Quality, Safety & Experience Committee

Tue 24 March 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
0 min

2. CONSENT AGENDA BUSINESS

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

09:00 - 09:00
0 min

3. GOVERNANCE/COMMITTEE BUSINESS ACTIVITY

3.1. Action Log

Discussion *Carolyn Donoghue, Committee Chair*

3.1 QSEC Action Log QSEC 24 March 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 - Podiatry Services

Discussion

4.2. People's Experience Activity Report December 2025 – January 2026

Discussion *Becky Gammon, Interim Deputy Director of Nursing*

4.2 Peoples Experience Report QSEC 24.3.26.pdf (11 pages)

4.3. Thematic Spotlight Presentation - Winter Wrap Up

Discussion *Richard Hughes, Interim Executive Director of Nursing/Care Group Nurse Directors USC and Planned Care/Head of Nursing for Infection, Prevention & Control*

4.3 Winter Wrap Up QSEC 24.3.26.pdf (42 pages)

4.4. Report from the Clinical Executives

Discussion *Richard Hughes, Interim Executive Director of Nursing*

4.4 Clinical Directors Report QSEC 24.3.26.pdf (12 pages)

4.5. Care Group Highlight Reports

4.5.1. Unscheduled Care

Discussion *Deborah Matthews, Care Group Nurse Director*

4.5.1 USC Care Group Highlight Report QSEC 24 March 2026.pdf (14 pages)

4.5.2. Planned Care

Discussion *Sharon O Brien, Care Group Nurse Director*

4.5.2a Planned Care Highlight Report QSEC 24 March 2026.pdf (8 pages)
4.5.2b Appendix 1 Audit Wales Eye Care Review Mgt Response.pdf (10 pages)

4.5.3. Children & Young People

Discussion *Carl Verrecchia, Care Group Services Director*

4.5.3 CF Highlight report QSEC 24.03.26.pdf (9 pages)

4.5.4. Primary Care & Community

Discussion *Zoe Ashman, Interim Care Group Nurse Director*

4.5.4 PCC Highlight report QSEC 24 March 2026.pdf (10 pages)

4.5.5. Mental Health & Learning Disabilities

Discussion *Lloyd Griffiths, Interim Care Group Nurse Director*

4.5.5 MHLD QSEC Highlight Report QSEC 24 March 2026.pdf (12 pages)

4.5.6. Diagnostics, Therapies, Pharmacy & Sciences

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

4.5.6 DTPS Highlight Report QSEC 24 March 2026.pdf (12 pages)

4.6. Quality Dashboard Report

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

4.6 Patient Safety and Quality Dashboard QSEC 24.3.2026.pdf (21 pages)

4.7. Healthcare Inspectorate Wales Improvement Plan Tracker Report

Discussion *Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care*

4.7a HIW Tracker Cover Report QSEC 24 March 2026.pdf (7 pages)
4.7b HIW Inspections Recommendations Tracker_QSEC 24.03.2026.pdf (6 pages)

4.8. Mortality Indicators and Mortality Reviews

Discussion *Dom Hurford, Executive Medical Director*

4.8 Mortality Reviews and Mortality Indicators QSEC 24 March 2026.pdf (11 pages)

4.9. CTMUHB’s NHS Research & Development Framework Assessment 2026

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

4.9a NHS RD Framework Final QSEC 24 March 2026.pdf (5 pages)
4.9b NHS RD Framework Assessment 2026 Final QSEC 24 March 2026.pdf (22 pages)

4.10. Organisational Risk Register - Verbal update

Discussion *Gareth Watts, Director of Corporate Governance*

09:00 - 09:00
0 min

5. CONSENT AGENDA

5.1. FOR APPROVAL

5.1.1. Unconfirmed Minutes of the meeting held on 20 January 2026

Decision *Carolyn Donoghue, Committee Chair*

5.1.1 Unconfirmed Minutes Public QSEC 20th January 2026 QSEC 24 March 26.pdf (13 pages)

5.1.2. Policies for Approval - All Wales Top Up Policy

Decision *Claire Tynan Preece*

5.1.2 Top Up Policy Paper to QSE 23rd March 2026.pdf (27 pages)

5.2. FOR NOTING

5.2.1. Non-Routine Committee Business (Forward Plan)

Information *Carolyn Donoghue, Committee Chair*

5.2.1 CTMUHB QSEC Non Routine Bus QSEC 24 March 2026.pdf (4 pages)

5.2.2. Annual Cycle of Business

Information *Carolyn Donoghue, Committee Chair, Independent Member*

5.2.2 QSEC Cycle of Business QSEC 2026 24 March 2026.pdf (9 pages)

5.2.3. Organ Donation Sub Committee Highlight Report

Information *Dom Hurford, Executive Medical Director*

5.2.3 Organ Donation Committee Highlight Report QSEC 24 March 2026.pdf (6 pages)

5.2.4. Highlight Report from the JCC Quality, Safety and Outcomes Sub-Committee

Information

5.2.4 QSOC Highlight Report 15 December 2025 QSEC 24 March 2026.pdf (17 pages)

09:00 - 09:00
0 min

6. CLOSE OUT BUSINESS

6.1. Committee Highlight Report to the Board

Discussion *Gareth Watts, Director of Corporate Governance*

6.2. 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?

6.3. Any Other Business

Information *Carolyn Donoghue, Committee Chair*

09:00 - 09:00
0 min

7. Private/Closed Session Business

Information *Carolyn Donoghue, Committee Chair*

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

09:00 - 09:00
0 min

8. Date & Time of Next Meeting

Information *Carolyn Donoghue, Committee Chair*

The next meeting will be held on Wednesday 3 June at 9:00am

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Committee Action Log

Name
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Date / action			Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	WAST produced Quality Report to be shared with Members at future meetings of the Committee to help Independent Members to triangulate data between WAST and the Health Board	Executive Director of Nursing	Executive Director of Nursing	20/05/2025 Now 22/07/2025 Now November 2025	Open	**In progress** Following discussion with the Welsh Ambulance Services Trust (WAST) concerning the triangulated data between WAST and the Health Board, a formal response from WAST is awaited. Once received, this will be reviewed and the action progressed accordingly.
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	Consideration to be given outside the meeting on the frequency of reporting on this matter to future Committee meetings. Deputy Director of Nursing to discuss further with Committee Chair to determine the level of information required moving forwards	Committee Chair	Executive Director of Nursing	25/03/2025 Now 22/07/2025 Now November 2025 **Now January 2026**	Proposed for Closure	**Proposed for Closure** Being proposed for closure once again due to further improvements in performance and compliance.
20.05.2025	4,1	3	Listening & Learning Story - Maternity Services	Update to be provided at a future meeting on the work being undertaken by the Team on how it was reaching the wider population via digital platforms.	Care Group Nurse Director, Children & Families	Executive Director of Nursing	TBC	Open	**In progress** Date to be agreed with Team
22.07.2025	6,1	13	Patient Safety, Quality & Experience Dashboard	Response to be provided outside the meeting regarding inconsistencies reported in figure contained in paragraph 2.2 regarding number of incidents reported compared to bar chart graph contained later in the report	Head of Concerns & Business Intelligence	Executive Director of Nursing	23.09.2025	Proposed for Closure	**Completed** Executive Director of Nursing has confirmed that he has discussed the context of this action with the Committee Chair and is proposing this action for closure
23.09.2025	7,5	15	Health, Safety & Fire Sub Committee Highlight Report 4 September 2025	Further clarity on reporting routes to be obtained for nutrition and catering activity.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	18/11/2025 Now 31 December 2025 Due to the review of Cycles of Business this action deadline has been extended to the end of December	Open	**In Progress** This action is being taken forward by the Corporate Governance team in their review of the Committee and Sub Committee annual Cycles of Business (timeframe to be complete by end of December 2025) Once a reporting route for nutrition and catering has been identified this will be fed back to the Committee. **As at March 2026, clarity is still being obtained on this matter.**
18.11.2025	6,2	12	Peoples Experience Activity Report	Further detail to be included in future reports in relation to how assurance was provided regarding actions taken from PALS queries	Interim Deputy Director of Nursing	Executive Director of Nursing	20/01/2026 **Now May 2026**	Open	**In progress** It is proposed that a report outlining the revised model for the Patient Advice & Liason Service will be presented to the May 2026 meeting of the Quality, Safety & Experience Committee
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	Open	**In Progress** This will be shared with Committee Members by end of April 2026.
20.01.2026	5,3	6	Clinical Executives Report	Winter Wrap up Report to be presented to the March meeting	Executive Director of Nursing & Chief Operating Officer	Executive Director of Nursing & Chief Operating Officer	24-mar-26	Proposed for Closure	**Proposed for Closure** Report is on the agenda for discussion at the March 2026 meeting
20.01.2026	5,3	6	Clinical Executives Report	Breakdown of the roles and responsibilities of the Health Board and other agencies in relation to Substance Misuse services to be submitted to the Executive Board.	Executive Director of Public Health	Executive Director of Public Health	23-mar-26	Proposed for Closure	**Proposed for Closure** Mapped breakdown being presented to the Executive Leadership Group taking place on 23 March 2026.
20.01.2026	5,3	6	Clinical Executives Report	Report to be presented to a future meeting of the Committee in relation to Physicians Associates outlining training, governance and patient communication.	Executive Medical Director	Executive Medical Director	24-mar-26	Proposed for Closure	**Proposed for Closure - Ongoing** Given the ongoing nature of this action and given that there is currently no progress being made on this nationally for at least the next 6 months, it is proposed that this is closed as an action and included on the forward work programme for the Committee.
20.01.2026	5.4.1	6	Primary Care & Communities Care Group Highlight Report	Next report to include further updates on the dental contract and the demand and the capacity activities of the Cellulitis service workload.	Nurse Director, Primary Care & Community	Executive Director of Nursing	24-mar-26	Proposed for Closure	**Completed** Updates on both matters have been included in the March 2026 Care Group Highlight report.
20.01.2026	6,1	10	Patient Safety, Quality & Experience Dashboard	In relation to Ombudsman cases, further consideration would need to be given to the recommendation contained within the report that stated that actions would need to be monitored via this Committee with further consideration to be given to the format this would be presented in.	Executive Director of Nursing	Executive Director of Nursing	24-mar-26	Open	**In progress** Work in relation to this action is ongoing. The Quality & Safety team are working through an OCP, which is scheduled to conclude on 18th March 2026. While the Quality, Safety and Experience Committee (QSEC) is not the designated committee for the monitoring of actions arising from Ombudsman reports, formal monitoring and assurance will be provided through the monthly Executive Management Board (EMB). A standing agenda item for the monthly EMB meetings will be included from April 2026, with the delivery of a monthly report in order to ensure continued executive scrutiny, delivery, and timely completion.
20.01.2026	6,1	10	Patient Safety, Quality & Experience Dashboard	More analysis to be provided on the Ombudsman report of how learning and improvement are presented	Executive Director of Nursing	Executive Director of Nursing	24-mar-26	Open	**In Progress** Work in relation to this action is ongoing. The Quality & Safety team are working through an OCP, which is scheduled to conclude on 18th March 2026. While the Quality, Safety and Experience Committee (QSEC) is not the designated committee for the monitoring of actions arising from Ombudsman reports, formal monitoring and assurance will be provided through the monthly Executive Management Board (EMB). A standing agenda item for the monthly EMB meetings will be included from April 2026, with the delivery of a monthly report in order to ensure continued executive scrutiny, delivery, and timely completion.
20.01.2026	7,1	10	Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Responses to be shared outside the meeting to the questions raised prior to the meeting regarding the Organisational Risk Register.	Head of Corporate Governance & Board Business	Director of Corporate Governance/ Board Secretary	24-mar-26	Proposed for Closure	**Completed** Questions and responses were shared with Members by email and the questions and responses have also been included within the minutes of the January 2026 meeting
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	Open	**In progress** Team have been asked to ensure this request is reflected in the next report being presented to the Committee in July 2026.
20.01.2026	8.1.6	11	IM and Exec Walkabouts Operating Model	Timelines to be reviewed in relation to a proposed go live date of the new IM and Exec Walkabouts Operating Model.	Executive Director of Nursing	Executive Director of Nursing	24-mar-26	Open	**In progress** The formal go live date for the New IM Walkabouts Operating Model is April 2026

Committee Action Log

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Date actio from			e / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
22.07.2025	5.2.3	8	Planned Care - Care Group Highlight Report	Update to be provided by G Hughes on what the impacts and expected outcomes were likely to be in relation to the developments within Gastroenterology and General Surgery, for example, reduction in waiting lists, patients having to spend less time in hospital.	Chief Operating Officer	Chief Operating Officer	23.09.2025	Proposed for Closure	**Completed** Information shared with members by email on 18 November 2025
22.07.2025	5,3	12	Stroke Services Report	Future reports to include focus on AHP and Therapies workforce availability to deliver a 7 day service, along with rehab goals and outcomes.	USC Care Group Service Director	Interim Executive Director of Nursing	20.01.2026	Proposed for Closure	**Completed** An update on this has been included in the report being presented to the January Committee
23.09.2025	5.2.5	10	Unscheduled Care - Care Group Highlight Report	Discussion to be held with DTPS Care Group to clarify any discrepancies and ensure understanding of the patient support model at YGT	Care Group Nurse Director, Unscheduled Care	Interim Executive Director of Nursing	18-nov-25	Proposed for Closure	**Completed** USC Care Group are holding an overarching action plan and includes the 35 cases raised as a concern by the therapy team. The review is ongoing, to date no harm has been identified. A review panel is being set up to include therapies to discuss each case and record a formal MDT outcome and any learning or further actions to be taken. There is a robust criteria to transfer to YGT, Pathway 1 and 3 patients and the ETOCS are quality assured by the Hub prior to agreeing transfer. Patients must not have any ongoing therapy needs and will have reached their threshold The Nurse Director for Unscheduled Care presented an update to ELG on the 10th November 2025 to provide assurances around improvement work.
18.11.2025	5.3.1	8	Unscheduled Care - Care Group Highlight Report	Next report to include more detailed performance data in relation to stroke performance, showing the trajectory of improvement.	Nurse Director, Unscheduled Care	Interim Executive Director of Nursing	20-jan-26	Proposed for Closure	**Completed** Data has been included in the report being presented to the January meeting
18.11.2025	6,1	11	Patient Safety, Quality & Experience Dashboard	Actual date of occurrence to be included in future reports in relation to the maternity adverse occurrence data in the table of reportable events by clinical area	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	20-jan-26	Proposed for Closure	**Completed** Addressed in the Patient Safety and Quality Dashboard for January's Committee.
18.11.2025	6,1	11	Patient Safety, Quality & Experience Dashboard	Clarity to be provided in future reports in relation to the variation between initial harm assessment and final outcome in relation to reported incidents	Head of Concerns & Business Intelligence	Interim Executive Director of Nursing	20-jan-26	Proposed for Closure	**Completed** Addressed in the Patient Safety and Quality Dashboard for January's Committee.

Agenda Item
4.2

Quality, Safety & Experience Committee

People's Experience Activity Report December 2025 – January 2026

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Jenny Oliver, Head of People's Experience Clare Ibbs, Interim Head of Corporate Nursing and People's Experience
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Clare Ibbs, Interim Head of Corporate Nursing and People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

1.1 This report provides the Quality, Safety and Experience Committee with a high-level overview of People's Experience activity for the period December 2025 to January 2026. It brings together key intelligence to support Board assurance on the delivery of safe, effective and person-centred care, in line with the All-Wales People's Experience Framework.

1.2 The report draws on a broad range of experience insight, including engagement activity, real-time and formal feedback, PALS, chaplaincy and bereavement services, volunteering, unpaid carers, and Armed Forces and veteran's support. This consolidated view enables the organisation to understand emerging themes, identify risk, and ensure that people's experience intelligence is informing quality improvement, safety oversight and organisational learning.

2. Specific Matters for Consideration

2.1 During December 2025 and January 2026, People's Experience services continued to provide strong, proactive support to patients, families and carers despite sustained operational pressures and workforce challenges.

Key areas of assurance include:

a) Effective early resolution of concerns through PALS, supporting timely issue resolution and reducing escalation.

b) Increasing engagement through chaplaincy and bereavement services, reflecting continued focus on compassionate care and support at times of vulnerability.

c) Strengthened partnerships with unpaid carers and the Armed Forces community, supporting inclusive and person-centred care.

d) Ongoing improvement to feedback systems, strengthening the organisation's ability to use experience insight to inform quality, safety and service improvement.

Collectively, this activity provides assurance that people's experience remains a core component of quality governance and continues to inform decision-making and learning across CTM.

2.2Thematic Summary of People's Experience

Theme 1: Early Resolution, Communication and Listening

What the evidence shows

a) 49% increase in PALS contacts from December to January 2025.

b) Top PALS themes: communication, clinical treatment/assessment, patient care.
c) Strong emphasis on early resolution preventing escalation to formal complaints.
d) Active ward presence and governance involvement despite 0.5 WTE vacancy.

Why this matters

a) Communication remains the single most significant driver of dissatisfaction and risk.
b) Early resolution protects patient experience, staff morale, and organisational reputation.

Actions being taken

a) Continued prioritisation of early PALS intervention and ward-based presence.
b) PALS representation embedded in key safety and quality forums (Falls, Nutrition & Hydration, Pressure Ulcers).
c) Organisational Change Programme (OCP) review of PALS underway to address capacity and sustainability.
d) Training and co-production of patient-facing resources to support clearer communication.

Despite increased demand, early resolution mechanisms remain effective, with PALS providing real-time intelligence that informs quality improvement and mitigates escalation risk.

Theme 2: Person-Centred and Compassionate Care

What the evidence shows

a) Overall satisfaction increased in January 2026.
b) Strong qualitative feedback through chaplaincy, bereavement, and engagement activity.
c) Peace lights initiative and Christmas service positively received.
d) Increasing chaplaincy reach across patients, families and staff.

Why this matters

a) Compassionate care during high-pressure periods (e.g. winter) is a marker of organisational culture.
b) Staff wellbeing is intrinsically linked to patient experience.

Actions being taken

a) Continued expansion of chaplaincy presence across acute and community sites.
b) Delivery of spiritual care awareness training (15 sessions, 74 staff).
c) Integration of compassionate care principles into People's Experience engagement activity.

d) Monitoring environmental risks impacting compassionate care (e.g. multifaith room capacity).

There is strong evidence that compassionate, person-centred care remains embedded despite operational pressures.

Theme 3: Support at Times of Vulnerability
(Bereavement, End-of-Life Care, Spiritual Support)

What the evidence shows
a) Sustained bereavement service delivery alongside national reporting and governance.
b) Multi-agency collaboration and contribution to Palliative and PEOLC priorities.
c) High volume of direct family support activity.
d) Chaplaincy supporting patients, relatives, and staff in significant numbers.

Why this matters
a) Quality of care at end of life and after death has a disproportionate impact on family experience and public trust.
b) Strong indicator of dignity, respect, and organisational values.

Actions being taken
a) Continued bereavement quality improvement and governance engagement.
b) Ongoing collaboration with wards, volunteers, and Palliative and End of Life Care (PEOLC) programmes.
c) Workforce pressures monitored, with mitigations in place to maintain service continuity – Chaplaincy and PALs service.

Support at times of vulnerability is sustained and improving, with clear links to quality improvement and national priorities.

Theme 4: Inclusive Care for Specific Communities
(Unpaid Carers, Armed Forces/Veterans, Faith Communities, Dementia Carers)

What the evidence shows
a) Increased engagement with unpaid carers via hubs, advice days, and partnerships.
b) Armed Forces survey developed to establish baseline need.
c) Work underway to improve identification (poppy emblem on e-whiteboards).
d) Faith-based capacity issue identified and risk-assessed (RGH multifaith room).

Why this matters
a) Inclusion reduces health inequalities and supports safe discharge.
b) Visibility of carers and veterans improves personalised care planning.
c) Actions being taken

d) Strengthened system-wide approach to unpaid carers as care partners.
e) Armed Forces awareness sessions delivered to clinicians and system leaders.
f) Risk logged and ongoing exploration of solutions for multifaith space constraints.
g) Continued partnership working with community and third-sector organisations.

There is demonstrable progress in embedding inclusive, equitable care models, with risks identified and actively managed.

Theme 5: Using Experience Insight to Improve Quality and Safety

What the evidence shows
a) Transition to new feedback system in October 2025.
b) Temporary reduction in response numbers anticipated and planned for.
c) Dashboards in development to support service-level insight (June 2026).
d) Manual data triangulation in place during transition.

Why this matters
a) Experience data is only valuable if it is timely, visible, and actionable.
b) Committees require assurance that intelligence informs decision-making.

Actions being taken
a) Phased implementation of dashboards with Values-Based Healthcare Team.
b) Close monitoring of feedback coverage during system transition.
c) Ongoing triangulation of qualitative and quantitative data.
d) Commitment to improved visibility of themes and trends at service level.

Short-term data risks are mitigated, with a clear trajectory toward improved experience intelligence and reporting.

Theme 6: Capacity, Workforce and Sustainability Risks

What the evidence shows
a) Vacancies in PALS, Volunteers, and Chaplaincy impacting proactive capacity.
b) Reliance on interim arrangements.
c) Volunteer numbers stable but growth constrained.

Why this matters
a) Experience services are preventative — capacity gaps increase downstream risk.
b) Sustainability is essential to maintaining visible, proactive engagement.

Actions being taken
a) OCP review of PALS underway.
b) Planned review of Volunteer Services in Q1 2026.

c) Volunteer working group proposed to better utilise skills and lived experience.
d) Ongoing monitoring of chaplaincy workforce impacts.

Capacity risks are recognised and under active review, with planned actions to support sustainability.

3. Key Achievements for People's Experience

a) People's Experience Strategy drafted and circulated for endorsement prior to approval and launch in quarter 1 of 2026.
b) Carers Passport Pilot commenced – 3rd March – and accepted for the All Wales Spread and Scale Academy
c) Visiting Guidance updated and due to launch on 1st April
d) Progress made with embedding patient feedback across the Care Groups utilising the new system

Table 2: Number of responses December 2025 – January 2026

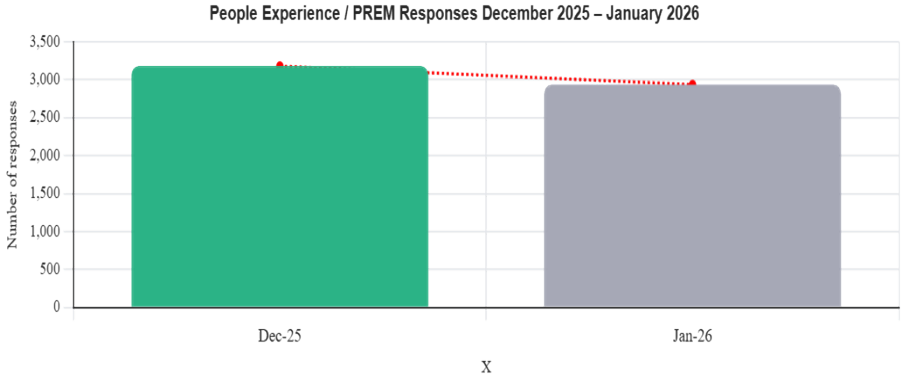
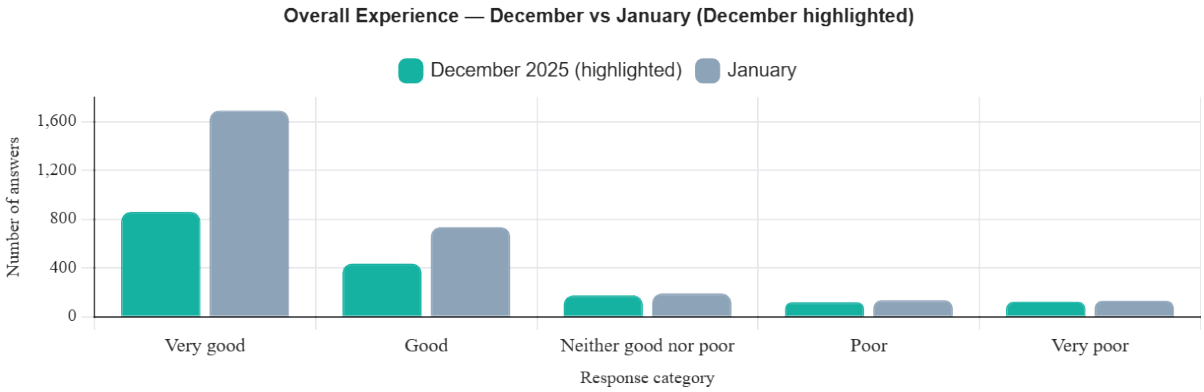


Table 3: Satisfaction rate for CTM December 2025 – January 2026



The data highlights an increase in satisfaction rate in January which may be accounted for by the acuity of services over the Christmas period.

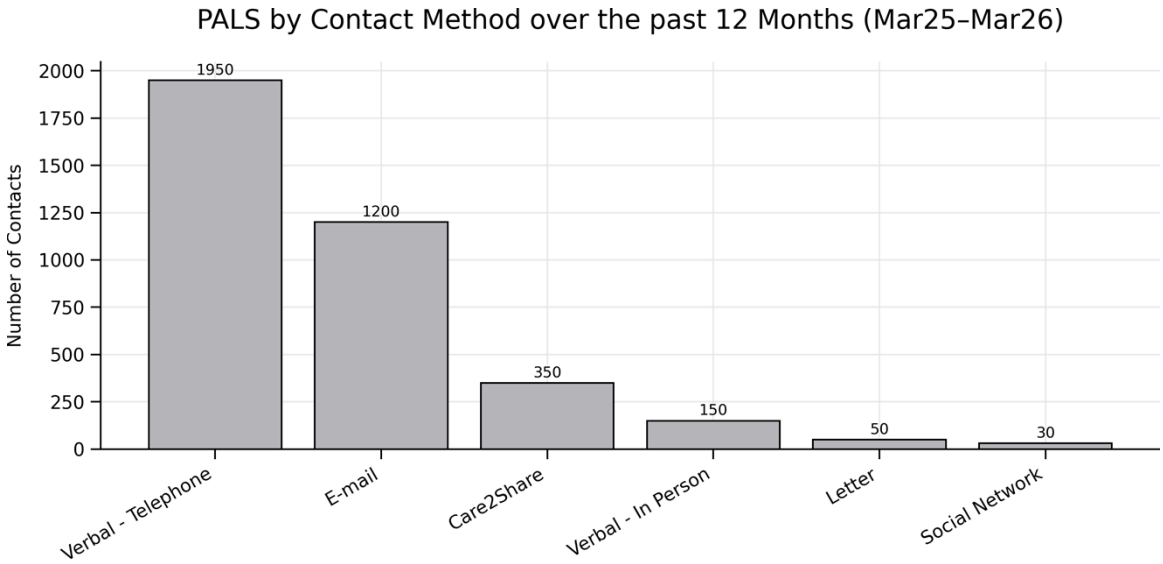
e) The PALS team continued to demonstrate significant impact during December 2025 and January 2026, delivering high-quality, person-centred support despite operational pressures and workforce constraints.

PALS contacts

PALS Cases	December 2025	January 2026
Number Opened	260	388
Number Closed	250	366

The above demonstrates a 49% uplift in PALS contacts, reflecting increased visibility and accessibility for patients, families and carers.

Table 4: Overview of contact method utilised by the public



Whilst the utilisation of 'Care to Share' clinics on the ward has decreased, the public are able to ask for support via the different contact methods highlighted above. Below is an example of the feedback received via the 'Care to Share' ward walks:

4. Key Risks / Matters for Escalation

Summary of Risk	Action taken to mitigate	RAG rating
People's experience capacity Vacancies within PALS and the volunteer service are being managed with interim arrangements, but sustained gaps would reduce proactive engagement, early concern resolution and visible support for patients and families.	Two vacancies in the Volunteers team (1 F/T WTE Volunteer Manager and 1 Volunteer Officer F/T WTE) impact on the service and one administrator (0.8) FTE are ensuring support for volunteers continues, but this has reduced the capacity to explore different opportunities and recruitment events. PALS (0.5 WTE) reduces impact of the team and visibility on acute site (POW). Both services will undergo a full review – PALS is underway through the current OCP and Volunteer service will be commenced in first quarter of 2026. Chaplaincy service – workforce retirement and sickness have impacted but the team continue to work proactively to increase presence on acute/community sites.	
Insight and data continuity: The feedback platform transition carries short-term risks to consistency of data capture and reporting, which are being mitigated through a phased approach and close monitoring of survey coverage.	Manual pulling of data while the 2 systems integrate and review of a people's experience dashboard is underway by the values-based healthcare team	
Environment for inclusive care: The size and configuration of the multifaith room at Royal Glamorgan Hospital do not fully meet demand,	This has been added to the Risk register – December 2025. Meeting held with the site Manager, Health and Safety, and Chaplaincy to explore capacity on RGH in December 2025.	

particularly for Friday prayers, and a risk has been logged while options are being explored.	Currently due to capacity of services on RGH site there has been no resolution of locating a larger space, this will continue to be monitored.	

5. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment(s).

Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment(s).
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	The work the People's Experience team supports and implements is crucial to ensure that person centred care, service development and shared learning is maintained across the HB footprint.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The People's Experience team is carrying vacancies in elements of the portfolio which impact on the ability to work proactively in these areas.	

6. Recommendation

The Quality, Safety & Experience Committee is asked to **NOTE** the activity reported in relation to People's Experience.

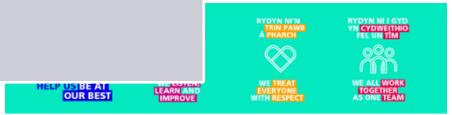
7. Next Steps

It is further noted that time-series data reporting will be available in future reports however, limitations within the current data set do not allow for presentation in this format at this time.

(Agenda Item) 4.3	24th March 2026	Quality, Safety, Experience and Risk Committee	Ambulance Handovers, Onboarding Impact, Winter Pressures (Winter Wrap-up): Learning and Improvement Outcomes

Report Details:	
FOI Status:	Please select: Open
If closed please indicate reason:	Not applicable
Prepared By: *If you do not wish for your name to be included in the public domain, please only include your job title*	**Deborah Matthews**, Care Group Director of Nursing (USC) **Sharon O'Brien**, Care Group Director of Nursing (Planned Care) **Filipe Leitao**, Head of Infection, Prevention & Control
Presented By: *If you do not wish for your name to be included in the public domain, please only include your job title*	**Deborah Matthews**, Care Group Director of Nursing (USC) **Sharon O'Brien**, Care Group Director of Nursing (Planned Care) **Filipe Leitao**, Head of Infection, Prevention & Control
Approving Executive Sponsor:	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Care.
Report Purpose	For Discussion For Noting
Engagement undertaken to date:	Prepared for committee

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Highlighting potential for harm and risks, identifying poor patient experience.
Related Health and Care Standard	Governance, Leadership, Accountability.
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No, this was a specific report on winter pressures and clinical pressures.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Improving Care



Chapter 1

Unscheduled Care

Ambulance Handovers and Onboarding Impact. Learning and Improvement Outcomes.

Chapter Author: Deborah Matthews, Care Group Nurse Director

System Context

Ambulance handover delays have been a major patient safety and operational risk across Wales.

Key Partners:

- NHS Wales
- Welsh Ambulance Services NHS Trust

Risks previously identified:

- Delayed clinical assessment
- Ambulance crews unable to respond to community calls
- Corridor care
- System-wide escalation

What is the 45-Minute Handover Standard

Definition:
Transfer of care completed within 45 minutes of ambulance arrival at hospital.

Why it matters:

- Earlier clinical assessment
- Reduced risk of harm
- Improved ambulance availability
- Better system flow

This is a **patient safety measure**, not just a performance target.

Improvement Approach

Interventions implemented:

- Dedicated handover roles
- Rapid assessment models
- Executive-level escalation triggers
- Real-time performance dashboards
- Daily operational command review

Focus:

Eliminate long delays (<12 hours)
Minimise delays >60 minutes
Increase 45-minute compliance

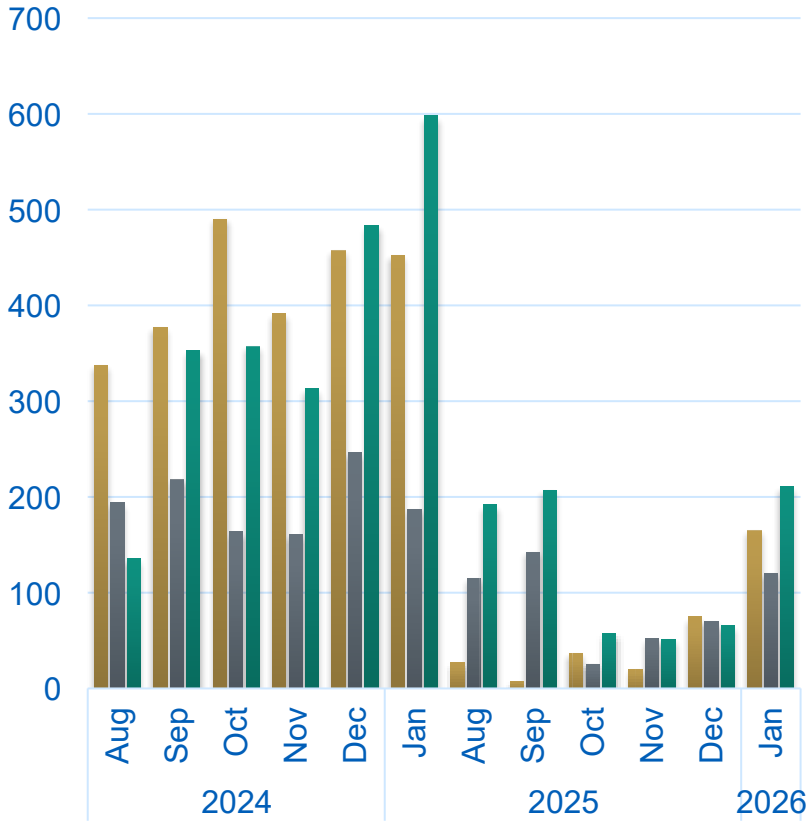
Emerging System Impacts

- Although handover performance has improved, wider system pressures remain and continue to influence 12-hour Emergency Department delays, with associated risks to patient experience and potential avoidable harm.
- In supporting timely ambulance release, staff have noted that they can at times feel pressure to complete handovers before clinical space is fully available, which may increase the risk of temporary or suboptimal patient placement.
- Ongoing pressures are contributing to workforce strain, reflected in reports of multidisciplinary tension, sickness absence, and increased reliance on temporary staffing, which may impact continuity and safety.
- Greater reliance on community and telephone triage has highlighted potential clinical risk in situations where alternative services are limited or decisions must be made under pressure.

