over time, the difference that unpaid carer involvement and support makes.

4. Compliance and Governance

4.1

The CTM Carers Programme is supported through Corporate Nursing and People Experience leadership and existing Health Board governance arrangements.

The programme aligns with CTMUHB's wider approach to person-centred care, quality and lived experience, including the principles reflected within the All-Wales People Experience Framework and CTM 2030. Unpaid carer experience is increasingly considered alongside patient experience and wider service improvement rather than as a separate area of activity.

Oversight through the Quality, Safety & Experience Committee provides a route for progress, learning and emerging risks to be considered at organisational level and for unpaid carer experience to inform wider decision making.

Programme development also takes account of relevant equality, Welsh language and quality requirements, with accessibility, inclusion and language needs considered as part of ongoing improvement.

As the programme matures, assurance will progressively incorporate agreed process and outcome measures alongside qualitative evidence. Until baselines and trend data are available, reporting will distinguish activity, implementation learning and early indications of benefit from demonstrated impact, and will continue to highlight variation, barriers and residual risk.

6. Conclusion

6.1.

The CTM Carers Programme made significant progress during 2025/26 in strengthening the recognition, involvement and support of unpaid carers across CTMUHB.

The year saw a broader range of work become established across hospital, community, workforce, partnership and governance settings. Importantly, lived

experience has increasingly been used to inform practical change, service improvement and organisational learning rather than being gathered in isolation.

The progress made during 2025/26 indicates movement towards a more coordinated and integrated approach, with unpaid carer considerations becoming more visible across wider Health Board activity. However, variation in implementation remains, and further evaluation is required before consistent organisational impact can be demonstrated.

The next phase will focus on consolidating this progress, embedding established work into routine practice, progressing outstanding developments such as the Carer Identifier/Icon, and developing proportionate outcome measures so that future assurance can demonstrate more clearly the impact of the programme on unpaid carers and the people they support.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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 8 Prevention & Early Intervention		
	If more than one applies please list below: Community & Partner Engagement		
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: A more equal Wales		
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective		
	If more than one applies please list below: Culture & Valuing People		
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	Outcome for Equality (delete as appropriate): POSITIVE	If no, please select a reason below.	



(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.)

Summary of impact:

The CTM Carers Programme is anticipated to deliver a positive equality impact by strengthening the recognition, involvement and support of unpaid carers. The programme is expected to be of particular benefit to older people, disabled people, individuals experiencing socio-economic disadvantage, and those with caring responsibilities, through improved communication, more person-centred care and enhanced access to appropriate support.

Outcome for Welsh Language (delete as appropriate):
POSITIVE

Summary of impact:

The CTM Carers Programme is expected to have a positive quality impact by strengthening the recognition, involvement and support of unpaid carers across hospital, community and wider service settings. During 2025/26, lived experience and engagement increasingly informed practical service improvement, workforce learning and organisational decision-making.

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)

The CTM Carers Programme has the potential to deliver a positive quality impact by strengthening the recognition, involvement and support of unpaid carers across hospital, community and wider service settings. During 2025/26, lived experience and



Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	engagement increasingly informed practical service improvement, workforce learning and organisational decision-making. The programme is intended to support person-centred care, communication, appropriate involvement in care and discharge planning, and access to information and community-based support. However, implementation remains variable and programme-wide outcome measures are still being developed. Planned monitoring and evaluation of the Carers Passport and AI-supported information platform will provide evidence on uptake, accessibility, experience and early outcomes, inform mitigation of identified risks and support future assessment of quality impact. The programme supports person-centred care, improved communication, appropriate involvement in care and discharge planning, and stronger connections to information and community-based support. The breadth of work across clinical services, workforce development and partner organisations also supports a more consistent and coordinated approach to unpaid carer-inclusive practice. Ongoing learning and the development of proportionate outcome measures will support future evaluation of impact and help ensure that improvements remain safe, accessible and responsive to the needs of patients and unpaid carers.
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) No additional resource decision is requested from the Committee as part of this report. The AI Chatbot project has a total project value of £50,000, comprising £25,000 secured through third-sector/Regional Partnership funding and £25,000 match funding from the University of South Wales, which has supported a dedicated researcher role. Wider programme activity is being



progressed through existing organisational and partnership arrangements.

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

Committee / Group / Individuals	Date	Outcome
Unpaid carers, patients and families; clinical teams; community and third sector organisations; Regional Partnership and local authority partners; NHS Wales Spread & Scale Academy. See Appendix 1 for detailed engagement activity.	Throughout 2025/26	Engagement activity during 2025/26 has directly informed the development of the CTM Carers Programme, with lived experience highlighting key themes around identification, communication, involvement in care and access to support. Engagement with carers, staff, clinical services and partner organisations has shaped practical improvements, including the Carers Passport and wider carer-inclusive approaches. Partnership working has strengthened links to community-based support, while learning from lived experience has increasingly informed service improvement, workforce development and organisational learning across CTMUHB. A summary of engagement and



		programme activity undertaken during 2025/26 is provided at Appendix 1.
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Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
QSEC	Quality, Safety & Experience Committee
AI	Artificial Intelligence
IAA	Information, Advice and Assistance
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
PCH	Prince Charles Hospital
YCR	Ysbyty Cwm Rhondda
NHS	National Health Service
EWLIA	Equality and Welsh Language Impact Assessment
Glossary of Terms	
Unpaid carer	A person who provides unpaid care or support to a family member, friend or other person because of illness, disability, mental health needs, frailty or other care and support needs.

Appendix 1 – Summary of Unpaid Carer Engagement and Programme Activity 2025/26			
Engagement / Activity	Who was involved	What was heard / learnt	What this informed or changed
CTMUHB Carers Week activity – June 2025	Unpaid carers, patients, CTMUHB staff, third sector organisations and partners across PCH, RGH and POW	Highlighted the wide range of unpaid caring roles and the importance of visible, accessible information and support in hospital settings.	Increased visibility of unpaid carers across acute sites and strengthened links with third sector support organisations.
Stroke Carers Café	Stroke patients, unpaid carers, Stroke services, Therapies and partner organisations	Demonstrated the value of providing an informal and accessible space where unpaid carers and patients could ask questions, share experiences and connect with relevant information and support.	Learning from the event supported the establishment of the Stroke Carers Café as a quarterly event, providing an ongoing opportunity for engagement, information and support.
Stroke patient and family story	Patient/family, Stroke service and wider CTMUHB colleagues	Highlighted the importance of communication, dignity, compassionate care and family involvement.	Informed service learning and was later used to support stroke nurse recruitment.
Veterans engagement event	Veterans, unpaid carers, Armed Forces/Veterans organisations and partners	Highlighted the overlap between veteran communities and unpaid caring responsibilities.	Strengthened links with Veterans networks and widened opportunities for unpaid carer awareness and support.
Regional Learning Disability Navigators Network	Learning Disability Navigators and regional partners	Highlighted the importance of recognising family and unpaid carer roles in supporting people with learning disabilities.	Strengthened consideration of unpaid carers within regional learning disability support pathways.
Creating Spaces for Meaningful Engagement – people with learning disabilities and unpaid carers	People with learning disabilities, unpaid carers and professionals	Reinforced the need to ensure both individuals and unpaid carers have meaningful opportunities to contribute.	Supported inclusion of unpaid carer views in wider engagement work.
Bridgend Carers Group engagement	Unpaid carers and local support organisations	Provided lived experience insight into the challenges faced by	Helped inform the wider CTM Carers Programme and ensured

		unpaid carers and their contact with health and care services.	local unpaid carer voice shaped development.
Regional Partnership Board engagement event	Unpaid carers, RPB partners, local authorities, third sector and CTMUHB	Highlighted the need for stronger mechanisms for unpaid carers and partners to influence priorities.	Supported discussion on the re-establishment of the regional Carers Steering Group.
Ward visits with PALS	Patients, families, unpaid carers and PALS staff	Provided direct feedback on patient and family experience and helped identify people who may not see themselves as unpaid carers.	Strengthened links between Patient Experience and unpaid carers work and informed programme development.
GP surgery engagement	Primary care staff and GP practices	Focused on recognising unpaid carers in primary care and the importance of identification, information and signposting.	Raised awareness in primary care and promoted earlier identification and support.
Falls and Pressure Ulcer event	Clinical staff and improvement teams	Explored how unpaid carers can support prevention and recognise deterioration, while avoiding inappropriate transfer of responsibility.	Introduced unpaid carer involvement into wider prevention and improvement discussions.
Cultural Competence training	CTMUHB staff and training participants	Highlighted how culture, language and family context can affect identification of unpaid carers.	Strengthened consideration of diversity and inclusion in unpaid carer identification and engagement.
Care and Nursing Home event	Care-home and nursing-home staff and partner organisations	Focused on how family members and unpaid carers can remain appropriately involved in care and decision-making.	Raised awareness of unpaid carers as partners in care in residential settings.

District and Community Nurse training	District nurses and community nursing teams	Highlighted the opportunity to identify unpaid carers in the home and recognise support needs that may not be visible in hospital settings.	Strengthened workforce awareness of identification, support and signposting in community settings.
Newly Qualified Nurse training	Newly qualified nurses	Focused on recognising unpaid carers in everyday practice and understanding the importance of communication and involvement.	Helped embed unpaid carer awareness early in professional practice and supported culture change.
Band 7 Community Managers – Bridgend	Band 7 community managers	Considered how managers can support staff to identify, support and signpost unpaid carers.	Strengthened leadership awareness and promoted unpaid carer support as part of routine community practice.
Volunteer engagement – questionnaires and Carers Passport	CTMUHB volunteers, patients, unpaid carers and families	Volunteers provided an additional route for gathering feedback and reaching people in clinical settings.	Supported questionnaire distribution, feedback gathering and wider Carers Passport engagement.
Merthyr Tydfil Health, Social Care and Wellbeing Forum	Health, social care, voluntary-sector and community organisations	Highlighted that unpaid carer identification and support is a shared responsibility across organisations.	Increased awareness across partner organisations and supported coordinated signposting and support.
Mouthcare Improvement meeting	Clinical teams and improvement leads	Explored how unpaid carers may support oral hygiene and the need for suitable information and guidance.	Introduced the unpaid carer perspective into mouthcare improvement work.
Turning Ponty Blue dementia activity group	People living with dementia, unpaid carers, community organisations and CTMUHB representatives	Highlighted the importance of accessible community based support for people living with dementia and unpaid carers.	Increased awareness of support and provided another route for hearing unpaid carer voices.

Welsh Government Health and Social Care Committee evidence	Welsh Government Committee and stakeholders	Provided evidence on CTMUHB activity and wider challenges affecting unpaid carers.	Enabled local learning to contribute to national discussion on support for unpaid carers.
NHS Wales Spread & Scale Academy	CTMUHB multidisciplinary team and NHS Wales improvement colleagues	Supported structured thinking on how the Carers Passport could be tested, refined and scaled.	Strengthened the implementation and evaluation approach for the Carers Passport.
Staff Carers Café	CTMUHB employees with unpaid caring responsibilities	Highlighted the value of peer support, information and signposting for staff who are also unpaid carers.	Established an ongoing mechanism for peer support and recognition of staff with caring responsibilities.
Palliative and End of Life Care engagement	PEoLC services, multidisciplinary colleagues and partners	Highlighted the importance of recognising and supporting unpaid carers through serious illness, end-of-life care and bereavement.	Helped incorporate unpaid carer considerations into wider PEoLC service development.



Quality, Safety & Experience Committee

Quality, Safety & Experience Dashboard

Eitem yr Agenda / Agenda Item	6.2.6
Dyddiad y Cyfarfod / Date of Meeting:	22/09/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter:	Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Committee are being asked to - NOTE the content of the report - DISCUSS the content of the report and flag areas (if not already identified) where further assurance is required NOTE the risks identified

1. Situation / Background

The report provides an overview of patient safety, quality and experience performance for the period 1st July to 31st August 2026, highlighting both areas of improvement and ongoing risks requiring assurance.

2. Summary

2.1 Listening to People and Complaints

- 254 complaints and 696 enquiries were received during the reporting period.
- Early Resolution activity increased from 105 to 120 cases, whilst formal complaints reduced from 143 to 134 cases.
- 75% of complaints initially managed through Early Resolution remained within that pathway.
- Formal complaint compliance was 89%, remaining above the Health Board's internal target of 85%.

2.2 Public Services Ombudsman for Wales (PSOW) Activity

- 24 open PSOW cases remain following reconciliation activity.
- A number of actions arising from Early Settlement recommendations and Final Reports remain in progress.
- Ongoing monitoring arrangements are in place to support completion of outstanding actions and recommendations.

2.3 Patient Safety Incidents

- 5,116 incidents were reported during the reporting period.
- Pressure Damage/Moisture Damage, Accidents/Injuries, Behaviour, Medication and Maternity incidents remain the highest-volume classifications.
- 32 NRIs remained open at the reporting cut-off date, of which 18 were outside the applicable completion timescale.

2.4 Learning from Incident Review

- Reporter-assessed harm, Manager's Interim Harm Assessment and post-investigation harm assessments continue to be reviewed through the Incident Management Framework.
- Ongoing audit and review activity is being undertaken to support consistency in harm grading and application of harm assessment processes.

2.5 Duty of Candour

- 28 Duty of Candour triggers were identified during July and August 2026.

- Monitoring and governance arrangements remain in place, including Rapid Review, multidisciplinary oversight, Care Group governance arrangements and Executive review processes.
- Further case-level validation is undertaken where differences exist between trigger numbers and recorded notifications.

2.6 Inquests and Claims

- 27 new inquests were received and 21 cases closed.
- 22 new Clinical Negligence Claims were received and 16 progressed to settlement stage.
- Claims and inquest activity continue to contribute to organisational learning and quality improvement activity.

2.7 Key Quality Metrics

- Medication incidents increased from 324 to 327 incidents.
- Patient falls increased from 505 to 514 incidents.
- Pressure damage, falls reduction, medication safety and mental health safety remain key improvement priorities.

3. Specific Matters for Consideration

3.1 Patient / Service User Feedback

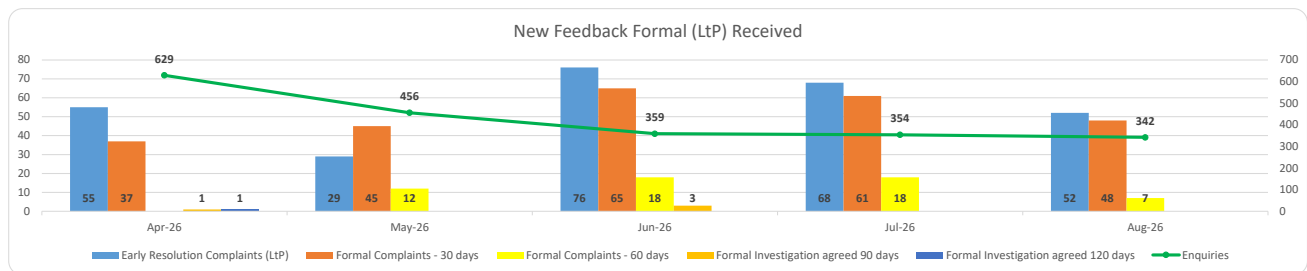
As we move through the second quarter of implementation, the Listening to People (LTP) framework is becoming increasingly embedded across the Health Board. Introduced on 1st April 2026 to replace the previous Putting Things Right arrangements, LTP represents a significant shift towards earlier engagement, stronger communication and a more person-centred approach to managing concerns. The new legislation places listening, empathy and early resolution at the centre of practice, supporting individuals to feel heard and understood at the earliest opportunity. Emerging performance trends indicate increasing use of Early Resolution and a reduction in concerns progressing to formal investigation, which is consistent with continued implementation of the Listening to People framework across the organisation.

Complaints & Enquiries

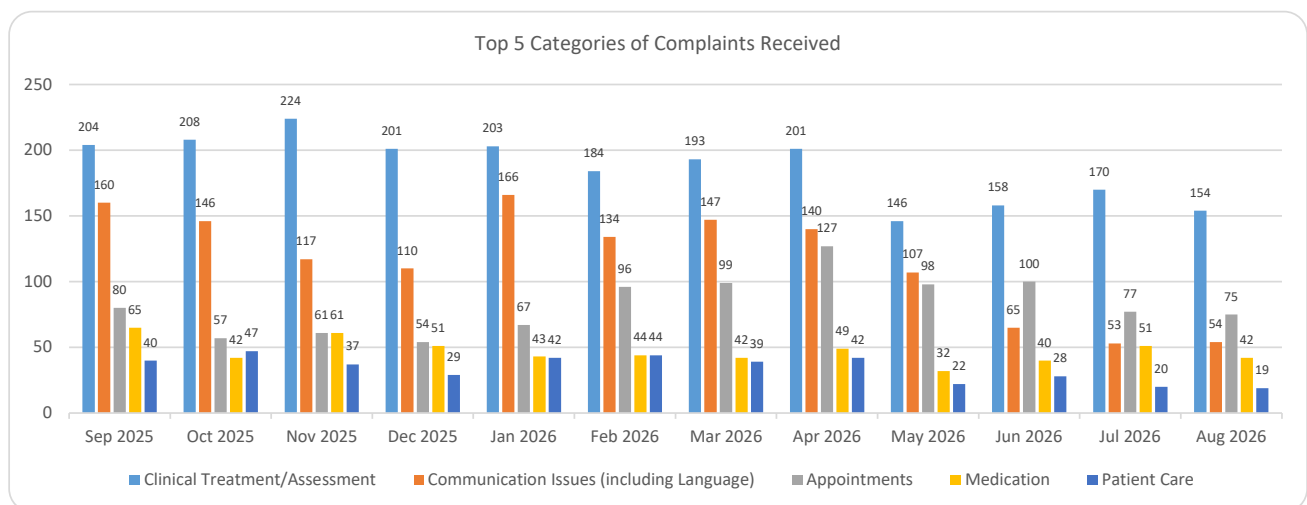
New Complaints Received - Listening to People (LTP)

Between the 1st July to 31st August 2026 the Health Board received a total of 254 complaints and 696 enquiries. Of the 254 complaints, 120 have been managed under the new early resolution process and 134 are being managed in the formal process.

We have seen an increase in the number of cases being managed under early resolution from 105 (1st May to 30th June 2026) to 120 (1st July to 31st August 2026) and a reduction in the number of cases managed formally from 143 (1st May to 30th June 2026) down to 134 (1st July to 31st August 2026), which is consistent with the increased use of the Early Resolution pathway under the Listening to People framework.



For all feedback (Complaints and Enquiries) received between the 1st July to 31st August 2026, accounting for 62% of the feedback received, the top 3 types remain consistent with the previous two months (1st May to 30th June 2026). These relate to Clinical Treatment / Assessment (324), Appointments (152) and Communication Issues (including Language) (107).

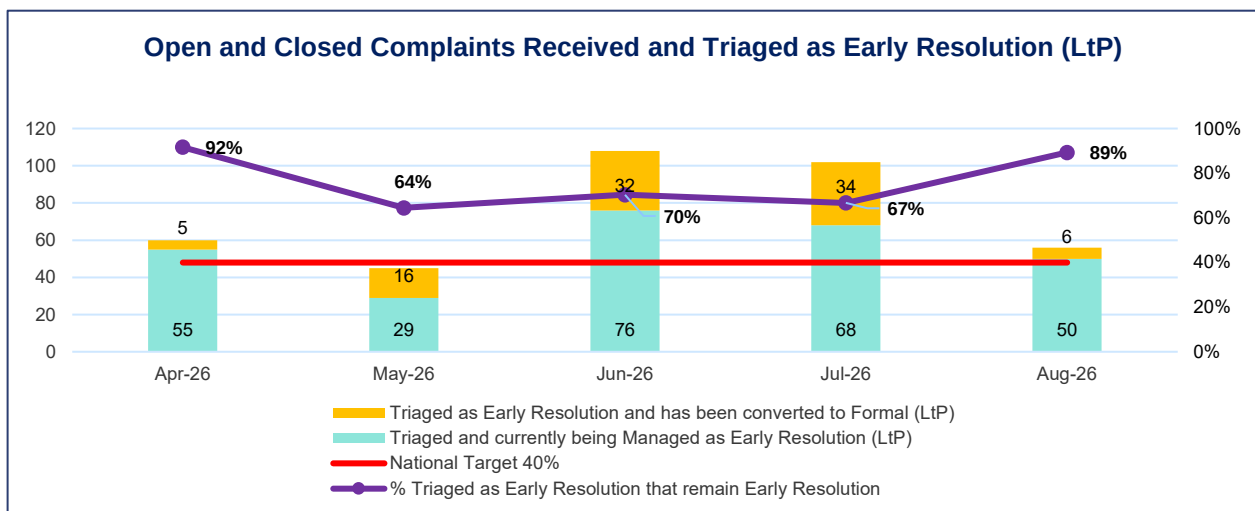


Closed Complaints

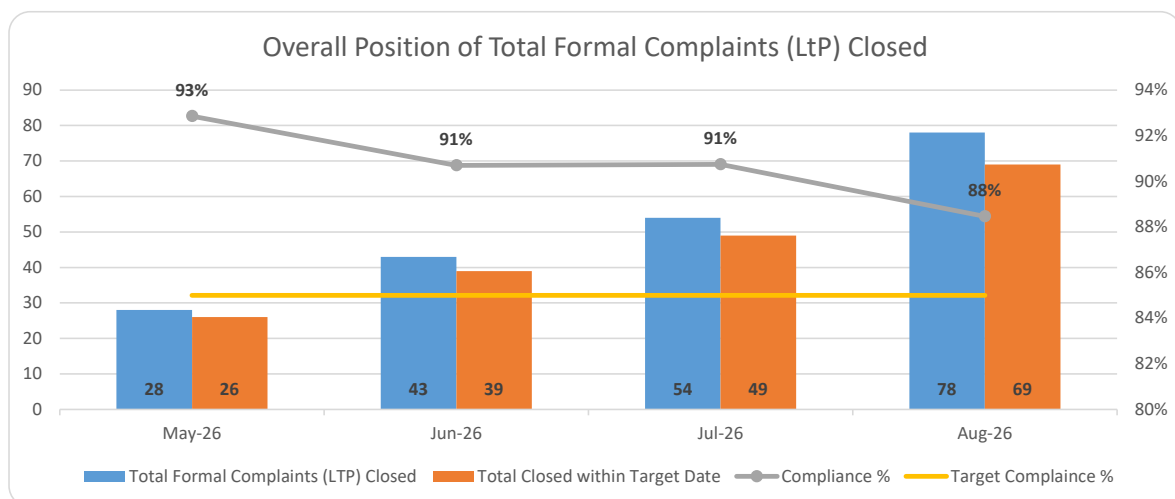
Listening to People

Within the period of the 1st July to 31st August 2026, the Health Board had logged 158 complaints as Early Resolutions (LTP). Of those complaints (158) received that were triaged as Early Resolution (LTP), 40 were transferred to Formal Investigations (LTP). Therefore, 75% of those complaints triaged as Early Resolution (LTP) were managed as Early Resolution (LTP).

This compares to the previous two months (1st May 2026 to 30th June 2026), the Health Board had logged 153 complaints as Early Resolutions (LTP). Of those complaints (153) received that were triaged as Early Resolution (LTP), 48 were transferred to Formal Investigations (LTP). Therefore, 69% of those complaints triaged as Early Resolution (LTP) were managed as Early Resolution (LTP).



LTP Closed Compliance



Between 1st July and 31st August 2026, a total of 132 formal complaints (LTP) were closed, of which 118 were closed within the target timescale, resulting in an overall compliance rate of 89%. This exceeds the Health Board internal target of 85%.

Compared with the previous two-month period (1st May to 30th June 2026), the number of formal complaints closed increased from 71 to 132, whilst the number closed within target increased from 65 to 118. Compliance reduced slightly from 92% to 89%.

Assurance and Impact

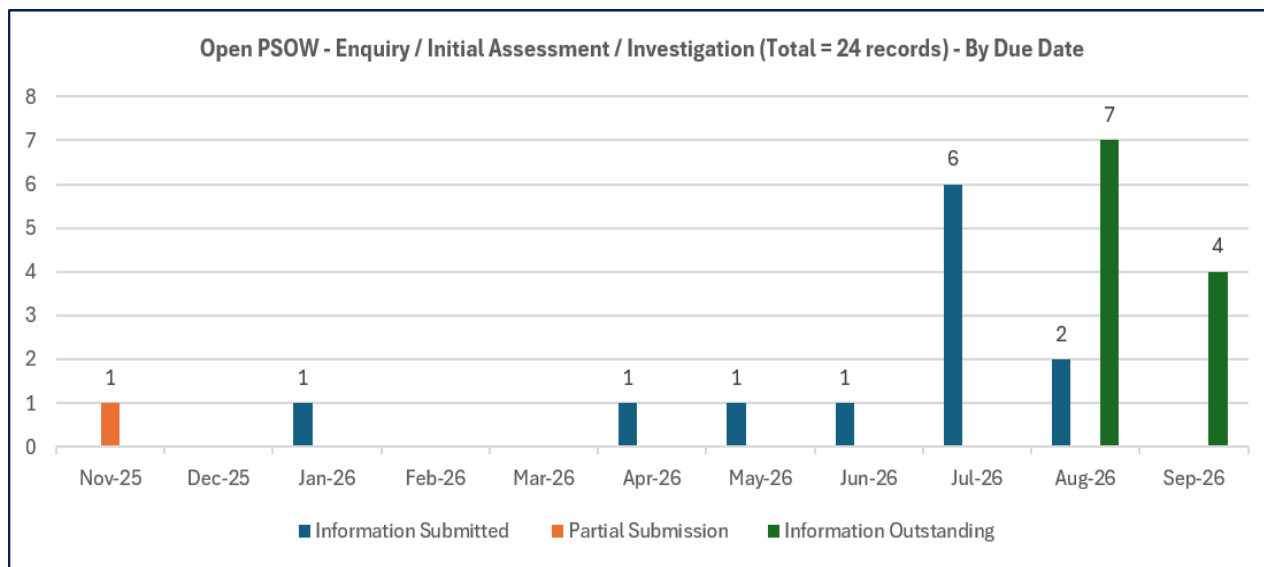
The increase in complaints successfully managed through Early Resolution is consistent with the intended direction of the Listening to People framework. Ongoing monitoring of conversion rates, timeliness and outcomes will continue to be undertaken to ensure that improvements are sustained and that individuals receive a consistent and person-centred experience.