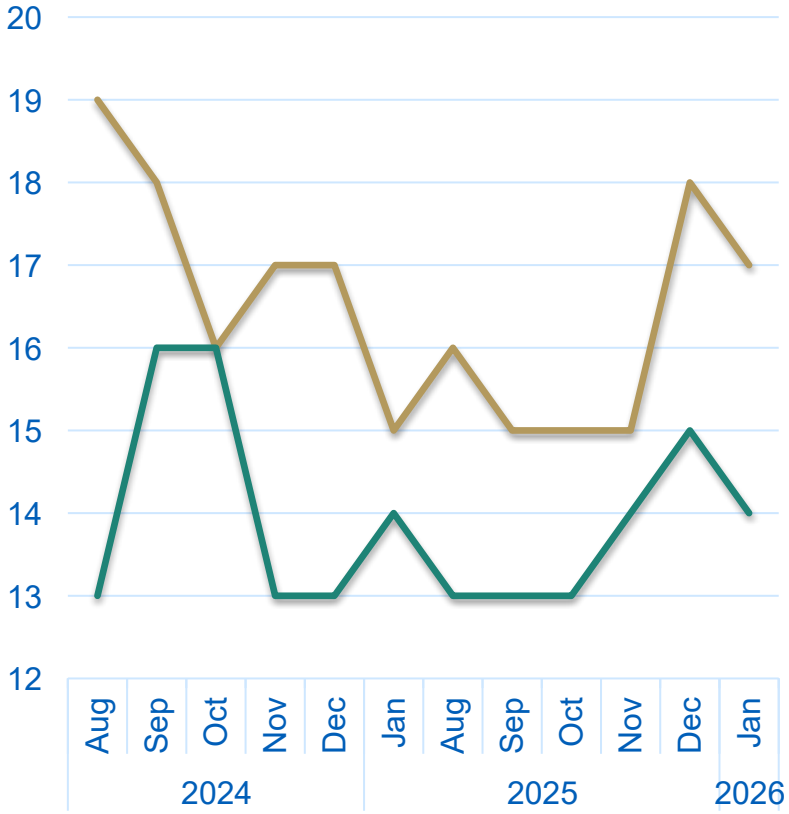
Operational Metrics

ctmuhb.nhs.wales

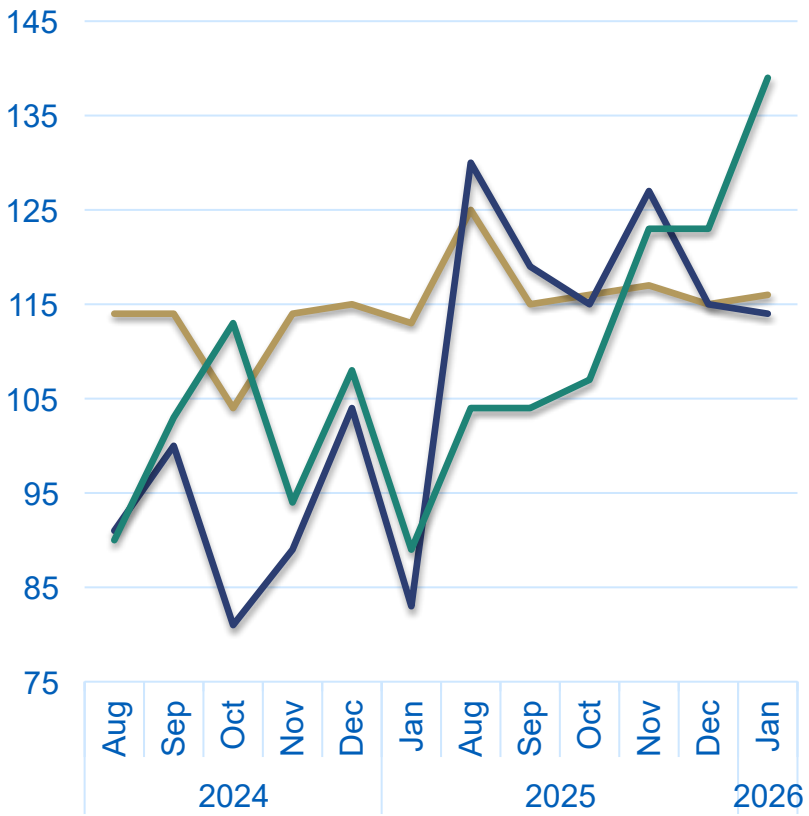
45 minute handover



Time to Triage (min)

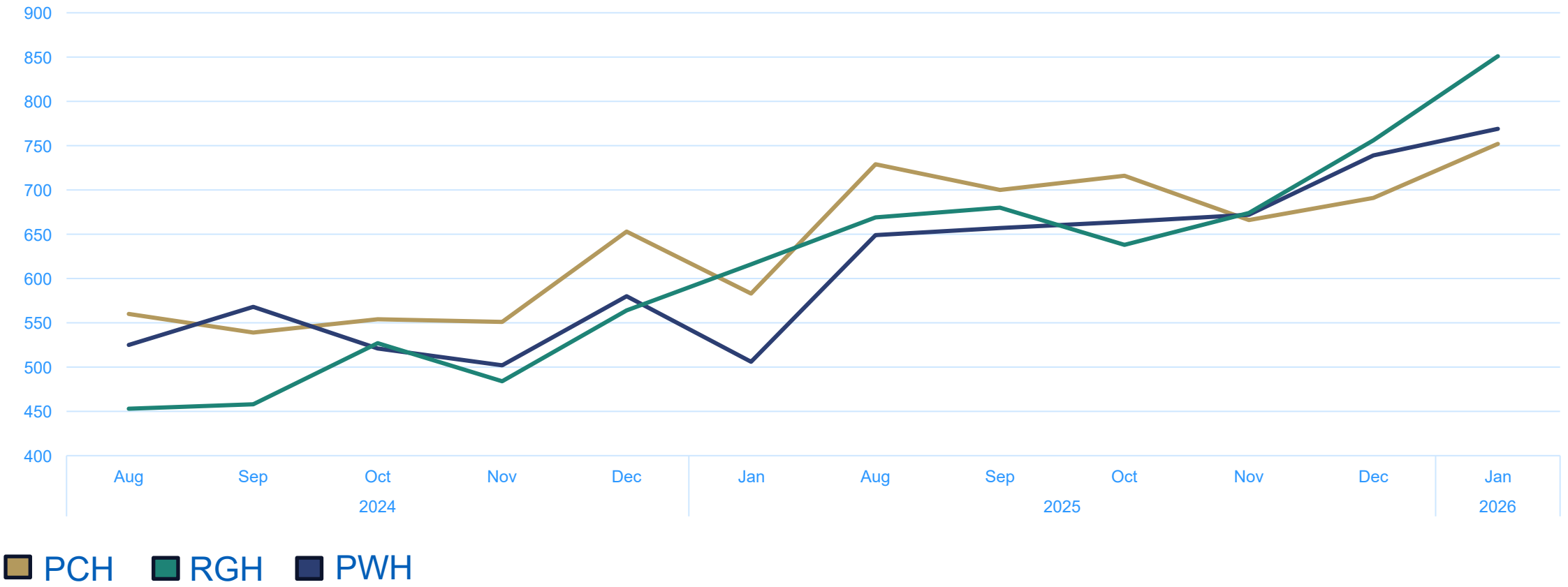


Time to 1st Clinical Assessment (min)

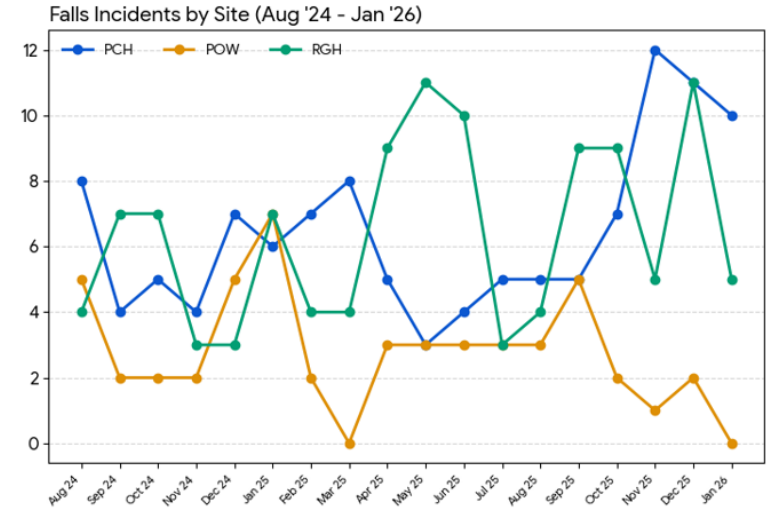


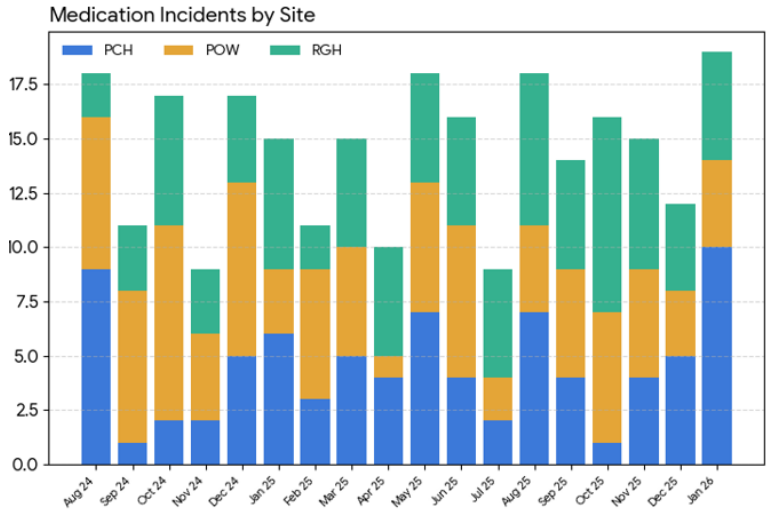
PCH RGH PWH

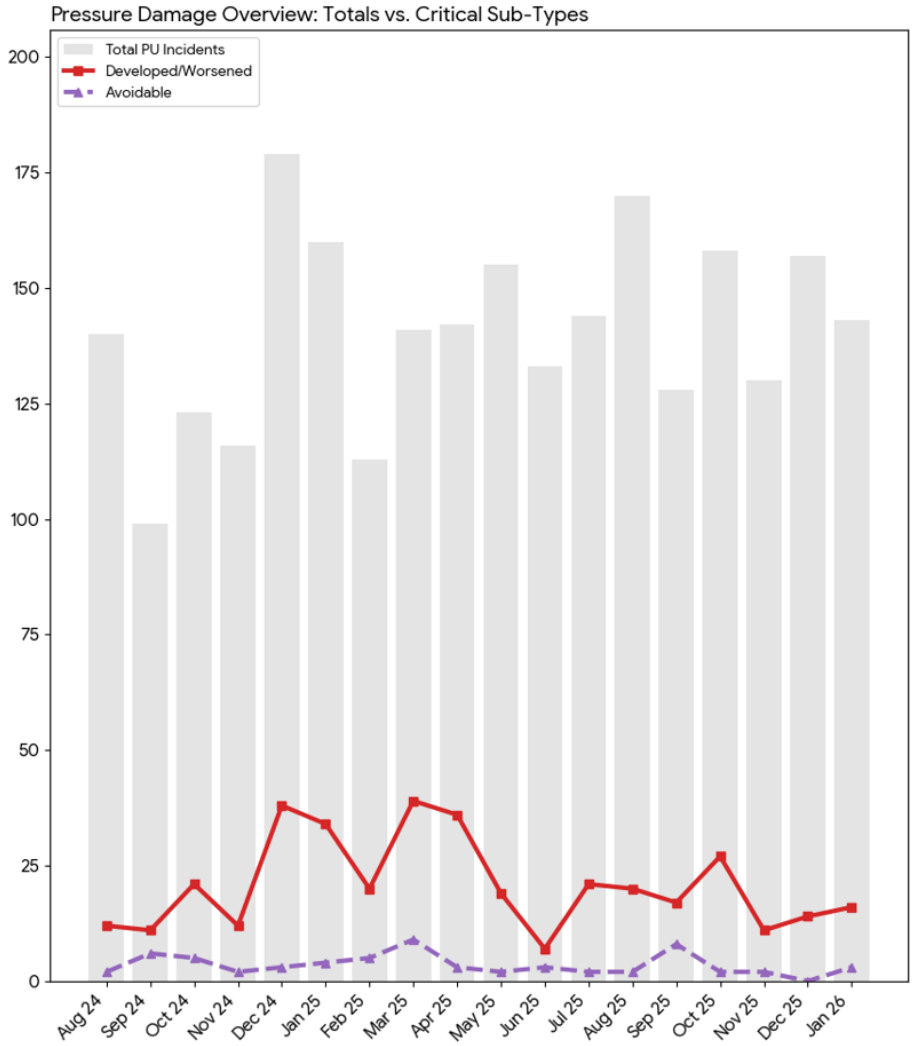
Number of 12 Hour Breaches



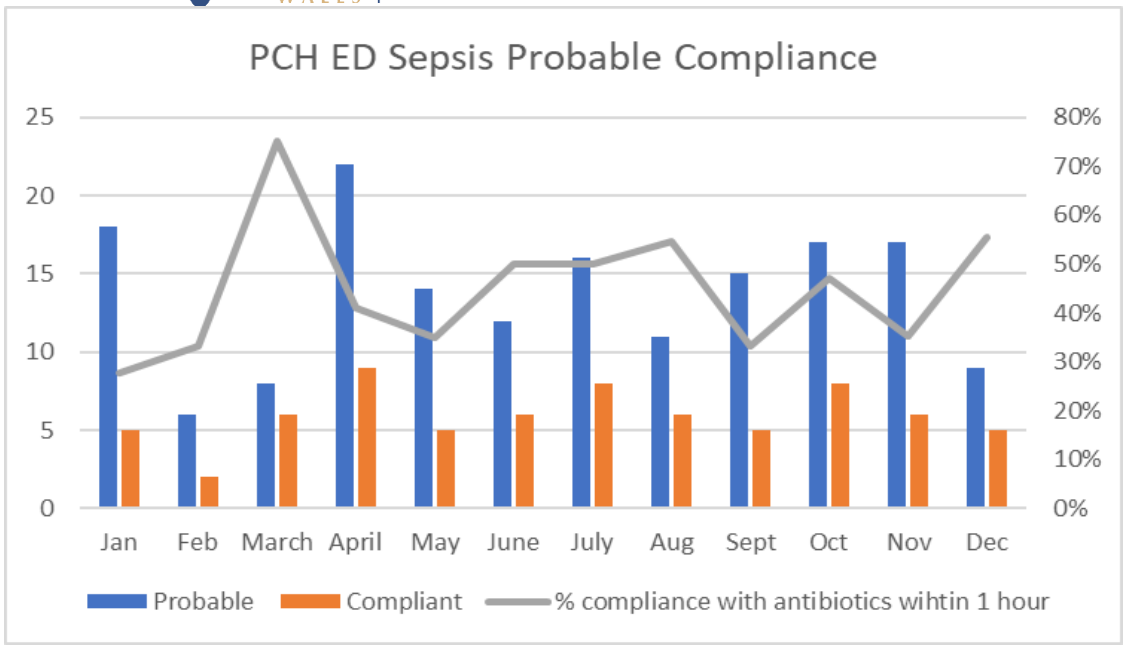
Clinical Metrics

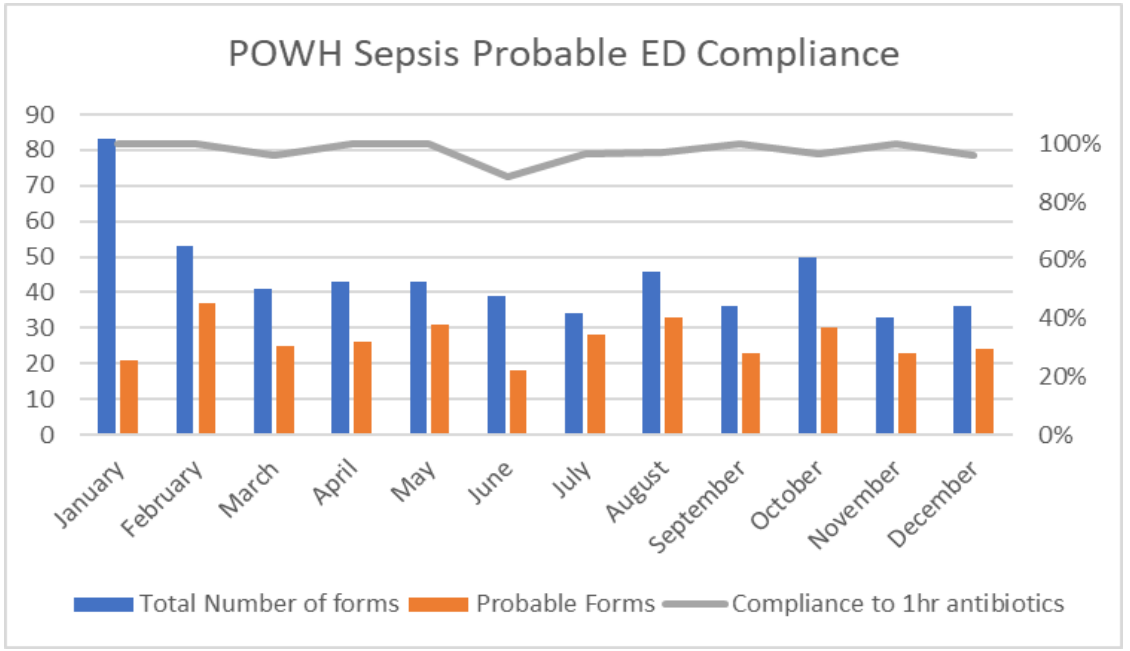


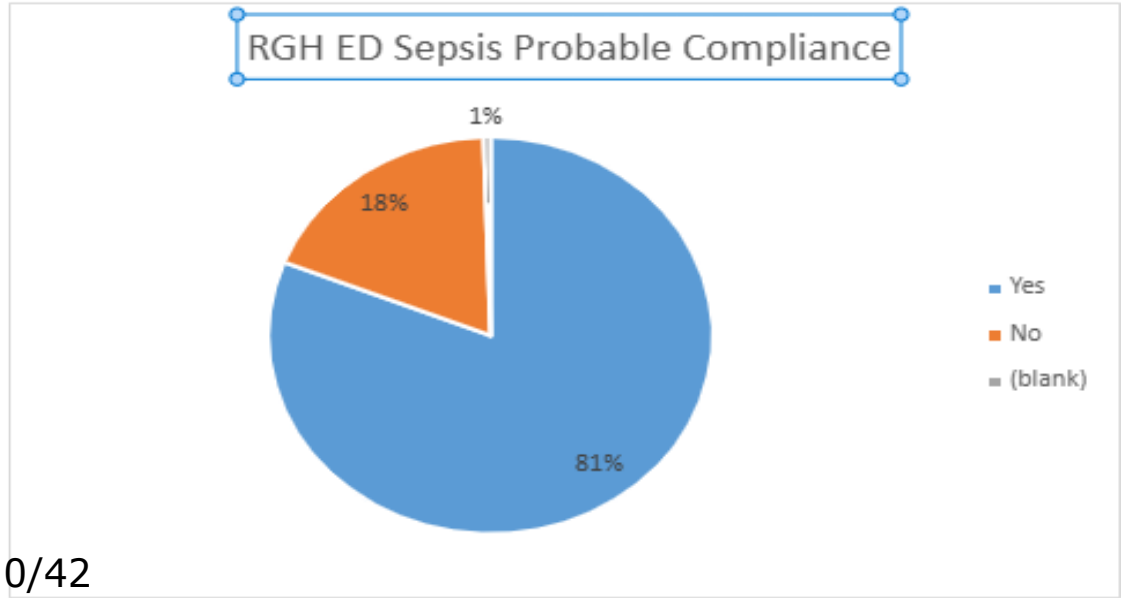




ED Sepsis Compliance







Plan:

- ACP POWH liaising with RGH and PCH sites to support audit
- Aim to get a sepsis group across all 3 sites
- Education and training –

Has Faster Handover Reduced Quality?

Board-Level Safety Review Included:

- Datix incident analysis
- Serious incident review panels
- Mortality & morbidity review
- Complaints trend analysis
- Executive walk-round feedback
- Review of ward boarding, in line with Escalation Framework

Findings:

- No increase in clinical harm
- No increase in serious incidents
- No evidence of rushed or unsafe assessment
- Reduced corridor care exposure, to no corridor care being undertaken
- Increased boarding onto wards and uncommissioned capacity

Conclusion:
No measurable adverse impact on patient safety identified.

Complaints & Public Feedback

Before:

- A number complaints regarding ambulance delays
- Reports of prolonged waits before assessment

Current Position:

- Complaints referencing handover delays reduced
- Improved public confidence in ED assessment
- Increased number of complaints referencing overcrowded ED's and delays in inpatient bed allocation.
- Increased concerns from external stakeholders, relating to the above and dignity compromisation.

Workforce & Onboarding Impact

Changes introduced:

- Structured induction for handover processes
- Clear role allocation at escalation levels
- Executive-led surge response

Impact:

- Improved accountability
- Clearer operational leadership
- Reduced ambiguity during pressure

Ongoing risk:

- Workforce fatigue remains monitored

Quality Impact of the Escalation Framework

Since implementation:

- Earlier identification of system pressure
- Faster executive intervention
- Reduced prolonged handover delays
- More consistent cross-Health Board response
- Improved system-wide accountability

Quality Assurance View:

Escalation framework strengthens governance and reduces unmanaged risk.

Learning & Improvement Outcomes

Key Lessons:

1. Performance targets must align to safety intent
2. Transparency improves system behaviour
3. Executive oversight reduces prolonged risk exposure
4. Workforce engagement determines sustainability
5. Data validation is critical for public confidence

Improvement Actions:

- Monthly Quality Review of handover cohort
- Ongoing incident deep-dives
- Staff wellbeing monitoring
- Public reporting via Board papers

Board Assurance Summary

- ✔ Significant improvement in 45-minute performance
- ✔ Elimination of extreme handover delays
- ✔ Improved patient feedback regarding ambulance handover delays
- ✔ Strengthened governance via escalation framework

Overall Conclusion:

The 45-minute handover improvement programme has delivered measurable system benefits without significant adverse impact on quality or safety in ED.

Patient experience whilst in ED remains a concern (longer waits in chairs and overcrowded) continues to be monitored closely.

Chapter 2
Planned Care

Chapter Author: Sharon O'Brien, Care Group Nurse Director

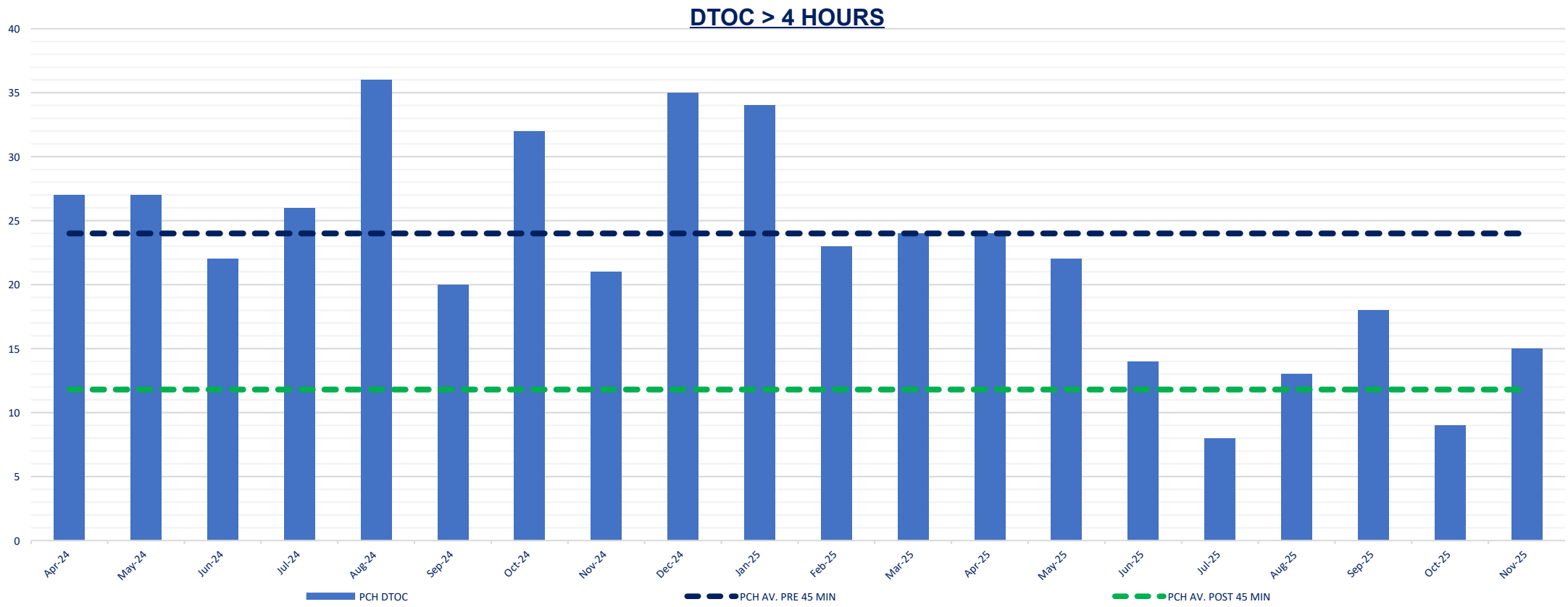
Improvements to support 45 minute handover

- Progressing Ministerial Priorities in line with 6 Goals
- Internal pathways to support rapid transfer from ED and admission avoidance via ED including:
  - Gynae Assessment Units (PoW & PCH),
  - Trauma Unit (RGH & PCH),
  - ENT Assessment Bays,
  - Surgical Assessment Unit (SAU) and Surgical Same Day Emergency Care (SSDEC) Units on 3 acute sites.
- Increase in Advanced Clinical Practitioners (ACP) in SAU in RGH and PCH to improve timely senior decision making
- SSDEC/SAU ACPs have developed a Watchlist for a virtual ward/follow ups with GP referrals or follow up patients are sent to the ACPs and they will monitor & review virtually to assess if a patient does need to attend SSDEC Unit or telephone advice resulting in:
- Improved patient experience as providing the patient's care in their own place of residence
- This is preventing unnecessary referrals attending the hospital, freeing up clinician's time for the SAU patients.
- Support to GPs to treat and review patients

Improvements to support 45 minute handover

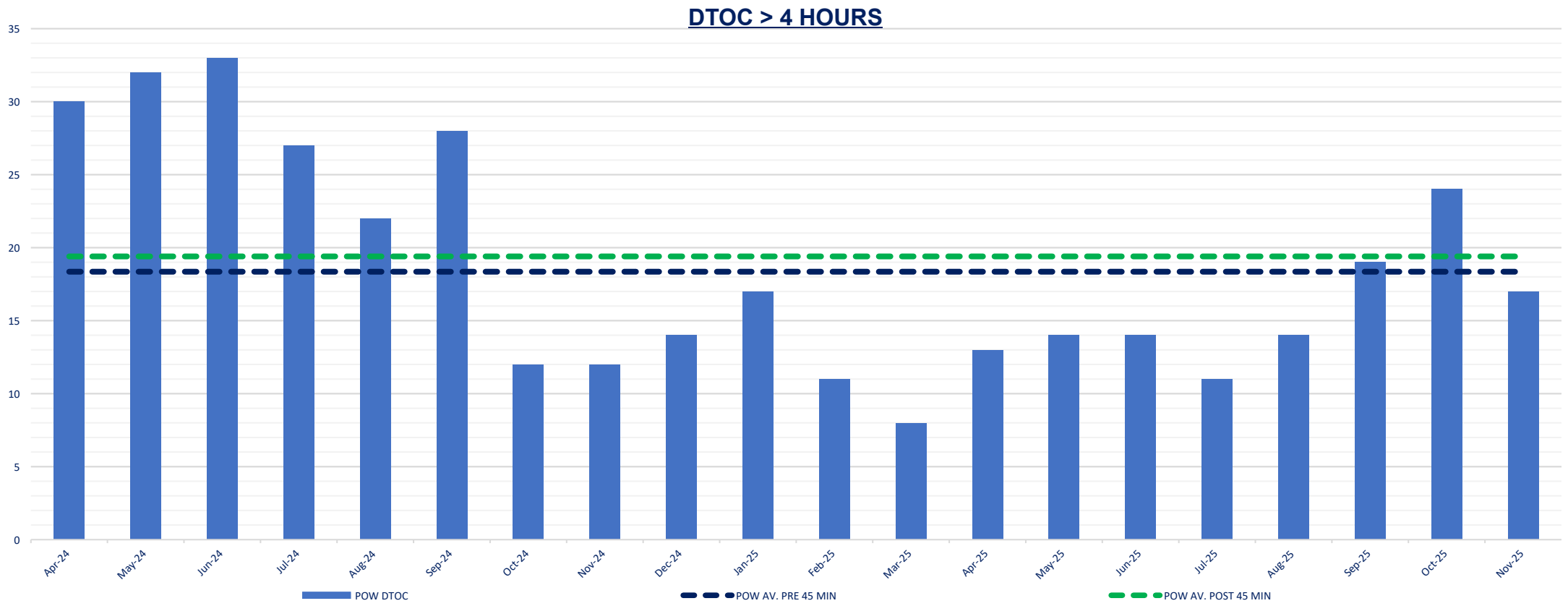
- Need focused piece of work on SAU metrics, LOS, chair waits, trolley mixed sex bays.
- Implementation of urology Advanced Clinical Practitioners in POW to support rapid decision making in ED for referral to RGH or treat and discharge in POW
- Expansion of Outreach Services to support acutely unwell in ED and across all the inpatient wards on the acute sites

Unintended consequences – Delayed Transfers of Care out of ITU
CRITICAL CARE: PCH



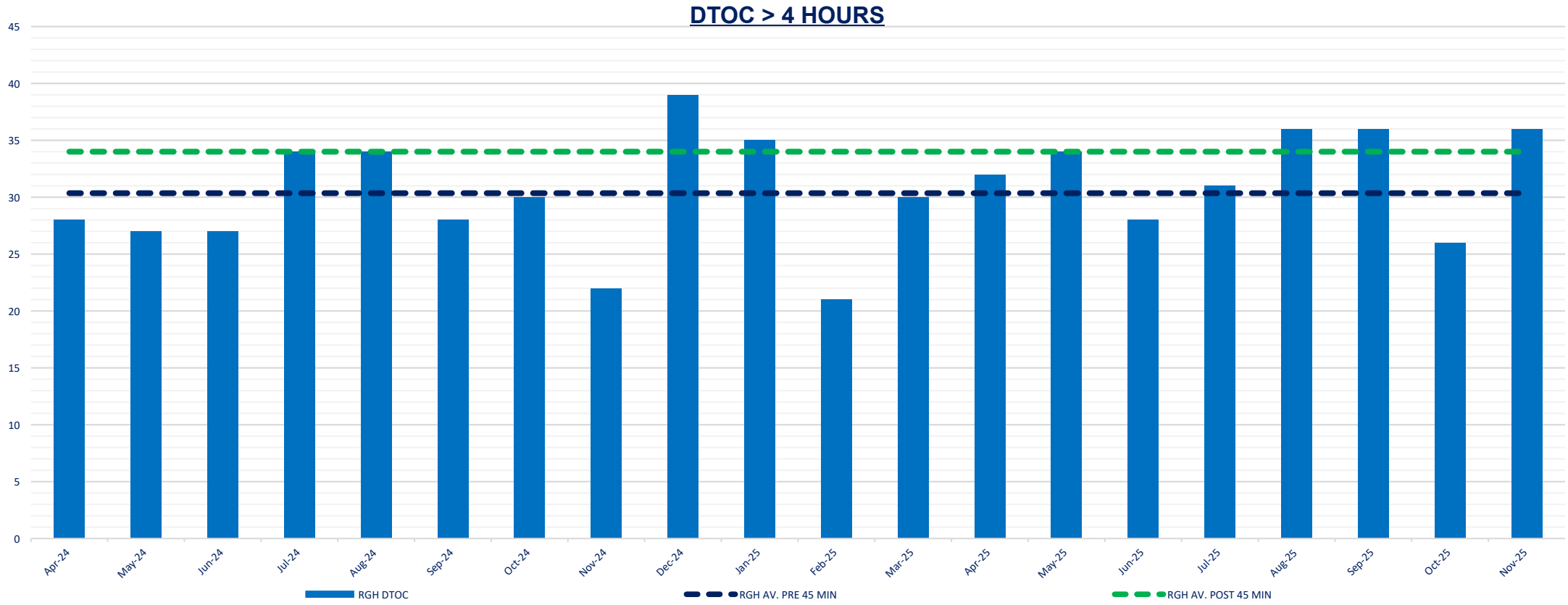
CRITICAL CARE: POW

DTOC > 4hrs:



CRITICAL CARE: RGH

Delayed admissions:
DTOC > 4hrs:



Summary Critical Care

- Increase in average Delayed Transfers of Care unable to come out of ITU on to wards.
- Exception in PCH, this may also be reflective of increase in bed capacity in PCH to 10 beds around same time as 45 minute ambulance handover introduced.
- ITU in PCH and POW combined HDU/ITU flex
- In RGH, HDU and ITU separate units

Use of boarding spaces on Planned and USC Care Wards

- 1 – 2 additional boarding beds on wards consistently in PCH and RGH
- Boarding spaces in RGH are in ‘window bay areas’ this area is cold in the winter and excessively hot in the summer months due the windows.
- Boarded areas have no fixed curtains for privacy,
- No designated space for locker and chair which impacts on manual handling for both patients and staff.
- Loss of these areas which are normally used to store bulky equipment such as ‘Steadies’ and hoists resulting in equipment cluttered around the ward environment, which affects ability to maintain effective cleaning of the environment
- Notably increase in IP&C outbreaks (influenza A, norovirus, scabies on trauma) specifically RGH

Boarding – Patient feedback

No privacy. No curtains. Nurse pull screens around me but it's not the same"

We are all too close. These men, need hoist to move in and out of bed but it means that me and all my stuff needs moving around to do this.

Swing a cat springs to mind

Governance Framework for use of boarding spaces on the acute sites

- Implementation of Escalation Framework includes Boarding in line with the Standard Operating Procedure
- Captured & discussed twice daily at Safe2Start Meetings on each site
- Right patient, right place first time
- Robust inclusion criteria for use of boarding spaces and suitable patients
- Discussion with patient, family and/or carer
- Individual risk assessment completed
- Patient information leaflet
- Minimal daily review by Ward Manager/Senior Nurse of every boarded patient. This is also part of the daily wider MDT Boardrounds
- Completion of boarding audit which is captured on AMaT & discussed at bi-monthly Care Group QSRE meetings

Patient Experience

Scenario 1

Bed plans agreed at 5pm to ensure capacity for the following morning's surgical activity, including urgent cancer surgery, were on occasion utilised overnight to support ambulance handover and maintain flow through the Emergency Department. Although this was a risk-assessed decision, it resulted in no beds being available when breast cancer patients arrived for surgery the next morning. To proceed with their scheduled operations, the only viable option was to transfer patients post-operatively, while still on a trolley, to the Vanguard unit for recovery rather than to a ward environment.

Scenario 2

A patient at the Princess of Wales Hospital with a complex tibia/fibula fracture, associated with a risk of significant complications including potential limb loss, was awaiting transfer from the Emergency Department to the Royal Glamorgan Hospital. The Emergency Department had been monitoring for signs of compartment syndrome. To facilitate an ambulance handover, a risk-assessed decision was made to transfer the patient overnight from the Emergency Department to a general surgical ward. This ward did not routinely manage trauma patients or undertake limb-specific monitoring for complex fractures, creating the potential for increased clinical risk.

Chapter 3 Summary

- Right patient, right place first time
- Leadership is key, clear roles and responsibilities and holding to account
- Improved collaborative working between Care Groups to support Ministerial Priorities and patient safety.
- Working closely with our LA partners and external stakeholders to support timely discharge from the acute sites and reducing patient deconditioning. Firming up a Health & social Care model. Accountability externally.

Chapter 3
IPC – Winter pressures response

Chapter Author: Filipe Leitao, Head of Infection, Prevention and Control

Purpose

To provide executive-level assurance on the Infection Prevention and Control (IPC) response to winter respiratory viruses including Influenza, RSV and COVID-19.

Focus of this chapter:

- Epidemiological position review across the Health Board
- Operational pressures associated with respiratory viruses
- IPC measures implemented to mitigate risk
- Impact of interventions and outbreak management
- Key learning to strengthen future winter preparedness.

System Context

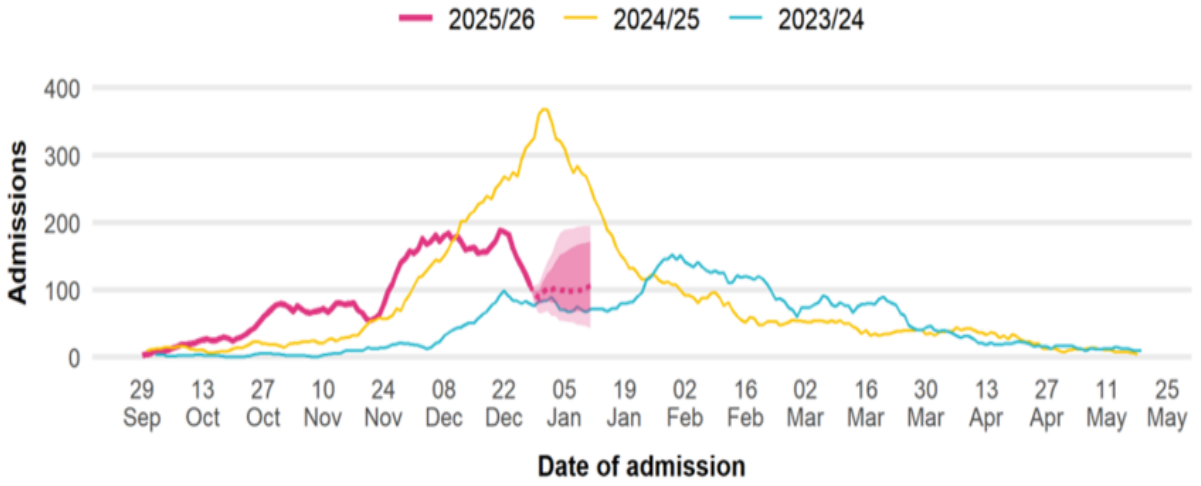
Respiratory viruses continued to be a significant seasonal pressure for healthcare systems and contribute to increased hospital admissions, outbreaks and workforce absence.