Whilst demand for concerns services remains significant, the reduction in overall enquiries and the sustained use of Early Resolution provides assurance that the Health Board is increasingly managing concerns through earlier intervention and improved communication. Analysis of themes continues to inform service improvement activity across Care Groups, with recurring issues relating to clinical treatment, appointments and communication being escalated through governance arrangements to support targeted improvement activity.

Public Services Ombudsman for Wales (PSOW)

PSOW Open cases

The Health Board has 24 open PSOW cases. This has reduced significantly following a reconciliation with the PSOW.



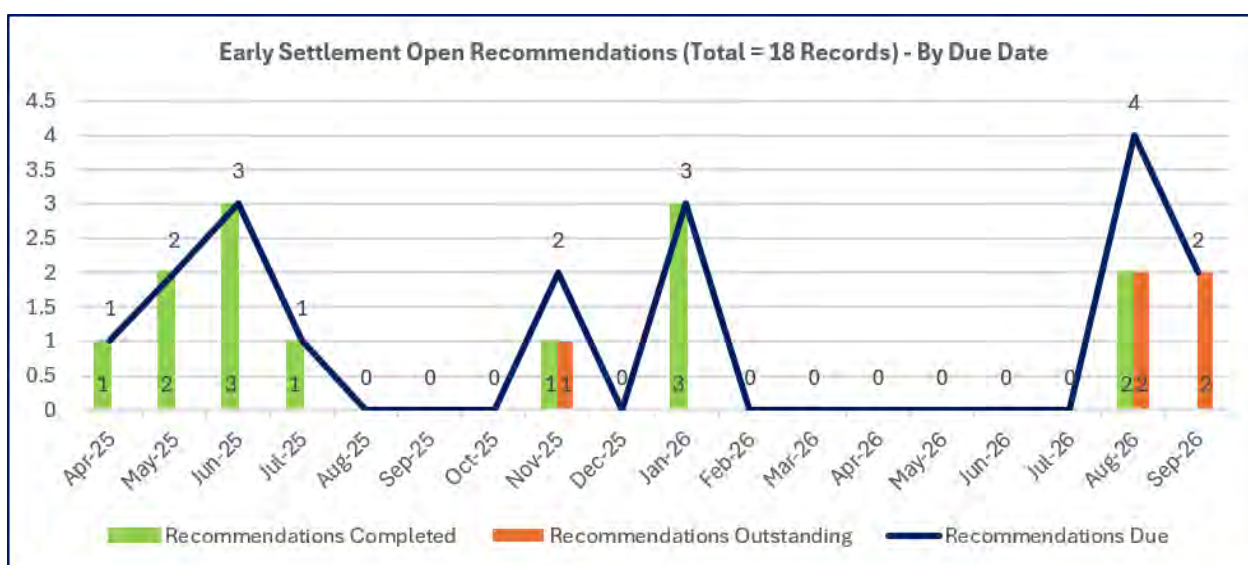
PSOW Early Settlement Recommendations

There are three outstanding actions:

Nov-25 – This relates to an ongoing redress case, where the PSOW has been regularly updated on progress and has requested a copy of the response letter in due course.

Aug-26 – Two actions on the same case are due for completion by the deadline of 19/8/26. These consist of an apology and further response letter to the patient which are currently being progressed.

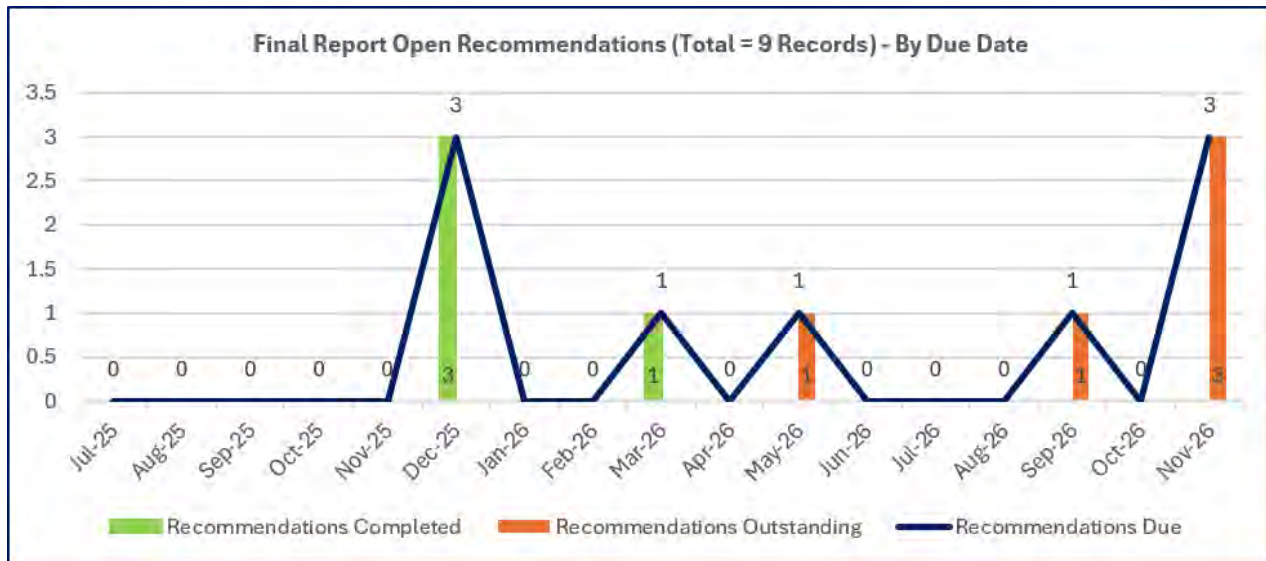
Sep-26 – The deadline for a further response letter to the patient has been extended to 18/9/26. The PSOW has been updated and has agreed to this extension. The second case is being progressed in order to meet compliance by September 2026



PSOW Final Reports

The Health Board has 9 cases currently in the final report stage of the PSOW process. There is 1 recommendation that remains outstanding:

May-26 – Since submission of the final action plan, the PSOW has requested further evidence. Whilst the PSOW has not indicated a deadline for the additional evidence, it is currently being progressed within the T&O service and monitored by the Concerns Team.



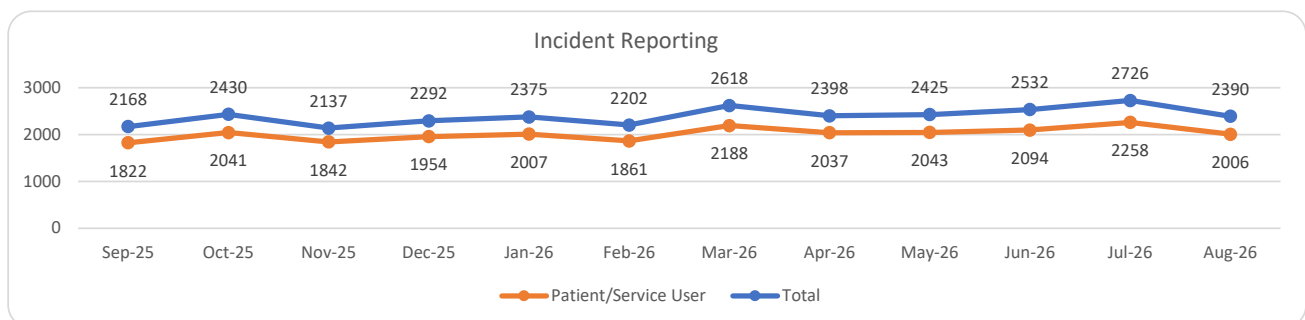
Assurance and Impact

Although PSOW activity continues to require significant organisational focus, there is evidence of progress in reducing the number of open cases following reconciliation work and in progressing actions arising from Early Settlement recommendations and Final Reports. Outstanding actions continue to be monitored through established governance arrangements, with responsible leads identified and progress tracked through the Concerns Team. This provides oversight of recommendations arising from PSOW investigations and supports progression toward completion, although continued focus is required to ensure compliance with agreed timescales.

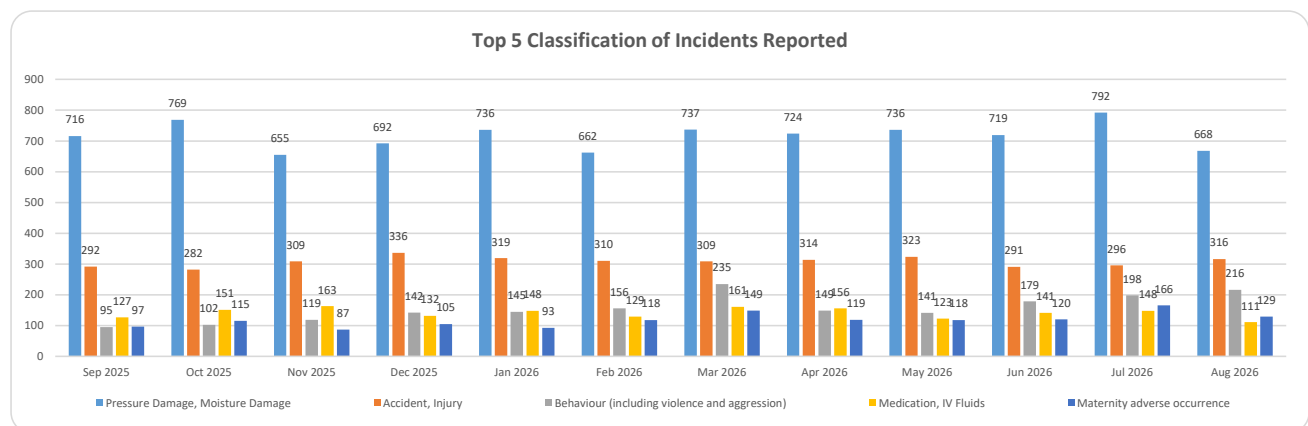
3.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 5,116 incidents were reported as occurring between 1st July and 31st August 2026, this represents an increase of 159 when compared with the previous 2 months (4,957). The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 5,116 incidents reported, 83% (4,264) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.



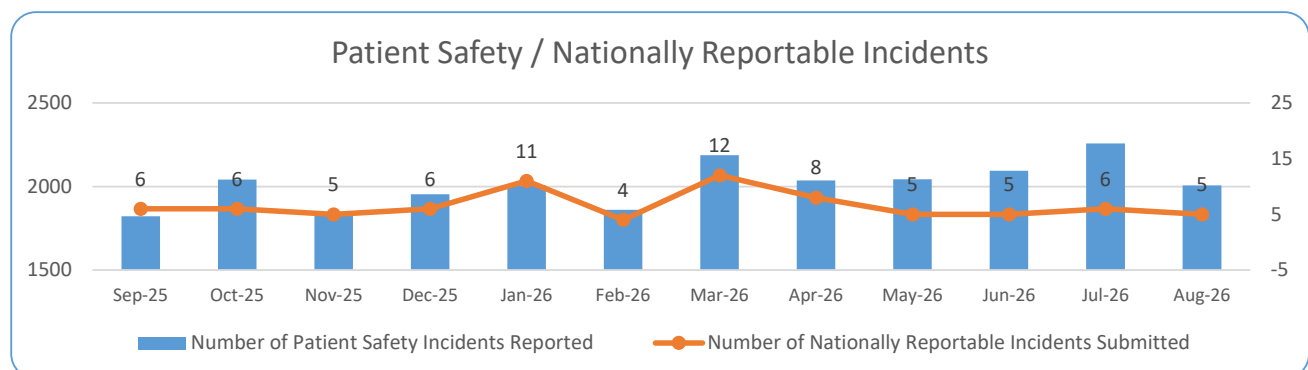
The top 5 classification of incidents reported as occurring in July and August 2026, linked to a patient affected incident are: Pressure Damage /Moisture Damage (1,460), Accident, Injury (612), Behaviour (including violence and aggression) (414), Maternity adverse occurrence (295) and Medication, IV fluids (259). This is consistent with the previous two-month period. The trend for the top 5 classification of incidents is highlighted in the chart below:



The figure of 1,460 reported within the overall patient safety incident profile relates to the combined Pressure Damage/Moisture Damage classification used within the top five incident categories. The figure of 1,056 reported within this section relates specifically to pressure damage incidents and excludes moisture damage incidents. The figures therefore represent different reporting datasets and are not directly comparable.

Nationally Reportable Incidents

Between 1st July and 31st August 2026, 11 Nationally Reportable Incidents were submitted to the NHS Performance & Improvement Team. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.

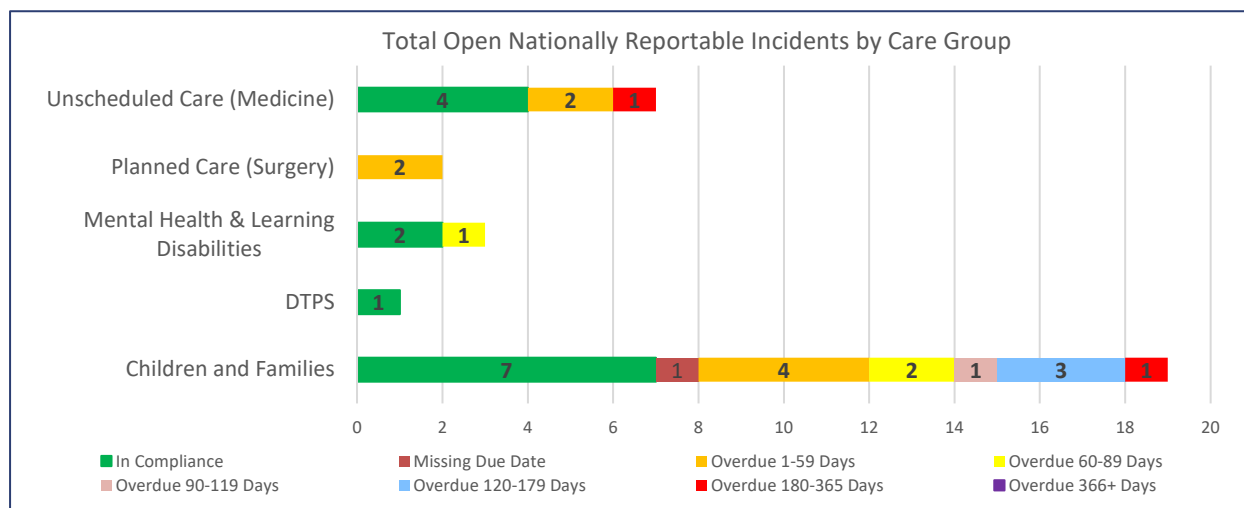


As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted

to the NHS Performance & Improvement Team. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026	Total
Access, Admission	0	0	0	0	0	1	1	0	0	0	0	0	2
Assessment, Investigation, Diagnosis	0	0	1	1	3	0	1	1	1	1	0	1	10
Behaviour (including violence and aggression)	0	0	0	0	0	1	0	0	0	0	0	0	1
Infection Prevention and Control	1	0	0	0	0	0	0	0	0	0	0	0	1
Maternity adverse occurrence	1	5	0	1	4	0	2	4	0	1	1	1	20
Medication, IV Fluids	0	0	0	0	0	0	1	0	0	0	0	0	1
Patient/service user death	1	0	0	0	3	0	0	0	0	0	1	1	6
Pressure Damage, Moisture Damage	3	1	2	4	1	2	6	3	4	3	3	2	34
Transfer, Discharge	0	0	1	0	0	0	0	0	0	0	0	0	1
Treatment, Procedure	0	0	1	0	0	0	1	0	0	0	1	0	3
Total	6	6	5	6	11	4	12	8	5	5	6	5	79

Focused work continues to be undertaken to ensure investigations are concluded and a timely outcome is provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Assurance and Impact

As at 3 September 2026, the Health Board had 32 open Nationally Reportable Incidents, of which 18 were outside the applicable completion timescale.

Review of the overdue position identified that delays arise for a range of reasons, including active investigations, Patient Medical Review Team (PMRT) requirements,

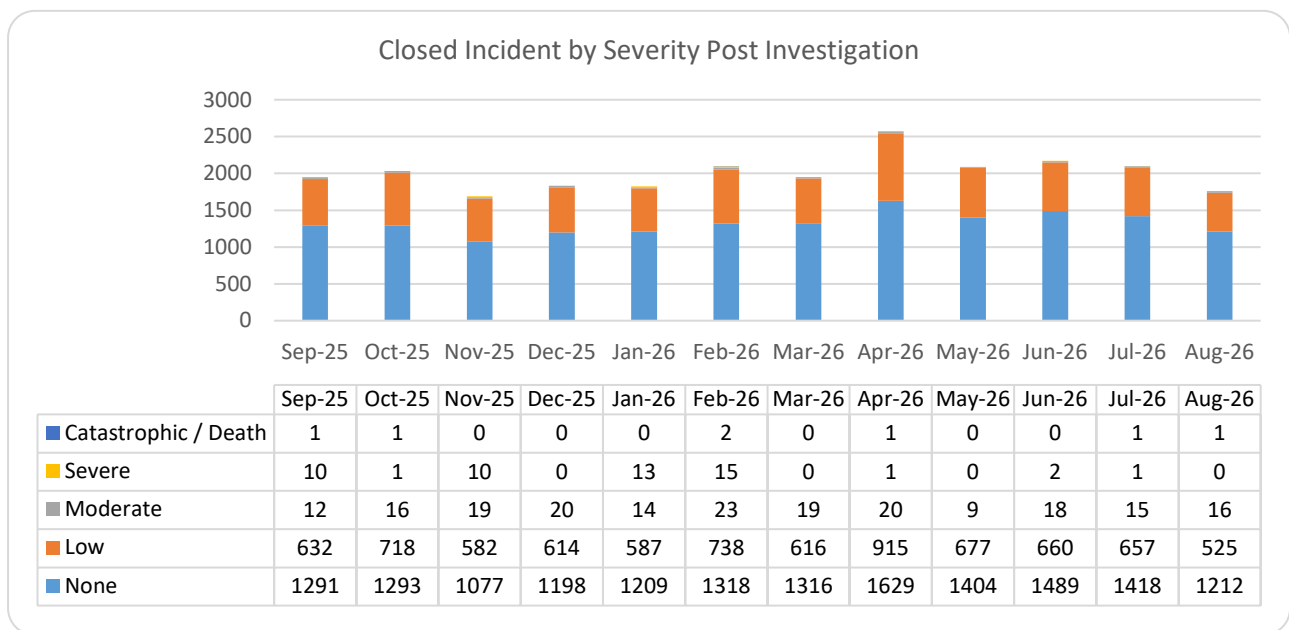
quality assurance processes, clinical and managerial sign-off arrangements, Executive approval processes and external dependencies including police investigations.

Care Group reviews indicate that a significant proportion of overdue cases are now progressing through final stages of investigation, quality assurance or approval. Current trajectories indicate a number of closures are expected during September and October 2026, with a small number of complex investigations extending into November 2026.

The position is regularly reviewed through Care Group governance arrangements, Patient Safety quality assurance processes and Quality & Safety oversight arrangements. Recovery actions remain focused on reducing the number of overdue investigations whilst maintaining appropriate quality assurance and ensuring patients and families receive a timely outcome.

Closed Patient Safety Incidents

Between the 1st July and 31st August 2026 a total of 3,846 patient safety incidents were closed. The 12 month trend is reflected in the table below.



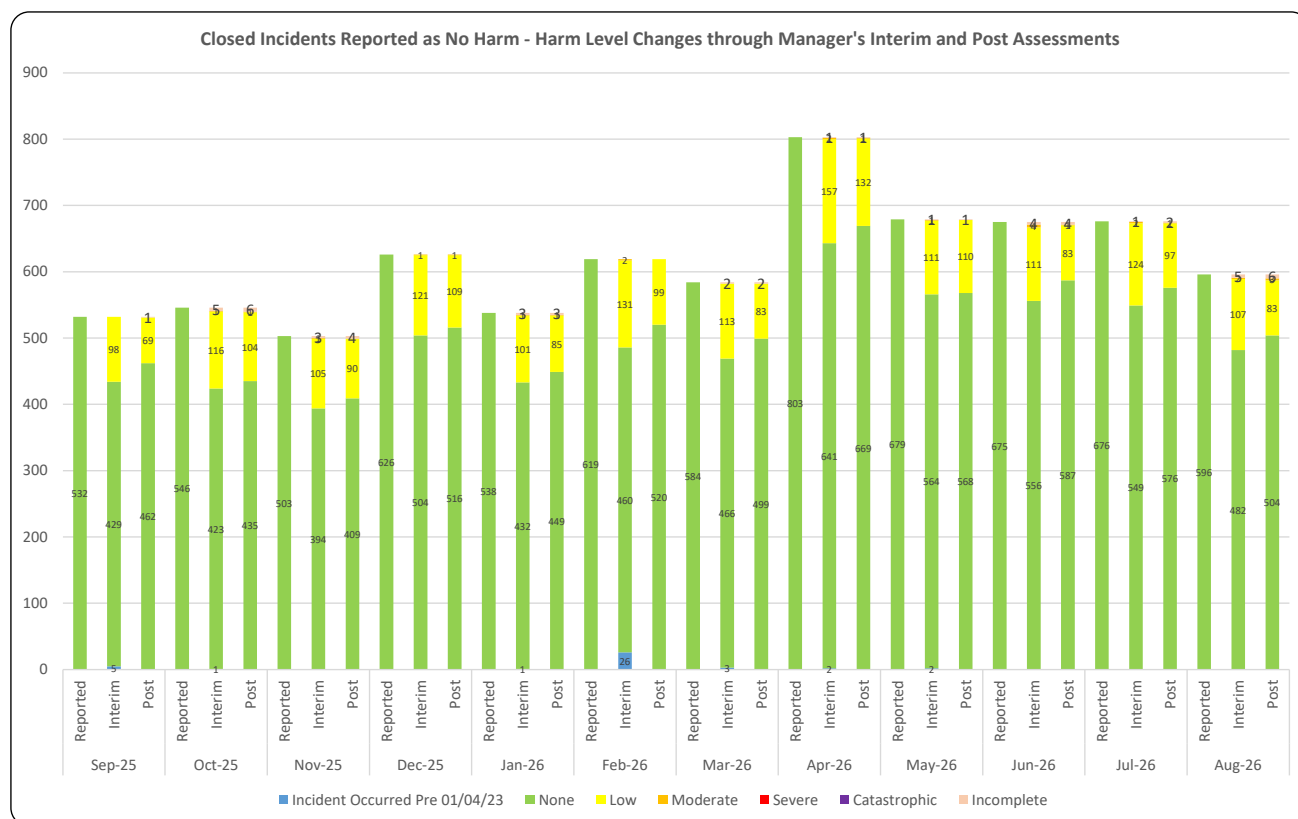
Of the 3,846 patient safety incidents closed, one was closed with a post-investigation severity of severe harm and two incidents were classified as catastrophic/death. A breakdown of incidents is provided in the table below:

	Planned Care (Surgery)	Unscheduled Care (Medicine)	DTPS	Total
Assessment, Investigation, Diagnosis	1	0	0	1
Medication, IV Fluids	0	0	1	1



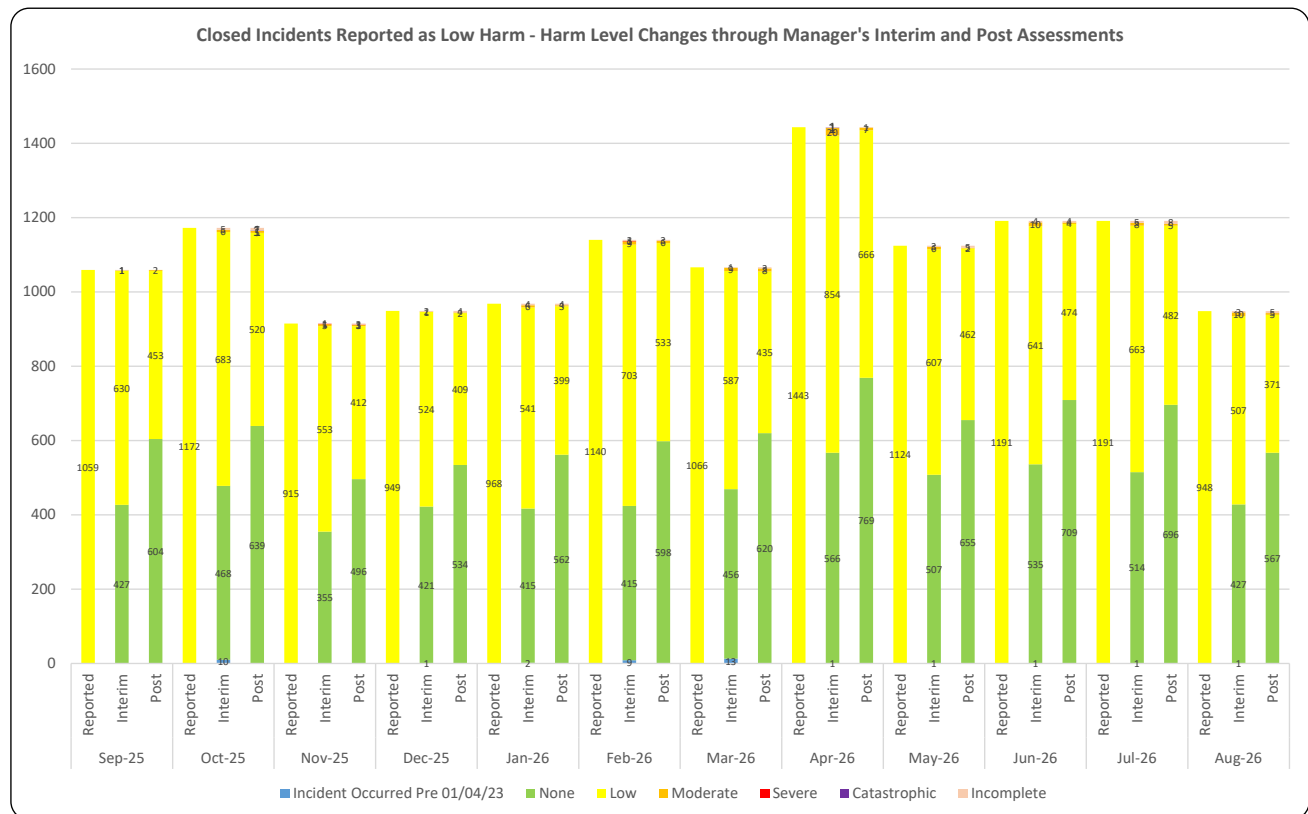
Patient/service user death	0	1	0	1
Total	1	1	1	3