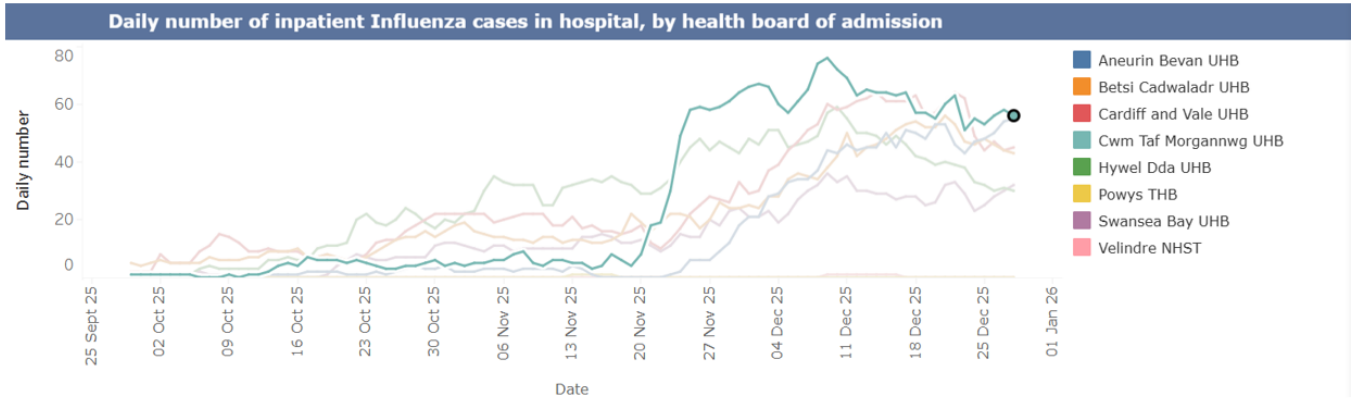
Key challenges during winter include:

- Increased emergency admissions with respiratory illness
- Healthcare-associated outbreaks affecting patient safety
- Reduced bed availability due to isolation requirements
- Workforce sickness absence
- Disruption to patient flow and elective activity

Effective IPC surveillance and preventative measures and rapid intervention are essential to protect patients, staff and system resilience.

Epidemiological Review - Influenza



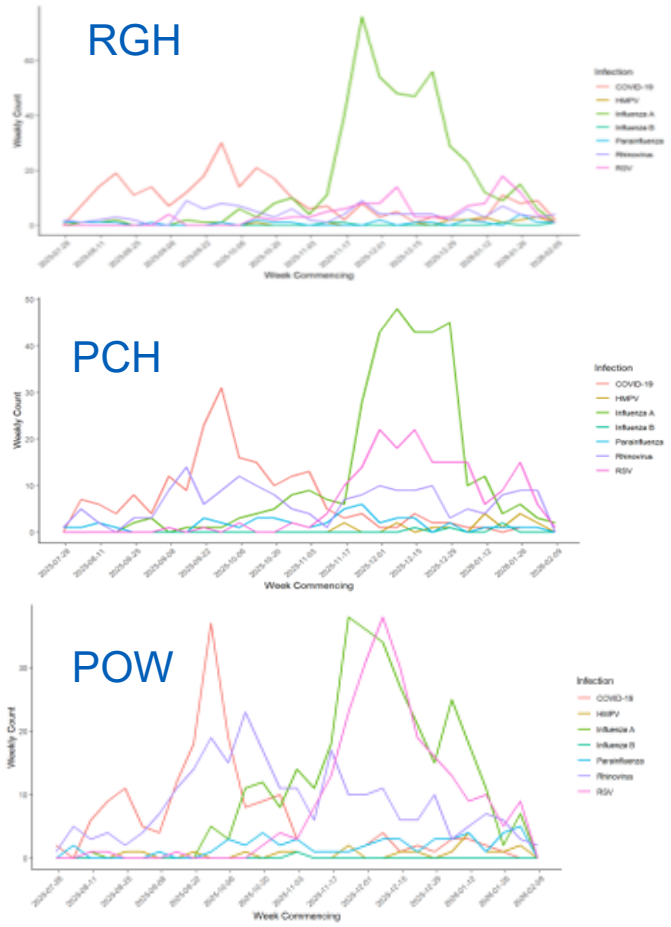


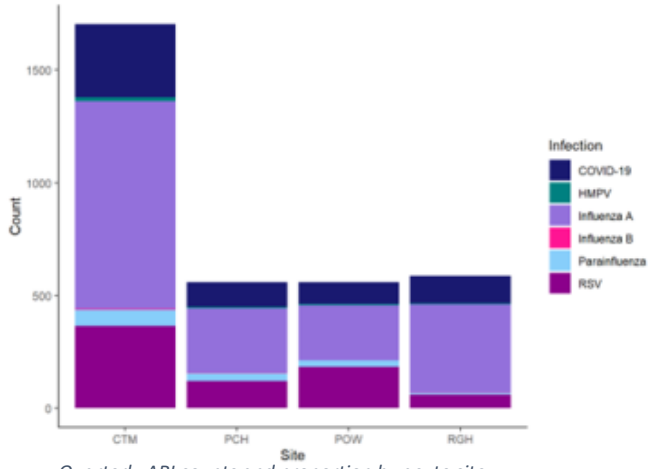
Surveillance data from Public Health Wales and internal Health Board monitoring identified an early increase in influenza activity during the winter period followed by a steady decline.

Key observations:

- Influenza cases have been seen earlier than anticipated by the PHW winter modeling
- Quick spread, in particular at RGH in the beginning with flu season, mainly driven by admissions
- Flu cases had a sharp increase during 2nd Half of October, compared to same period on previous 2 years and remained above previous year numbers until the week of 8th of December.

Epidemiological Review - Influenza

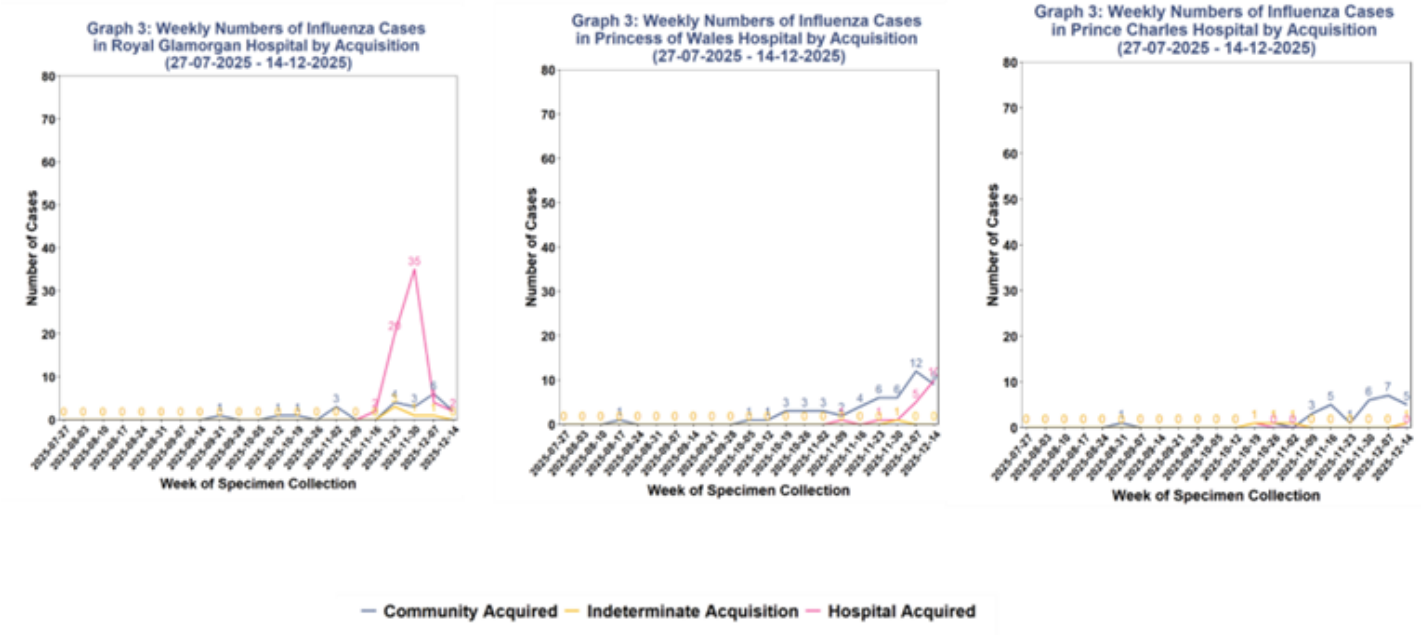




Quarterly ARI counts and proportion by acute site 2025/26 Q3

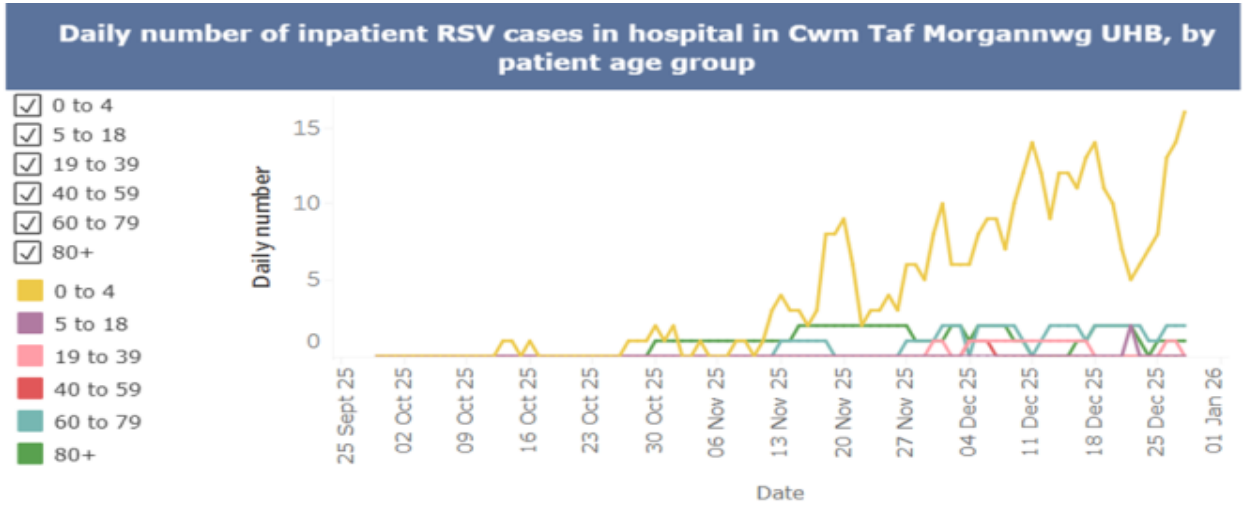
- RGH the earliest rise of cases and had the highest number of outbreaks – 6 between 21 and 26 of November
- RGH had the highest number of cases of Flu across the 3 main acute sites
- 10 Deaths recorded (HO) – 6 Flu A on part 1a of the Death Certificate and remaining 1b and 1d. All cases were reviewed with 2 cases identified as moderate harm and remaining low or no harm related to flu
- RGH has the lowest number of RSV cases across the 3 sites
- PCH was the 2nd most affected site by flu
- POW was the site with highest number of RSV cases within the 2 acute sites

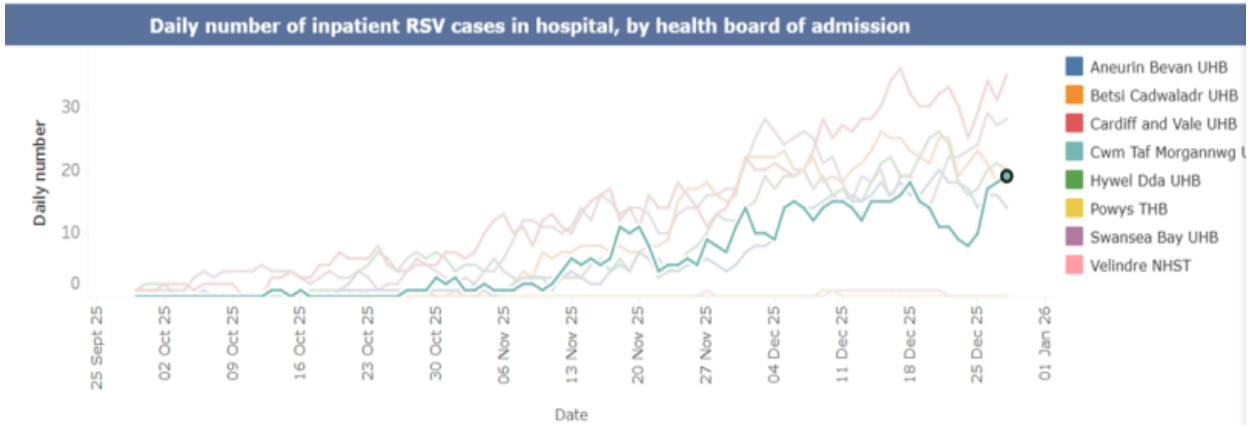
Epidemiological Review - Influenza



- RGH was the first to have cases of Influenza A, which resulted on the spike on HO cases identified with rapid decrease
- POW and PCH mainly had CO cases, which reflects the effectiveness of measures implemented once the first cases were reported at RGH

Epidemiological Review - RSV





Surveillance data from Public Health Wales and internal Health Board monitoring identified a later rise than in previous years.

Key observations:

- RSV activity increased later than in previous years
- No RSV outbreaks were recorded across CTM
- The majority of RSV cases occurred in the paediatric population (0-4 years).
- CTM reported relatively low RSV activity compared with other HB in Wales

Operational Impact

Respiratory viruses contributed to operational pressures across the Health Board including:

- Increased respiratory admissions across acute hospital sites
- Demand for isolation rooms and cohort areas
- Increased system pressures including emergency department crowding and boarding across the organization

Infection Prevention and Control Interventions

A range of IPC measures were implemented to reduce transmission risk:

<u>Enhanced surveillance & Response</u>

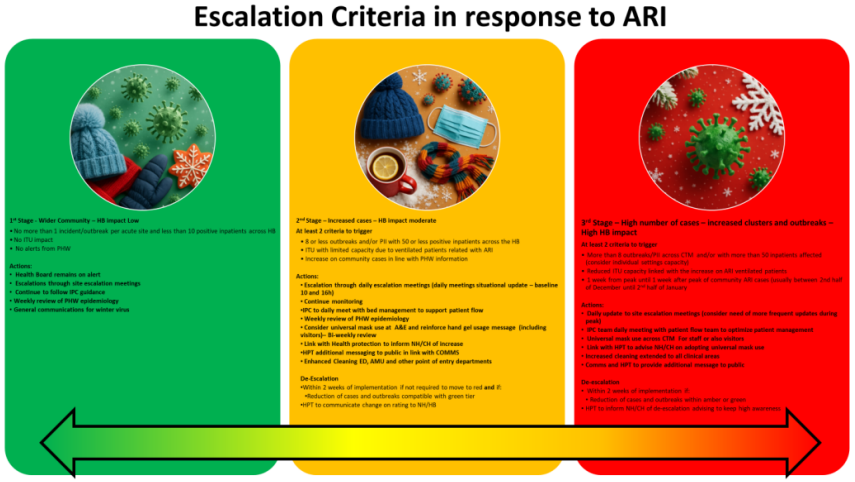
- Winter Virus Escalation and Preparedness Plan implemented with RAG escalation matrix
- Daily monitoring of respiratory virus activity and outbreaks
- Deployment of IPC Cell to coordinate operational response
- Close collaboration with Public Health Wales

<u>Targeted infection control measures</u>

- Isolation and cohorting of confirmed cases
- Enhanced environmental cleaning
- Reinforcement of respiratory hygiene and hand hygiene

<u>Personal protective equipment</u>

- Temporary introduction of universal mask use during the influenza peak
- Continued mask use in outbreak areas and high-risk clinical settings



Outbreak Management

The IPC team maintained oversight of respiratory virus outbreaks across acute sites.

Key actions include:

- Rapid outbreak identification and investigation of suspected outbreaks
- Immediate implementation of control measures
- Isolation or cohorting of affected patients
- Temporary visiting restrictions
- Enhanced environmental cleaning
- Deployment of admission bays to avoid admission of positive cases to wards
- Deployment of mandatory use of masks until evidence showed significant decrease of community cases

The establishment of the cell meetings and implementations of control measures were part of a multidisciplinary effort to ensure a balanced, fast and safe response across the HB

Learning and Improvement

Key lessons from the winter response include:

- Multidisciplinary IPC Cell meetings supported rapid decision-making.
- Admission bays for community-onset cases reduced transmission risk within wards
- Clear communication with staff and the public is essential when introducing or standing down IPC measures.
- Admission bays for positive CO cases reduced the impact on inpatient settings
- Escalation triggers within the winter RAG matrix require refinement to reflect early influenza activity
- Governance processes for operational cell meetings should be strengthened.
- Universal mask adoption was proportioned and decision to stand down had no impact on increase of cases.

Overall learning will inform future winter preparedness planning

Assurance summary

- ✔ Early surveillance identified emerging influenza activity.
- ✔ IPC escalation measures were implemented rapidly and proportionately.
- ✔ Outbreaks were effectively managed and contained.
- ✔ Patient and workforce safety were maintained during peak activity.
- ✔ Universal masking was safely stood down once epidemiology improved.
- ✔ Systems remain in place to rapidly re-escalate measures if required.

Final Conclusions

Winter respiratory viruses presented significant but anticipated seasonal pressures across the Health Board.

The high number of cases earlier than predicted in PHW models (above last years) created added pressures and challenges.

Despite an early rise in influenza activity and wider system pressures, outbreaks remained manageable and control measures were implemented rapidly across the acute sites.

Through early surveillance, coordinated IPC leadership and close collaboration with operational teams, the organization implemented proportionate infection control measures to mitigate transmission risks.

As epidemiological indicators improved, IPC interventions were safely de-escalated while maintaining readiness to respond should activity increase again.

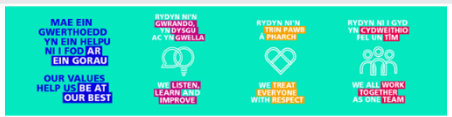
Overall, the Health Board maintained safe care delivery throughout the winter period, and the learning from this season will further strengthen preparedness, escalation processes and system resilience for future winters.

Specific Matters for Consideration:

- Continued overcrowding and prolonged waits in Emergency Departments, creating ongoing risk to patient experience and flow.
- Sustained boarding pressures across acute sites, including environmental limitations, privacy concerns and increased manual-handling challenges.
- Rising trends in Delayed Transfers of Care from Critical Care in RGH and POW, impacting timely step-down and bed availability.
- Increased incidence of IPC outbreaks (e.g., influenza, norovirus, scabies), most prominently at RGH, contributing to bed closures and reduced capacity. Recurrent cases where risk-assessed decisions to facilitate ambulance handovers have required patients to be placed in areas not routinely designed or staffed for their clinical needs.

Key Risks / Matters for Escalation:

- Potential for compromised patient experience due to overcrowding, boarding and reduced isolation capacity during peaks in respiratory viruses.
- Risk of increased clinical variation where specialist monitoring (e.g., trauma, limb-related assessments) is required but not routinely provided in the receiving area.
- Workforce fatigue and sickness absence linked to sustained operational pressure, with associated reliance on temporary staffing.
- Impact on elective surgical pathways when bed plans are disrupted to maintain flow through ED, including the need for recovery in non-ward areas.
- System resilience challenges arising from concurrent pressures across Unscheduled Care, Planned Care and IPC, affecting ability to return to baseline operations.



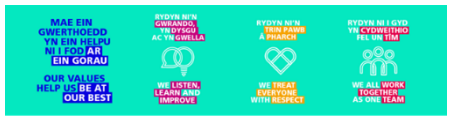
Recommendation

The Committee are asked to:

- *Note the report*
- *Continue oversight through QSEC, with a focus on cross-Care Group working to address system-wide flow risks.*
- *Endorse an on-going review of the Escalation Framework to ensure clarity of triggers, boarding criteria and safety mitigations.*
- *Support further development of specialty-specific rapid assessment and outreach models to avoid unnecessary ED attendance and reduce handover delays.*
- *Recommend that IPC winter learning is embedded into annual preparedness planning, with earlier escalation triggers aligned to epidemiological patterns observed this year.*

Next Steps

- *Consolidate lessons from Unscheduled, Planned and IPC chapters into a unified improvement plan for 2026/27.*
- *Strengthen site-level governance for boarding through consistent audit, daily review and visibility of risks.*
- *Implement a multi-disciplinary quality and experience review of DTOC trends in Critical Care to identify contributory factors and required mitigations.*
- *Progress work with Local Authority partners to accelerate safe discharge pathways and reduce deconditioning.*
- *Continue monitoring of handover performance, ED crowding and outbreak data, ensuring QSEC receives regular assurance on progress.*



Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
4.4

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report	
Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes- Executive Director Nursing, Midwifery and Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes- Executive Director Nursing, Midwifery & Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	1. Richard Hughes-Executive Director Nursing, Midwifery & Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science
Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
AMD	Assistant Medical Director
POW	Princess of Wales
AHP	Allied Health Professional
HCS	Healthcare Support Worker
HEIW	Health Education Improvement Wales
OD	Organisational Development
YCC	Ysbyty Cwm Cynon

1. Situation /Background

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

- Richard Hughes-Executive Director Nursing, Midwifery & Patient Care
- Dom Hurford-Executive Medical Director
- Lauren Edwards-Executive Director of AHPs and Health Science

Additional information and assurance against the Quality metrics, together with Patient Experience activity continues to be reported to each of the Quality, Safety & Experience Committee meetings through the Quality, Safety & Patient Experience Dashboard.

2. Specific Matters for Consideration - Clinical Executive Director specific Updates:

2.1 Nursing & Midwifery-Richard Hughes

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

Specialist Palliative Care Services

In 2024, a decision was taken to amend the admission criteria for Ward 6 at YCC from Specialist Palliative Care to a Care of the Elderly (COTE) model. This change was necessary due to sustained challenges in recruiting medical staff to deliver safe palliative care on the ward, alongside evidence of significant under-utilisation of available beds, with occupancy at YCC recorded at 62%. Despite this alteration in ward function, the delivery of palliative and end-of-life care remains consistent across community hospital sites, with dedicated specialist admissions continuing at Y Bwthyn and Y Bwthyn Newydd.

a. Workforce and Service Delivery

Specialist Palliative Care provision continues to be supported through in-reach consultant input and the Clinical Nurse Specialist (CNS) service. Notably, there are currently **no nursing vacancies** within the SPC service, and retention remains strong, providing assurance regarding workforce stability and continuity of expertise. Marie Curie has been commissioned to deliver fast-track discharge at the end of life, enabling more patients to receive care at home when clinically appropriate. Early feedback from patients and families has been highly positive, indicating good acceptance of this model of care.

b. Public Engagement and Next Steps

A formal public engagement period commenced on 11 February 2026 to support the proposed service change. This has included a public meeting held on 5 March, with engagement activities continuing until 1 April. The planned timeline includes the publication of an engagement summary and feedback report on 15 April, followed by the commencement of the Organisational Change Process (OCP) on 20 April. The OCP is scheduled to conclude on 15 May, with final feedback and an implementation plan to be issued on 1 June. This structured approach ensures transparency, maintains public confidence, and supports a safe and well-governed transition of the service model.

Approach to Essential Service Delivery During Health Visitor Industrial Action

During industrial action, the Health Visiting service is operating a structured and risk-based approach to maintain essential functions. The service is prioritising statutory birth contacts, safeguarding responsibilities and crisis response, recognising that stepping down universal and early intervention elements carries a degree of risk. The early postnatal period, particularly the first 42 days, remains a critical focus as this is when new health, developmental and safeguarding concerns are most often identified. The approach ensures that mandated elements of the Healthy Child Wales Programme are maintained where possible, with partner agencies engaged to support safe information sharing and continuity of care.

a. Operational Delivery and Mitigation Measures

The service is currently working through three hubs to support effective triage and allocation of essential work. A Single Point of Access is in place, offering families and professionals a clear route to raise concerns, with timely review and onward action. Midwifery teams are extending their involvement up to 28 days post-birth to support safe monitoring and early identification of concerns, creating capacity within the Health Visiting workforce for high-risk cases. Clinical Nurse Specialists and non-striking staff are being deployed to support safeguarding oversight, statutory functions and multi-agency processes as required.

b. Governance, Risks and Committee Considerations

The service is maintaining communication with Local Authorities, the Regional Safeguarding Board and Independent Reviewing Officers to support statutory conferences, information sharing and decision-making during industrial action.

The Quality Impact Assessment identifies that stepping down non-statutory elements presents some risk, though this is mitigated by focusing available capacity on the highest-risk children and families. The committee is asked to note that statutory and safeguarding functions are being delivered, but universal contacts cannot be sustained during this period, and a backlog is expected. This

appraisal sets out the current approach to managing risk and maintaining essential services throughout the industrial action.

National Maternity and Neonatal Assessment

The recently published Path to Safer Beginnings in Wales sets out a comprehensive national picture of maternity and neonatal services, highlighting areas of strength while identifying significant vulnerabilities in safety, governance, workforce sustainability and the consistency of women's and families' experience. The findings reinforce the need for a whole-system, multi-professional response, with particular focus on triage, induction of labour, postnatal care, neonatal configuration, equity of access, and the development of a trauma-informed and relational approach throughout the perinatal journey. The review also notes the positive commitment of staff across Wales, but recognises the constraints placed upon them by system pressures, estate limitations and the absence of consistently robust national oversight mechanisms.

In CTM, we are taking a structured and considered approach in response to the national findings. Our first action is a full review and analysis of the assessment report to ensure we understand the breadth of the recommendations and how they apply to our services. Each theme, clinical safety systems, workforce, governance, user experience, equity, and neonatal pathways will be mapped against CTM's current position to identify areas of assurance, areas requiring further strengthening, and any gaps that may necessitate improvement or reconfiguration. This work will be led through our perinatal leadership structures with Executive oversight.

Following this analysis, CTM will develop a clear local approach describing how we will respond to the recommendations, align with emerging national expectations, and prioritise areas requiring earlier intervention. This includes reviewing our workforce and skill-mix models, assessing triage and induction pathways against national standards, and strengthening our approach to postnatal care and trauma-informed practice. We are also examining how we further embed meaningful engagement with women, families, and communities to ensure alignment with the new Perinatal Engagement Framework. This will support more equitable and responsive services, particularly for those with complex social, cultural, or health needs.

A briefing is being prepared for the April Integrated Care Board (ICB) meeting, outlining CTM's current position, an early assessment of gaps, and proposed actions. This briefing will also highlight where national system decisions, such as neonatal transport and cot configuration, may have downstream implications for CTM and will require coordinated action across Health Boards. Our local plan will then be formally overseen through the Executive Management Board (EMB), ensuring consistent Executive visibility, accountability, and monitoring of

progress. Regular updates will be brought through QSEC to ensure appropriate scrutiny of quality, safety and experience as we implement the required changes.

This structured and proactive approach is intended to ensure that CTM is fully aligned with national expectations while maintaining a strong focus on safety, equity and the lived experience of women, babies and families. It places emphasis on whole-system thinking, multidisciplinary leadership and transparent oversight, supporting our ambition to continue strengthening perinatal services across the Health Board.

Update on Coronial Matters and high-level indications

Long-term trends highlight that Inquest activity across the Health Board remains consistent, with an average of 23 new inquests being opened each month. As of March 2026, the Health Board is managing 317 open inquests requiring the submission of 540 statements, of which 85% have been submitted. Compliance with the timescales for the submission of statements remains a challenge, with the Coroner's Officer issuing schedule 5s as a result of the delays. The Legal Services Team has reviewed and updated the Health Board process for the management of Inquests, along with detailed guidance to support clinical teams throughout the inquest process. A training programme to be rolled out across the Health Board is currently being developed.

Although activity has remained stable, the complexity of cases has continued to increase, with shortened timescales for submitting information to the Coroner. This is in addition to a greater expectation on the Health Board to produce an internal investigation report and to source and provide expert evidence. The increasing complexity is reflected in the current inquest caseload, where 40 cases have been RAG-rated as Red (17) and Amber (23). These relate primarily to high-risk clinical themes such as maternal, child or prison deaths, delays in diagnosis and failure to follow up. Further to this, 56 cases have been referred to Legal & Risk due to the anticipated need for specialist representation and expert evidence.

Wider learning from inquests management, including regulation 28 reports and letters from the Coroner, relates to failure to recognise the deteriorating patient, referral and diagnostic delays, shortcomings in the follow-up pathway and inadequate documentation.

2.2 Medical Directorate-Dom Hurford

Section 2 Medical Directorate

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

Achievements

This section covers the following achievements:

1. New Assistant Medical Director (AMD) roles and appointments

2. CTM Genomics oversight team
3. Primary – Secondary Care Interface Group

New Assistant Medical Director Roles and Appointments

We are pleased to confirm the appointment of three key Medical Leadership roles within CTM.

- Kevin Conway has been appointed as AMD for Clinical Transformation. This role will work closely with the Executive Director for Strategy and Transformation, Claire Thompson, to drive forward CTM's clinical redesign agenda. New role.
- Esther Flavell has been appointed as AMD for Effectiveness and Value. This is a pivotal role that will support the delivery of CTM's medical workforce savings and ensure our clinical services remain high-quality, sustainable, and value-driven. New role.
- Mo Elnasharty has been successfully appointed to the position of Interim Assistant Medical Director (AMD) for Workforce. This role provides strategic leadership across Medical Workforce planning and Workforce Policy development.

These appointments strengthen our Medical Leadership Team and position us well to deliver our strategic priorities.

CTM Genomics oversight team

We have made significant progress in establishing the CTM Genomics Oversight Team. Aside from Cardiff and Vale UHB, who are leading the national programme, CTM is currently the most engaged Health Board and is ahead of plan in several key areas across Wales.

This work has positive implications across multiple domains, notably pharmacy, education and training, and clinical genetics, where our early engagement is already supporting clearer pathways, improved governance, and strengthened multidisciplinary collaboration.

Primary – Secondary Care Interface Group

The Primary–Secondary Care Interface Group has continued to work proactively to address a range of long-standing challenges between the two clinical communities. We are now seeing meaningful progress in several areas that were previously considered difficult to resolve, including communication, mutual respect, and the quality and consistency of referrals.

While there is still more work to do, the commitment from both primary and secondary care teams to collaborate on a shared way forward is evident. This joint approach is beginning to deliver sustainable improvements and is strengthening relationships across the interface.

Areas of Focus

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

1. Physicians Associates
2. Gabapentinoid Usage

Physicians Associates

We continue to work closely with Welsh Government on the *Leng Review for Wales*, which is focused on defining the future roles, scope of practice, and development pathways for our current Physician Associate colleagues and for the profession more broadly. This work forms part of a wider Four Nations approach, ensuring that workforce planning, regulation, and professional standards are aligned across the UK.

As a result of the need for national consistency and multi-government agreement, progress is inevitably slower than any of us would prefer. Nevertheless, CTM remains fully engaged in shaping the future direction of Physician Associates in Wales and ensuring our colleagues are supported throughout this transitional period.

Gabapentinoid Usage

Gabapentinoid usage within CTM remains the highest in Wales and is among the highest in the UK for analgesic purposes. This trend is evident across both Community/Primary Care and Secondary Care settings. The Pain Oversight Group has identified this as a priority area for improvement.

While financial cost is a consideration, the greater concern relates to the extent of off-licence prescribing and the use of Gabapentinoids in clinical contexts where evidence of benefit is limited compared to alternative analgesic options. The current prescribing pattern poses risks in terms of patient safety, effectiveness, and alignment with best practice.

The Oversight Group is now focused on strengthening governance, improving prescribing behaviours, and supporting clinicians with clearer guidance to ensure Gabapentinoid use is appropriate, evidence-based, and consistent with national recommendations.

2.3 Allied Health Professions and Healthcare Science-Lauren Edwards

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

Successes and Recognition

Healthcare Science Week 9th-15th March 2026

Healthcare Science Week is an annual week of celebration and awareness raising, for the many careers in healthcare science.

Healthcare scientists play a crucial role within the NHS, applying scientific knowledge and technical expertise to prevent, diagnose, and treat illness.

They contribute to the development of clinical and technological innovations that enhance patient care, working either in direct patient-facing roles or in essential supporting capacities. Their work spans the entire innovation pathway, from academic and translational research to patient-centred service transformation.

Within CTMUHB, we have healthcare scientists working in Audiology, Clinical Engineering, Cardiac Physiology, Medical Illustration, Neurophysiology, Operating Theatres, Pathology, Radiology and Respiratory Physiology. Our teams will be celebrating Healthcare Science Week in a number of ways.

40 Years Service

Several of our colleagues working in Allied Health and Health Science professions, including Radiology, Physiotherapy and Clinical Engineering, will be recognised for their dedication to the NHS at the upcoming 40 years' service recognition event.

Presentation to British Heart Rhythm Society

David Williams, specialist cardiac physiologist, presented the first 100 left bundle branch area pacing (LBBAP) and conduction system pacing (CSP) patients performed in POW at the British Heart Rhythm Society this week.

CSP is a pacing modality that utilises the heart's natural conduction system. This is a new and evolving Pacing technique, first used in POW in 2018, placing pacemaker leads into the heart that delivers a physiological and more natural ventricular activation. Potentially reducing the risk of heart failure and pacing-induced cardiomyopathy.

Awareness

Performance, Improvement and Transformation

There has been a strong focus on improving efficiency through the work of the Allied Health Professions (AHP) and Audiology Workstream of the Performance and Improvement (PIT) Board. Several actions have been implemented to optimise outpatient clinic capacity, with the aim of enhancing access to services across AHP professions. The rollout of See on Symptoms (SOS) and Patient-initiated Follow-up (PIFU) pathways is supporting a more responsive and needs-led approach to follow-up care, ensuring that patients are reviewed at the right time and in the most appropriate way.

Assure

Education Commissioning

AHP and HCS colleagues have been working with our Workforce & OD and HEIW colleagues on the education commissioning submission for 2027-28.

This forward-looking document supports us to futureproof our services through workforce planning, helping us to commission the workforce of the future and ensure we continue to provide high quality, patient focus services.

Affina Programme

To ensure a high-quality clinical service is delivered, the Clinical Engineering department has been engaging with Workforce and Organisational Development colleagues to promote a high-functioning successful team using a variety of individual and team building techniques e.g. Clevry and Lencioni.

They join CTM audiology and dietetic teams in undertaking this structured work, designed to build and improve team dynamics through coaching, collaborative development and enhancement of leadership skills.

3. Assessment

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

Impact Assessment

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

4. Recommendation

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

5. Next Steps

5.1 Members of the Quality, Safety & Experience Committee will continue to receive regular update reports to provide assurance and maintain awareness of key successes, challenges, and any emerging patient safety and quality risks. These reports will also enable the Committee to request specific areas for further exploration, with agreed actions and next steps taken forward and reflected through future reporting.

Agenda Item
4.5.1

Quality, Safety & Experience Committee

Highlight Report from the Quality & Safety Committee.