Work continues to be undertaken to ensure that a severity of moderate, severe or catastrophic / death recorded on conclusion of an investigation accurately reflects where it can be determined that an incident has been directly caused or attributable to an intervention (action/inaction) by the Health Board. In addition, mechanisms to support a comparison of reporter's view of level of harm and the severity recorded post investigation have been established. The level of harm attributed to an incident is reviewed and recorded at 3 stages within the incident management process, reporter view on Level of harm, level of harm following management review and severity determined post investigation. Trend information providing a comparison between the reporters view on level of harm, level of harm following management review and severity of incident post investigation is provided below:

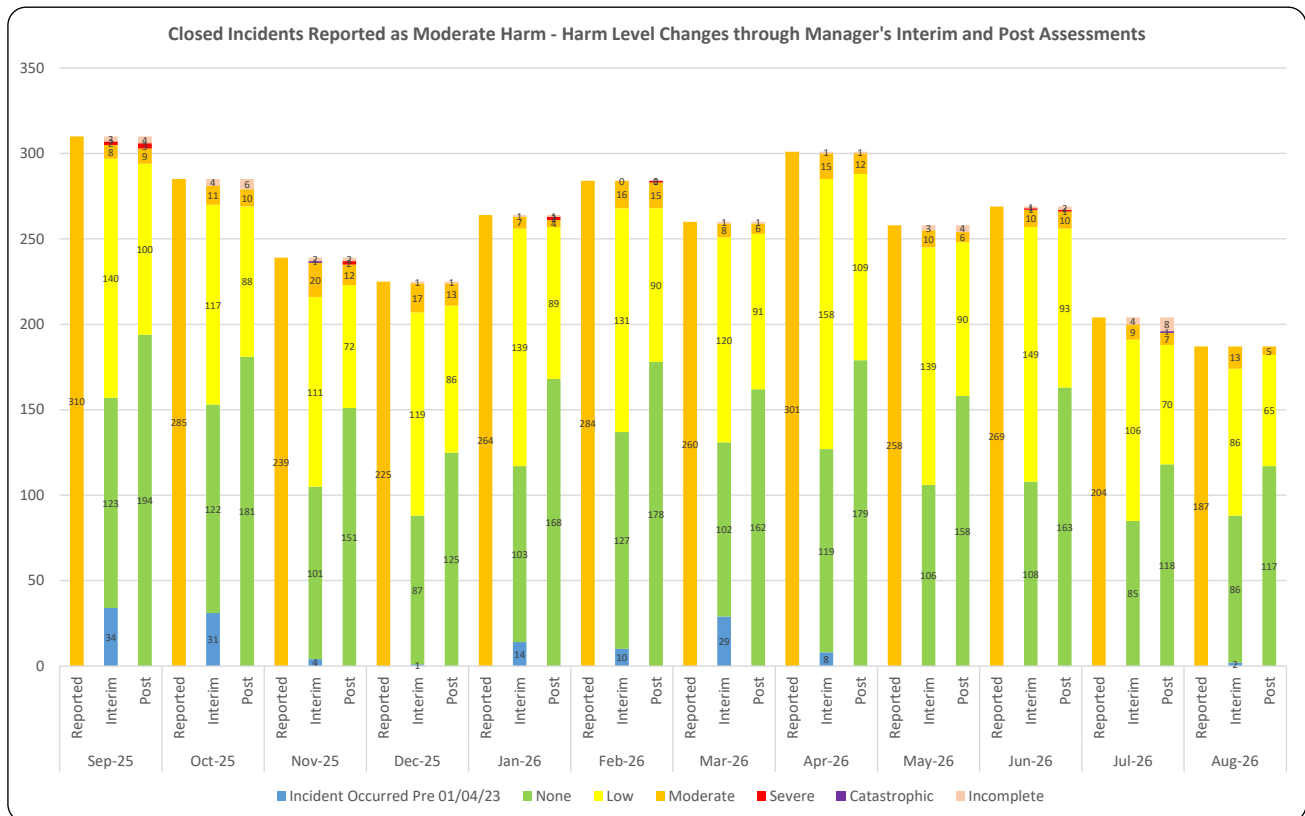


Between 1st July and 31st August 2026, a total of 1,272 incidents were initially reported as 'No Harm', representing a decrease of 82 incidents compared with the previous two-month period (1,354). Across the period, approximately 19% of incidents were upgraded to a higher harm level at the interim stage, reducing to around 15% at post-review. No incidents were classified as severe or catastrophic at post-review, and

incomplete reviews remained minimal (6 at interim and 9 at post across the period). The trend in harm level changes is reflected in the chart above.

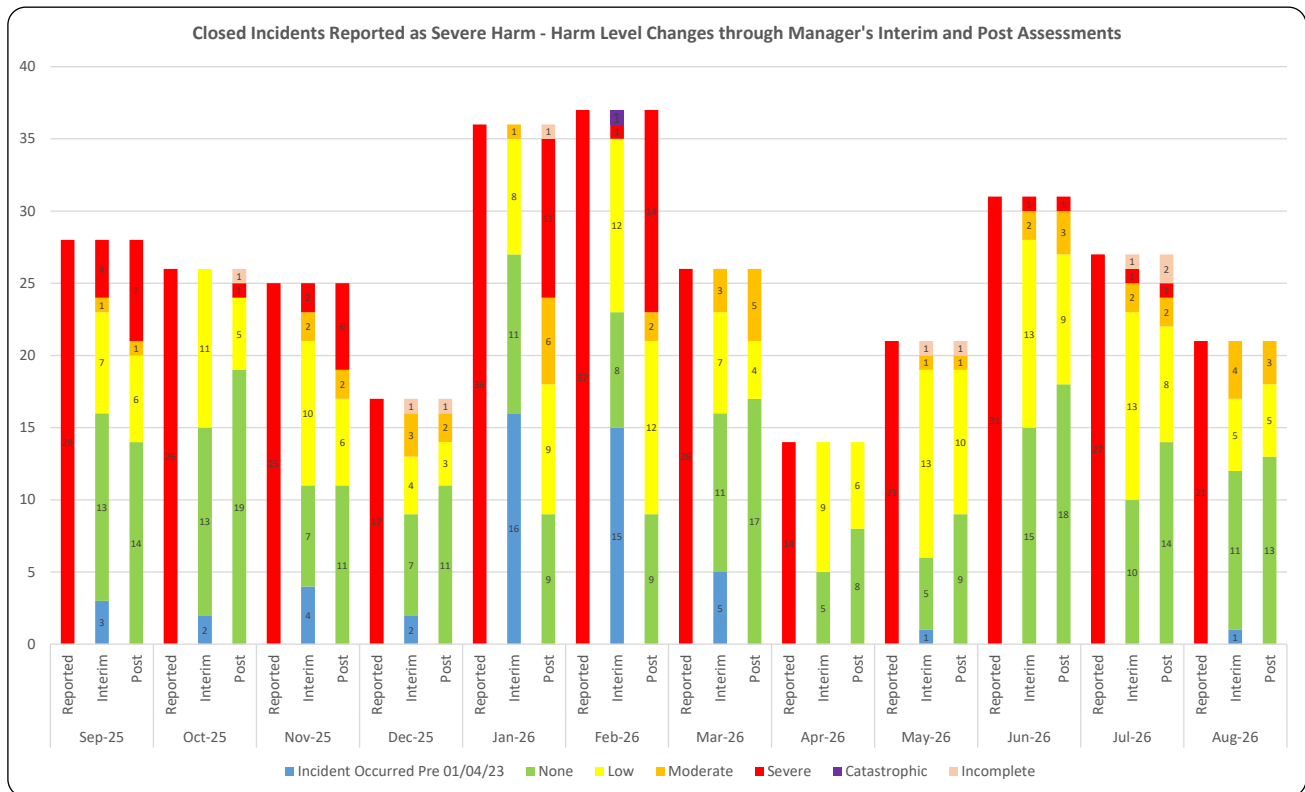


Between 1st July and 31st August 2026, a total of 2,139 incidents were initially reported as 'Low Harm', representing a decrease of 176 incidents compared with the previous two-month period (2,315). Across the period, approximately 46% of incidents were downgraded to a lower harm level at the interim stage, increasing to around 59% at post-review. No incidents were classified as catastrophic, while 10 incidents were classified as severe harm at post-review, and incomplete reviews remained minimal (8 at interim and 10 at post across the period). The trend in harm level changes is reflected in the chart above.

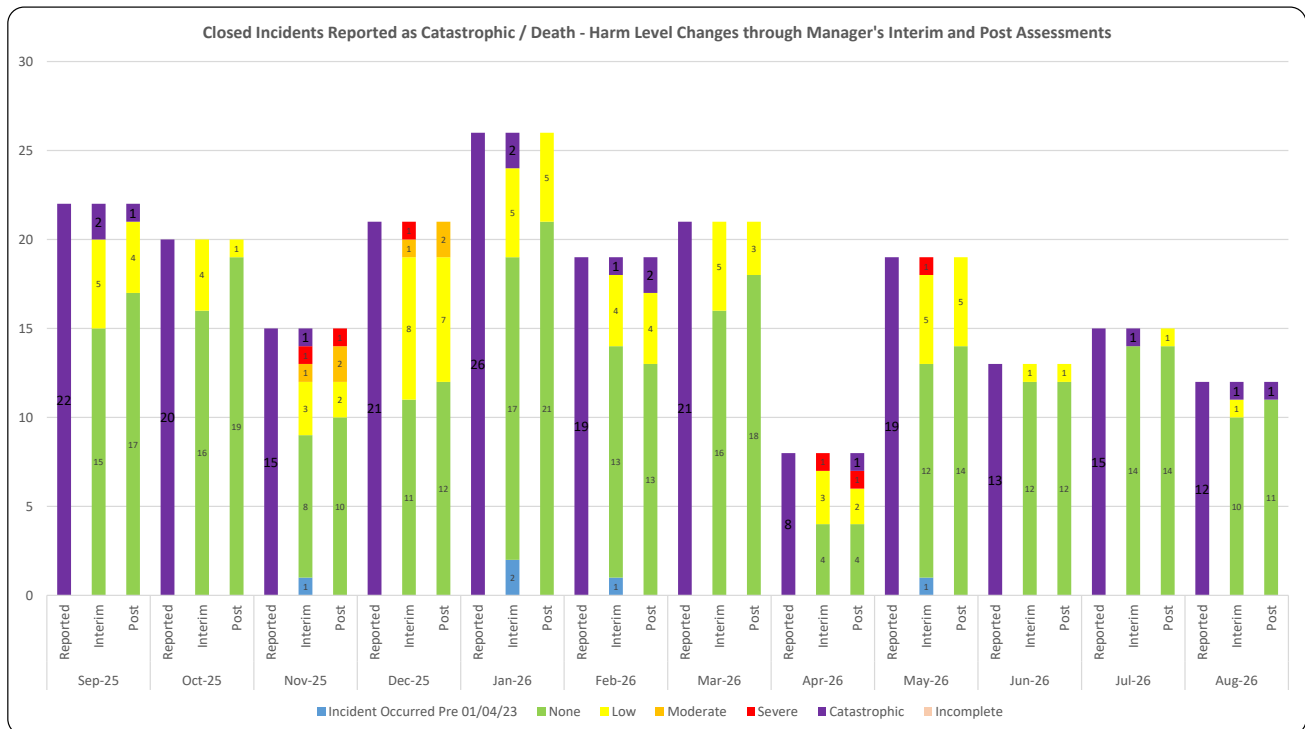


Between 1st July and 31st August 2026, a total of 391 incidents were initially reported as 'Moderate Harm', representing a decrease of 136 moderate harm incidents compared with the previous two-month period (527) – this is due to improvements in accurate harm reporting and working in line with the IMF.

Across the period, approximately 93% of incidents were downgraded to a lower harm level at the manager's interim harm assessment, increasing to around 95% at post-review. One incident was upgraded to catastrophic harm at post-review, while incomplete reviews remained minimal (4 at interim and 8 at post across the period). The trend in harm level changes is reflected in the chart above.



Between 1st July and 31st August 2026, a total of 48 incidents were initially reported as 'Severe Harm', representing a decrease of 4 incidents compared with the previous two-month period (52). Across the period, approximately 96% of incidents were downgraded to a lower harm level at the manager's interim harm assessment, decreasing to around 94% at post-review. No incidents remained classified as severe harm following post-review, and 2 incidents were upgraded to catastrophic harm. Incomplete reviews remained minimal (1 at interim and 2 at post across the period). The trend in harm level changes is reflected in the chart above.



Between 1st July and 31st August 2026, a total of 27 incidents were initially reported as 'Catastrophic Harm', representing a decrease of 5 incidents compared with the previous two-month period (32). Across the period, approximately 93% of incidents were downgraded to a lower harm level at both the manager's interim harm assessment and post-review stages. Only 2 incidents remained classified as catastrophic harm following review, with no incomplete reviews recorded across the period. The trend in harm level changes is reflected in the chart above.

Assurance and Impact

The incident management process includes three separate harm assessments:

- Reporter-assessed harm at the point of reporting.
- Manager's Interim Harm Assessment.
- Post-investigation harm assessment following completion of review and investigation.

Differences between these stages can occur as additional clinical information becomes available through the investigation process and as the avoidability and attribution of harm are considered in more detail.

The high level of reclassification demonstrated within the data requires careful interpretation and does not necessarily indicate inappropriate initial reporting. In some

pathways, incidents are reported conservatively to ensure appropriate review and escalation before a final determination regarding harm is made.

Moderate, severe and catastrophic incidents continue to be subject to review through the Health Board's incident management arrangements, including Rapid Review processes, multidisciplinary discussion and ongoing quality assurance. Further work is ongoing through audit and review activity to provide additional assurance regarding consistency of harm grading and application of the Incident Management Framework across the organisation.

Duty of Candour

The Duty of Candour regulations were implemented from the 1st April 2023. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at a glance along with the introduction of weekly data validation audits.

Number of Incidents	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026
Where Duty of Candour Triggered	14	28	10	17	12	9	17	15	15	12	15	13
Where In-person notification completed	13	24	10	13	11	8	15	14	10	10	12	6

Assurance and Impact

Duty of Candour remains subject to daily oversight by Patient Safety teams, review through the Incident Management Framework, Rapid Review processes, Care Group governance arrangements and Executive quality and safety oversight arrangements.

Potential qualifying incidents are reviewed through multidisciplinary discussion to determine whether the statutory threshold has been met. Clinical teams remain responsible for determining application of the Duty of Candour requirements, supported by governance oversight and established escalation processes.

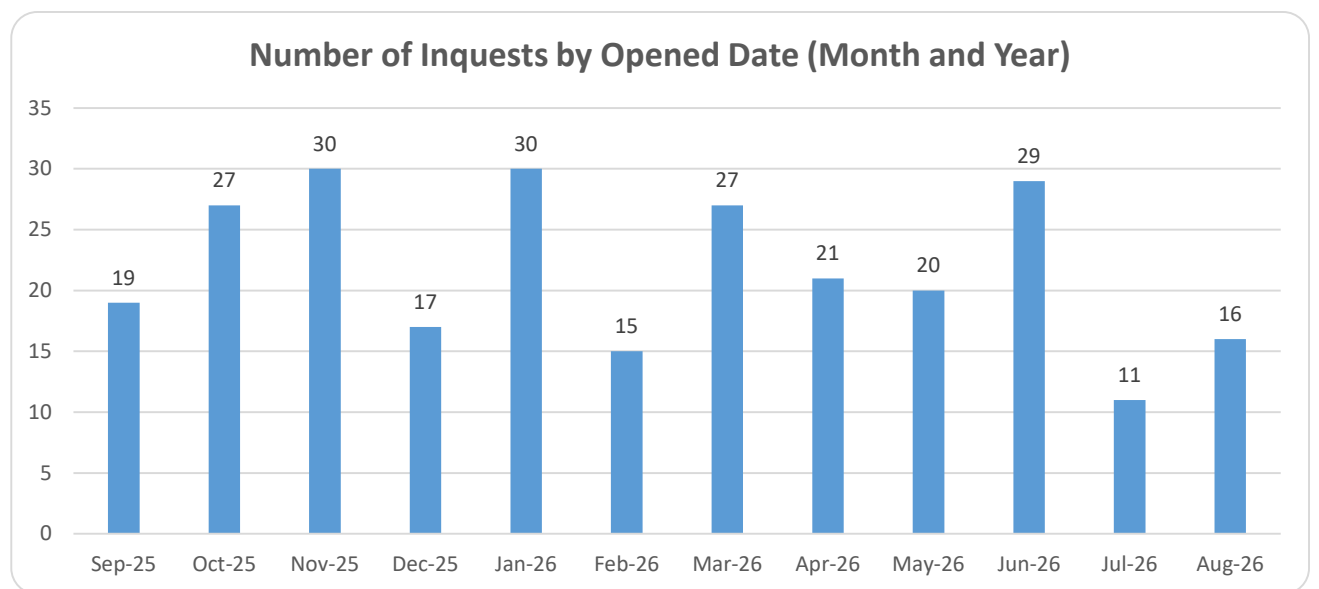
Differences between Duty of Candour triggers and recorded notifications do not necessarily indicate non-compliance and require case-level review and validation. Individual circumstances may include inability to contact the patient or next of kin, lack of valid contact information, capacity considerations or safeguarding issues. These cases require individual review and validation.

Live dashboard reporting, weekly validation activity, governance review arrangements and ongoing staff training continue to provide assurance regarding identification, monitoring and management of Duty of Candour incidents.

3.3 Inquests Case Activity

New Inquests Received

Between 1st July and 31st August 2026, the Health Board received notification of 27 inquests. This represents a significant decrease compared with the previous two-month period (49).



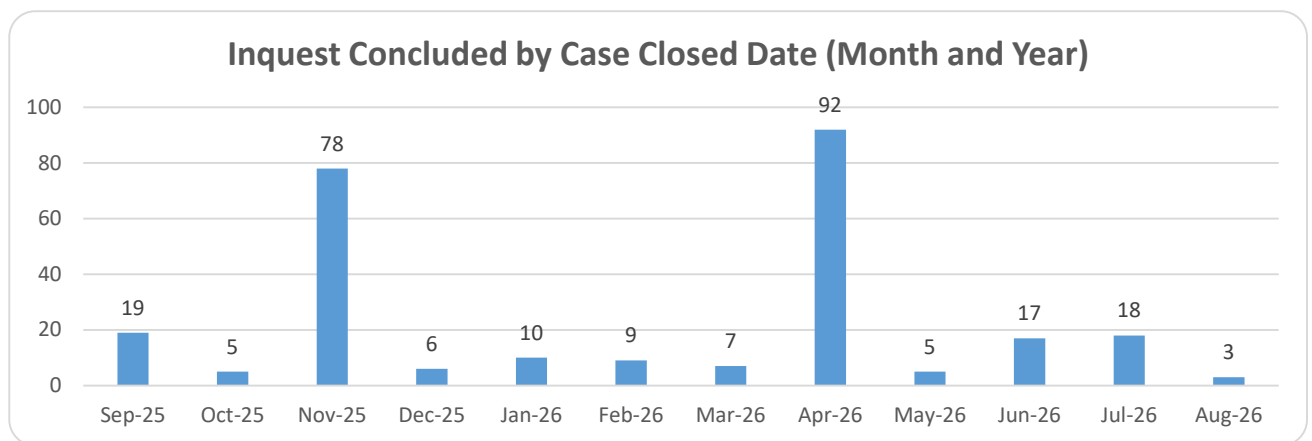
Of the 27, the highest number of inquests were received for Unscheduled Care (12). A breakdown of inquests received by Care Group is provided below.

Care Group	Number Received
Children and Families	0
Primary Care and Community	8
Mental Health and Learning Disabilities	0
Planned Care	7
Unscheduled Care	12
DTPS	0
Not Specified	0
Total	27

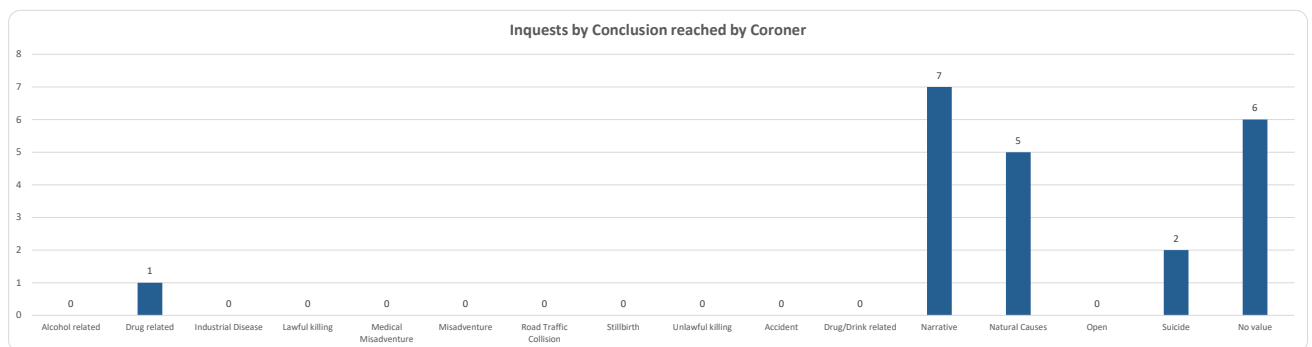
Inquests Concluded

During the same period, there was a small decrease in the number of cases closed with 21 inquest cases closed between 1st July and 31st August on the Health Board's Datix system, compared to the previous two months (1st May to 30th June) which was 22.

A trend graph of inquests concluded for the previous 12-month period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 21 inquests cases that were closed on Datix, the hearing date or conclusion has been made available by the Coroner to the Health Board for 15 cases, a breakdown of the outcome of inquests closed between the 1st July and 31st August 2026 is provided in the chart below.



Regulation 28 Reports / HMC Letter Received

On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. Between the 1st July and 31st August 2026, there were no Regulation 28 Reports issued by the Coroner.

Assurance and Impact

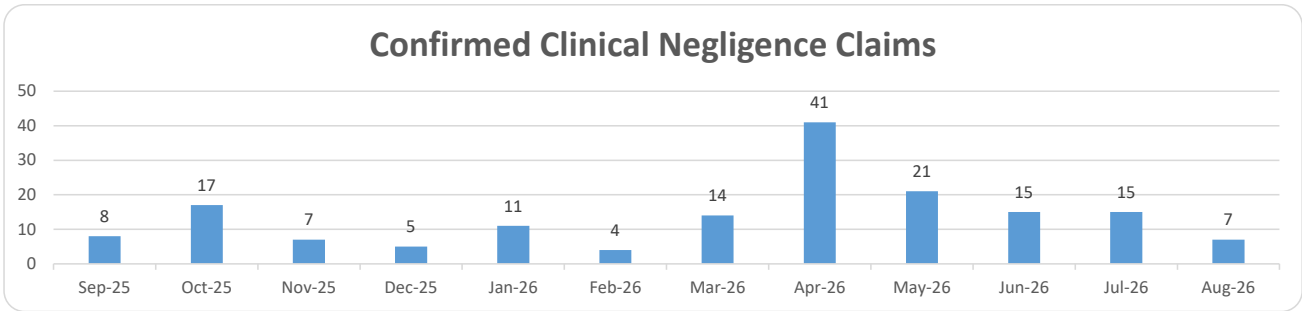
The reduction in new inquests compared with the previous reporting period has been noted; however, the Health Board continues to maintain close oversight of inquest activity to ensure timely responses to requests from HM Coroners and effective identification of learning opportunities.

No Regulation 28 reports were issued during the reporting period. Inquest activity continues to be monitored to support learning and identify any areas requiring improvement.

3.4 Clinical Negligence Claims

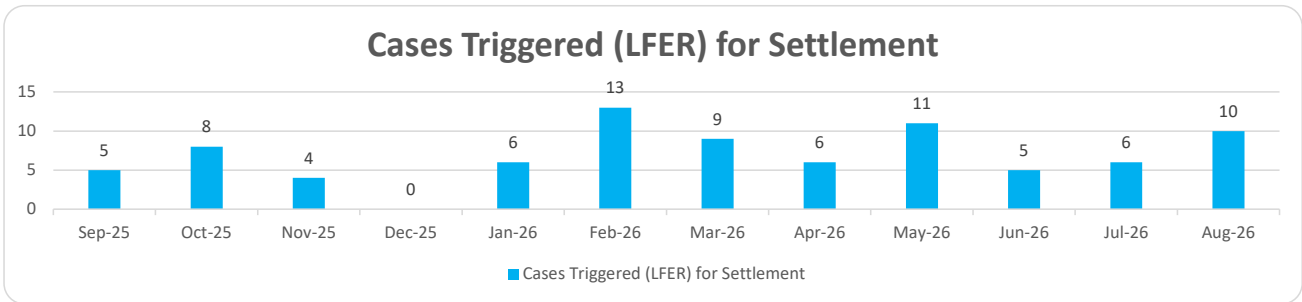
New Confirmed Clinical Negligence Claims

Between the 1st July and 31st August 2026 the Health Board received confirmation of a total of 22 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



Clinical Negligence Claims triggered for settlement

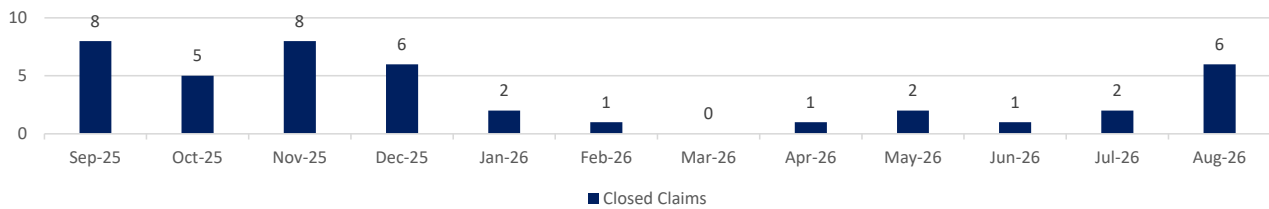
Between the 1st July and 31st August 2026 the Health Board, 16 Clinical Negligence Claims were triggered for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



Closed Clinical Negligence Claims

Between the 1st July and 31st August 2026, the Health Board, 8 Clinical Negligence Claims were closed on the Datix Cymru System. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:

Closed Clinical Negligence Claims



Assurance and Impact

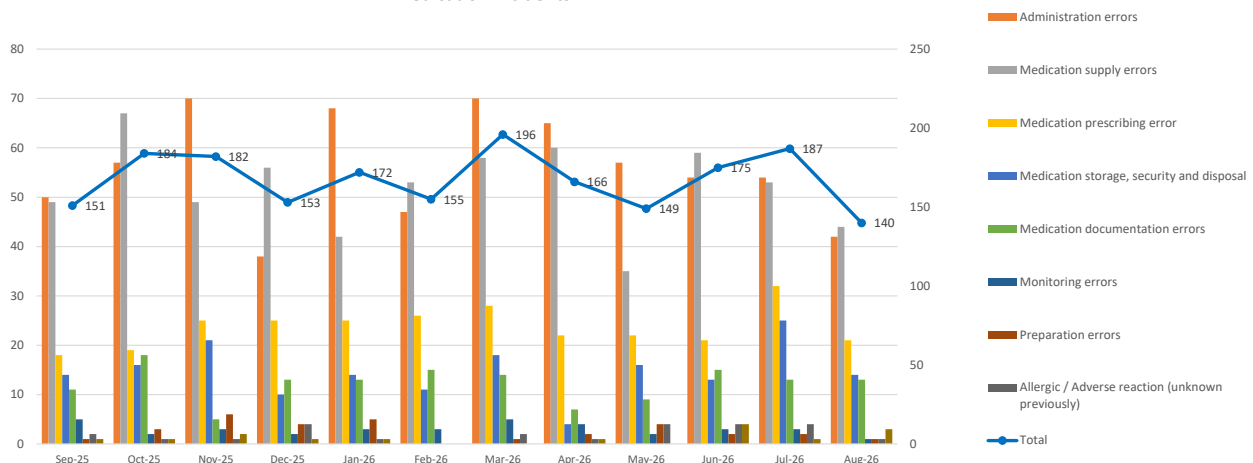
Claims activity continues to provide an important source of organisational learning and quality intelligence. Regular monitoring of claims, settlements and emerging themes supports identification of potential areas of clinical risk and informs improvement activity across services. Learning arising from claims is shared through governance processes to support safer care and reduce the likelihood of similar events recurring.