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows, Operational Director for Unscheduled care. Deborah Matthews, Unscheduled Care Nurse Director Owen Weeks, Unscheduled Care Medical Director Robin Martin, Unscheduled Care Deputy Medical Director Victoria Healey, Head of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Deborah Matthews, Unscheduled Care Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Choose an item. Richard Hughes, Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Quality & Safety Committee	24/03/2026	

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

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 24th March 2026.

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

2. Purpose of this Meeting

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

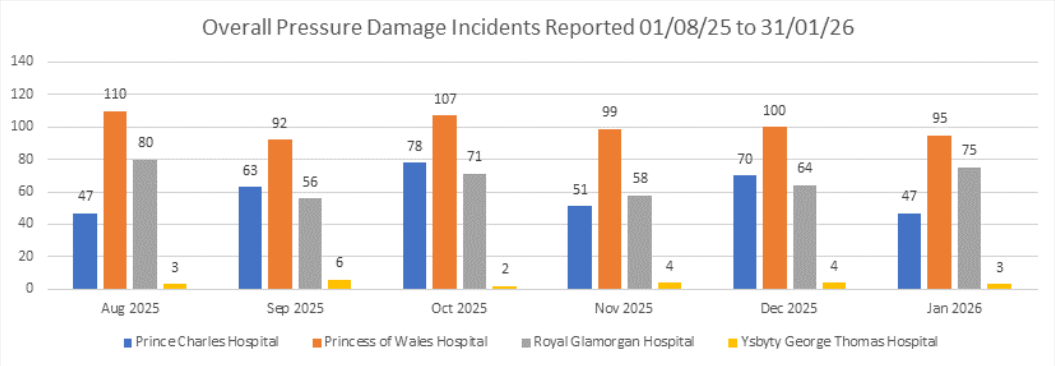
2.2 The Committee is requested to **NOTE** the report

Highlight Report

Alert / Escalate	**Fundamentals of Care; Nutrition, Hydration and Oral Hygiene** A combined Nursing and Therapy "deep dive" is currently underway across the Stroke Unit RGH, to review all incidents between January 2025 to 31st January 2026. The detail of the findings will be reported in the next QSEC, May 2026. **Resuscitation Training** Unscheduled Care overall compliance 44%, (Health Board compliance 61%) Level 1 – 59% Level 2 - Adult Basic Life Support – 49.39% Level 2 - Paediatric Basic Life Support – 17.71% Level 3 - Adult Immediate Life Support – 47.30% Level 3 - Paediatric Immediate Life Support – 25.19% **Training Provision Plan:** • Deep Dive has been undertaken across all wards and ED's to understand our baseline. • 30 Level 3 (24 ILS /6 PILS) course per month across 3 sites to meet demand (Use of HB ILS/ALS trainers used to support also) • ED's have in house trainers, bespoke training arranged and will support staff from ward areas • 42 level 2 (BLS adult and or paediatric) per month across 3 sites • ESR requires realigning to staff requirements to ensure accuracy of compliance reported.
Advise	**Ysbyty George Thomas (YGT; 54 Bedded Unit)** The formal YGT OCP concluded on 20th October 2025 to progress the transfer of service from Unscheduled Care to Primary and Community Care potentially from 1st April 2026. 34 cases of potential deconditioning incidents raised by the Therapy Team have had a preliminary review, with 5 having been discussed at MDT panel and deemed No Harm and 1 requiring a further review to establish the level of harm. **Stroke** Improvement Programme:

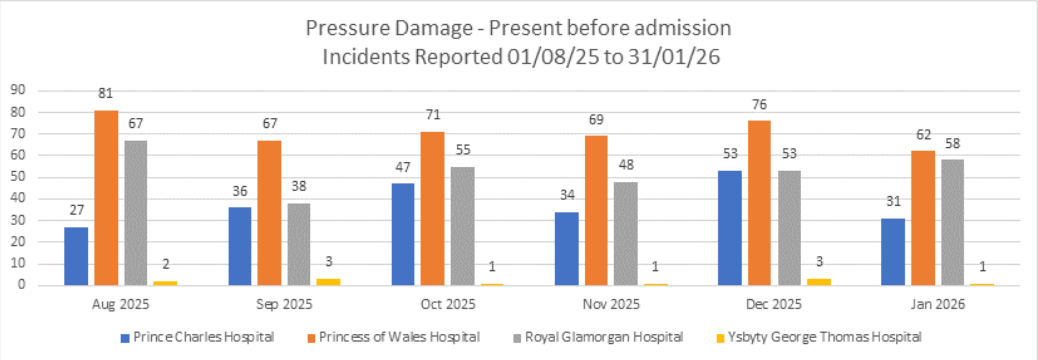
	• Focused KPI improvement work continues at RGH – time to CT and time to Stroke Unit. • Daily multidisciplinary huddles with review of all stroke presentations – breach reasons and actions agreed. • SOP to support clinical pathway. • CNS based in ED 6/7. • Daily and weekly performance reporting. Q3 Internal CTM Performance target for RGH Phase 1: • 80% of CT scans within 45 minutes • 60% admissions to ASU within 4 hours
Assure	CTMUHB continues to deliver safe and compassionate care across the Unscheduled Care Services. Incident reporting remains stable, with no statistically significant increase in severe harm events this quarter. However, system pressures, particularly within urgent and emergency care, continue to present a material quality risk. Prolonged waits in ED's and delayed transfers of care are impacting patient flow and increasing clinical risk exposure. Specific detail described in the presentation delivered today. Ambulance handovers are included within agenda item 4.3 of this meeting, with increased level of detail. The overall quality assessment for Q3 is: • **Safe:** □ Substantial assurance • **Effective:** □ Moderate assurance • **Patient Experience:** □ Substantial assurance • **Governance:** □ Substantial assurance Pressure area management, falls and medicines management remain a key focus, specifically over the winter months when CTMUHB is under significant pressures. Below outlines the number of incidents reported between 1st August 2025 - 31st January 2026 and includes all Unscheduled Care inpatient areas and the ED's. **Graph 1** *Overall Pressure Damage Incidents reported 1st August 2025 – 31st January 2026.* There is no significant difference in the numbers reported month on month, noting October and December higher numbers and the RGH

consistently the highest.



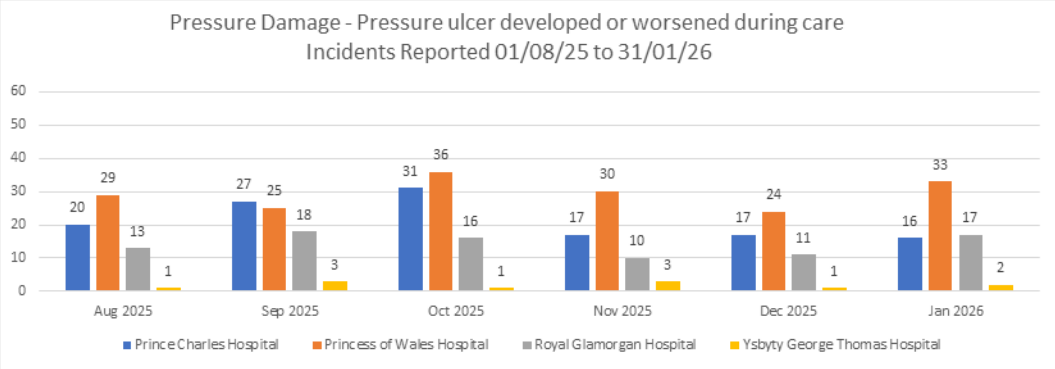
Graph 2
Pressure Damage Present Before Admission Incidents reported 1st August 2025 – 31st January 2026.

The detail below is self-explanatory, and the numbers remain consistent monthly. The numbers also impact on the numbers reflected in Graph 1, thus the total number reported internally is much less.



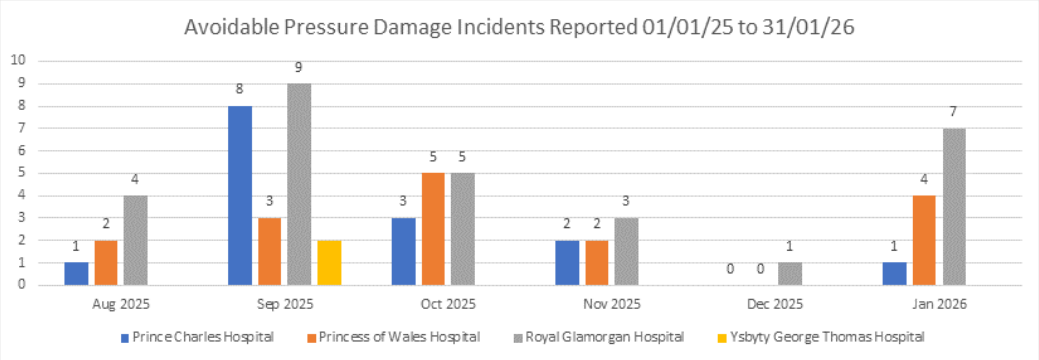
Graph 3
Pressure Ulcers Developed or Worsened During Care reported 1st August 2025 – 31st January 2026.

The numbers remain consistent and do not reflect any significant trend. All pressure damage is reviewed in monthly assurance panels and wider learning implemented as part of the collaborative and locally based on identified themes.



Graph 4
Avoidable Pressure Damage Incidents reported 1st August 2025 – 31st January 2026.

September demonstrates an increase in trend for both PCH and RGH, whereas January 2026 when CTMUHB remained in BCI for extended period - POWH and RGH have the highest trend.



Themes identified include:-

- No care plan or plan does not mitigate the risk.
- Inconsistent documentation and grading.
- Failing to act timely upon changes to skin before damage presents itself.
- Lack of meaningful and actual positioning
- Gaps in repositioning

Actions

Weekly assurance panels have been reset aligned with the new modelling across Unscheduled Care, where the Lead Nurses are taking responsibility for their service. Encouraging all grades of staff to attend the panels

Targeted work continues in areas where trends are identified and learning is shared at the monthly PFG.

Pressure Ulcer Prevention training remain a focus

PU collaborative/champions.

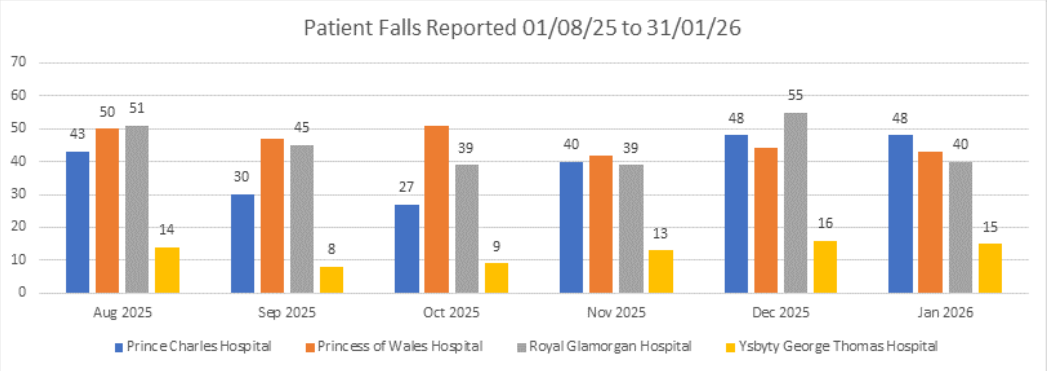
Refocus and wards creating PU prevention information boards/updating with relevant detail to speciality.

TVN's supporting with specific equipment reviews.

Graph 5

Patient Falls reported 1st August 2025 – 31st January 2026.

Other than a slight decreasing trend for all sites in October, the numbers remain consistent monthly.



Themes identified include:-

No Lying and standing BP recording pre fall.
MFRA to be completed on admission, post ward transfers, post falls or when a change is identified.
Inaccurate assessment.

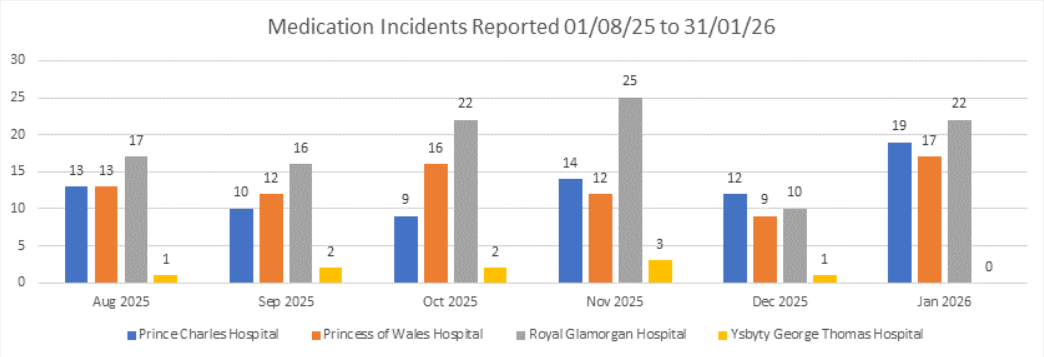
Actions

Timely review at weekly assurance panels as with Pressure Ulcers.
Continuing to target Care Falls ESR module.
Enhanced supervision-areas involved in new trials of nursing documentation.
Review of falls incidents daily to ensure timely make safes and learning is identified at ward level
Falls collaboration attendance is being monitored
Falls champions and information boards being reviewed/updated/implemented across all wards

Graph 6

Medication Incidents reported 1st August 2025 – 31st January 2026.

Fluctuations identified month on month, notably January 2026 having the highest trend for the 3 sites. Key themes identified are discussed in Medicines Management Committee for wider learning as well as bespoke training implemented locally.



Themes identified include:-

Documentation-

Allergy not recorded on medication chart but documented in the medical clerking.

CD drug stock discrepancies/incorrect storage of patients own medications.

Prescribing

Incorrect method when stopping VRII

Administration

Nurse giving drug to wrong patient

Omission of IV fluids

Crushing medication that should not be crushed

Not removing old patch when placing a new one

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.

Sepsis Compliance

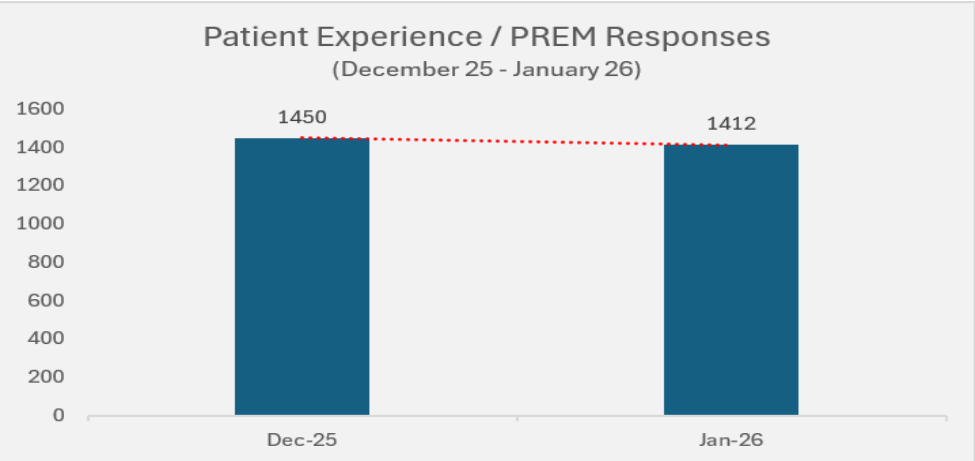
This is an area that requires a refocus and in light of the soft launch "Call for Concern" in POWH October 2025. See detail included in presentation, agenda item 4.3.

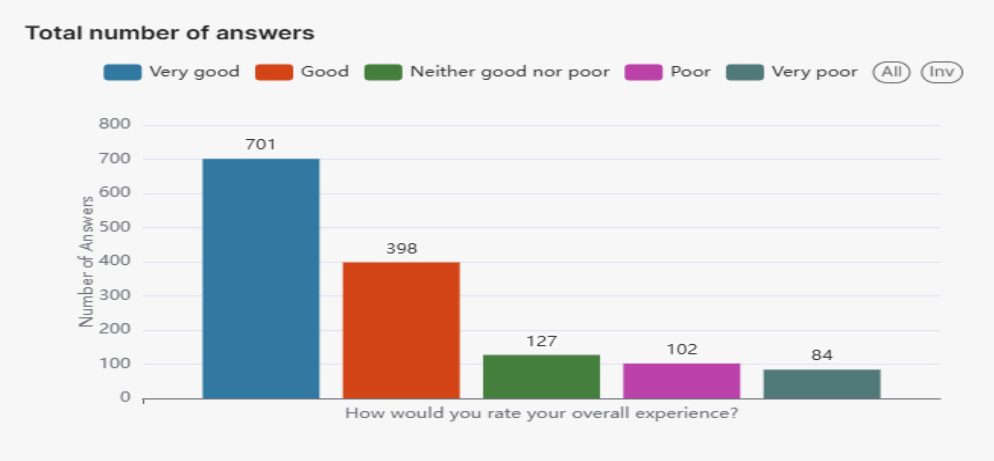
- UK SEPSIS TRUST TOOL/CTM version revised with current NIC guidance.
- All Wales approach.
- Development of All Wales measures.
- Safety netting resources.
- Public awareness campaign.

The Outreach Team are working closely with the ED Teams to improve compliance, PCH a specific area of targeted support.

Patient Experience

Patient feedback remains positive overall and is consistent with previous quarters.

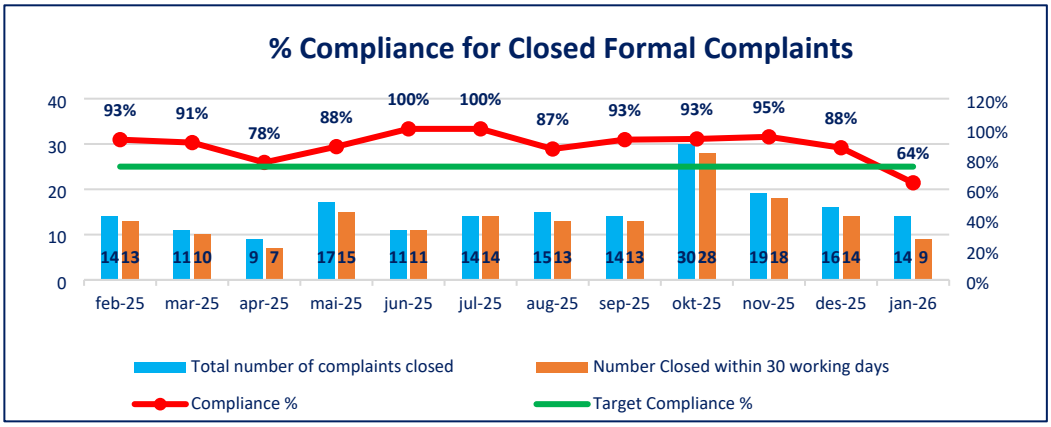




There were 24 formal complaints received in January 2026:

- Primary themes: communication issues, care and treatment and delays in treatment.

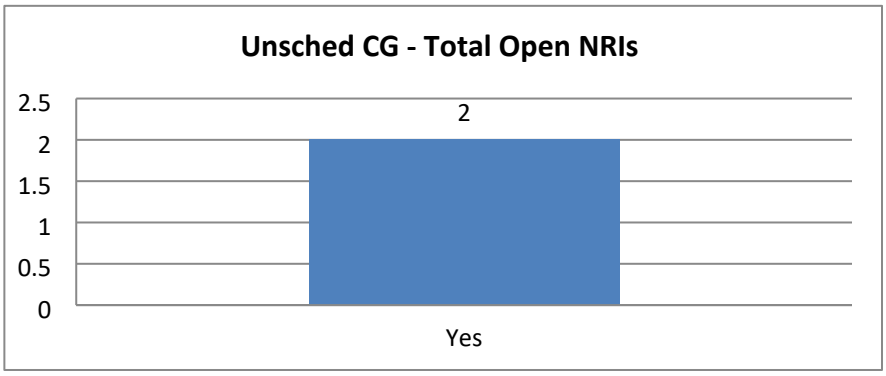
- 64% responded to within timescale, this was due to the organisation being in business continuity and leadership teams were required to support in the operational functionality.



Complaints triangulation shows a clear link between emergency department delays and dissatisfaction. Improvement work is aligned to patient flow initiatives.

NRI's

There are currently two nationally reportable incidents open: one within timescale and one out of time. The delay relates to an ongoing inquest, as we are awaiting post-mortem histology results before we can conclude the Health Board's investigation.



External Stakeholders

There have been 3 HIW concerns responded to specifically in relation to ED PCH and PCH Acute Services (Unscheduled Care and Planned Care). One of the concerns raised has also been responded to as part of formal PTR.

For further assurances the Senior Leadership Team including the CEO, COO and Executive Nurse Director met with HIW 25th February 2026 and included a presentation of key issues identified, reported, mitigation in place and senior oversight.

	RGH ED-updated HIW Action Plan completed 18th March 2025, reference 03472 (unannounced visit 5th-7th August 2025). One concern raised by LLais in relation to advice provided by the MIU YCR. The organisation remains compliant with statutory quality governance requirements, and there has been 1 case escalated to the Court of Protection with specific learning identified and will be shared across CTMUHB, an RCA is currently being undertaken. **Risk Register** No new risks greater than 15 have been added to the Risk Register Stroke – 4632 – risk score 16. ED Overcrowding – 3826-risk score 16.
Inform	**Celebrations** **Dare to Dream Charity-** have supported a quiet room on the Acute Care of the Elderly Unit that has received positive feedback from patients, families, staff, and visitors. External musicians regularly attend alongside other pre planned activities to support patient well-being. A lovely video has been put together with positive comments from the Charity Lead; Barbara Chidgey and all members of the multi-disciplinary team. **Ward 6 POW-100% Fluid Balance Compliance**  **TVN's/Heart Failure Team drop in sessions (as part of 12 days of Christmas RGH**

	 
Appendices	

3. Assessment

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

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

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

Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	
	People	

4. Recommendation

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

Agenda Item
4.5.2

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
KPI	Key Performance Indicators
ANPs	Advanced Nurse Practitioners
SSDEC	Surgical Same Day Emergency Care
SAU	Surgical Assessment Unit

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience meeting on 16th February 2026.

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

2.1 Purpose of this Meeting

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

2.2 The Planned Care/Surgery QSRE Group will:

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

3.0 Highlight Report

Alert / Escalate	**Trauma** Trauma demand in the Royal Glamorgan Hospital (RGH) • Inpatient trauma demand across RGH. Resulting in a high number of trauma outlier patients on surgical wards. • Reduced community rehabilitation capacity and local authority placements impacting on discharges. • Consistent use of boarding spaces on Trauma Unit in RGH and Prince Charles Hospital (PCH). Mitigation & Assurance • Care Group implementation of 'Trauma Reset Fortnight' 23rd February – 6th March involving different ways of working, processes and pathways with key stakeholders including Occupational Therapy, Physio and Orthotics. • Orthogeriatric in reach service in RGH has commenced. Team consists of an Orthopaedic Registrar, Orthogeriatric Consultant and Advanced Clinical Practitioner (ACP).

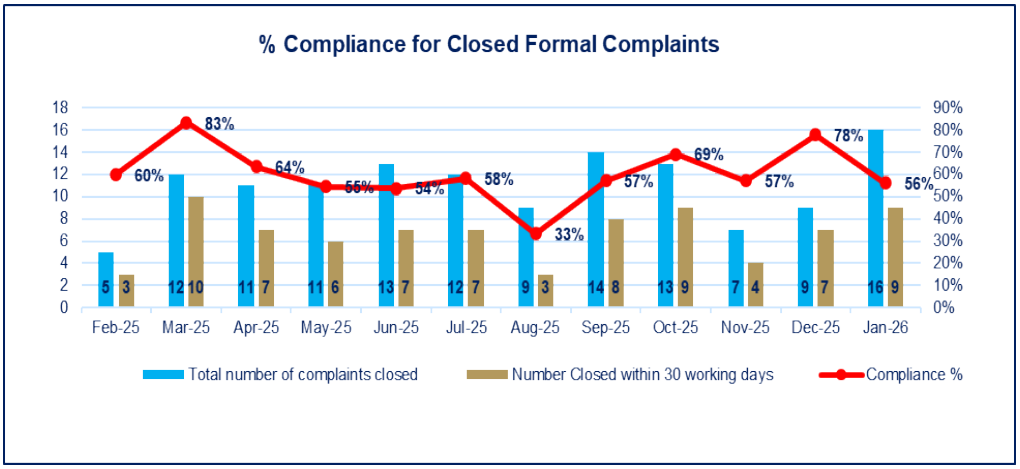
- Clear Guidance produced for Site Managers to inform designated surgical wards in PCH and RGH where staff are also trained to care for certain trauma patients. Also provides guidance on which trauma must go to the Trauma Unit/wards only.
- Weekly review with Governance Leads regarding quality-of-care KPIs to pick up any trends in relation to falls, pressure damage, patient experience.
- Boarding Patient - Risk assessment completion

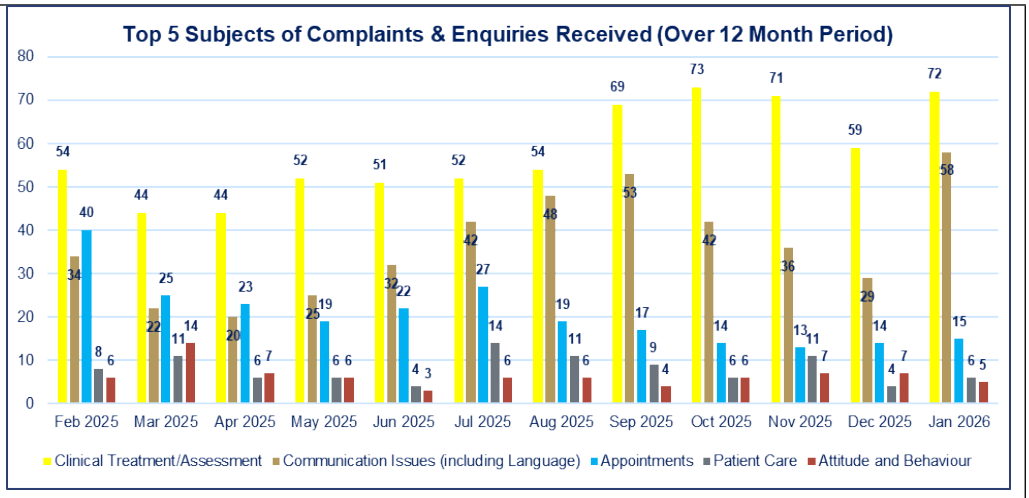
Theatres

- Estates work on 4 Theatres in RGH near completion.
- Decant has commenced from Vanguard Mobile Unit back into RGH main theatres.
- 2 theatres are moving back over the next 2 weeks and the final 2 will be the end of March 2026.
  A new theatre timetable has been shared and finalised for CTMUHB from 1st April onwards. The capacity matches the demand of each service.

Advise

Concerns

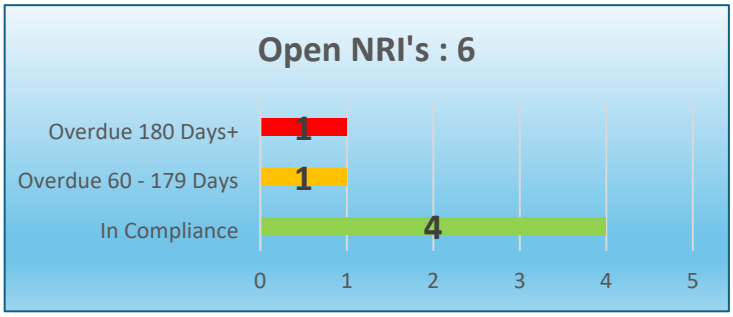




- Clinic Treatment/Assessment with a large amount relating to waiting lists in Trauma & Orthopaedics (T&O).

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

Incidents
Nationally Reported Incidents (February 2026)



Falls

- No avoidable falls across Planned Care in January 2026.
- Continued focus on Falls Prevention and Management Training Timely investigation reviews

Pressure Damage

- 3 avoidable pressure ulcers in February 2026 (1x T&O, 2 x Surgery)

Key Themes include:

- Purpose T not completed correctly with enough clinical information
- Care plan with insufficient information or not individualised

	• Patient not on optimum surface i.e. correct mattress or air cushion. • Inconsistency of mattress choice • Frequency, consistency and gaps in repositioning regime. Actions – So What? • Key themes have been shared and discussed at Professional Focus Group monthly meetings • Emphasis on timely and detailed investigations • Ward Manager and Senior Nurses working to improve Pressure Ulcer training compliance as a priority • Ward Managers & Senior Nurses focusing on areas of improvement and regular audits • High risk patients to be alerted to Ward Manager and included on ward handovers • Pressure relieving oxygen tubing available in all clinical areas • Focus on device related pressure • Standard Operating Procedure being created
Assure	**In-patient Elective Arthroplasty** • Arthroplasty 7 day working model commenced in Princess of Wales Hospital (POWH) from the 13th December using Bridgend Clinic for the weekend operating lists. • Aiming to have 0 patients on 104 week waiting times by March 2026. • On 16th February 2026, 1000 patients have received arthroplasty surgery since 13th December 2025, with an average length of stay for hip and knee arthroplasty of 2.5 days. **Insourcing Outpatient (OP) Clinics Weekend Activity** Between September 2025 to end January 2026 15,738 patients reviewed. Reducing OP waiting lists. **RGH – Surgical Assessment Unit (SAU) & Surgical Same Day Emergency Care (SSDEC) Virtual Ward** SSDEC/SAU Advanced Nurse Practitioners (ANP's) have developed a Watchlist for a virtual ward/follow ups. GP referrals or follow up patients are sent to the ANPs and they will monitor & review virtually to see if a patient does need to attend SSDEC Unit or telephone advice resulting in: • Improved patient experience. • This is preventing unnecessary referrals attending the hospital, freeing up clinician's time for the SAU patients. • Providing patient's care at home

	• Support to GPs to treat and review patient **Single Cancer Pathway (SCP)** The Health Board has been de-escalated to Level 1 due to improved delivery in its cancer performance. SCP compliance target was 65% in November and 64.1% in December compliance in month. This is the highest in-month performance post COVID with Dermatology achieving 93% and Breast achieving 83% in December. **Audit Wales Eye Care Review** Following the review a Management Response form with actions was completed on 4th September 2025. This has been further updated (February 2026) and attached in Appendix 1.
Inform	• RGH Ward 8– News2 chart completion champions 2025! • RGH Ward 10 – Fluid Balance chart completion champions 2025  
Appendices	Appendix 1 – Audit Wales Eye Care Review (CTMUHB)

2. **Assessment**

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

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

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

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

3. Recommendation

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

Management response form

Audit Wales use only	
Audited body	Cwm Taf Morgannwg University Health Board
Audit name	Eye Care Review
Issue date	4 September 2025

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R1	To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes	December 2025	Chair of Regional Ophthalmology Programme Board	
R2	Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality	March 2026	Chair of Regional Ophthalmology Programme Board	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	each partner organisation to realistically deliver each phase of the strategy.				
R3	Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.	The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result, the Regional Strategy will be reviewed as part of the programme plan in 25/26, with appropriate phasing and timeframes assigned to programme priorities	March 2026	Chair of Regional Ophthalmology Programme Board	
R4	The Health Board should urgently develop an eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: • based on current and projected future demand for services; • includes capacity plans based on realistically ambitious levels of productivity;	• Finalised and implemented the Eye Care Plan based on demand and capacity analysis. • Completed demand and capacity reviews for stages 1, 3, and 4 and address gaps by subspecialty. • Reviewed and updated job plans and clinic templates to increase activity and ensure sustainability. • Centralised cataract surgery to POWH (from 1 Sept 2025) and	Completed December 2025 Completed September 2025 Ongoing Completed	Directorate Manager PCR Manager /Directorate Manager Directorate Manager	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	• costed, at a minimum, for the medium term (3-5 year); • supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; • supported by clear delivery actions and milestones; and • approved by the Board.	delivering higher volumes through HVLC lists. Achieving 7 eyes on HVLC lists. • Only HB that has achieved 104 weeks for all sub specialities • Implemented Straight to Listing from Sept 2025 to increase outpatient capacity. • Virtual clinics established for medical retina and macular patients to expand outpatient access. • Reduced cataract waiting times to 86 weeks stage 1 cataracts by end of Sept 25 • Continued to undertake bilateral cataract surgeries using the Surgicube at POWH.	September 2025 Completed September 2025 Completed September 2025 Completed October 2025 Completed September 2025 Completed	Directorate Manager Service Manager Directorate Manager Directorate Manager Service Manager	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		• Increased virtual clinics for medical retina and macular patients – again increasing outpatient capacity. • Redesigned waiting list cards for better list planning and high-risk case identification. • Implemented Medical Comorbidities SOP. • Implementation of Service Improvement Group with focus on theatre utilisation, PIFU / SOS and DNA rate	September 2025 Completed October 2025 Completed September 2025 Completed September 2025 Completed September 2025	Service Manager Service manager Clinical Director Directorate Manager	
R5	Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spotlight' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support	• Produce a Planned Care Report for the Quality, Safety & Experience Committee, covering waiting times, harm, mitigation, and long-term plans.	October 2025 Ongoing	Directorate Manager / Lead Nurse Directorate Manager	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	continued oversight and action. The report should include: • comprehensive overview of current ophthalmology waiting times; • information on avoidable harm suffered by patients as a result of waiting for treatment; • mitigating actions in place; and • outline of longer-term plans for eye care services.	• Continued with regular updates to IQPD meetings with Welsh Government. • Maintain reporting of harm and incidents through the Harm Review Panel, ensuring RCA and Duty of Candour processes are followed. • Full implementation of WGOS pathways updates: **WGOS 4 Filtering** – Completed for Glaucoma, Wet AMD, Independent prescribing. Medical Retina – Identified lead – developing SOP, training sessions in progress for optometrists. HCQ screening – pathway agreed with full implementation from April 26 when open eyes rolled out **WGOS 4 Monitoring** – Completed for Glaucoma. DR – local scheme in place - still to transition to WGOS **WGOS 5** – Independent prescribing. Waiting administrative support	Ongoing with expectation of completion of historic harm reviews by end March 2026 Ongoing – Some completed as per narrative Local scheme in place since Feb 2025	Directorate Manager Directorate Manager / Clinical Director Service Manager Directorate Manager Directorate Manager / Clinical Director	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		• Recruited into band 3 admin post to support WGOS pathway implementation.	Planned to implement April 2026	Directorate Manager	
		• Appointment of clinical lead in Optometry and Orthoptist to lead on implementation of WGOS pathways	Completed January 2025 – however funding expires March 2026	Clinical Director Service Director	
		• Launch HCQ pathway and ensure transfer of identified patients to primary care. – HCQ pathway agreed with full implementation scheduled from April 2026 when open eyes rolled out	Completed May 2025	Service Manager	
		• Implemented Glaucoma pathway and manage referrals to optometry practices.	Scheduled April 2026	Directorate Manager Nurse Director	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		• Develop and finalise SOP for Medical Retina pathway and commence filtering once approved. • Continue weekly internal RTT review meetings to monitor high-risk subspecialties and maintain 104-week targets. • Validation of list as high numbers of cataracts patients are inappropriately categorised as R1. Internally agreed vetting prioritisation to mitigate against this risk. – Process changed and no longer are we prioritising patients to R1 following expedite letter • Updated risk register as Risk to patients due to volume, waiting list and service demand is captured on the HB's generic Risk Register • Ensure Planned Care Group provides incident overviews and NRIs to the Q&S Committee.	Completed October 2025 Ongoing – Expected finalisation of SOP April 2026 Ongoing and completed Ongoing Completed		

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
			Ongoing & Completed		
R6	The Health Board should provide routine updates to an appropriate committee on its progress with implementing the ophthalmology GIRFT recommendations.	• Provide regular progress updates on GIRFT implementation at Quality & Safety and Operational Delivery Committees. • Continue to track actions via the Operational Management Group, ensuring alignment with IMTP progress.	Completed October 2025 & ongoing Completed November 2025	Directorate Manager / Service Director Directorate Manager / Service Director	

Point 30

While there is improved focus on efficiency, it is having mixed success. Between April and October 2024, the service has seen a 15% increase in theatre utilisation and reduced surgical cancellations. Ophthalmology outpatient Did Not Attend rates are slowly getting better at 6% in June 2025, this is quite close to the 5% target5.