3.5 Specific Quality & Safety Metrics

3.5.1 Medication Safety

A total of 327 medication incidents were reported as occurring between 1st July and 31st August 2026. This is an increase of 3 when compared with the previous 2-month period (324). Of the total number of medication incidents reported, the top 3 types of medication incidents relate to medication supply errors (97), administration errors (96) and medication prescribing errors (53).

Medication Incidents



91% of the medication incidents were reported as resulting in 'no' (142) or 'low' (154) harm, with the remaining reported as resulting in moderate harm (24), Severe (6),

Catastrophic / Death harm (1). It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

Assurance and Impact

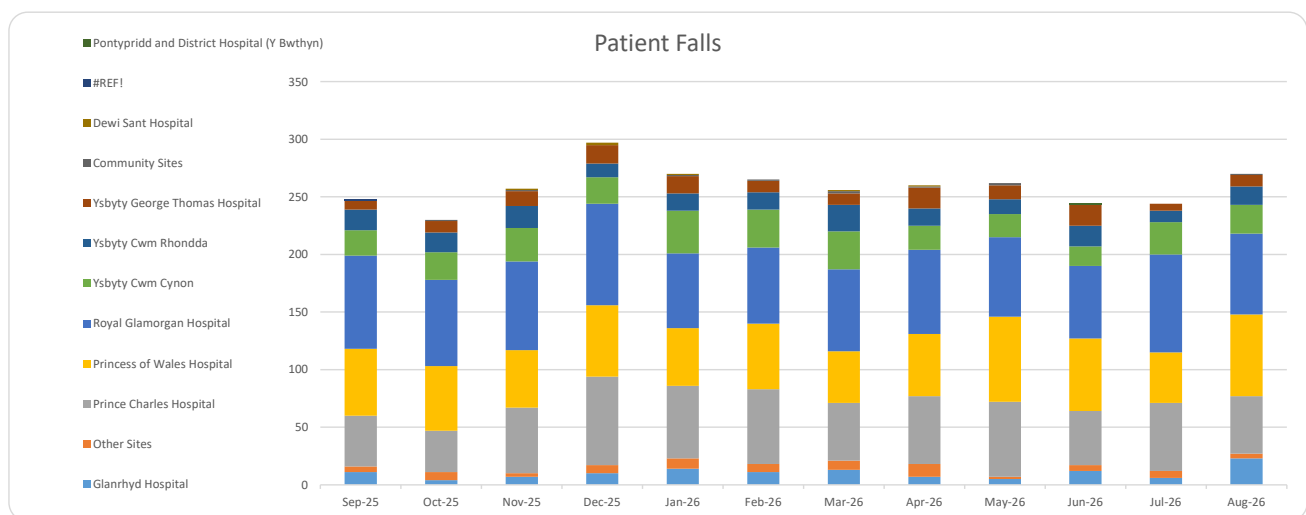
Although there has been a small increase in medication incidents, the majority of medication incidents continue to be initially reported as no or low harm.

These classifications remain subject to review and investigation. Learning arising from medication incidents continues to inform medication safety improvement initiatives and staff education.

3.5.2 Patient Falls Incidents

A total number of 514 falls, where the person affected was a patient, were reported during July and August 2026. This represents an increase compared with the previous two months (505).

Of the falls incidents within the time period, 94% were reported as no (158) or low (324) harm. The remaining incidents were reported as resulting in moderate (29) and severe (3) harm. No incidents relating to patient falls were reported as resulting in catastrophic harm / death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



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

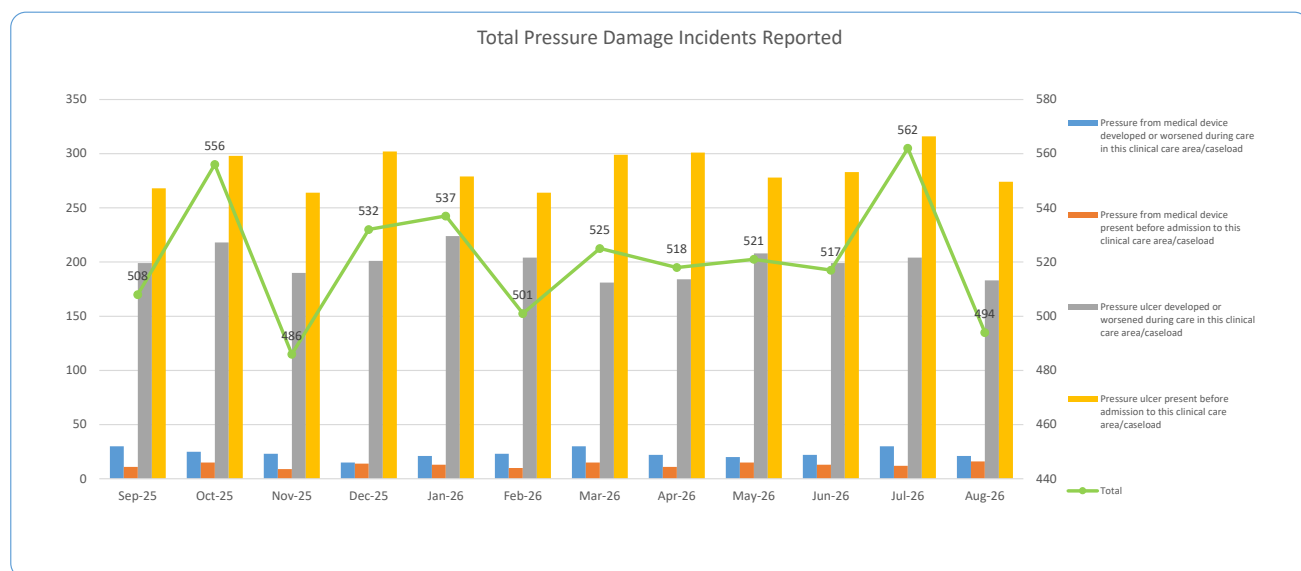
Assurance and Impact

Falls remain a significant contributor to incident reporting across the Health Board; however, most incidents continue to result in no or low harm.

The Falls Improvement Programme continues to oversee implementation of preventative initiatives aimed at reducing avoidable falls and associated harm.

3.5.3 Pressure Damage

Between the 1st July and 31st August 2026, a total of 1,056 pressure damage incidents were reported, of which 438 were reported as developing or worsening during the current caseload. The remaining 618 pressure damage incidents were reported as being present before admission to this clinical care area/caseload.



Of the 438, identified as developing or worsening during current caseload, 224 were identified as occurring within the community, which represents a decrease of 6 compared with the previous two-month period (230).

The Pressure Ulcer Steering Group has been established to provide strategic oversight and develop a robust prevention and monitoring programme and ensure learning is shared and embedded where available pressure damage has occurred.

The figure of 1,460 reported within the section of the paper (noted above) for overall patient safety incident profile relates to the combined Pressure Damage/Moisture Damage classification used within the top five incident categories. The figure of 1,056 reported within this section relates specifically to pressure damage incidents and excludes moisture damage incidents. The figures therefore represent different reporting datasets and are not directly comparable.

Assurance and Impact

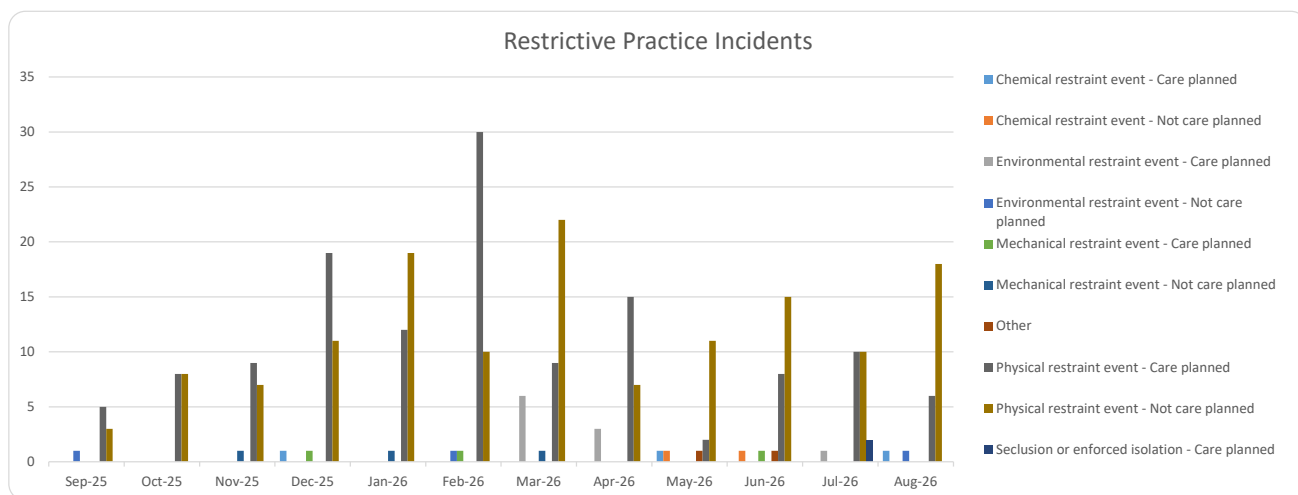
Pressure damage continues to represent one of the most frequently reported patient safety concerns and remains a priority area for improvement. The establishment of the Pressure Ulcer Steering Group provides strengthened governance and oversight

arrangements, supporting a coordinated approach to prevention, monitoring and organisational learning. Ongoing scrutiny of pressure damage incidents is providing greater visibility of contributory factors and opportunities to reduce avoidable harm.

3.5.4 Mental Health Metrics

Restrictive Practices

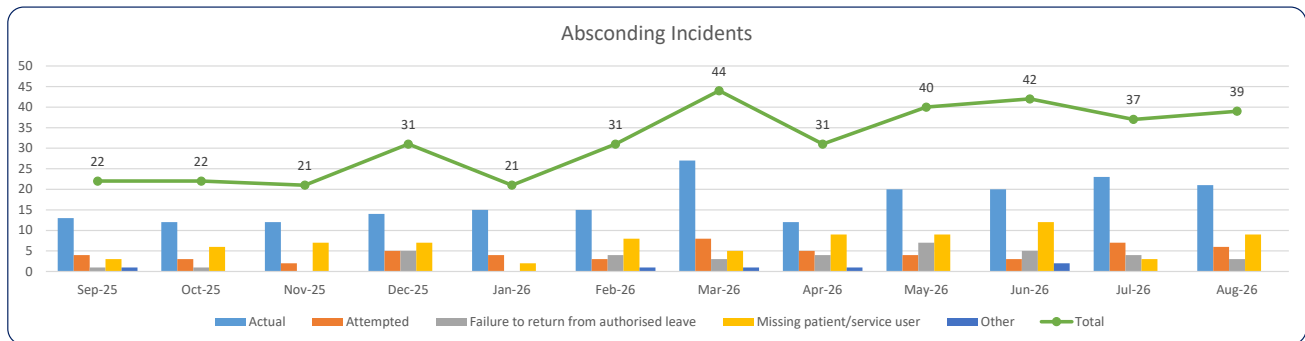
Between 1st July and 31st August 2026, a total of 50 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 6 incidents when compared to the previous two months (44).



Of the 50 incidents, 30 were reported as not care planned (not included in the care and treatment plan for the patient) and 20 were reported as care planned (included in the care and treatment plan for the patient), 0 were recorded as Other. The highest number of incidents were reported as occurring on the Coity Clinic POW (PICU), Princess of Wales Hospital (13).