However, outpatient efficiency remains a challenge. The limited use of See on Symptom and Patient-Initiated Follow-Ups, at just 3.1% and 0.1% respectively in October 2024, are well below the 20% target.6

KPI's for last 3/12 below

- Increase in % of SOS / PIFU
- Increase in DNA rate
- Reduction in FUNB > 100% - Strategic plan put in place for implementation for all FUNB > 5 years – discharge & all FUNB via agreed CIN pathways to be put on PIFU / SOS

SERVICE	SOS/PIFU (20%)	DNA RATE (5%)	FUNB > 100%
OPHTHALMOLOGY	5.7%↑	10.2% ↑	7,160↓

Jan 2026

- Improvement noted across all KPI's.
- Achieving target pan CT for in session utilisation and late starts
- Improvement noted in early finishes pan CTM

SERVICE Jan	IN SESSION UTILISATION			LATE STARTS (<10mins)			EARLY FINISHES (<30mins)		
SITE	RGH	PCH	POW	RGH	PCH	POW	RGH	PCH	POW
TARGET	85%			20%			10%		
OPHTHALMOLOGY	↑93.1%		↑80.2%	↓0%		↓15.6%	↓13.3%		↓40.6%

Point 54

We have seen evidence of the Quality, Safety and Experience Committee receiving high level updates on ophthalmology harm, specifically nationally reported incidents (NRI). For example, at the November 2024 committee nine ophthalmology related NIRs were reported, and two at the January 2025 committee. These are mainly reported through the planned care group highlight report. While the Health Board is using lessons learned to improve care, long waiting times still pose a significant risk to some patients.

This is ongoing with sustained reduction in historical NRI's being reviewed as described in report as illustrated in main body of response form. Expected completion of all historical NRI's by end of March 2026.

Agenda Item
4.5.3

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Angharad Oyler, Head of Midwifery, Debbie Jones, Head of Midwifery, Lucy Collins, Head of CYP Nursing Carl Verrecchia, Service Director Mohamed Elnasharty, Medical Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Carl Verrecchia, Service Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Interim Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Introduction

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

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

2. Specific Matters for Consideration

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

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

3. Highlight Report

Alert / Escalate	• Health Visiting Industrial action commenced on 23rd February and continues until 20th March with one Trade union and a large number of Health visitors (circa 108). Mitigation plans were drawn up for all families of children at high risk and a Single point of access has been set up which has worked very well in the first few weeks. At the time of writing this highlight report we have received formal notification of continued strike action starting 23rd March through to 15th May 2026. An evaluation of what has worked well is underway and planning for this next period of industrial action is being developed. Community Midwives and community childrens nursing has been supporting the plans to keep our families safe while the industrial action continues. The daily strike action cell meetings are continuing and picking up any concerns and acting on them immediately. • Special school nursing (RISK ID 5753) remains our highest risk (20) in Children and Families – We have been able to appoint to all funded vacancies and are working through competencies to ensure the 5 Special Schools have a provision of service. Welsh Government are working on a document that will outline both Health and local Authority responsibilities for the core service and Healthy Child Wales. Our head of Childrens Nursing is fully engaged in this development. A meeting was held with the special school leads in the education authorities last week which was helpful in agreeing a way forward. We have committed to review and update the service level agreements between CTM and RCT, MCBC and BCBC by end of April 2026 then regroup to progress. • Badger net implementation – The community booking element will go live from 16th March 2026. There are a number of workarounds whilst the system does not fully integrate with current IT systems but these have been worked through in both Clinical groups and the Badgernet Programme board and are felt to be of minimal risk compared to current vulnerabilities of reliance on paper based information. The second phase will take place in June when all maternity records will transfer over to Badgernet giving us better compatibility across the region. This is a really positive step towards a digital maternity Information system that the clinicians are excited about and are fully engaged in.

	• Maternity Priority Unit. - The Maternity Priority Unit is an assessment unit for women in pregnancy requiring Urgent attention and care. The BSOTS (Birmingham Symptoms specific Obstetric Triage System) model is used to standardise the assessment and prioritisation process, it aims to improve the overall efficiency of the maternity unit and enhance patient safety. Using the BSOTS model is also a directive from Welsh Government. Risks and Mitigation escalated in November QS&E committee. Scoping regarding alternatives and options to enhance the environment continues as areas in PCH from the ground floor works progress.
Advise	• National Maternity and Neonatal Assurance Assessment has concluded. Feedback has been received nationally on the 25th February with some recognised themes of acuity significantly rising across all wales and staffing levels. At the feedback meeting it was advised that Health board specific reports were aiming to be distributed in the next couple of months. At the time of writing this highlight report CTM has not received its tailored report. • Birth rate + report under review, suggestive of requirement of significant additional staffing and funding in clinical and specialist/management workforce to align with the standard. Business justification case is being discussed with Heads of Midwifery on what is achievable. • Waiting time performance for Neurodevelopment children (RISK ID 2808) currently remains at a risk score of 12. Monthly trajectory meetings with Performance and Improvement team continue and this is also featured in regular IQPD meeting with Welsh Government. Current wait is at just under 102weeks and we will meet the target of no patients waiting over 104 weeks by end of March 2026. The 2026-27 allocation for NDIP funding has not yet been received to plan the scale of improvement we would like and need to see. • Menopause service review has taken place. The review has shown that provision within CTM was not adequate to meet the demand in accordance with national standards and guidance. Additional activity has been allocated to the service via medical sessions and we are working together with Primary Care on appropriate patients with menopause symptoms being supported and reviewed through the

	Womens Health Hub pathfinder service which commenced successfully in February. • Multi-professional baby abduction drills carried out across all maternity units last year identified some inconsistencies. The exercise highlighted the need for standardised security systems across all sites (weighted mattresses at RGH and PoW vs fully secure XTAG system in PCH). We have had approval to purchase the XTAG system at POW and are awaiting the delivery date which will standardise our security measures and reduce our variation and risk. • Discussion continues with anaesthetics and perioperative services regarding provision for elective theatres lists for maternity services in PoW. Currently midwifery workforce are undertaking scrub duties which is impacting on midwifery staffing on the units. There is no dedicated Anaesthetics team for obstetrics, currently anaesthetics are covering maternity and the site resus bleep. We are looking to secure a firm date to meet and agree outstanding issues in April. • Review of plan for Midwifery sonography service has concluded that we need another Midwife Sonographer and we are progressing this within establishment to improve outcomes for women and babies and enhance consistent governance across sites which will include: 1. Electronic U/S/S referrals 2. Establish prematurity clinic 3. Establish Rainbow Clinic 4. Establish Placental site/complications clinic 5. Establish in house training and governance for Midwifery and Medical teams undertaking ultra-sound scanning.
Assure	• Work underway establishing Vulnerable families team, Teenage pregnancy midwife and Wellbeing Midwife now in post. Conversations ongoing with local authority regarding collaboration and alternative models of care to support this cohort of mother and babies. • School entry hearing screening service has moved to audiology and is working well. • Further conversations with Audiology are underway to replace some retired community paediatrician clinics

(audiology related) with Audiologists and this is anticipated to establish the new model in the next 2 months.

- Gynaecology Cancer action plan is underway and is delivering a significant improvement in cancer treatment for our population.

- Gynaecology RTT target of no patients over 104 weeks at end of February has been met and we are anticipating a maximum wait of 98 weeks at the end of March 2026 which meets the ministerial target but is still too long. Further allocation of theatre sessions to Gynaecology have been provided in the new theatre template and we are working through booking logistics with a small and fragile booking team to ensure high theatre utilisation to maximise our capacity to treat our patients in a more timely manner.

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

Risk Register

There are currently three risks scoring high with 16 or more. Discussed with executive colleagues

Risk ID	Description	Score
5753	Inadequate Special School Nursing provision	20
3576	No Therapy and Psychologist Provision for Neonatal services across CTM	16
	Health Visiting industrial action impacting on services to families across CTM	16

Inform	• Consent training within maternity is continuing across sites for obstetricians and midwifery staff (as this has been picked up in incidents previously) and included into Induction programme for all new staff into maternity. Training also provided for Gynaecology medical staff. • The project to refurbish the Gynae Hub in RGH is progressing well. Decant is commencing in March to enable the work to start in earnest at the end of march for a period of 12 weeks. This will provide a much more fit for purpose environment where outpatient hysteroscopies can be undertaken with adequate air changes and allowance of safe use of entenox. The benefit of this to our women is that we will not need to convert a significant amount of procedures to needing general anaesthetic which is better for women's recovery. • There are still challenges with the capacity for paediatric neurophysiology tests (in particular EEG). **Risk ID 6187** At present the urgent patients are being escalated so they can be prioritised but the service does need a review. There were 3 urgent requests in January. NWJCC issued a consultation document in October which we have responded to highlighting our challenges on a number of fronts. Awaiting next steps but urgent patients are being expedited without significant delay. • Transition work for paediatrics into Adulthood with complex conditions is progressing steadily. We are looking to adopt the Ready Steady Go approach which is an app based aid in early 2026. Further dialogue with Adult long term conditions is required and we are mapping the children who will most likely need to be considered for this in the coming months. • Sickness absence among nursing workforce within special care baby units at PCH and PoW is showing signs of improvement but PCH Midwifery still recording higher levels of sickness. All cases are being managed appropriately and People services are supporting a review of circa 27 cases of long term sickness with the Heads of Midwifery. • Awaiting completion of emergency call bell system in wards 31/32 and electrical trip issue resolution (PCH). These are regularly discussed with estates and articulated through OCMG. • Awaiting start dates in 2026 for medication room refurb in POW paeds and also decommissioning of childrens pool which has not been used for years in RGH.

	• New risk identified for paediatric areas (all three acute sites) for high flow oxygen equipment required for transport between ED, radiology and other areas. A statement of need has been prioritised and we are likely to get this approved for purchase in the next couple of weeks.
Appendices	

4. Assessment

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

	• Efficient • Effective • Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below: • Repurpose • Reuse • Refine • Recycle

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

5. Recommendation

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

Agenda Item
4.5.4

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Zoe Ashman, Interim Care Group Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Zoe Ashman, Interim Care Group Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
PCC Quality, Safety, Risk and Experience Meeting	03/03/2025	Noted

Acronyms / Glossary of Terms	
C&V	Cardiff and Vale Health Board
CTM	Cwm Taf Morgannwg University Health Board
D2RA	Discharge to Assess
DAP	Dental Access Portal

DHCW	Digital Health Care Wales
DN	District Nursing
FNC	Funded Nursing Care
GA	General anaesthetic
GAA	General Anaesthetic Assessment
GMPI	General Medical Practice Indemnity
GMS	General Medical Services
GP	General Practitioner
HMPPS	His Majesty's Prison and Probation Service
IPC	Infection Prevention Control
LA	Local Authority
LES	Locally Enhanced Service
LFER	Learning From Events Report
NCIP	National Cellulitis Improvement Programme
NHS	National Health Service
OCP	Organisational Change process
OOH GP	Out of Hours General Practitioner
PBMA	Prevention and Behavioural Management Assessment
PCH	Prince Charles Hospital
POWH	Princess of Wales Hospital
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
SBUHB	Swansea Bay University Health Board
SCD	Special Care Dentistry
SPOA	Single Point of Access
UCAF	Unified Contract Assurance Framework
WIS	Welsh Immunisation System
WG	Welsh Government
WL	Waiting List
WCP	Welsh Clinical Portal

1. Situation /Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience Primary Care and Communities Care Group at its meeting on the 3rd March 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 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	**Dental Contract** A new General Dental Service contract is due to be implemented across Wales from the 1 April 2006; as anticipated not all contract holders wish to transition. Subsequently CTMUHB have received termination of 5 contracts effective from 31/03/26 (1x Merthyr, 4x Bridgend). The total value of these contracts is £1.87m. While it is difficult to determine the exact number of patients affected, initial estimates suggest around 26,000 patients. However, some of these individuals will not be directly impacted as they have only accessed urgent care and are not considered historic patients of the practice, therefore the number of patients affected numbers will be lower. These patient numbers are not yet being reflected on the Dental Access Portal (DAP), despite patients being informed their practice will no longer provide NHS services and being advised to register on the DAP. The current number is around 5,000 however the team are regularly allocating patients to practices, so this will reduce again in the coming weeks. Possible reasons for this could be that some patients are unaware to add details to the DAP, have chosen to remain with the practice as a private patient or patients will add their details to the DAP when they require treatment or possibly after the 31 March when the NHS contract closes. This will be continually monitored over the next 12 months by the Primary Care Team to determine if commissioning requires

to replace lost activity, however under the new model, Health Boards will always require a pool of patients on the DAP, as all new NHS patients must be allocated via the portal.
A higher level of urgent care will be commissioned for 2026-7 via the contract segmentation in practices, ensuring patients waiting for allocation to a practice still access NHS dental care.
Health Boards may continue to receive contract terminations, particularly once the variation notices are issued in March.

Shift Fill for GP OOH/Nav Hub - Risk ID 6397 – Score 16
Due to the ongoing discussions at a national level around the GP OOH contract / worker status the Health Board has had a hold on GP recruitment. This decision has been taken to limit the possible financial risks associated with the contractor status. Historically OOH GPs are recruited through 'rotamaster' where they can book 'shifts' they chose to work, sometimes on a short notice and ad hoc basis. Many of the experienced GPs do this as they work elsewhere during the day or in the week.

The impact of this has been unfilled shifts, especially for the overnight home visiting shifts. To mitigate this risk a new process of recruitment has been introduced via Locum Nest. However, this has not proved to have a positive impact as the process is not flexible and does not to suit the needs of GPs. Further work continues to explore recruitment options whilst national discussions are concluded.

Cellulitis Service
Committee were previously informed that the care group had planned to terminate contract arrangements with the national cellulitis service. This decision has been reconsidered following more detailed review aligned to demand, capacity and outcomes.

The benefits of remaining with the national scheme of work include:

- Reduced hospital admissions for cellulitis and reductions in length of stay.
- Significant opportunity cost savings with an estimated £5,000 per patient or 10 bed days saved where National Cellulitis Improvement Programme (NCIP) intervention occurs.
- Improved patient reported outcomes (CELLUPROM) and quality of life (EQ5D5L).
- High activity levels: over 7,229 CTMUHB patients invited (Up until December 2025) with substantial unmet need identified and offered appropriate treatment.
- 1929 patients treated during this period. Out of those 1,929 patients, they reported 1,509 episodes of cellulitis,

	with 420 of the 1929 being misdiagnosed (wasted antibiotics not treated effectively). • Of the 1,509 episodes, 899 resulted in hospital admissions. Following this same cohort since treatment, there have been 59 further episodes reported and 9 hospital admissions. • Direct service dependency: over 300 CTMUHB patients currently under active care, with a further 240 newly identified admissions needing NCIP follow up. • Withdrawal of CTMUHB funding for 1wte x band 7 would potentially cause poor patient outcomes and risks as well as destabilising a functioning, high value clinical model with 1,200 patient contacts per annum not being managed appropriately. • NCIP has demonstrated a consistent reduction in cellulitis recurrence in reducing emergency admission (EA) admissions and general practitioner (GP) appointments supported by risk factor management and patient education. • CTMUHB patients show high levels of unmet need with 56% diagnosed with Lymphoedema and 65% not known to local services before NCIP engaged with them. • NCIP reduces misdiagnosis (often around 49% in cellulitis cases) and prevents inappropriate antibiotic use, improving antimicrobial stewardship. • NCIP work with differing specialities including Primary Care, Heart failure, Diabetes, Orthopaedics, Dermatology, Pharmacy and Wound Care services providing high levels of advice on cellulitis management including have a team of non-medical prescribers reducing patients' needs on other services and decreases admissions to ED.
Advise	**Continuing Health Care (CHC)** Recent legislation has been introduced in Wales to enable Direct Payments for CHC. The implementation timeline has now changed to implement prior to the pre-election cut off end March 2026 in readiness for the May 2026 Senedd elections. This reduces the implementation time by six months. To support implementation the DP leads have developed several work streams which CTM are contributing to. Informal conversations ongoing with LA to discuss how they can support with the process for paying of the direct payment and the potential training of social care needs. Lead Nurse for CHC working with WG to understand some of the wider challenges. **Funded Nursing Care**

The Funded Nursing Care (FNC) rate for 25/26 has been approved and the sector has been informed.

All Wales Retrospective Review process, currently have 61 cases in total:

- 44 activated
- 18 pending
- 3 Breaches not allocated at time of report

To ensure timely review process workload has now been shared across the entire team to target the breaches. Ongoing challenges accessing notes from care homes and LA's, which impact on breach dates. These concerns have been raised with the registered individuals and Welsh Government.

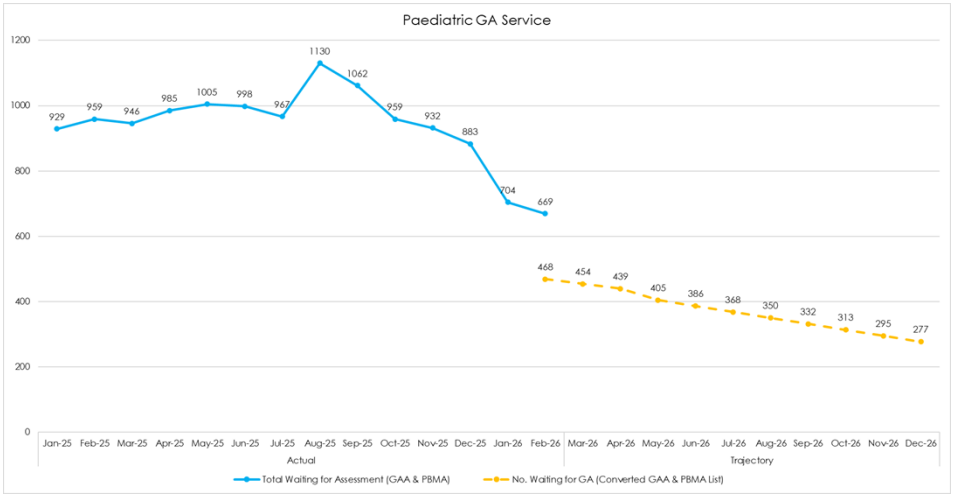
There is also difficulty in setting up independent retrospective review panels and securing an independent representative for all services. This has been highlighted to WG, through the CHC leads meeting and through the Value and Sustainability Board, and CHC workstream. This is a national issue and could result in financial implications for the HB, due to interest charges.

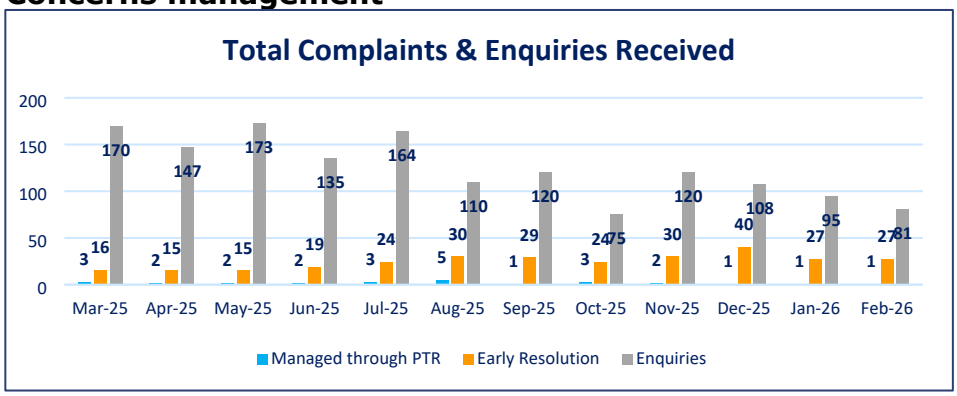
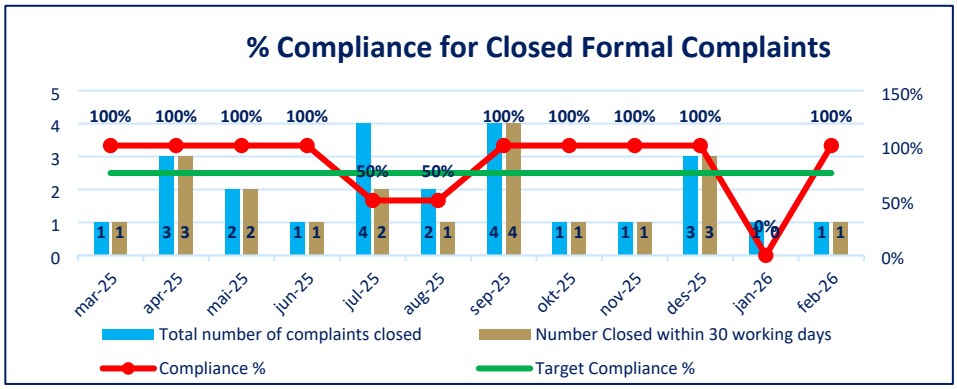
Death in Custody – Update
Two inquests have been completed since last reporting period; one further inquest is scheduled prior to next reporting period. A Death in Custody Review Group is in place to support learning and improvements whilst strengthening governance arrangements.

Dental Services Parc Prison:
A reduced dental service has been in place for over a year due to there being insufficient accommodation space in the facility to deliver the number of dental sessions required to meet demand. This together with the high demand for urgent care means that the service is only providing urgent care and access to full course of treatment is limited.

Parc Prison
Establishment review is being undertaken to support current model of care along with requirements when the planned expansion is completed in 2028 – this will add an additional 22% capacity to the prison population.

Community Hospital – Ward D4 Stroke Services
Staffing model within the ward is being reviewed to ensure the appropriate team around the patient. Alignment to the data associated with acuity and demand will inform the model

	required whilst supporting appropriate rehabilitation and discharge planning.
Assure	**Paediatric GA Risk 5417 Risk 12** The numbers waiting continue to reduce aligned to the increased activity/lists – trajectory provided in table below.  **Lymphoedema service** Improvement programme of work being undertaken with implementation phase plan commenced Feb 2026. Waiting lists are challenging with increased demand and complexity for those accessing the service. Funding has been sourced to support improvement plan for 4 months initially. Use of PREMS have been positive for the service provided, improvement programme to commence March 2026. **HMIP Independent Review of Progress (IRP) – January 2026** The IRP for HMP Parc was undertaken in the first week in January 2026 to assess progress made against the priority recommendations issued during the full HMIP inspection in January 2025. The IRP highlighted clear and meaningful advances across key areas of healthcare delivery, reflecting sustained effort and strengthened leadership since the previous inspection. Inspectors commended significant improvements in governance, risk management, estate development, and partnership working—particularly the enhanced coordination with G4S and the increased transparency of performance data. Progress within mental health and substance misuse pathways was noted as especially encouraging, with expanded psychiatry sessions, reduced waiting times, strengthened psychosocial

	interventions, and improved pathway integration delivering visible benefits for patients. Although operational constraints, such as dental capacity and escort availability, continue to challenge full delivery, the IRP acknowledged that the foundations for sustained improvement are now firmly in place, with leaders demonstrating commitment, responsiveness, and a proactive approach to addressing remaining barriers.
Inform	**Community bed base:** Options currently being considered regarding the model for community bed base across the health board. It is anticipated that this will be agreed by the end of March 2026. **Concerns management**   Open redress 8 Learning from Events Report (LFER) 14 General Medical Practice Indemnity (GMPI) 6 **Themes & Trends** • Medication • Clinical Treatment / Assessment • Appointments • Communication

	Feedback Focus will be given to promoting the use of PROMS and PREMS across the care group during 2026/27, numbers currently used are limited. This will support the continued transformation and service development across the care group. **National Audit Office (NAO) Report - The Costs of Tackling Drug Harms in Prisons** The NAO's 2026 review highlights that drug harms in prisons continue to rise, with around 40,000 people in custody identified with drug problems and 136 drug-related deaths recorded between 2022–24. The report emphasises the significant pressures this has on prison healthcare services, particularly substance misuse and mental health provision, with notable regional variation and long waits for triage, where 24% of prisoners were not assessed within three weeks of screening. High levels of missed treatment appointments (35%) and operational pressures such as staffing shortages, prison lock-downs, and inadequate facilities continue to hinder effective healthcare delivery. The Prison Healthcare Directorate will develop an action plan to review its position against these recommendations and identify areas for improvement.
Appendices	

4. Assessment

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

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies, please list below: Culture and valuing people Leadership	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective	
	If more than one applies, please list below: Efficient, Person centred, Equitable, Timely, Safe	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies, please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒ N/A
	Outcome for Equality (delete as appropriate): Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

Agenda Item
4.5.5

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths Interim Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths Interim Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AMAT	Audit Management and Tracking system
APB	Area Planning Board
CAMHS	Child and Adolescent Mental Health Services
CMHT	Community Mental Health Team
CTM	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
HCSW	Health Care Support Worker
HIW	Healthcare Inspectorate Wales
IAS	Integrated Autism Service
KPI	Key Performance Indicator
LPMHSS	Local Primary Mental Health Support Service
MDT	Multi-Disciplinary Team
MH	Mental Health
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
PMVA	Prevention and Management of Violence and Aggression
POW	Princess of Wales Hospital
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
RCN	Royal Collee of Nursing
RGH	Royal Glamorgan Hospital
RN	Registered Nurse
SLT	Senior Leadership Team
YPDAS	Young People's Drug and Alcohol Service

1. Situation /Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Mental Health and Learning Disability
1.2 (MHLD) Care Group at its Quality Safety and Experience (QSE) meeting on 25/02/2026.

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

2. Specific Matters for Consideration

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

2.2 The MHLD Care Group QSE Board will:

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

3. Key Risks / Matters for Escalation

Alert / Escalate	• The Local Primary Mental Health Support Service (LPMHSS) provides assessment, brief psychological interventions, advice, and signposting for individuals presenting with mild to moderate mental health difficulties. The service delivery requires a consistent team of administrative and business support staff, however, current staffing shortages have resulted in a marked operational deficit. This has been compounded by practitioner sick and maternity leave.

	This has resulted in a backlog of referrals and deteriorating waiting times for people in need of 1 to 1 and group therapies. Mitigating actions include, admin bank recruitment, fixed term recruitment, support from the other MHLD directorates, weekend working, waiting list validation and revised job planning. The Care Group are continuing to monitor the mitigations implemented to ensure the service remains safe, prioritised, and clinically effective until staffing establishments are restored in weekly meetings between the Directorate and Care Group Senior Leadership Teams (SLG).
Advise	**Closure Report on the Inpatient Mental Health Improvement Programme** • The Adult Mental Health Inpatient Improvement Board was established in 2023 by the Care Group to oversee the delivery of key actions and improvements in response to the publication of HIW's report "Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board", which contained 40 recommendations. The Board had an Executive Chair (Executive Director of Allied Health Professions and Health Science) and oversaw nine Work Streams which were aligned to one of three overarching projects: 1. Quality of Leadership and Management 2. Safe and Effective Care 3. Quality of Patient Experience. In February 2025, 38 of the 40 actions had been completed. One outstanding action related to the development of an electronic patient record, but procurement work was underway. The other related to the review of out-of-date policies: 66 policies had been reviewed and 11 were waiting ratification, and the Care Group had established a robust process to ensure sustainable approach moving forwards. Due to the extent of the progress made by the Improvement Board, it was agreed that an Executive Chair was no longer required and that the MHLD Nurse Director would continue to oversee the 2 outstanding actions and ongoing improvements within the internal QSRE process. In October 2025 the remaining 2 actions were completed, and the fully completed

Healthcare Inspectorate Wales (HIW) action plan was agreed by HIW.

The focus on the adult inpatient improvement work has since evolved so that it is aligned to the National Patient Safety Programme.

The National Patient Safety Programme has recently had a reset and has moved away from the previous workstreams to focus on 7 key deliverable projects.

1. Implementation
2. Safewards
3. Patient Centred Safety Planning
4. Risk Formulation
5. Relational and Procedural Safety
6. Outcome Measures
7. MH Community Secondary Care

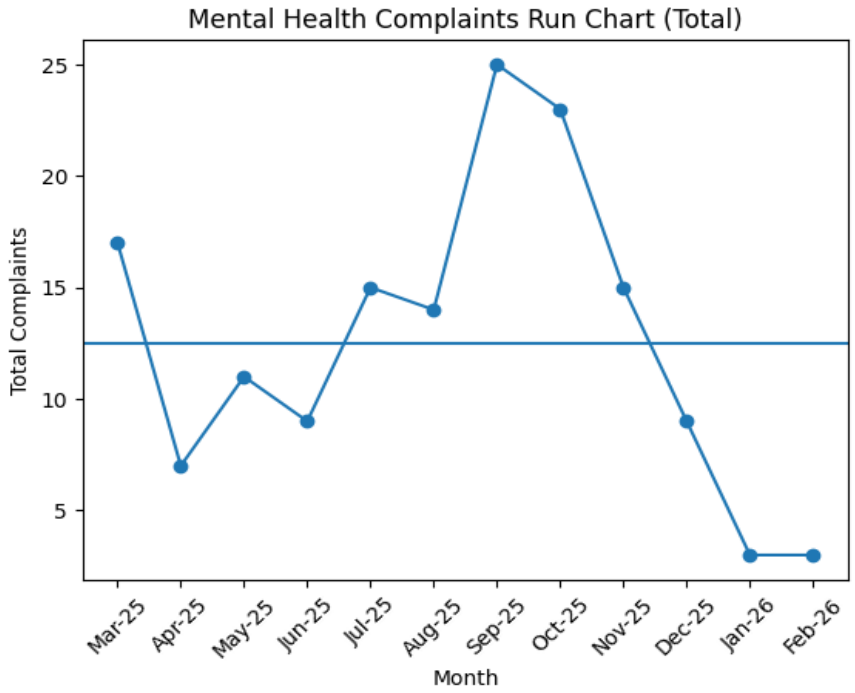
These projects are at different stages of implementation and the Care Group is represented as appropriate (for example, Ward 14 POW is one of 5 pilot sites for Safewards). The Nurse Director and deputy attend the National Group

In line with this, the Care Group has brought the previous workstreams together to ensure that improvement actions are effectively prioritised and delivered. The group meets monthly to review progress, confirm completion of actions, and identify the next set of priorities. The meeting continues to be chaired by the MHLD Nurse Director, and the programme reports to the MHLD QSE.

- Young People's Drug and Alcohol Service (YPDAS) deliver specialist substance misuse services to young people aged up to 18 across CTM. There are currently 24 young people on the waiting list, the longest wait is 75 working days (the KPI target is 20 working days). To mitigate a Registered Nurse (RN) has been employed through APB funding, waiting list management is in place with weekly MDT/partner agency discussion. The young people and their families are updated at 4 weekly intervals. The progress and impact of these mitigations is being monitored by the Child and Adolescent Mental Health Services (CAMHS) and Specialised Services Directorate.

- The Care Group is responsible for the delivery and update of Prevention and Management of Violence and Aggression (PMVA) Module D training to applicable MH staff. Following an options appraisal the care group concluded that the previous train the trainer model was unsustainable and the only viable

	option was to commission an external provider to deliver Module D. The in-house training ended in March 2025; the appointment of an external provider has recently been delayed due to complications in the procurement process. To maintain training compliance the Care Group continues to spot purchase individual courses. • In January, a meeting was held with Public Health colleagues to discuss the current level of smoking cessation support across CTM, with particular attention to the challenges experienced within acute inpatient mental health settings. During the discussion, the inpatient team outlined the difficulties in supporting acute patients to manage nicotine dependence, including the risk of relapse, increased distress, and the need for consistent support across inpatient environments. These challenges were acknowledged and the conversation focused on identifying practical, achievable solutions. Positive outcomes from the meeting included further exploration of nicotine-replacement options, craving-management strategies, and consideration of a broader range of products to better support mental health patients during admission.
Assure	• The number of complaints received by the Care Group during this reporting period (3 in January and 3 in February) was lower than the yearly monthly mean of 13 and the 2 years monthly mean of 18. The number of formal complaints received during this period (5 in total) being lower than the monthly mean of 5.



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

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

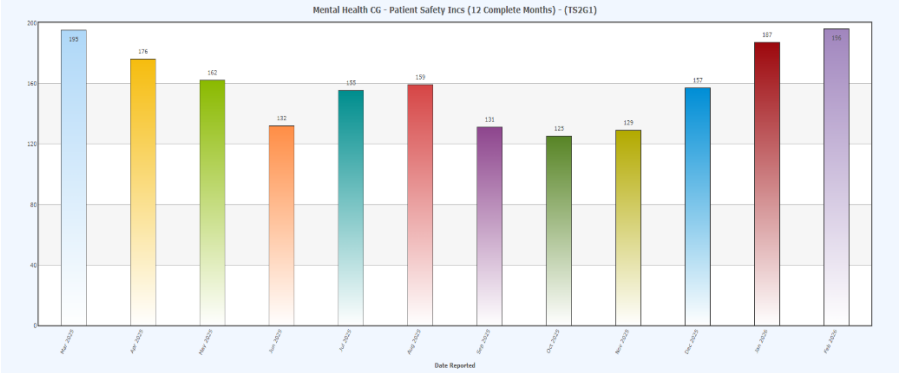
The Adult Community Directorate has the highest number of complaints; however, this is to be expected as it is the directorate with the largest number of service users in areas such as outpatients and LPMHSS.

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

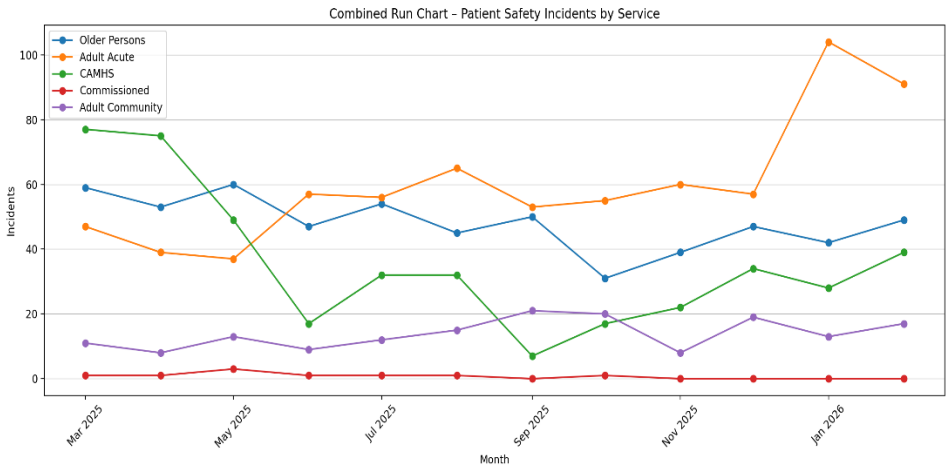
At the time of compiling this report there are 4 open formal complaints in the MHLD Care Group, all 4 were received during this reporting period and are in date.

The Care Group's Datix dashboard allows all team, and service leads to see their formal complaints and Early Resolution complaints, this has enabled the Care Group to focus on closure of Early resolution complaints, at the time of compiling this report there are 7 open Early Resolution complaints.

- The Datix incidents reported this period, 187 in January and 196 in February are higher than in recent months but still lower than the 2-year mean of 198 per month.



- The Adult Acute Directorate has the highest number of incidents as is to be expected given the nature of MH wards. However there has been an increase in incidents in January and February 2026. On investigation this increase has been driven by a significant increase in incidents occurring on Ward 14, POW. These incidents are mainly low harm and are made up of a variety of incident types, there are no discernible themes at this point other that the continued use of surge capacity. The Adult Acute Directorate will continue to monitor incident rates and report themes and trends to the MHLD QSE, an update will be provided in the next MHLD report to committee.



- There are 3 open Nationally Reportable Incidents (NRI) which is consistent with the 2-year mean. 2 of these are overdue but are in the final stages of approval.

  There was 1 new NRI reported during this period.

- The use of Audit Management and Tracking (AMAT) system is firmly embedded in the Care Group. Compliance with ward audits as of the end of February is shown below.

Project	No. audits	Current compliance	Improvement	Overdue actions
Health & Safety	1			0
Health and Care Standards	1			0
Infection Control	16	G 96.3%		15
Medicines Management	2	A 88.9%		3
Patient Safety	28	A 91.1%		37

In the Patient Safety category, the overdue actions have gone up from 22 to 37 as more audits have been added. Of the 37 24 of are RAG rated green with 11 RAG rated as amber and 2 as red, all 5 relate to Care and Treatment Plan (CTP) compliance. Performance against these audits is monitored in the individual directorate's QSE meetings.

- In January, HIW conducted a 2-day review of the Taf Ely CMHT. The feedback received was largely positive particularly around care planning, governance, and leadership.

  Immediate assurance was requested regarding medication management and prescribing. An action plan containing 14 actions was submitted and accepted, 9 of the actions were completed with the remaining 5 underway and on target.

  The Care Group is awaiting the full report and improvement plan.

- The Care Group continues to run a programme of quality assurance reviews which are coordinated by the Senior Nurse of Quality Assurance and Improvement and are designed to replicate a HIW inspection. They also offer staff the chance to experience a process similar to a Healthcare Inspectorate Wales (HIW) inspection, helping to build confidence and prepare for future assessments. Feedback from colleagues in the Taf Ely CMHT was that their assurance review was great preparation for their recent HIW review as described above.

Inform

- In January HIW completed an unannounced 3-day inspection at Ty Llidiard. Overall, the feedback was excellent. Several of the reviewing team had been to Ty Llidiard at the start of the improvement work in 2021/22 and commented on the positive and sustained improvements between now and then. No immediate assurances were required.

	• The Senior Nurse for Specialised Services has been offered a place on the 2026 Florence Nightingale Scholarship. The scholarship will give Claire the opportunity to develop a project on supporting people who are on the waiting list for Integrated Autism Service (IAS). • The Primary Care Support Worker in Older Peoples Mental Health Services (OPMHS) Memory service co-chaired the RCN HCSW conference, Sarah was the 2024 RCN Wales HCSW of the year. • The 'Preparing for Discharge (P4D) Programme' will launch in RGH March 2nd. This programme consists of five consecutive sessions and three community drop-in sessions facilitated by the Care Group Recovery College Lead. A face-to-face meeting with all ward managers in RGH is scheduled for Thursday, January 15th to prepare for implementation. Originally developed within Cardiff and Vale UHB, the programme not only supports patients in transitioning from hospital to home but has also demonstrated a 30% reduction in readmission rates. Once this is embedded this will be implemented across all inpatient services.
Appendices	None

4. Assessment

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

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

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

5. Recommendation

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

Agenda Item
4.5.6

Quality, Safety & Experience Committee

Highlight Report from the Diagnostics, Therapies, Pharmacy and Sciences QSRE

Dyddiad y Cyfarfod / Date of Meeting	24.03.2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Hannah Wilton, Director of Pharmacy and Medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AHP	Allied Health Professionals
CDs	Controlled Drugs
CT	Computed Tomography
CTM	Cwm Taf Morgannwg University Health Board
DHCW	Digital Health and Care Wales
DI	Designated Individual
DRL	Diagnostic Reference levels

DTPS	Diagnostics, Therapies, Pharmacy and Sciences
FUNB	Follow Up Not Booked
HB	Health Board
HTA	Human Tissue Authority
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
ISO	International Organisation for Standardisation
LIMS	Laboratory Information Management System
NOUS	Non-Obstetric Ultrasound Scan
MRI	Magnetic Resonance Imaging
MH&LD	Mental Health & Learning Disabilities
OOH	Out Of Hours
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QSRE	Quality, Safety, Risk & Experience
RGH	Royal Glamorgan Hospital
SDEC	Same Day Emergency Care
SLT	Speech and Language Therapist
SLA	Service Level Agreement
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
HO	Home Office
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy and Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 2nd March 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 QSRE meeting is to ensure delivery of workplace health and safety standards and safe, high-quality care to the population we serve, including prevention through public health, primary and secondary care. The purpose of this report is to provide assurance regarding these matters to the Quality, Safety Experience Committee.

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

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

1. **Highlight Report**

Escalate	**<u>Pathology</u>** **Laboratory Information Management System (LIMS) 2.0:** The Programme rating has been downgraded to red/amber, CTM remains Red • Status remains red due to low confidence of achieving all discipline deployment timelines by September 2026. • Blood Sciences (Biochemistry) have low confidence in achieving completion of User Acceptance Testing (UAT) dates due to configuration issues and volume of defects outstanding. • Blood Transfusion remains a discipline of high concern, low confidence of achieving deployment by September 2026, due to overlapping BT legacy data testing and completion of UAT, this position is supported by the BT community nationally. An options appraisal paper has been submitted outlining the considerable operational and financial risks of not meeting the project timeline, and this has been updated within the risk (5276) that is already escalated to the organisational risk register. **Microbiology Containment Level 3 Laboratory (CL3):** This has been a long-standing risk on the Pathology Risk Register due to its age and deteriorating condition. Capital funding was approved for refurbishment of the laboratory for post-April 2026. In January 2026, the risk score has been increased to 20 and was included in the most recent iteration for escalation to the organisational risk register. There has been a further decline in the condition of the CL3 laboratory resulting in it no longer being sealable, the Microbiology department has also received informal notification from the Health & Safety Executive (HSE), informing they will be inspecting the CTM CL3 laboratory in the coming months. Mitigations are limited; we are currently referring any specimens where clinical details indicate hazard group 3 organisms may be present. Fortunately, these are low in numbers. At present we would not be able to use the CL3 facility in the event of an outbreak such as Viral Haemorrhagic Fever (VHF), this would mean that no samples from a patient with highly suspected or confirmed VHF would be able to be processed in CTM and these will be sent out for testing.

	Healthcare Science **Bed Management** There is currently a reduced number of mattresses available across the Health Board due to full hospital sites and a high number of mattresses/pumps being condemned as considered beyond repair. Short-term mitigations are being pursued, along with long term considerations for a full rolling-replacement programme. **Radiology** Radiology-supported endoscopy services at PCH had been temporarily suspended because of critical faults in the endoscopic equipment at RGH. The new stacks and equipment have been purchased, and we are working with Planned Care colleagues to reinstate the service back at PCH. **Medicines Management (MM)** Issues have been escalated to MM QRSE of inappropriate requests of pharmacist prescribers in YCR. The team were asked for further detail and for Datix reports to be completed to record these incidents. These have been forwarded to Primary Care and Communities triumvirate, and we are working closely to identify and remedy any issues around cover, and clarification of roles and responsibilities. A number of patient queries have been received by the concerns team with regards to the upcoming closure of the Prescribing Hub in Bridgend in April 2026. A response letter has been provided by the MM team that the Concerns Team can share with patients.
Advise	**Radiology** **RGH MRI** Current MRI staffing consists of one radiographic assistant (9am–5pm) and two Band 6 radiographers (7:30am–8pm) covering both scanners operating seven days a week. Despite a review and mitigation efforts, patient safety risks remain due to remote waiting areas and limited emergency response capability. Plans to relocate the MRI booking desk and create an adjacent waiting room are underway, with construction expected to finish by May 2026.

Pathology

Human Tissue Authority (HTA) Reportable Incident (102575):

Reported in January 2026, a relative who had pre-arranged to drop off clothing to the mortuary entered the mortuary building through a rear entrance that had been left open. This is considered unauthorised access and is HTA reportable under security compromise or breach. Fortunately, the relative did not pass through the family room door and the door was immediately secured. An immediate security brief was communicated to all mortuary staff, and a full investigation and Corrective Action and Preventative Action (CAPA) are being undertaken for submission to HTA.

Cellular Pathology TCLe (LIMS)Risks:

CTM Cellular Pathology successfully implemented TCLe LIMS w/c January 26th. The implementation has slowed down the laboratory whilst staff learn to navigate the system. Although for the most part implementation has been successful, two issues have emerged having potential to result in clinical impact. There are some complexities in the reporting format that is presented on Welsh Clinical Portal (WCP) (content is correct but presented in such a way that may prove difficult to read). A notification has been added to WCP to inform clinicians to use extra vigilance when reviewing Cell Path results. This issue is being experienced nationally and has been escalated to DHCW for resolution.

A second issue was disruption of a data feed into the breast Multi-Disciplinary Team (MDT) report dashboard, resulting in 6 patients' MDT discussion being delayed by a week. A full investigation has been undertaken to determine any further impact. The issue appeared only to affect the breast MDT and mitigations were put in place to ensure all patients were captured for MDT discussion. The issue was escalated and has now been resolved.

Point of Care Testing (POCT) Unauthorised Ketone Testing:

It is a prerequisite that Nursing staff receive 'Think Glucose Training' (via the District Nursing Service (DNS) Team) prior to being authorised to test for POCT ketones. This is to ensure testing is undertaken only when clinically indicated and that results are escalated and acted on appropriately. We have seen an increase in incidents reported for unauthorised ketone testing and testing on meters that are not enrolled on an external quality assessment (EQA) scheme, therefore results cannot be quality assured. The POCT team is supporting with

targeted training and advice, incidents continue to be monitored.

Blood Transfusion Never Event:
ABO incompatible blood transfusion occurred in an Emergency Department, where A+ blood was transfused into an O+ recipient. This is classified as a Never Event. An Early Warning Notification has been submitted to Welsh Government (WG), along with a Nationally Reportable Incident (NRI) notification. The incident was identified quickly, and the transfusion was swiftly stopped. Although the NRI investigation will be undertaken by Unscheduled Care colleagues, it has been included in this report to highlight the swift action of the Blood Transfusion team. The Blood Transfusion Clinical Lead and Consultant Haematologist were immediately notified by the laboratory and were able to provide clinical advice and support to Emergency Department (ED) clinicians to ensure the patient was managed appropriately and the patient remained stable. The incident is SHOT (serious hazards of transfusion) reportable, and the team will continue to support with the investigation.

Weekend Orthopaedic Pre-assessment Clinics:
Additional clinics have been arranged over the weekends at PCH. This has resulted in increased weekend workload for Biochemistry and Haematology. Over the weekend, laboratories are operated by a single Biomedical Scientist (BMS) for each discipline. The workload for these lone workers is already considerable. The additional workload was unexpected, resulting in additional pressure and sample reception errors have already been detected. Care Group leadership team discussions will ensure that there is consideration of the potential knock-on impact on Pathology in any future arrangements.

Neurophysiology
Deficit continues between demand and capacity, which has been further exacerbated by HSC (external company) onboarding work, with higher rates of conversion than expected from neurology to neurophysiology. Plans to increase neurology consultant capacity within the HB is also expected to increase activity.

Short-term mitigations include the use of Planned Care Recovery funding to hold additional weekday clinical sessions and the procurement of additional sessions provided by an external outsourcing company to increase activity and reduce

	waiting lists. Longer-term mitigations continue to be considered. **Physiotherapy** The current on-line self-referral form for accessing Musculo-Skeletal (MSK) Physiotherapy in CTMUHB is outdated and poses a clinical risk. The issues with the self-referral form are: • it does not comprehensively screen for red flags that indicate a need for an emergency or urgent medical opinion and • the absence of a branching logic function prevents necessary changes to allow signposting of patients to the most appropriate clinical pathway. Previously, timely clinical triage of self-referrals mitigated the shortcomings of the form. However, due to a significant capacity shortfall as self-referral rates have risen to an unsustainable level, timely triage is no longer achievable. Following engagement with the digital team, there is currently no timely solution to improving the current self-referral form. To mitigate this risk self -referral to MSK physiotherapy will need to be ceased whilst an improved solution is established. **Medicines management** RGH Robot installation: the team are expecting a period of disruption to dispensing services for 7 weeks, working from a temporary dispensary in the pharmacy footprint. Offices have been cleared and furniture stored with support from clinical engineering; IT have supported with movement of hardware; estates have supported with extensive movement of shelving. Mitigations in place to reduce the impact on patient flow and patient experience include: • support from dispensaries on the other acute sites. • public campaign and with Welsh Ambulance Services NHS Trust (WAST) and Navigation Hub to encourage patients bring their own medicines to hospital; and • review of outpatient prescribing to reduce volume of outpatient attendances at pharmacy.
Assure	**<u>Health Sciences</u>** **Cardiac physiology** Additional weekend clinics have been undertaken Nov-Mar to reduce echocardiogram waiting lists. High levels of staff sickness did delay progress by a couple of weeks, but the work remains on target to deliver echocardiograms waiting lists to below the diagnostic target of 8 weeks by the end of March 2026.

Medicines Management

Controlled Drugs (CD) audits: Target= 100%. Current figures for completion of CD audits are:

	RGH	PCH	POW	YCR/YCC
Current compliance with CD ward Audits %	**98.7**	**100**	**82**	**100**
Previous months compliance %	94	100	100	YCR 100% YCC 85%

Parc: An Independent Review of Progress (IRP) visit has occurred, following the His Majesty's Inspectorate of Prisons (HMIP) inspection completed January 2026. The IRP inspection highlighted a strengthened and actively managed risk register; improved and effectively embedded mental health processes with reduced waiting times; more integrated substance misuse pathways with measurable impact; and increased capacity through additional clinical space.

New datix assurance panel for Medicines Management to be implemented. Work from all areas to reduce number of open Datix reports.

Pathology

Serious Hazards of Transfusion (SHOT) Transfusion Safety Standards Gap Analysis

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

Following on from the report, the Serious Hazards of Transfusion (SHOT) Transfusion Safety Standards were introduced July 2025. CTM Blood Transfusion department has completed the gap analysis against these standards and was found compliant for the most part. The resulting action plan is progressing at pace through fortnightly meetings.

Transport Issues:

There has been a recent surge in numbers of delay in transit incidents, resulting in multiple patient sample rejections as samples have been too old to process. There have been instances where a bag of samples was found to have been left on a transport van overnight, or samples have been dropped to

	an incorrect location. This has been escalated to the AD for Facilities, with options being considered. In the interim, Pathology teams are working with Facilities to improve porter/driver sign off process for sample tracking and strengthen the porter/driver induction training process. **Exploded Device (Pacemaker) in Crematorium:** The pathology department was notified in February of an incident where a pacemaker exploded during a cremation. It is the responsibility of the qualified attending practitioner (QAP) completing the Medical Certificate of Cause of Death (MCCD) form to note the presence of a pacemaker or any other in-situ device, this instance the QAP was a member of the surgical team. On this occasion no damage was done, and a multidisciplinary review meeting has been arranged in early March to discuss how this happened and action preventative measures. **Radiology** The Radiology Information System Programme (RISP) is progressing well, with a cross-section of staff having completed Super User training in preparation for implementation in March 2026. **Allied Health Professionals** • Following the approval of 3 new SOPs to support practices around dysphagia (Mouth Care, Acute Dysphagia referrals and Eating and Drinking at Acknowledged Risk), the Speech and Language Therapy Department have been rolling out awareness training to support staff and improve outcomes and experience for our patients.
Inform	**Pathology** **POCT CRP Testing in Primary Care** CTM are leading on a Welsh government funded project. A 2-year pilot is being rolled out in primary care for Point of Care Testing (POCT) CRP analysis. The aim is to support access to healthcare closer to home and will help target antibiotic prescribing, supporting antibiotic stewardship.
Appendices	

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Improving Care

Link to CTMUHB Strategic Goal(s)	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required at this point
Cydraddoldeb a'r Gymraeg	Yes: ☐	No: ☒
	Outcome for Equality: NEUTRAL	If no, please include rationale below:

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

4. Recommendation

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

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
4.6

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Services

Pwrpas yr Adroddiad / Report Purpose	For Review

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

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

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.01.26 and 28.02.26 taken from systems on 06.03.26, unless otherwise specified.

Key areas to note in this reporting period are:

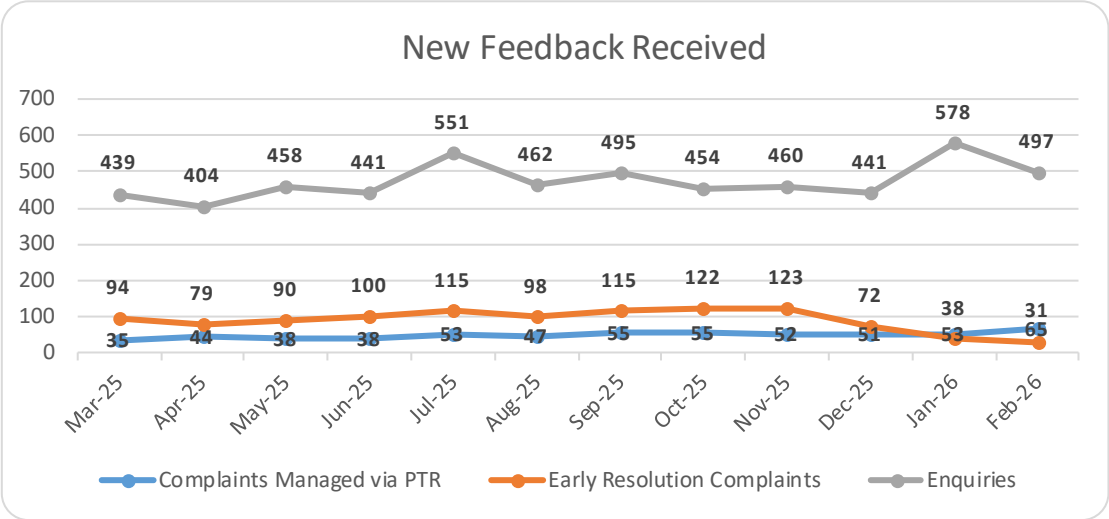
- **Complaints & Feedback**
  Fewer complaints open over 30 working days, but performance still below national standard.
  Top themes remain consistent: clinical treatment, communication, and appointments.
- **PSOW Activity**
  47 open cases; a small number of actions remain overdue.
  Four final reports received — investigations were undertaken and the allegations of the complainant were all not upheld.
- **Patient Safety Incidents**
  4,581 incidents reported; slight increase overall.
  Increased medication and patient falls incidents.
  42 Nationally Reportable Incidents open, with 26 overdue.
- **Duty of Candour**
  Fewer triggers this period; strengthened by weekly validation audits.
- **Inquests & Regulation 28**
  40 new inquests; 17 concluded.
  One Regulation 28 report issued highlighting issues in escalation, documentation, and non-standardised paediatric crash trolleys.
- **Clinical Negligence Claims**
  13 new claims, 19 triggered for settlement, 3 closed.

2. Specific Matters for Consideration

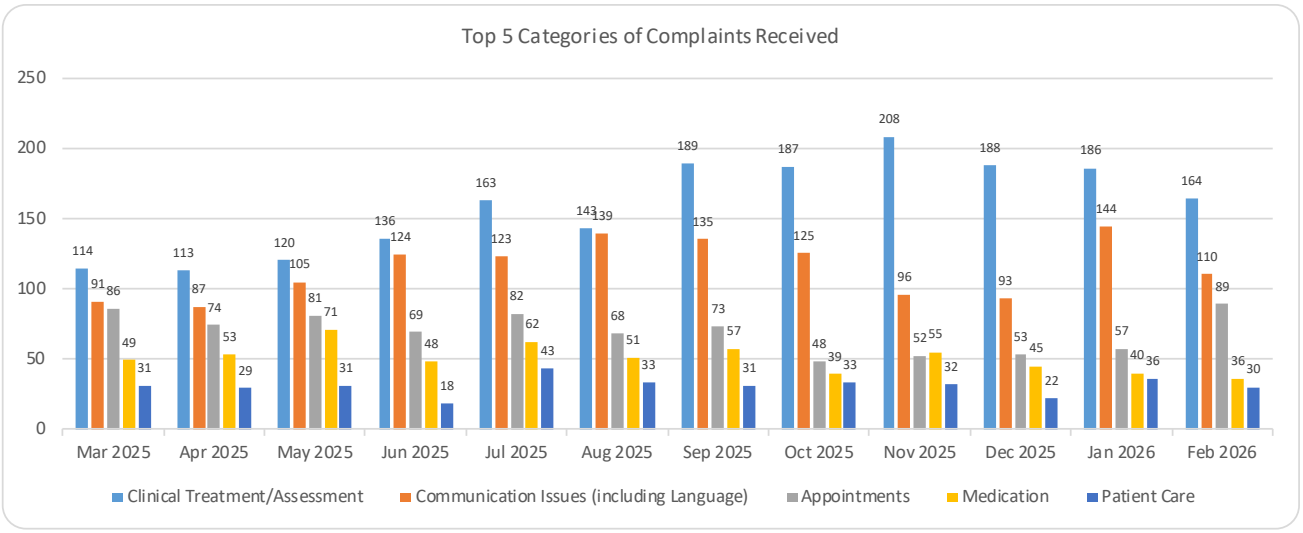
2.1 Patient / Service User Feedback

Complaints & Enquiries

<u>New Complaints Received</u>
Between the 01.01.26 and 28.02.26 the Health Board received a total of 187 complaints and 1075 enquiries. Of 187 complaints received, 118 were categorised as formal and managed under the Putting Things Right Regulations (PTR). The number of Early Resolution complaints has decreased steadily over the past two months. PTR complaints reduced during December 2025 and January 2026 compared to November 2025, before rising slightly again in February 2026. Enquiries also dipped in December, increased in January, and then fell back in February.

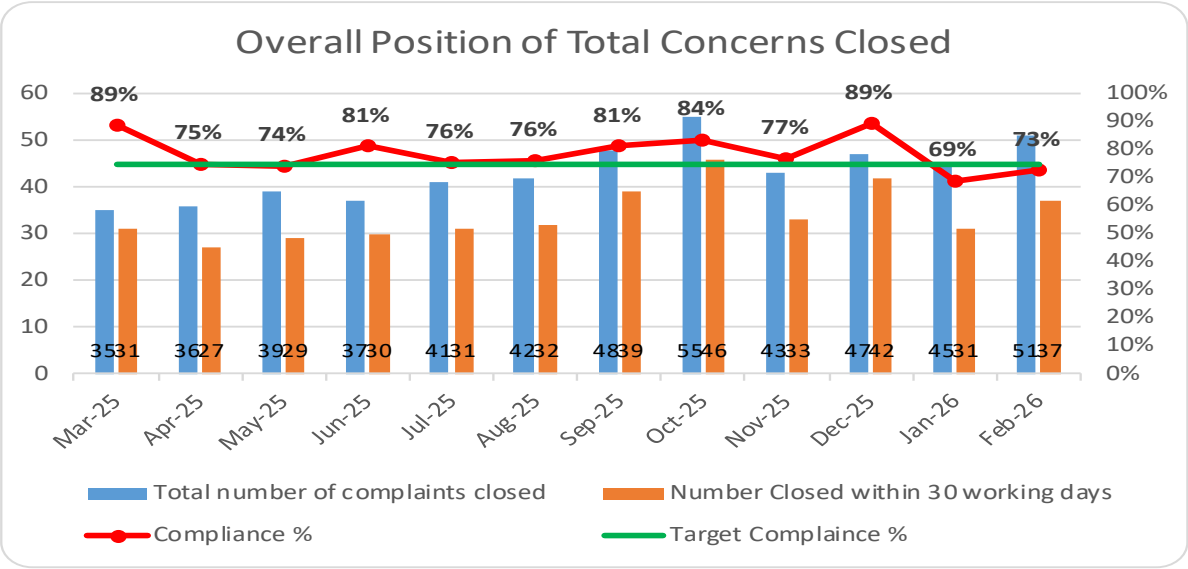


For <u>all feedback (Complaints and Enquiries)</u> received in January 2026 and February 2026, accounting for 63% of the feedback received, the top 3 types remain consistent with previous months. These relate to Clinical Treatment / Assessment (350), Communication Issues (including Language) (254) and Appointments (146).



<u>Closed Complaints</u>

Within the period of 01.01.26 and 28.02.26, the Health Board closed a total of 96 formal complaints (managed through PTR). During the 2 month period, the national target of 75% compliance for responding to complaints within 30 working days was not achieved (71%). As at 06.03.26, the Health Board had 96 open formal complaints. Of these, 25 complaints were open over 30 working days which is 5 less open complaints compared to the position at the beginning of January. Focused work continues to be undertaken to improve the efficiency of the Health Board's concerns triage process to ensure a timely response.



Public Services Ombudsman for Wales

Open cases

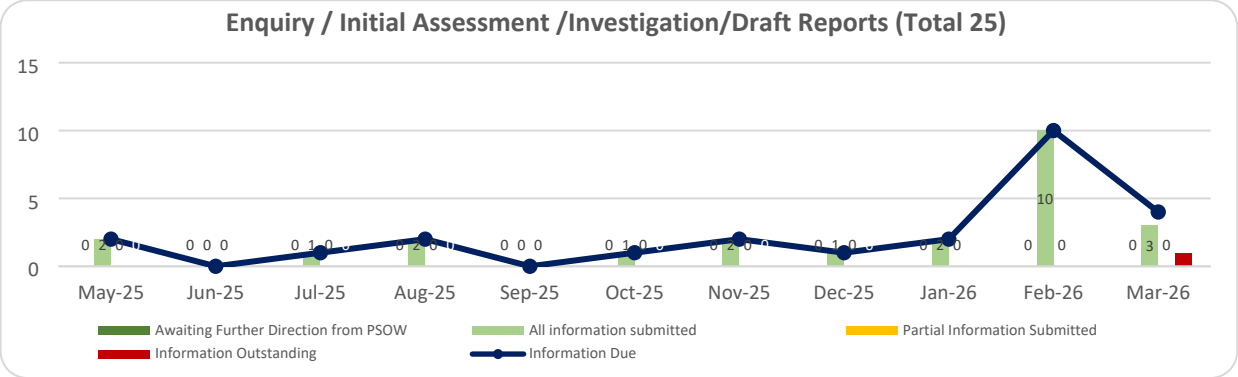
As at the 09.03.26 the Health Board has 47 open Public Services Ombudsman for Wales (PSOW) Cases. Of these, 32 are awaiting a response from the PSOW.

Current Status	Enquiry / Initial Assessment/ Investigation	Early Settlement	Draft Report Comments	Final Report Compliance	Information Only	Total
All evidence submitted and awaiting closure by PSOW	0	2	0	2	0	4
Awaiting further direction from PSOW	0	0	0	0	2	2
Information Received	0	0	0	0	0	0
Information Submitted	23	3	0	0	0	26
Information Outstanding	2	7	0	4	0	13
Information Partially Submitted	0	1	0	1	0	2
Total	**25**	**13**	**0**	**7**	**2**	**47**

New PSOW Cases Received

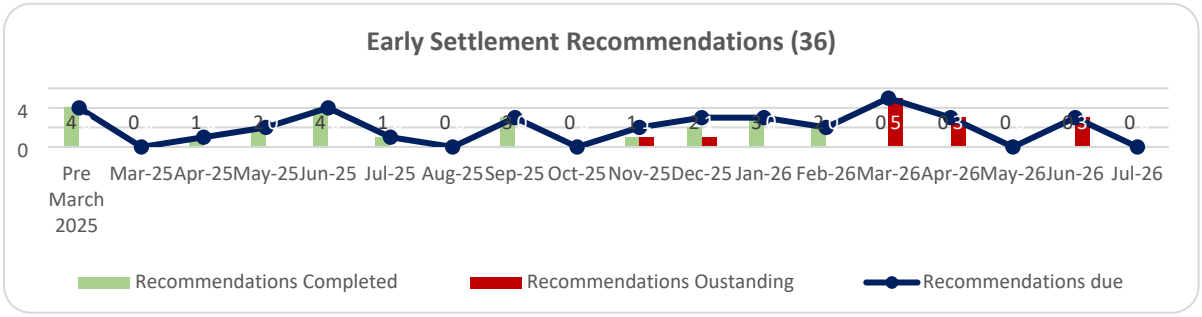
The Health Board received notification of 21 new referrals to the PSOW between the 01.01.26 and 28.02.26. Of the 21, 17 were received as enquiries, 3 as decision not to investigate and 1 as an early settlement proposal.

Of the 25 cases, the Health Board currently has open at 09.03.26 in the enquiry / initial assessment/investigation stage, 1 case has an outstanding action. No actions are currently overdue. This is reflected in the chart below:



Early Settlement Proposal

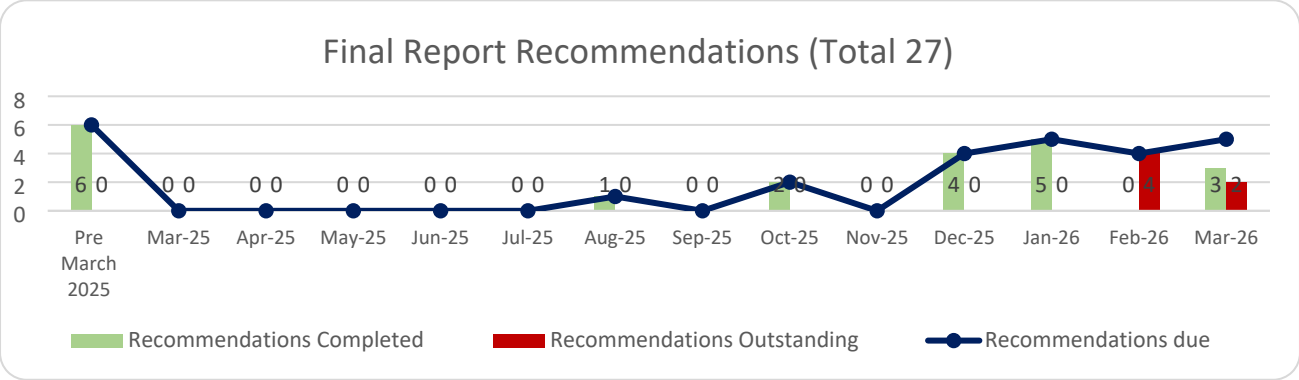
During the same period the Health Board agreed 9 early settlement proposals. It should be noted that more than one action can be attributed to a case. As at the 09.03.26, the Health Board has 13 open early settlement cases, with 36 associated case actions. Of the 36 actions, two are currently overdue the deadline agreed with the PSOW.



Final Reports

During January and February 2026, the PSOW issued 4 final reports to the Health Board, investigations were undertaken and the allegations of the complainant were all not upheld.

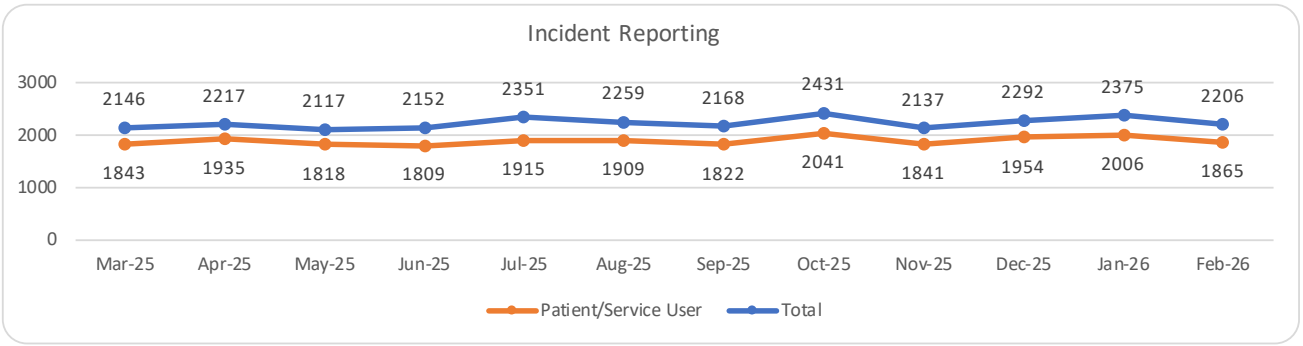
As at 02.03.26, the Health Board has 7 cases which are currently in the final report stage of the PSOW process. These cases have 27 associated recommendations. Of these recommendations, 5 are currently outstanding, with 4 currently overdue the timescale for completion which are subject to further ongoing discussion between the PSOW and the Health Board.



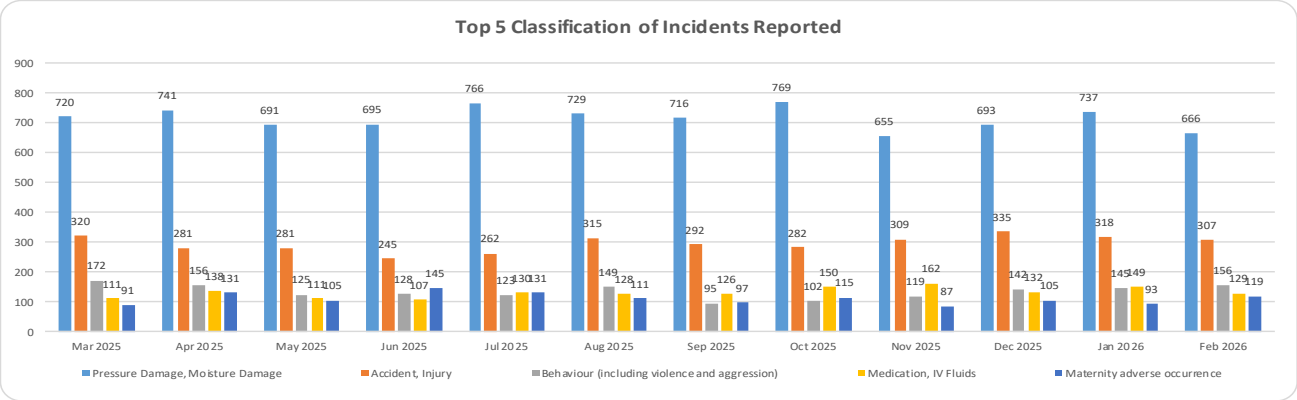
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,581 incidents were reported as occurring between 01.01.26 and 28.02.26, this represents a slight increase of 152 when compared with the previous 2 months (4,429). The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,581 incidents reported, 85% (3,871) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

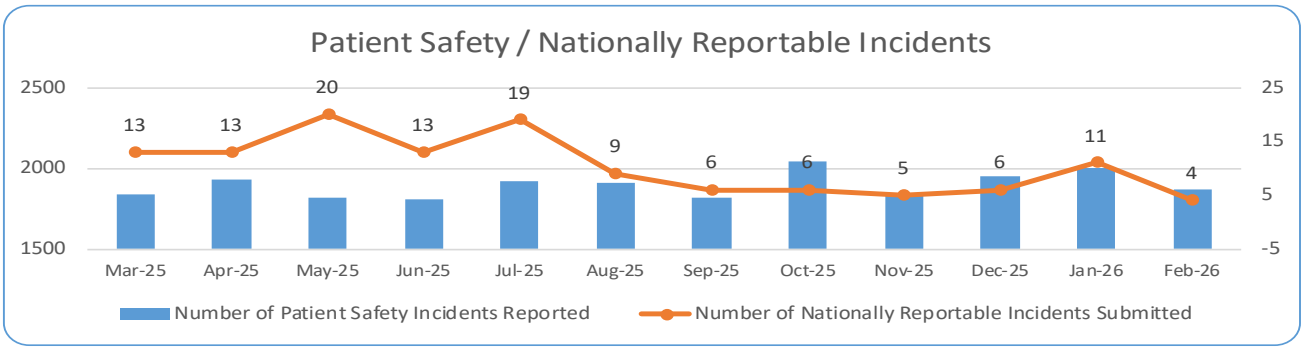


The top 5 classification of incidents reported as occurring in January and February 2026, linked to a patient affected incident are: Pressure Damage /Moisture Damage (1,403), Accident, Injury (625), Behaviour (including violence and aggression) (301), Medication, IV fluids (278) and Maternity adverse occurrence (212). This is consistent with the previous two-month period. The trend for the top 5 classification of incidents is highlighted in the chart below:



Nationally Reportable Incidents

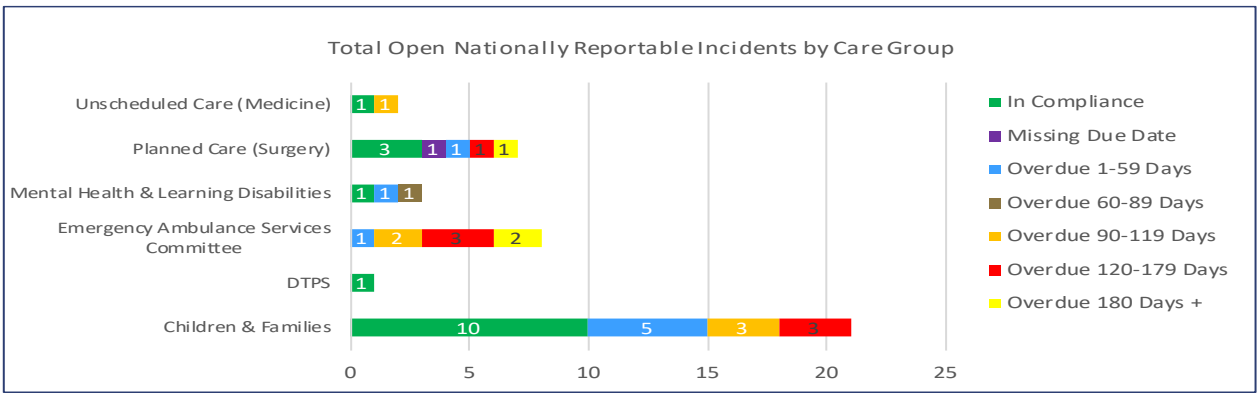
Between 01.01.26 and 28.02.26, 15 Nationally Reportable Incidents were submitted to the NHS Performance & Improvement Team. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



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:

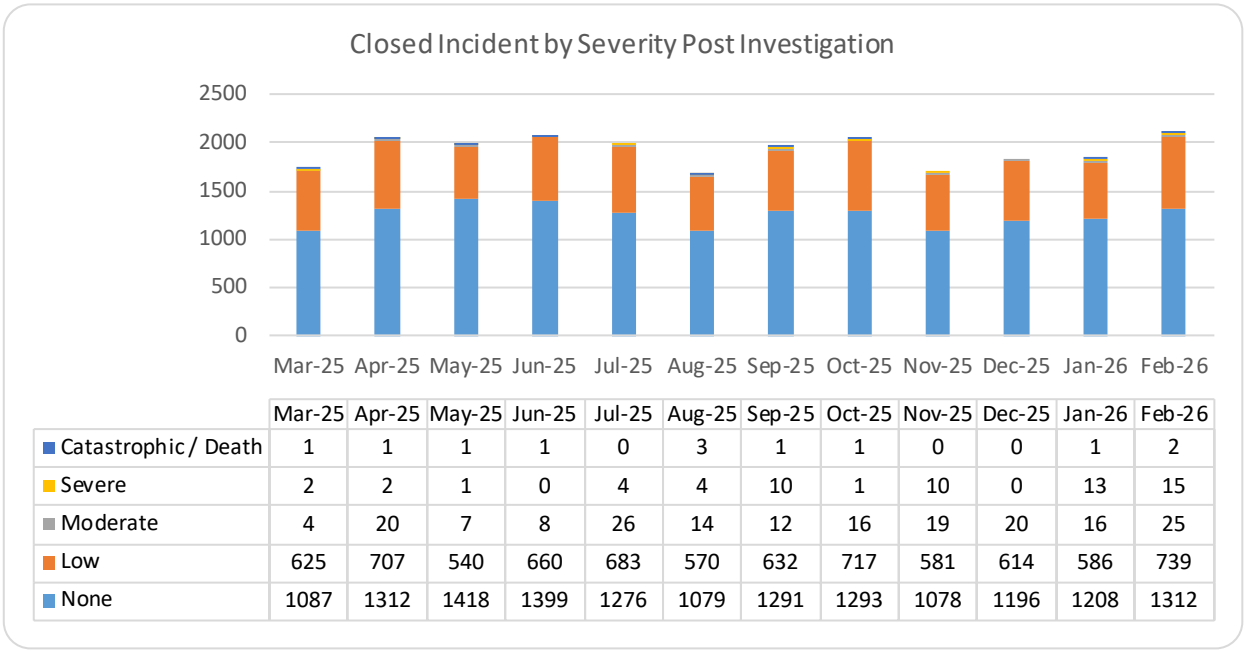
	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Total
Access, Admission	1	1	3	1	0	0	0	0	0	0	0	1	7
Assessment, Investigation, Diagnosis	1	0	2	0	2	0	0	0	1	1	3	0	10
Behaviour (including violence and aggression)	0	0	0	0	0	0	0	0	0	0	0	1	1
Equipment, Devices	0	1	0	0	0	0	0	0	0	0	0	0	1
Infection Prevention and Control	4	3	2	0	0	0	1	0	0	0	0	0	10
Maternity adverse occurrence	3	0	5	2	0	5	1	5	0	1	4	0	26
Patient/service user death	0	1	1	1	1	1	1	0	0	0	3	0	9
Pressure Damage, Moisture Damage	4	3	7	6	15	3	3	1	2	4	1	2	51
Transfer, Discharge	0	4	0	2	0	0	0	0	1	0	0	0	7
Treatment, Procedure	0	0	0	1	1	0	0	0	1	0	0	0	3
Total	13	13	20	13	19	9	6	6	5	6	11	4	125

As at the 03.03.26, the Health Board currently has 42 open Nationally Reportable Incidents, of which 26 are overdue the timescale for completion. Focused work continues to be undertaken to ensure investigations are concluded and ensure a timely outcome is provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

Between the 01.01.26 and 28.02.26 a total of 3,917 patient safety incidents were closed. The 12 month trend is reflected in the table below.