Absconding incidents

During July and August 2026, a total of 76 incidents were reported under the category of absconding, which represents a decrease of 6 when compared with the previous two-month period (82). 44 were recorded as actual absconding, with the remaining recorded as attempted absconding (13), missing patient/service user (12), failure to return from authorised leave (7), and other (0). The highest number of incidents were reported as occurring in the Accident and Emergency RGH at the Royal Glamorgan Hospital (19).



Assurance and Impact

Mental Health safety indicators, including restrictive practice and absconding incidents, continue to be monitored through established governance arrangements to ensure that interventions remain proportionate, person-centred and consistent with best practice. Analysis of trends, locations and contributing factors is informing quality improvement activity across Mental Health services, supporting efforts to improve patient safety and reduce risk.

4. Organisational Learning and Improvement Impact

Learning arising from incidents, Nationally Reportable Incidents, Learning from Events Reviews, claims, inquests, complaints and PSOW investigations continues to be shared through:

- Care Group governance meetings;
- Quality & Safety governance arrangements;
- Seven-Minute Briefings;
- learning repositories;
- staff newsletters;
- targeted improvement programmes;
- the Improving Care Board;
- specialty-specific improvement forums.

These mechanisms support dissemination of learning and monitoring of actions arising from investigations and reviews. Future reports will continue to strengthen reporting regarding the specific impact of improvement actions and evidence of measurable change arising from organisational learning.

Themes arising from complaints, concerns, patient safety incidents, PSOW investigations, claims and inquests continue to be reviewed to identify recurring issues and opportunities for improvement across the Health Board. Key areas of focus include communication with patients and families, pressure damage prevention, falls reduction, medication safety and improvements to incident investigation processes.

5. Key Risks / Matters for Escalation

- Maintaining complaints timeliness standards whilst embedding the new Listening to People operating model and supporting organisational transition.
- Work continues to align the Datix Cymru system to the Care Group structure and ensure accurate, accessible reporting across the Health Board.
- The Concerns Team continues to experience staffing pressures and vacancies which may impact service capacity and resilience. However, a range of mitigating actions have been implemented, including temporary support arrangements, cross-team working and prioritisation of workload, to minimise disruption and maintain service delivery standards.
- Ensuring timely management of PSOW cases and implementation of recommendations arising from investigations.
- Reduce backlog and overdue NRIs.
- Responding to Coroner's Inquest requests within timescales.
- Managing data and reporting challenges linked to the new operating model.
- Ensuring consistency of harm classification, Duty of Candour determination and incident review processes across Care Groups.

6 Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> 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 Service Transformation & Outcomes
	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) /	No - Not Applicable



Environmental Sustainability Impact (5Rs)	If more than one applies please list below:
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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 This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment. Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment. 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)	This report outlines key areas of quality across the Health Board.	
Cyfreithiol / Legal	Yes (Include further detail below) The report includes areas associated with statutory, regulatory and legal responsibilities, including Duty of Candour requirements, incident investigations, Nationally Reportable Incidents, PSOW actions, claims and inquests. Failure to manage these effectively may increase organisational risk. Relevant oversight arrangements are described within the report.	



Enw da / Reputational	Yes (include further detail below) Areas including overdue NRIs, outstanding PSOW actions, Duty of Candour compliance and patient safety performance have the potential to impact stakeholder confidence if not effectively managed. The report outlines the actions and governance arrangements in place to address these areas.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (include further detail below) Delivery of incident management, investigations, complaints handling, PSOW actions and governance responsibilities requires appropriate workforce capacity. The report identifies staffing pressures and mitigating actions in some areas of service delivery

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Forum Individuals	Date	Outcome
Care Group Quality & Safety Leads, Concerns Team, Patient Safety Team and Corporate Governance colleagues	10/09/2026	Review of dashboard content, validation of metrics and narrative, and agreement of actions and assurances included within the report

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

4 Next Steps

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

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: • Carolyn Donoghue, IM University	Committee Vice Chair • Kath Palmer, Vice Chair	Executive Leads for Agenda Planning • Richard Hughes, Interim Executive Director of Nursing
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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 BAE	
Shared Listening & Learning Story	Executive Director of Nursing	All Regular Meetings						 Defer to July	 Falls Story		 Epilepsy 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 Requirement s.e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAE
Peoples Experience Activity Report <i>(to include an annual update on CTM Carers End of Year Progress Report)</i>	Executive Director of Nursing	All Regular Meetings	R		R			R	R Not required		R		R		X	R	No	N/A	Strategic Risk 2
Thematic Spotlights – Learning and Improvement Outcomes Future topics for scheduling: - Spotlight on LD Services - Spotlight on Deteriorating Patient Measures (including Sepsis and NEWS scoring)	Lead Clinical Executive	All Regular Meetings	R Compassionate Care		R Quality Impact of the new Escalation Framework & Hospital at Home			R Not required	R Nutrition & Catering & Hospital at Home		R Not reqd		R		X	R	N/A	N/A	Will be assigned to a strategic risk dependent on topic
Report from the Clinical Executives <i>(to include bi-annual updates on Coroners Inquests – activity & lessons learnt)</i>	Clinical Executives	All Regular Meetings	R		R			R	R Not required		R		R		X	R	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	R		R			R	R Not required		R		R		X	R	N/A	N/A	Each Care Group Highlight Report will crosscut several of the strategic risks
Quality Dashboard Report <i>To include an addendum relating to</i>	Executive Director of Nursing	All Regular Meetings	R		R			R	R Not required		R		R		X	R	N/A	N/A	Strategic Risk 2

<i>Ombudsman activity</i>																			
Ombudsman's Letter & Annual Report	Executive Director of Nursing	Annually									Defer to Nov					X	EMB	Yes	Strategic Risk 2
Organisational Risk Register <i>Risks assigned to the QSEC</i>	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 Requirement s.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		Consent					(to be added to the main agenda on a 6-monthly basis)	Yes - EMB	No	• Strategic Risk 2
Mortality Board Report <i>(including indicators, reviews and the highlights from the Mortality Board)</i>	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									Defer to Nov					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 <i>(Including Controlled Drugs Local Intelligence)</i>	Executive Medical Director	Annually plus exception reporting														X	N/A	N/A	• Strategic Risk 2

Network (CDLIN) / Prescribing Annual Report) Prescribing errors captured in quality dashboard)																			
Cancer Services Annual Report	Executive Medical Director	Annually						R							R	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	R					R							R	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 Requirement s.e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAE
Clinical Audit update – for awareness on clinical outcomes from audits	Executive Medical Director	Twice Per Annum	R						R						R	X	EMB	Yes	• Strategic Risk 2
Individual Patient Funding Request Annual Report	Executive Director of Public Health	Annually									R				R	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						R					R		R	X	N/A	N/A	• Strategic Risk 2
Human Tissue Act Authority – Progress Report	Executive Medical Director	Twice Per Annum	R						R						R	X	EMB	N/A	• Strategic Risk 2
Anti-Microbial Resistance Reports	Executive Medical Director	Twice Per Annum						R					R		R	X	N/A	N/A	• Strategic Risk 2
Harm Free Care Agenda	Executive Director of Nursing	Twice Per Annum						R					R		X	R	N/A	N/A	• Strategic Risk 2



Annual Duty of Quality Report	Executive Director of Nursing	Annually						Defer to Sept 26						X	Defer	EMB	Yes	• Strategic Risk 2
Consent to Examination for Treatment Annual Report	Executive Medical Director	Annually					Defer to Sept 26			Defer				Defer	X	EMB	N/A	• Strategic Risk 2

Creating Health Strategic Goal aligned to Committee Business																				
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB / OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAE	
Health Inequalities Population Inequality Service Inequality <i>(Quality & Safety impact of services we currently run – differential in quality)</i>	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																			
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	
Clinical Education Annual Report	Executive Director of Nursing	Annually														X	EMB	Yes	Strategic Risk 3

Sustaining our Future Strategic Goal aligned to Committee Business																			
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	
Commissioned Services <i>Quality Reporting Process – Annual Appraisal</i>	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	R		R			R	R		R		R		R 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			R				R Defer to Sept		R		R		R 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							R Defer to Sept		R Defer to Jan 27				R	X	N/A	N/A
Organ Donation Sub Committee Highlight Reports	Executive Medical Director	All meetings following a Sub Committee			R				R		R Defer to Nov		R		R Unless there is an area for escalation	X	N/A	N/A
Organ Donation Sub Committee - Annual Committee Report	Executive Medical Director	Annually	R												R	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	R		R			R N/A for this meeting	R N/A for this meeting		R		R		R Unless there is an area for escalation	X	N/A	N/A
Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings	R		R			R	R		R		R		R If all actions are complete	R If there are actions in progress / overdue actions	N/A	N/A
Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings	R		R			R	R		R		R		R	X	N/A	N/A
Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings	R		R			R	R		R		R		R	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	R		R			R	R		R		R		R Except for the annual review in November	R Annual Review only	N/A	N/A
Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually						R							X	R	N/A	Yes
Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually						R Defer to July	R						X	R	N/A	N/A
Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually						R Defer to July	R						X	R	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 (<i>Including Culture, Values and Behaviours</i>)	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

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	Proposed for Closure As reported in the June Clinical Executives report, work is being undertaken to establish an Urgent and Emergency Care Oversight Group. This group will align CTM activity to NHS Wales priorities and provide an integrated focus on quality, safety, patient flow and operational performance, including the targeted application of improvement science. WAST-related issues will be incorporated within this oversight framework, with formal reporting through to the Executive Management Board.
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 Now November 2026	In progress To be captured in the Listening & Learning Stories Annual Evaluation of Lessons Learnt report scheduled for the November 2026 meeting
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 Now November 2026	In progress To be captured in the Listening & Learning Stories Annual Evaluation of Lessons Learnt report scheduled for the November 2026 meeting

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 Now March/May 2027	In progress Given that the trial did not commence until March 2026, it is proposed that the 12 month review is presented to the Committee either in March 2027 or May 2027.
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 An update on the current position is included in the Clinical Executives Report being presented to 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 22 September 2026 Now 24 November 2026	In progress This will now be presented to the November 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 (Status Update) Substantive update to be presented to the 24 November 2026 meeting	In progress It was agreed at the agenda planning session held on 13 August that a status update will be included in the September Clinical Executives report and a substantive update would be provided at the November 2026 meeting
28 April 2026	Request made at agenda planning that this item is added to the agenda for the September meeting.	Committee Chair	A further ophthalmology update to be brought to a future meeting given the interest and importance of the Audit Wales Eye Care review.	To be presented to the Committee for discussion	Planned Care Nurse Director	Executive Director of Nursing	24 November 2026	In progress Scheduled for the November 2026 meeting
3 rd June 2026	Request made in the Clinical Executives Report presented to the June 2026 meeting.	Executive Director of Nursing	A paper on multi-professional workforce challenges, including training, commissioning and retention.	To be presented to Committee for discussion	Executive Director of Allied Health Professionals & Health Sciences	Executive Director of Allied Health Professionals & Health Sciences	22 nd September 2026	Proposed for Closure An update has been included in the Clinical Executives report being presented to the September 2026 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 Scheduled for the November 2026 meeting
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 Date to be agreed with Director of Digital
21 July 2026	Action captured at the meeting held on 21 July 2026	Care Group Nurse Director, Primary Care & Community	Full evaluation of the Hospital at Home service to be presented to the committee for further assurance and decision-making.	To be presented to the Committee for further assurance and decision making	Care Group Nurse Director, Primary Care & Community	Executive Director of Nursing	24 November 2026	In progress This item will be presented to the November 2026 meeting
21 July 2026	Action captured at the meeting held on 21 July 2026	Executive Director of Nursing	Formal review of boarding practices, including scope, space, and impact on staff and patients, and report findings to be presented to the committee prior to winter.	To be presented to the Committee for further assurance	Executive Director of Nursing	Executive Director of Nursing	24 November 2026	In progress This item will be presented to the November 2026 meeting
10 August 2026	Request received by email from the Medical Director Business Manager	Medical Director Business Manager	Position Paper - Hydroxychloroquine Monitoring Pathway (Closed report)	To be presented to the Committee for discussion in closed session	Executive Medical Director	Executive Medical Director	24 November 2026	In progress This item will be presented to the November 2026 meeting
13 August 2026	Request made by the Chair at the August 2026 agenda planning session	Committee Chair	Update on Medical cover in Mental Health Services	To be presented to the committee for further assurance	Executive Medical Director	Executive Medical Director	Date to be confirmed	In progress
7 September 2026	Request received by email from the Principal Pharmacist – Community Services	Principal Pharmacist – Community Services	Pharmaceutical Needs Assessment	To be presented to Committee for endorsement prior to Board approval	Executive Medical Director	Executive Medical Director	22 September 2026	Proposed for Closure – On agenda This item is on the agenda for the September 2026 meeting
9 September 2026	Request received from the Executive Director of Nursing	Executive Director of Nursing	Redress Update	To be presented to Committee for discussion	Executive Director of Nursing	Executive Director of Nursing	22 September 2026	On agenda This item is on the agenda for the September 2026 meeting
Completed Items								

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	Completed Received at 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 outcome of the national assessment	To be presented to the Committee for discussion	Director of Midwifery	Director of Midwifery	24 March 2026 Now July 2026	Completed Received at 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	Sexual Health Safeguarding Update	To be presented to the Committee for discussion	Head of Safeguarding	Executive Director of Nursing	21 July 2026	Completed Closure report received at the July 2026 meeting