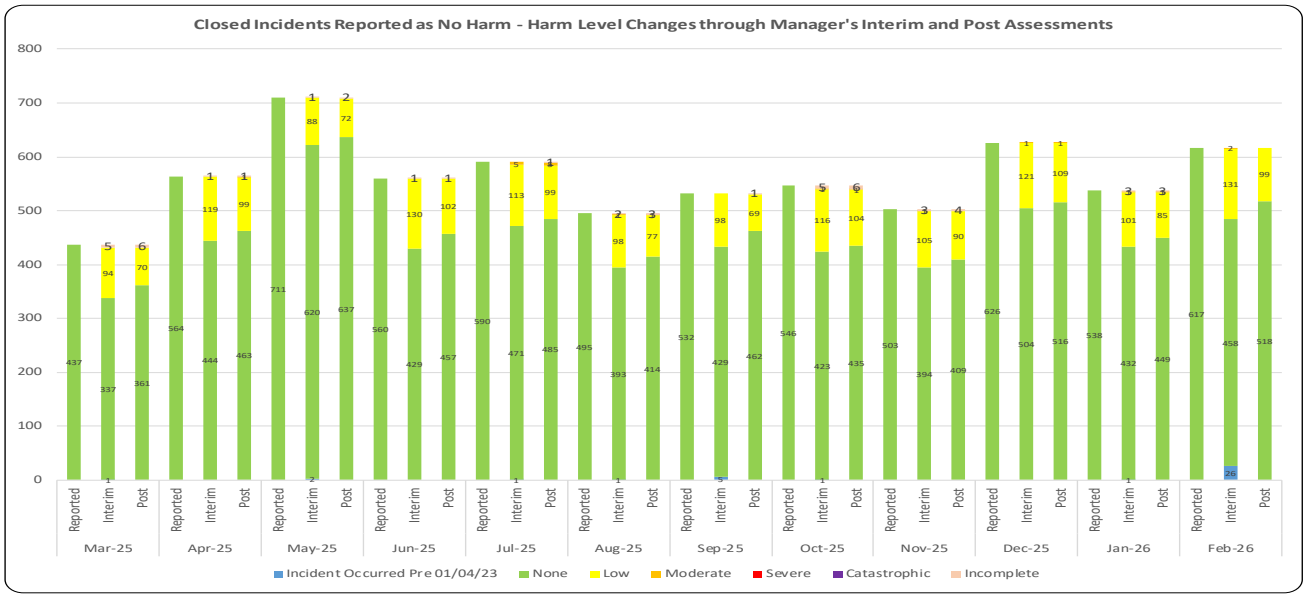


	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Catastrophic / Death	1	1	1	1	0	3	1	1	0	0	1	2
Severe	2	2	1	0	4	4	10	1	10	0	13	15
Moderate	4	20	7	8	26	14	12	16	19	20	16	25
Low	625	707	540	660	683	570	632	717	581	614	586	739
None	1087	1312	1418	1399	1276	1079	1291	1293	1078	1196	1208	1312

Of the 3,917 patient safety incidents closed, 28 were closed with severity post investigation of severe harm and 3 incidents of catastrophic/ death. A breakdown of incidents is provided in the table below:

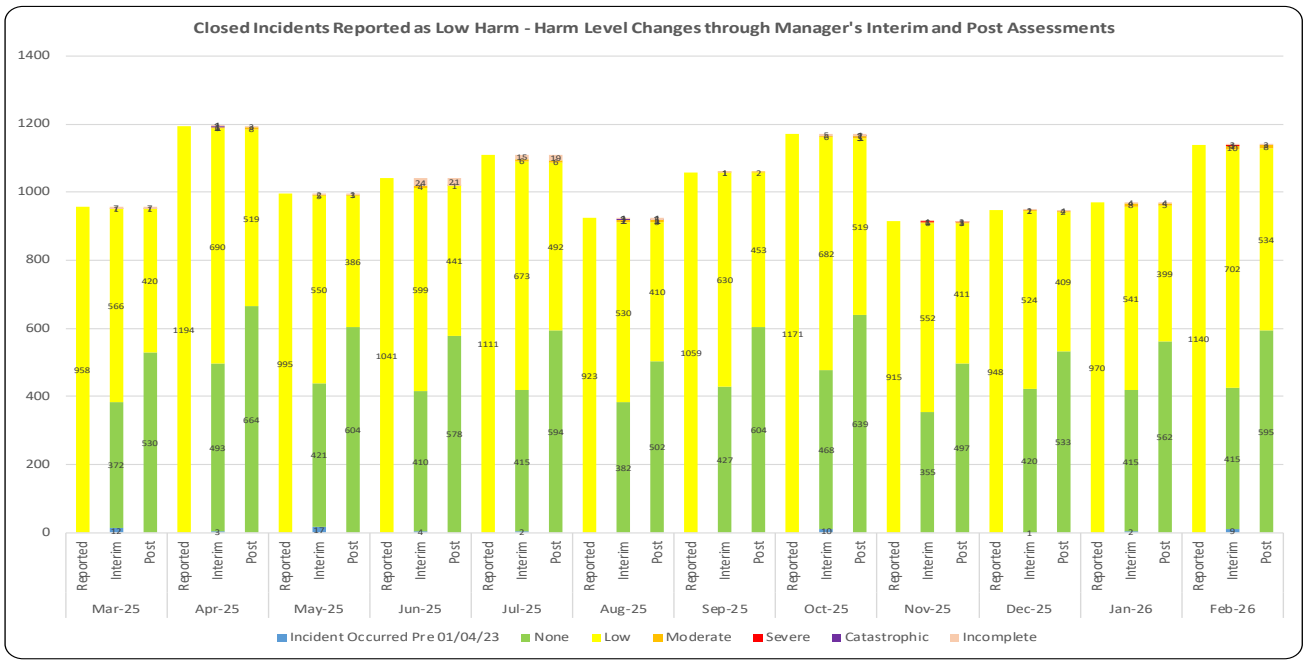
	Patient Care and Safety	Children and Families	Unschedule d Care	Planned Care	DTPS	Total
Access, Admission	0	1	0	3	0	4
Accident, Injury	0	0	2	0	0	2
Assessment, Investigation, Diagnosis	0	0	0	1	0	1
Medication, IV Fluids	0	0	0	0	1	1
Patient/service user death	2	0	0	0	0	2
Treatment, Procedure	0	0	0	21	0	21
Total	2	1	2	25	1	31

Work continues to be undertaken to ensure that a severity of moderate, severe or catastrophic / death recorded on conclusion of an investigation accurately reflects where it can be determined that an incident has been directly caused or attributable to an intervention (action/inaction) by the Health Board. In addition, mechanisms to support a comparison of reporter's view of level of harm and the severity recorded post investigation have been established. The level of harm attributed to an incident is reviewed and recorded at 3 stages within the incident management process, reporter view on Level of harm, level of harm following management review and severity determined post investigation. Trend information providing a comparison between the reporters view on level of harm, level of harm following management review and severity of incident post investigation is provided below:

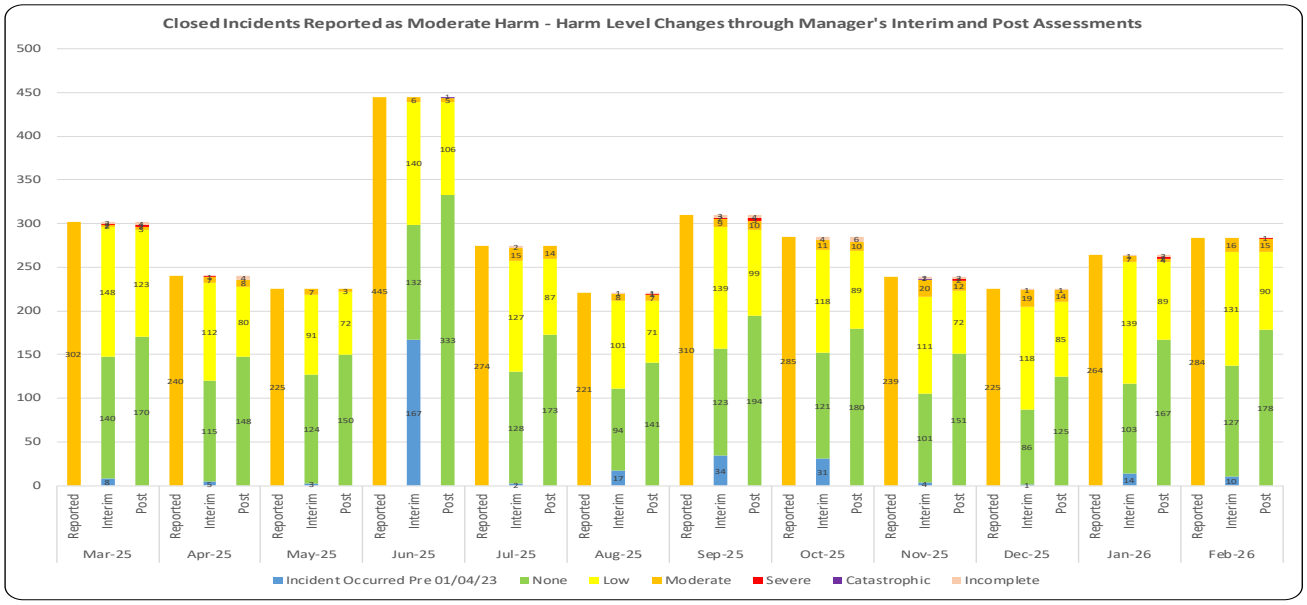


Between 01.01.26 and 28.02.26, a total of 1,155 incidents were initially reported as None harm, representing an increase of 26 compared with the previous two-month period (1,129). Following review, the majority remained classified as None harm. Across the period, approximately 20% of incidents were upgraded to a higher harm

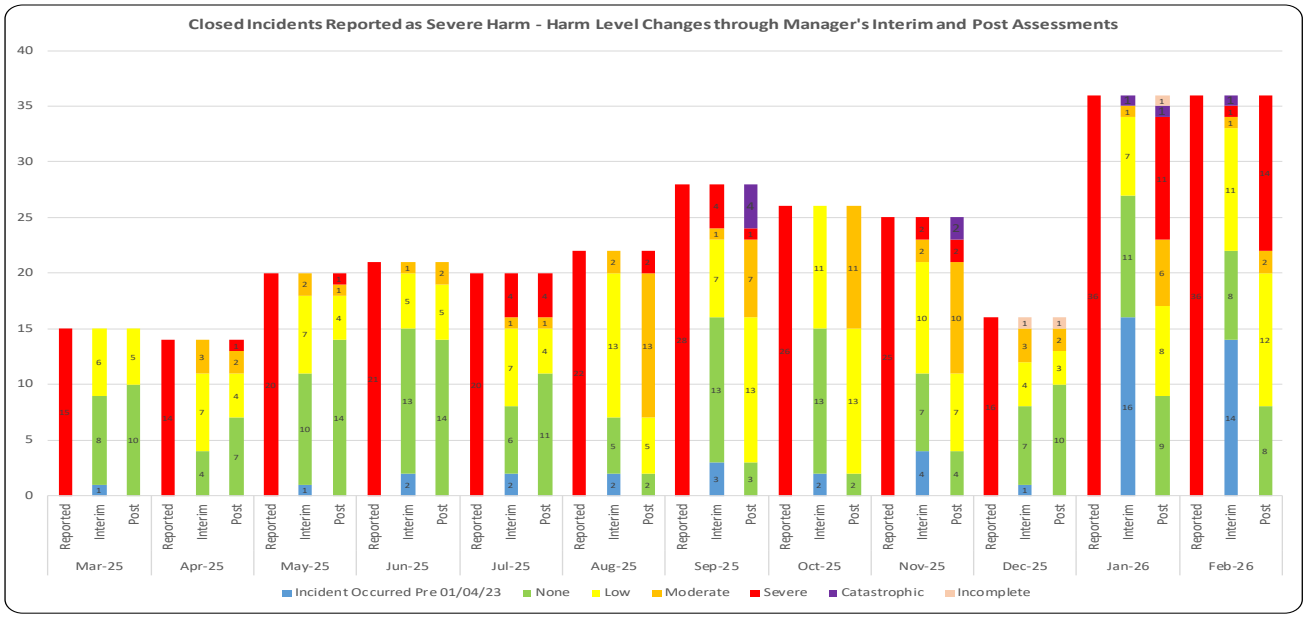
level at the interim stage, reducing to around 16% at post-review, with most upgrades reclassified to 'Low harm' and very few to 'Moderate'. No incidents were classified as severe or catastrophic, and incomplete reviews were minimal (three at interim and three at post across the period). The trend in harm level changes is reflected in the chart above.



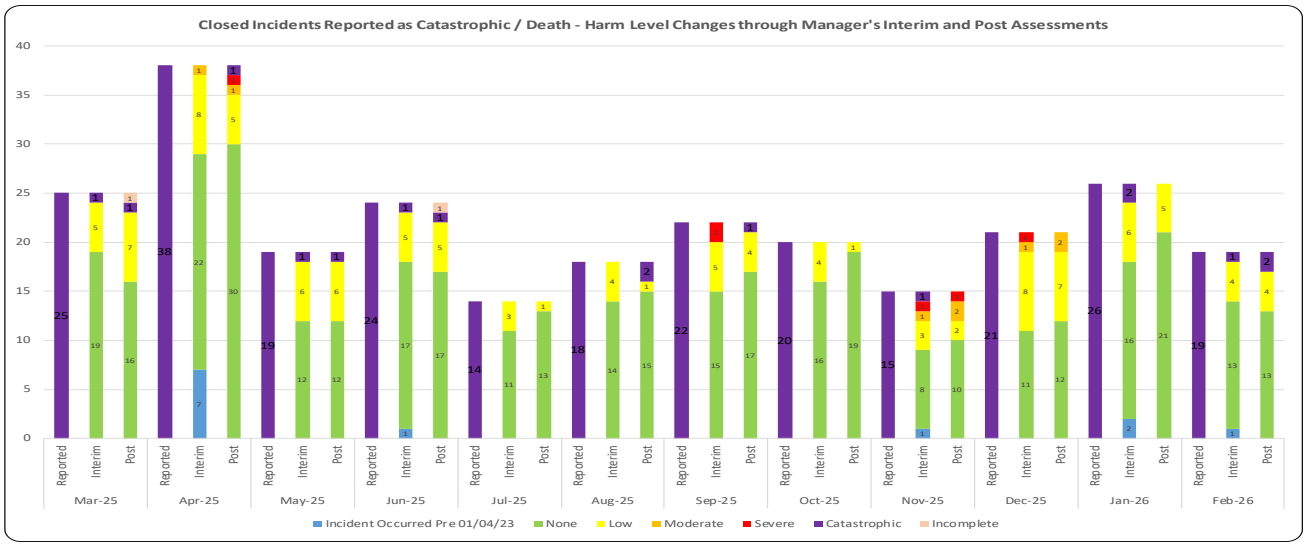
Between 01.01.26 and 28.02.26, a total of 2,110 incidents were initially reported as Low harm, representing an increase of 247 compared with the previous two-month period (1,863). Following review, most incidents were reclassified to None harm, with a smaller proportion remaining as Low or being reassessed as Moderate. Across the period, approximately 1% (0.90%) of incidents were upgraded to a higher harm level at the interim stage, reducing to around 0.6% (0.62%) at post-review. Upgrades beyond Moderate remained rare, with only isolated transitions into Severe or Catastrophic categories. The trend in harm level changes is reflected in the chart above.



Between 01.01.26 and 28.02.26, a total of 548 incidents were initially reported as Moderate harm, representing an increase of 84 compared with the previous two-month period (464). Following review, most incidents were downgraded at the interim stage (95.6%), primarily to Low (49% of all reported) and None (42%), with a small proportion recorded as Incident Occurred Pre 01/04/23 (4%). By post-review, the overall downgrade rate remained high (95.6%), with the majority recorded as None (63%) and Low (33%), and none recorded in the Incident Occurred Pre 01/04/23 category. Upgrades to a higher harm level were rare, 0% at interim and 0.5% at post.



Between 01.01.26 and 28.02.26, a total of 72 incidents were initially reported as Severe harm, representing an increase of 31 compared with the previous two-month period (41). Following review, the majority were downgraded at the interim stage (95.8%), with most incidents reclassified to 'None', 'Low', or 'Moderate', and a smaller proportion recorded as 'Incident Occurred Pre 01/04/23'. By post-review, downgrade levels remained high (62.5%), with most incidents reassessed to 'None', 'Low', or 'Moderate'. Upgrades to 'Catastrophic harm' were rare occurring in a small number of cases during the review period.



Between 01.01.26 and 28.02.26, a total of 45 incidents were initially reported as 'Catastrophic harm', representing an increase of 9 compared with the previous two-month period (36). Following review, the majority were downgraded at the interim stage (93.5%), most commonly to 'None' and 'Low', with smaller proportions reassessed as 'Moderate' or 'Severe'. By post-review, downgrade levels remained high (94.7%), with most incidents recorded as 'None', 'Low', or 'Moderate'. No incomplete reviews were recorded across the period.

Duty of Candour

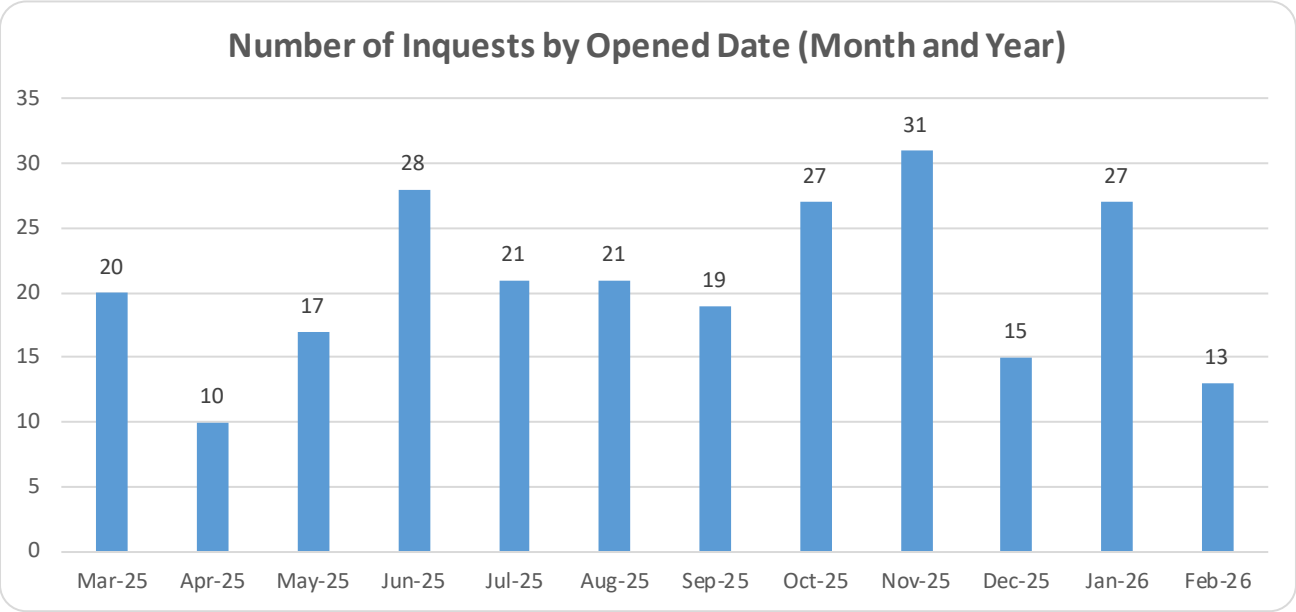
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

Number of Incidents	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026
Where Duty of Candour Triggered	13	15	22	19	8	12	13	28	10	17	10	9
Where In-person notification completed	12	15	21	18	8	9	12	23	10	13	9	8
Where letter of notification sent	12	14	19	17	7	8	10	20	9	13	7	7

2.3 Inquests Case Activity

New Inquests Received

In the time period 01.01.26 and 28.02.26, the Health Board received notification of 40 inquests. This is a slight decrease when compared with the previous 2-month period (46). A trend graph of the inquests opened during period is provided below.



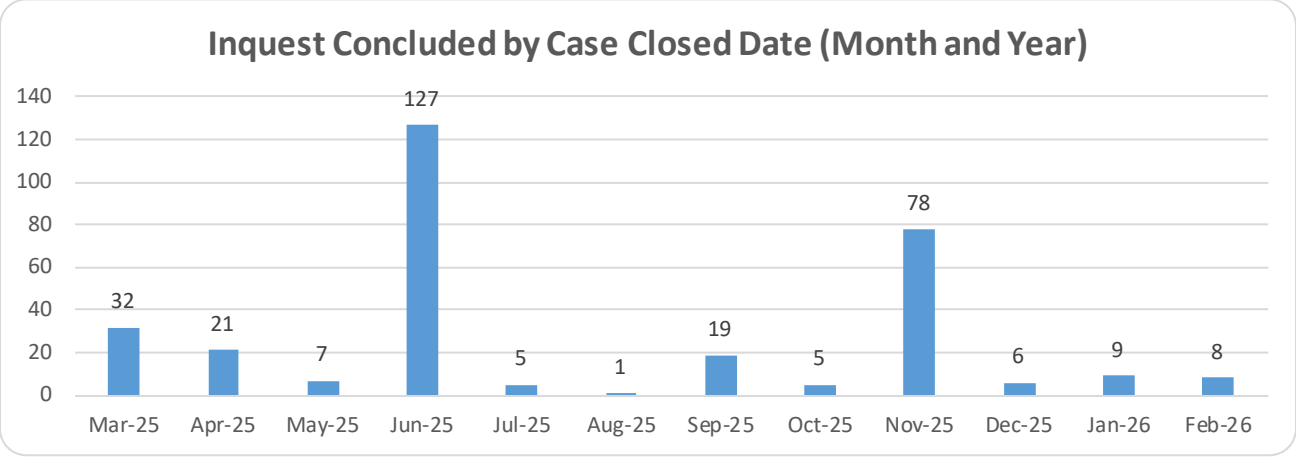
Of the 40, the highest number of inquests were received for the Primary Care and Community (17). A breakdown of inquests received by Care Group is provided below.

Care Group	Number Received
Children and Families	2
Primary Care and Community	17
Mental Health and Learning Disabilities	1

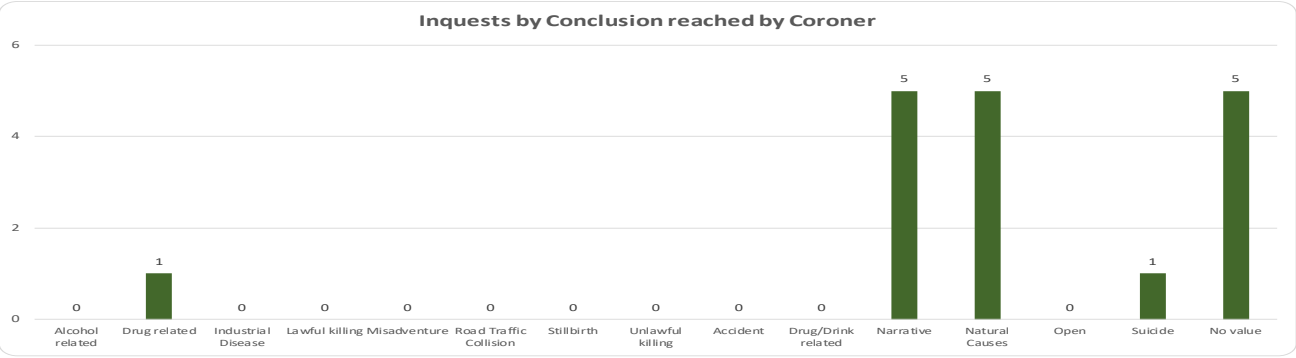
Planned Care	10
Unscheduled Care	10
DTPS	0
Not Specified	0
Total	40

Inquests Concluded

During the same 2 month period, 17 inquest cases were closed on the Health Board's Datix system. A trend graph of inquests concluded during the period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 17 inquests cases closed on Datix, 3 were discontinued by the Coroner prior to hearing. Of the remaining cases (14) a breakdown of the outcome of inquests closed between the 01.01.26 and 28.02.26 is provided in the chart below.



Regulation 28 Reports / HMC Letter Received

On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports.

Between the 01.01.26 and 28.02.26 the Coroner issued 1 regulation 28 report to the Health Board.

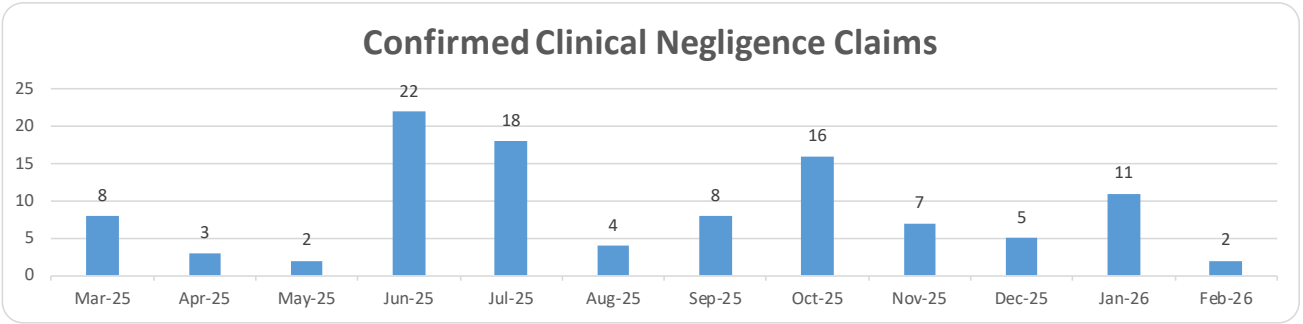
The inquest in relation to this case highlighted significant issues in relation to deterioration recognition, clinical decision-making, and the integration of parental concerns. Across 14–18 March 2024, deterioration indicators were not consistently escalated, and key collapse events were incompletely documented. Parental warnings about mask intolerance and visible deterioration were not fully incorporated into clinical decision-making, contributing to the preventable hypoxic events that resulted in catastrophic brain injury.

The transition from High Flow Nasal Oxygen to CPAP was a pivotal decision point where clinical risk was underestimated. Equipment availability and staff familiarity also played a critical role. During resuscitation, paediatric adrenaline could not be located quickly due to variation in crash trolley layouts and limited overnight staffing. Communication gaps were identified including incomplete handover to external critical care teams and retrospective documentation further compounded the risk profile and hindered system learning.

The Coroner's Regulation 28 report identifies the Wales-wide risk arising from non-standardised paediatric crash trolleys, particularly for rotating junior staff. Required actions now include strengthening local deterioration escalation processes, improving documentation standards, embedding parental involvement, and addressing emergency preparedness through equipment standardisation. At a national level, Health Boards and Welsh Government are expected to collaborate on a single standardised paediatric crash trolley model and provide an agreed multi-agency response within the extended timeline.

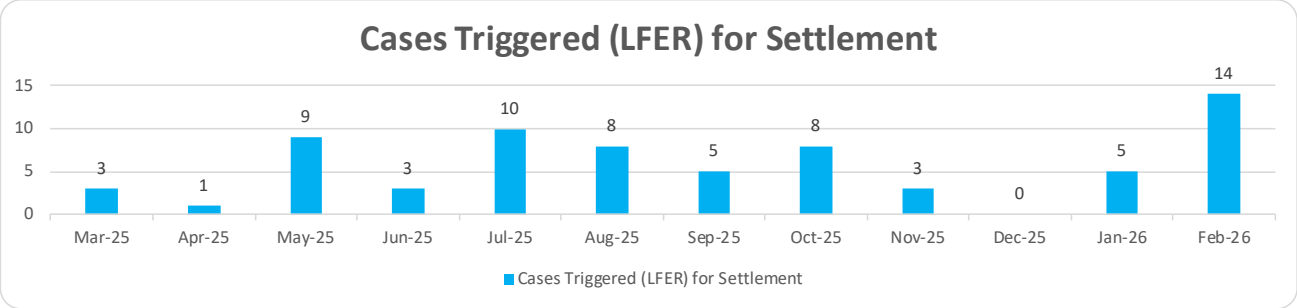
2.4 Clinical Negligence Claims

<u>New Confirmed Clinical Negligence Claims</u>
Between the 01.01.26 and 28.02.26 the Health Board received confirmation of a total of 13 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



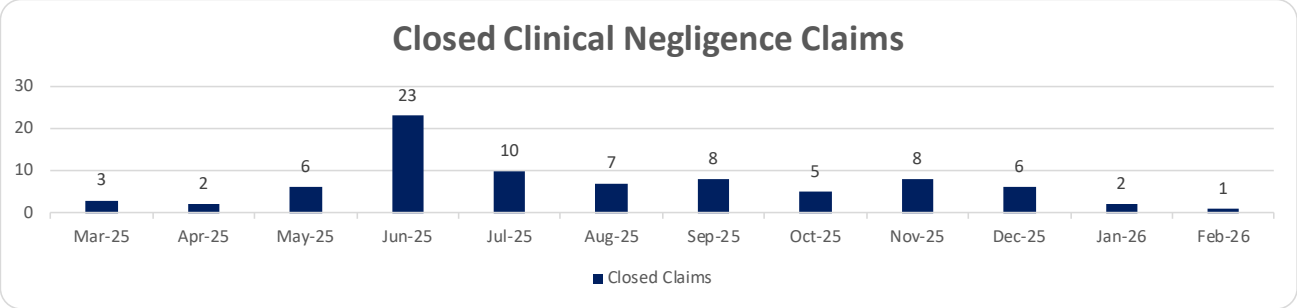
Clinical Negligence Claims triggered for settlement

Between the 01.01.26 and 28.02.26, there were 19 Clinical Negligence Claims for trigger for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



Closed Clinical Negligence Claims

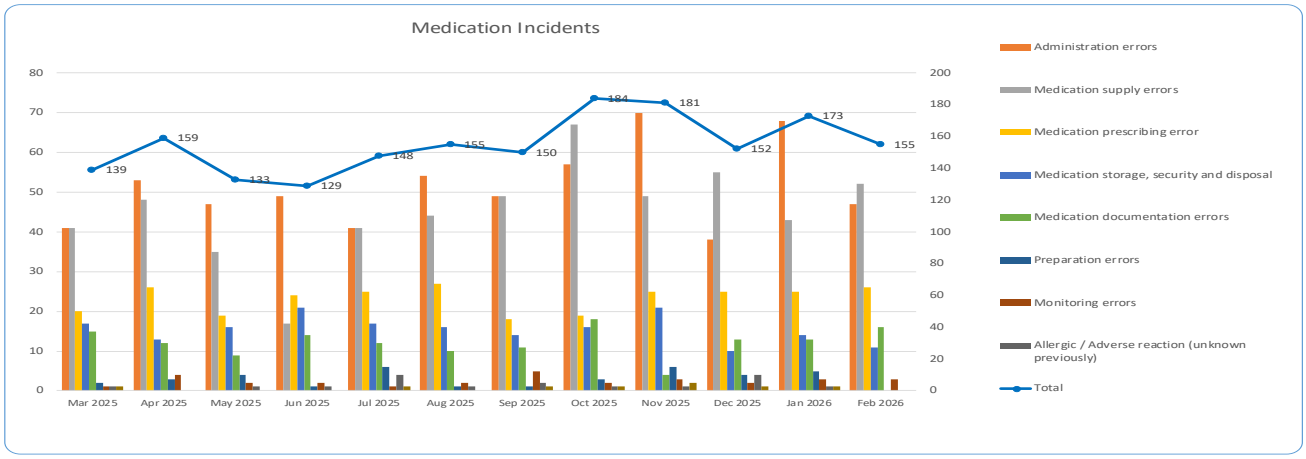
Between the 01.01.26 and 28.02.26 the Health Board closed 3 Clinical Negligence Claims. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



2.5 Specific Quality & Safety Metrics

2.5.1 Medication Safety

A total of 328 medication incidents were reported as occurring between 01.01.26 and 28.02.26. This is a decrease of 5 when compared with the previous 2-month period (333). Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (115), medication supply errors (95) and medication prescribing errors (51).

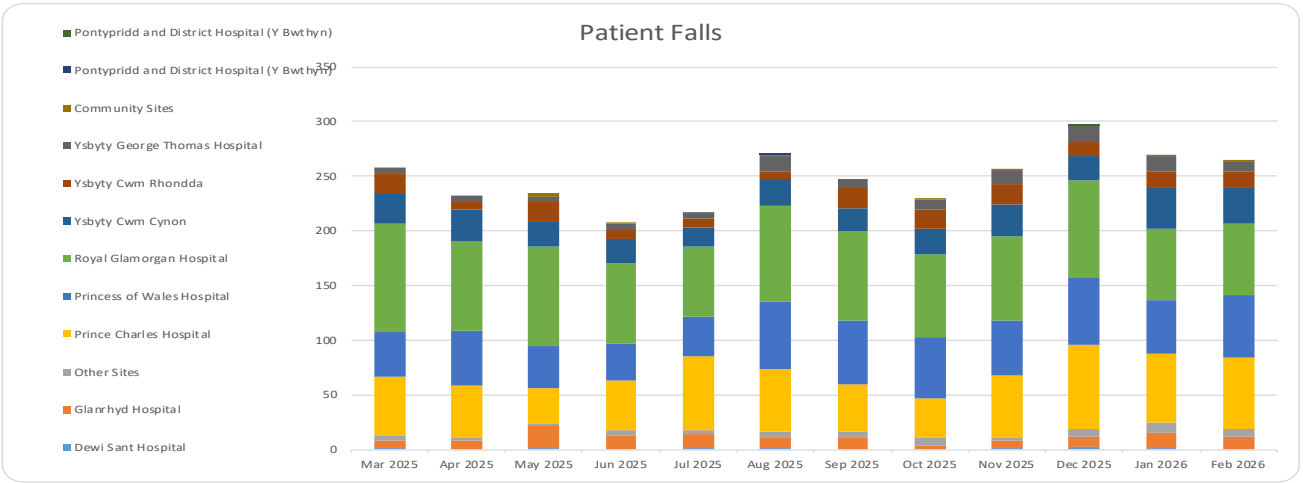


90% of the medication incidents were reported as resulting in none (149) or low (145) harm, with the remaining reported as resulting in moderate harm (24), Severe (9), Catastrophic / Death harm (1). It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.5.2 Patient Falls Incidents

A total number of 536 falls, where the person affected was a patient, were reported during January and February 2026. This represents a decrease compared with the previous two months (554).

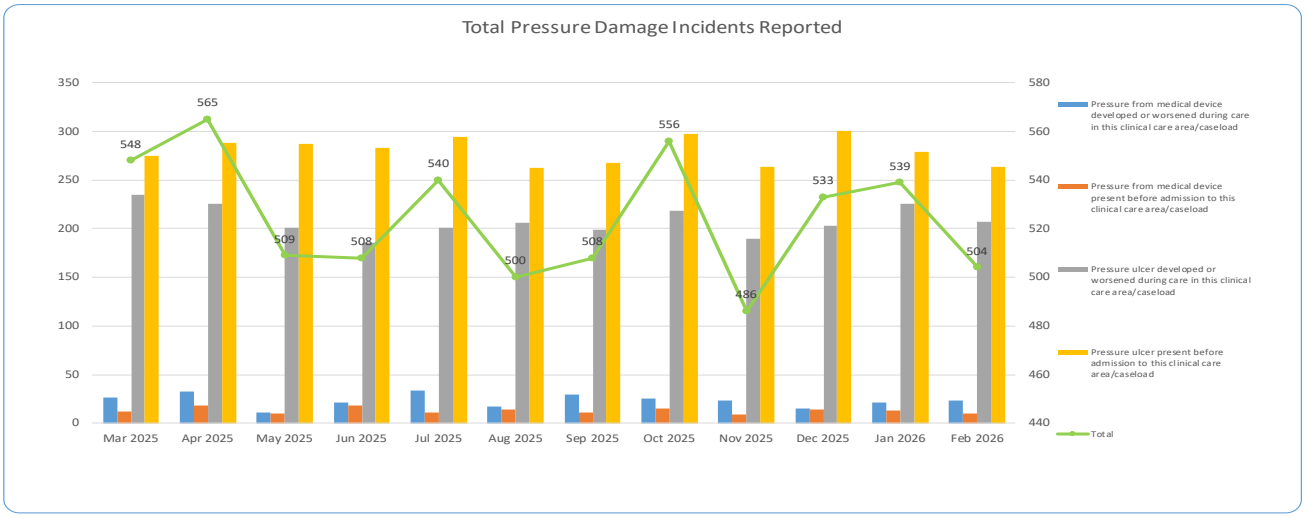
Of the falls incidents within the time period, 95% were reported as no (181) or low (330) harm. The remaining incidents were reported as resulting in moderate (23) and severe (2) harm. No incidents relating to patient falls were reported as resulting in catastrophic harm / death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



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

2.5.3 Pressure Damage

Between the 01.01.26 and 28.02.26, a total of 1043 pressure damage incidents were reported, of which 477 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (566) were reported as being present before admission to this clinical care area/caseload.



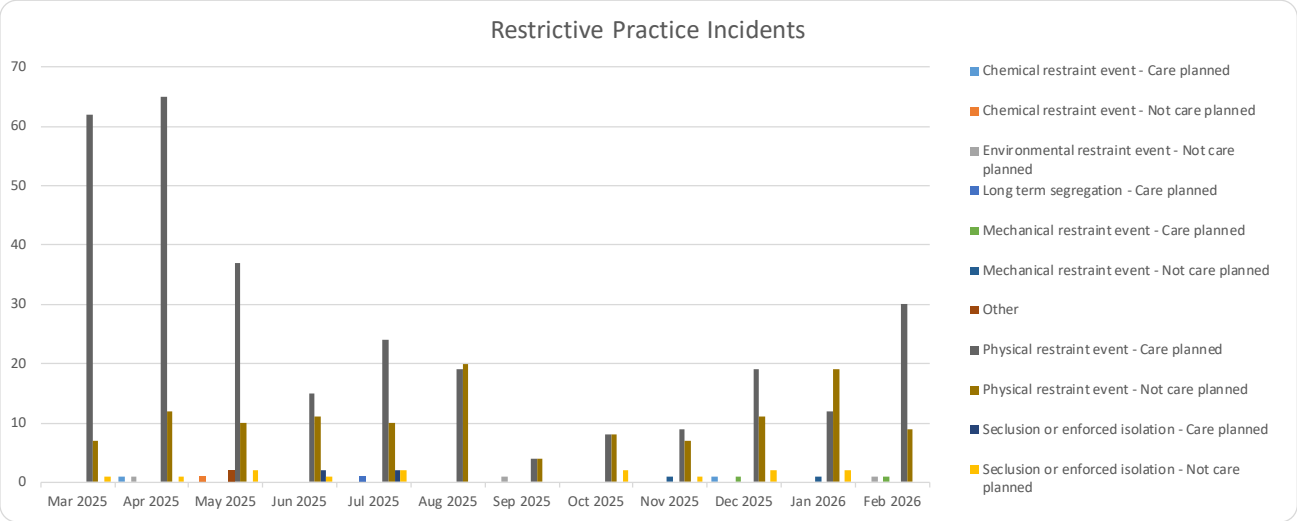
Of the 477, identified as developing or worsening during current caseload, 245 were identified as occurring within the community, which represents an increase of 29 compared with the previous two-month period (216).

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

2.5.4 Mental Health Metrics

<u>Restrictive Practices</u>

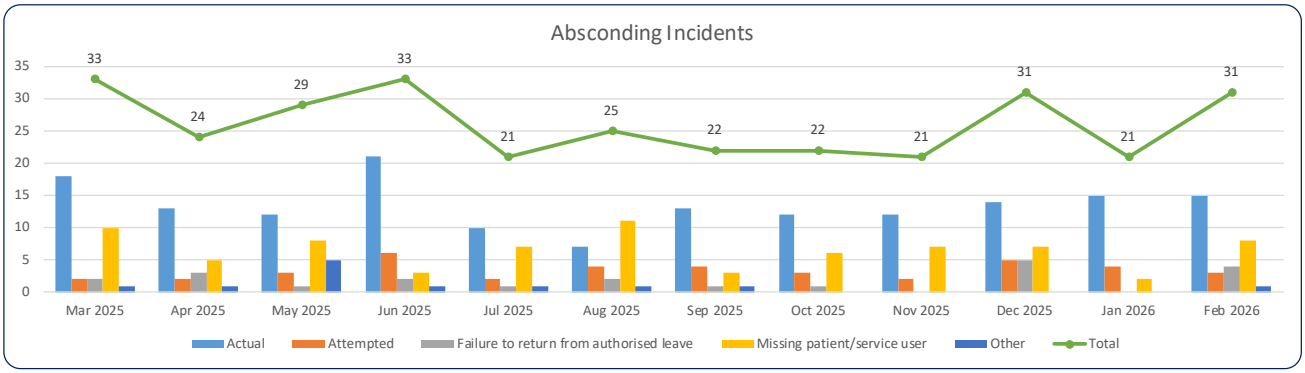
Between 01.01.26 and 28.02.26, a total of 75 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 23 incidents when compared to the previous two months (52).



Of the 75 incidents, 32 were reported as not care planned (not included in the care and treatment plan for the patient) and 40 were reported as care planned (included in the care and treatment plan for the patient), 0 were recorded as Other. The highest number of incidents were reported as occurring on the Seren Ward POW, Princess of Wales Hospital (22).

Absconding incidents

During January and February 2026, a total of 52 incidents were reported under the category of absconding, which represents no change when compared with the previous two-month period (52). 30 were recorded as actual absconding, with the remaining recorded as missing patient/service user (10), attempted absconding (7), failure to return from authorised leave (4), and other (1). The highest number of incidents were reported as occurring in the Emergency Care Centre PCH at the Prince Charles Hospital (15).



3. Key Risks / Matters for Escalation

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

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

4. Assessment

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

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

5. Recommendation

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

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

6. Next Steps

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

Agenda Item
4.7

Quality, Safety & Experience Committee

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

Dyddiad y Cyfarfod / Date of Meeting	24th March 2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Jones- Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery & Patient Care

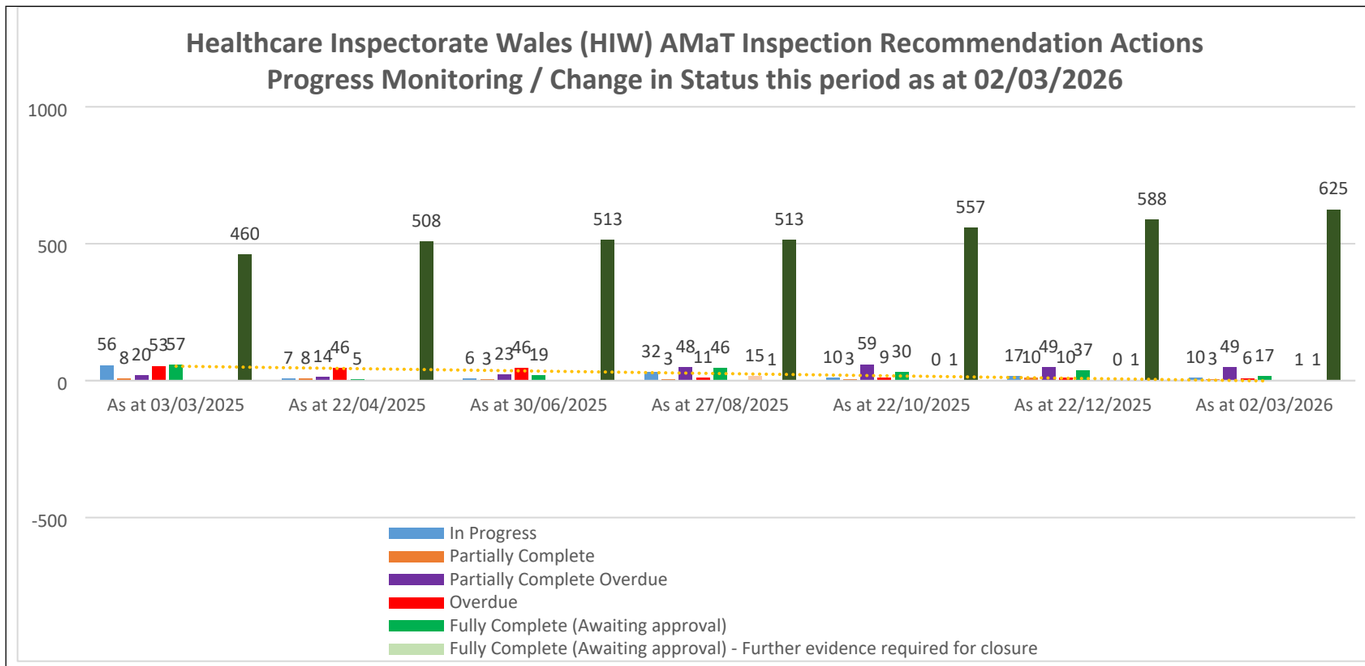
Pwrpas yr Adroddiad / Report Purpose	For Noting

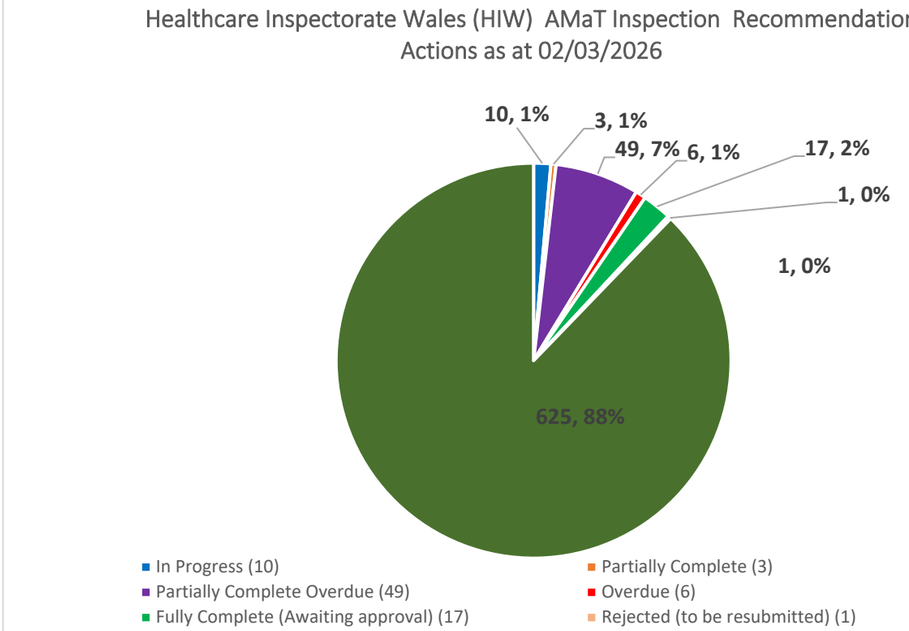
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	9th March 2026	

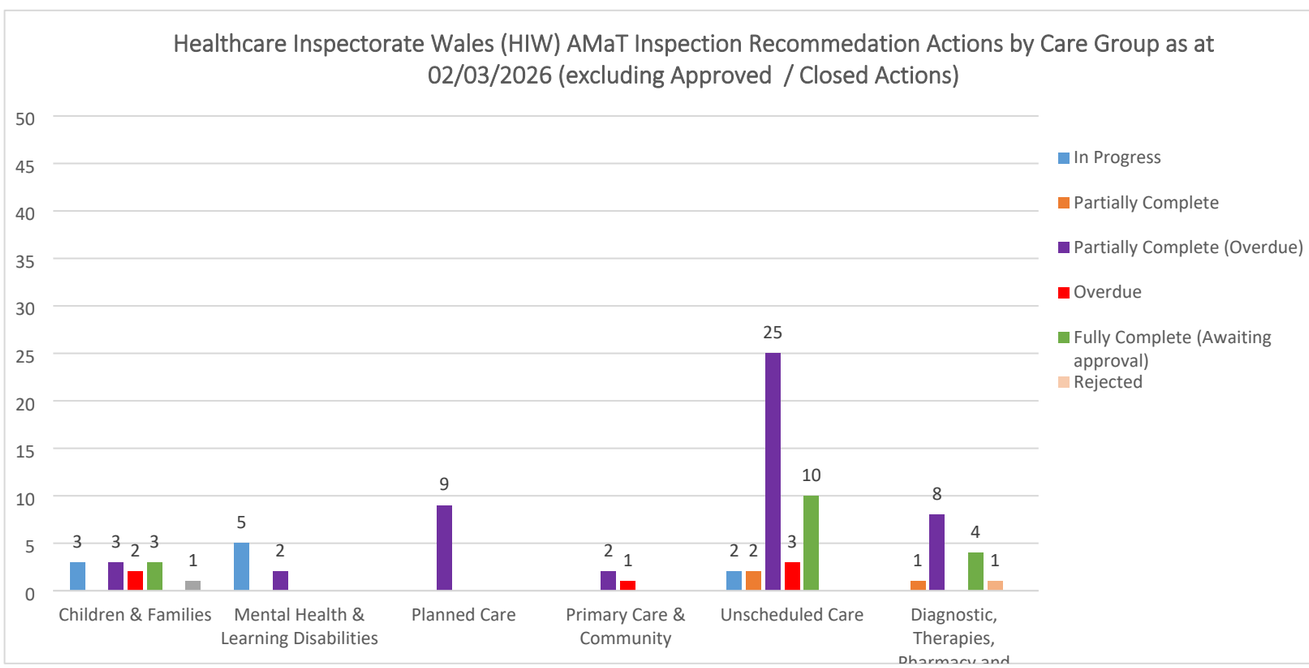
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales

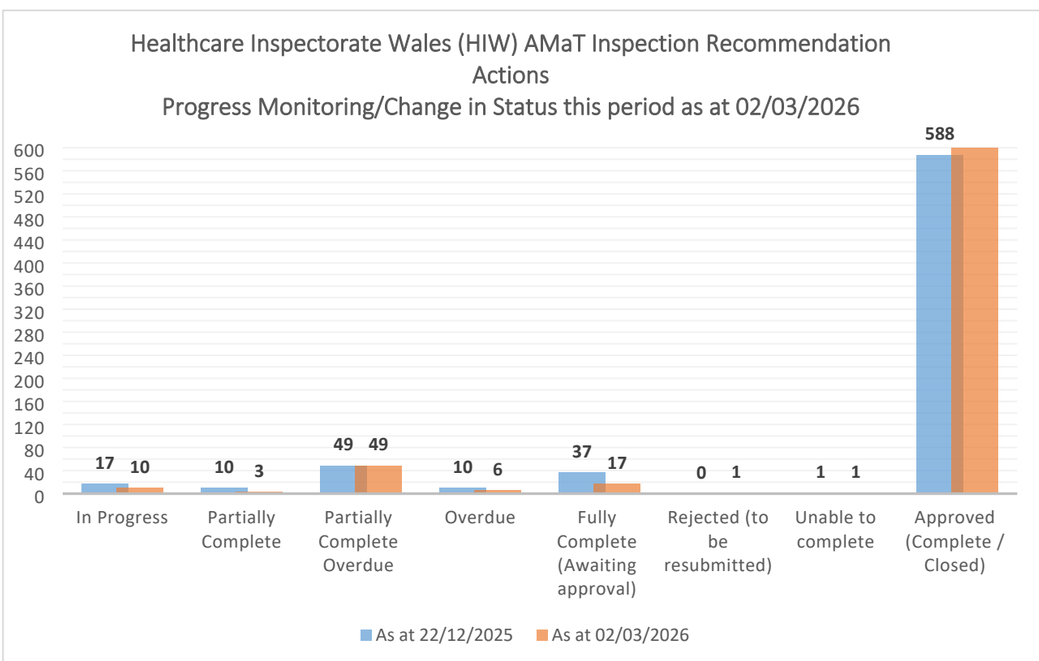
AMaT	Audit Management and Tracking

Compliance Dashboard









1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker (Appendix 1) of the accepted Improvement Plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 22nd December 2025 to 2nd March 2026.

2. Specific Matters for Consideration

2.1 There are no new development updates from AMaT noted by the team for this period that impact the Inspections module in terms of improving governance and assurance.

2.2 Positive progress has been noticed in reducing the numbers of overdue actions *(Graph 1 and 4).* Sustained efforts to address the partially complete overdue actions is suggested.

2.3 Engagement in providing updates for outstanding actions has been sporadic this period with some Care Groups needing increased levels of support. The Quality Assurance team have been offering further support via one-to-one emails and in offering further help and support via re-sharing of the step-by-step process guide. Care Groups are encouraged to contact the Quality Assurance Team if further support and training is required.

2.4 Ongoing cleansing of the current actions is required. The team will continue to engage with Care Groups and Inspection leads to review the original wording of the recommendation to assess whether the recommendation has been actioned appropriately to be closed. The team will continue to engage with the Care groups to reflect on the original recommendation/action.

2.5 A breakdown of the status position with regards to all actions up to the 2nd March 2026 is detailed below.

- A total of **712 actions** are reported with a further breakdown of the stages towards compliance reported in *table 1* located in the dashboard at the beginning of this report.

- Although there were no inspections marked fully complete this period, there has been progress made and **17 actions** have been marked as fully completed awaiting approval.

3. New Inspections / Actions

There were **0** new Improvement Plans and **0** new actions added for this period.

4. Key Risks / Matters for Escalation

4.1 The HIW actions tracker continues to use the live AMaT system with a continued targeted focus on actions where the action agreed due by date has passed or no update has been received. Sustained effort to reduce the number of partially complete overdue actions is required.

4.2 Care Groups are reminded that the process of using the AMaT system for the tracking and management of HIW Inspections requires a different level of governance and processing than what Care Groups may use in the clinical setting. Care Groups are encouraged to review the internal approval process and engage with the Quality Assurance and Compliance Team on how this aligns with the tracking and management process in place to ensure good governance is in place.

4.3 Regular and consistent updates are encouraged throughout each period to ensure updates are captured for each report. Inspection leads are reminded that when updating an action progress, it is always helpful to refer back to the original management action that was agreed as often it can be that the original ask has been completed and the action can close. It is evident that on some occasions there is a tendency to update based on the previous update which can lead to the original action being left open for longer than necessary.

4.4 The Quality Assurance and Compliance team continue to encourage Care group leads to engage in the AMaT process for Audits and Inspections whereby the approval process differs slightly to the AMaT programme used in the clinical setting allowing for more robust governance and assurance.

5. Assessment

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

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

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

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

6. Recommendation

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

7. Next Steps

7.1 The Quality Assurance and Compliance Team will send further reminders of the AMaT for governance process and continue to encourage engagement and offer support to Care Groups to focus on improving upon the regularity and quality of updates by bringing the focus of updates back to the original management action agreed in the Improvement Plan.

HIW Inspection Recommendations Tracker
Leads as at 02/03/2026

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group 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 (Interim DoN: Zoe Ashman)
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 (Interim DoN: Zoe Ashman)
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

In progress	Inspection action is in the process of being completed and has not yet reached the deadline.
Partially complete	Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.
Partially complete (Overdue)	Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.
Overdue	Inspection action deadline has been reached and no recommendations have been completed.
Fully complete (Awaiting approval)	Inspection actions have been fully completed and are waiting to be approved to be closed.
Rejected (To be resubmitted)	This Inspection action was submitted as Fully complete (Awaiting Approval) however more narrative is required to satify closure of the action and to provide assurance it has been completed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.
Unable to Complete	This action is unable to be completed.

HIW Inspections Recommendation Actions Tracker as at 02/03/2026
(for Quality, Safety and Experience Committee 24/03/2026)

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	31.12.2025	Partially complete (Overdue)	February 2026 Update - Escalated to Executive Director of Nursing, Midwifery & Patient Care and to Care Group DoN for an urgent update on the outstanding action, whilst noting that the roll out is expected end March 2026. December 2025 Update (19/12/25) - Working group established. On target to roll out by end of March 2026. Glaucoma already implemented. Next phase cataracts.
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 2026 Update - No update against this recommendation action has been received on this occasion. 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 cancelled	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	March 2026 Update - No update against this recommendation action has been received on this occasion. December 2025 Update (19/12/25) - FUNB list known. CYK recommendation agreed for those on PIFU / SOS. Retrospective application of CYK 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 2026 Update - No update against this recommendation action has been received on this occasion. 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 2026 Update - No update against this recommendation action has been received on this occasion. 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 2026 Update - No update against this recommendation action has been received on this occasion. 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 2026 Updates - No update against this recommendation action has been received on these occasions. August 2025 Update (27/08/25) - 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 hidemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. October 2025 Update (14/10/2025) - No further updates to provide.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HIW)/2017/141/MD21/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	March 2026 Update - No update against this recommendation action has been received on this occasion. 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 - Word 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 2026 Update - No update against this recommendation action has been received on this occasion. November 2025 Update (27/11/2025) - Head of Quality Assurance and Compliance email to Head of Nursing Primary Care & Community.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MD3/1	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete (Overdue)	February 2026 Update - Delay in signing off due to medic provision, this has been escalated with a view to conclude at next QSE. December 2025 Update - Plan to review and discuss with aim to complete end of January 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: 31233)]	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	February 2026 Update - Escalated to Executive Director of Nursing, Midwifery & Patient Care for review and guidance to ensure required action is completed. August 2025 Update - this action is unable to be completed - this matter has been escalated to the exec colleagues and was raised on the recent HIW inspection Aug 2025.
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: 3359)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales (HIW)/2023/134/MD2/1	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance:- ED •Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. •An 8a Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. •A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCSWs Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ILS and PILS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	February 2026 Update (19/02/2026) - improving trajectory, require a further summary for 24th February 2026. December 2025 Update - Emergency Department PCH: Basic Life Support (BLS) 78.57% Intermediate Life Support (ILS) 62.92% Advanced Life Support (ALS) 47.83 % (Band 7 and Band 6) Emergency Paediatric Life Support (EPLS) 60% Advanced Paediatric Life Support (APLS) -29% (Band 7) awaiting further course dates to be released Updated trajectory action plan to be uploaded by Jan 2026
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 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 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 ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/155/MD6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based SafeZZdart 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)	February 2026 Update (19/02/2026) - no change from November 2025 update. November 2025 - Update - no further update on dedicated pharmacist. However stroke specific pharmacy training and support to be provided internally via Dep Head of Pharmacy.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD11/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	February 2026 Update - await training compliance. November 2025 Update - FAST training for ED Reception teams to be coordinated and delivered by newly appointed Senior Nurse for Professional Development.
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 POH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	February 2026 Update - Improvement in Stroke flow and creating sufficient ring fenced capacity including weekends/out of hours. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 update - This action remains ongoing. Stroke inpatient services currently centralised at Royal Glamorgan Hospital. Stroke Service Redesign programme reviewing the full stroke pathway, including community / rehabilitation provision with bed modelling and workforce review to ensure that flow through the pathway is not blocked.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	February 2026 Update - Triage compliance monitored weekly as part of governance arrangements in ED targeting any areas for improvement. Discussed in performance & Assurance as well as CQSC. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Awaiting update from Clinical Director, Emergency Medicine re internal ED mitigations. Triage times and numbers of patients awaiting triage are noted on 3x daily FB conference calls. E-triage not currently implemented in any Health Board Emergency Departments.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	February 2026 Update - Being reviewed as part of the transformation work. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Review of stroke clinical workforce is included in the Stroke Service Redesign programme. Stroke services currently centralised at Royal Glamorgan Hospital with clinical teams combined to support one Acute Stroke Unit. New stroke consultant recently appointed and will start January 2026. CNS workforce also centralised at Royal Glamorgan Hospital to support emergency presentations and ward patients. The 3 CTM Emergency Departments continue to provide emergency stroke care. Stroke teaching is included in induction programmes for ED resident doctors.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	February 2026 Update - ACP currently 6 day service. Working on 7 day service as part of the transformation work. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 - Stroke Services currently centralised at the Royal Glamorgan Hospital. CNS Stroke Workforce currently centralised too. CNS workforce being reviewed as part of the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	February 2026 Update - No change. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - remains ongoing with digital team as per August 24 update. August 2024 Update - remains ongoing with digital team - Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.
Healthcare Inspectorate Wales (HIW)/2023/155	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 LSC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	October, December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Clinical Director, Emergency Medicine
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the LSC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	October, December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Clinical Director, Emergency Medicine.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD22/1	The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	February 2026 Update - Stroke Improvement Programme: •Focused KPI improvement work continues at RGH – time to CT and time to Stroke Unit. •Daily multidisciplinary huddles with review of all stroke presentations – breach reasons and actions agreed. •SOP to support clinical pathway. •CNS based in ED 6/7. •Daily and weekly performance reporting. Q3 Internal CTM Performance target for RGH Phase 1: •80% of CT scans within 45 minutes •60% admissions to ASU within 4 hours October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Time to CT Scan KPI is now 20 minutes. Performance against this KPI is reported via Stroke Operational Group to Stroke Performance Board. Current improvement programme in progress to identify any delays to scan and process map patient journey to CT scan with involvement of all key stakeholders.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD25/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	February 2026 Update - Consultant recruitment in place fully including a new Neurologist who will support the on-call rota. Stroke Improvement Programme: •Focused KPI improvement work continues at RGH – time to CT and time to Stroke Unit. •Daily multidisciplinary huddles with review of all stroke presentations – breach reasons and actions agreed. •SOP to support clinical pathway. •CNS based in ED 6/7. •Daily and weekly performance reporting. Q3 Internal CTM Performance target for RGH Phase 1: •80% of CT scans within 45 minutes •60% admissions to ASU within 4 hours October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Thrombolysis guideline has been updated nationally to 30 minutes (following CT scan within 20 minutes). Performance against this target is monitored monthly and reported via Stroke Operational Group to Stroke Programme Board. Current improvement work reviewing this key metric with all key stakeholders engaged.

HIW Inspections Recommendation Actions Tracker as at 02/03/2026
(for Quality, Safety and Experience Committee 24/03/2026)

Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	February 2026 Update - Stroke Improvement Programme: •Focused KPI improvement work continues at RGH – time to CT and time to Stroke Unit. •Daily multidisciplinary huddles with review of all stroke presentations – breach reasons and actions agreed. •SOP to support clinical pathway. •CNS based in ED 6/7. •Daily and weekly performance reporting. Q3 Internal CTM Performance target for RGH Phase 1: •80% of CT scans within 45 minutes •60% admissions to ASU within 4 hours October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Work continues to improve 4 hour performance. Stroke inpatient services are currently centralised at Royal Glamorgan Hospital and improvement work ongoing to support improvement in 4 hour performance with process mapping and key stakeholder involvement. Dedicated ambulance transfer vehicle commissioned for clinical transfers from PCH / POW to RGH to support transfer for emergency patients to Royal Glamorgan Hospital. 4 hour performance measured and reported at Stroke Operational Board and Stroke Programme Board. 4 hour performance included within Stroke Service Redesign programme as KPI for acute patient pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025, March 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)	February 2026 Update - No Change. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Following the temporary relocation of stroke services the therapy workforce has been reviewed and an investment proposal has been submitted as part of the IMTP process, the outcome of which is awaiting. This is linked to recommendation 38 regarding the need for funded 7 day service.
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)	February 2026 Update - No Change. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - due to critical incident and urgent service move, Stroke Services now currently centralised at Royal Glamorgan Hospital. There is currently no psychology support for stroke patients across the Health Board. The lack of psychology support is noted on the corporate risk register (risk ID 4632). 0.6 wte Neuropsychology post currently advertised. This will support stroke services. The need for psychology support will be included in the workforce review as part of the Stroke Service Redesign programme.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	February 2026 Update - No Change. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - CTM UHB continues to offer a 5 day clinical model. The Health Board aim is to provide a 7 day clinical model to support patient outcome and experience. Workforce requirements to support this are being identified as part of the Stroke Service Redesign programme and will require investment as the current workforce is unable to support 7 day working.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	February 2026 Update - Rehabilitation is being reviewed as part of the overall CTM stroke transformation work. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Inpatient acute stroke services currently centralised at Royal Glamorgan Hospital. Dedicated therapy bay established within the Acute Stroke Unit for use by all therapists. Community hospital provision - 8 funded stroke specific rehabilitation beds at Ysbyty Cwm Rhondda (ability within current workforce to flex up to 14 patients if required). Stroke Service Redesign programme reviewing workforce model and optimum patient pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the 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)	February 2026 Update - Work ongoing and discussed in monthly Integrated Discharge meetings, compliance monitored (a clear KPI as part of Optimise). October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Primary & Community Care Group DM.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	February 2026 Update - partially progressed, supported patient discharge flow Dec, Jan and Feb 2026. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Primary & Community DM.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD41/1	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	February 2026 update - Hospital @ Home has progressed partially and supported during Dec, Jan and Feb 2026. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - awaiting update from Primary & Community DM
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD42/1	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	October, December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Partially complete (Overdue)	February 2026 Update - No Change. No formal discharge lounge in PCH or RGH but a surge area created over winter months to support patients waiting discharge and facilitate patient flow to inpatient wards. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Stroke inpatient services currently centralised at Royal Glamorgan Hospital. There is currently no discharge lounge at RGH but feasibility is being considered as part of patient flow / capacity discussions to support the ambulance handover performance targets. Potential requirement for capital investment and funding for specific workforce.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD44/1	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	February 2026 Update - No change. October, December 2025 Update - No update against this recommendation action has been received on these occasions. August 2025 Update - Patient discharge manually updated on whiteboards by ward staff. Currently no progress with 'push report' functionality.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	Overdue	February 2026 Update (19/02/2026) - update remains unchanged, as at October 2025. October 2025 Update - capital work is still ongoing and PCH major construction works are continuing. Welsh Government funding continues to be explored, which will facilitate improved patient clinical areas allowing for improved patient and staff experience. .
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/6	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	February 2026 Update (19/02/2026) - No change to October 2025 update. October 2025 -pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care has been implemented. This reinforces that patient flow is a team approach across the site. The plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area are ongoing. Capital environmental works remain ongoing across the site.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/7	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	Overdue	February 2026 Update (19/02/2026) - No further update as advised in October 2025. October 2025 Update - no change to action - part of ongoing capital plans. We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DoLS (CDU) training.	Healthcare Inspectorate Wales (HIW)/2023/167/MD29/1	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug'23 fire training for staff is as follows:- ED-RN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	February 2026 Update - This action can be finally approved as completed, advised in October 2025. October 2025 Update - ED Fire Training Compliance Registered Nurses - Department Training - RNs 94% and HCSWs 90% Classroom Training - RNs 90% and HCSWs 88% CDU (now AMU) Fire Training Compliance - RNs 100% and HCSWs 100%
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD30/1	Monthly mandatory training study days and reports now include V & A, DoLs, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration-action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	February 2026 Update - action can be closed as completed. October 2025 Update - Violence and aggression training compliance AMU - (Module A ESR) - RN - 100% HCSW - 100%, Module B Classroom - RN 16% Has -10% Awaiting training dates from Violence and Aggression Training Teams Violence and aggression training compliance ED RN - 75% HCSW - 84%% MCA training compliance AMU RN - 59% HCSW - 87% Awaiting training dates from Training Teams MCA training compliance ED - RN - 48% HCSW - 80% Safeguarding training compliance AMU (Adult) - RNs -100% HCSWs -96% (children) RN -100% HCSWs - 89% Safeguarding training compliance ED (Adult) - RNs - 80% HCSWs -92 % (children) RN - 94% HCSWs -89% Jove within the next 3 months.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	June, August, October, December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. March 2025 Update - Meetings planned to revisit this work for PCH and PoW in March 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits of attracting staff to CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	June, August, October, December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. March 2025 Update - Mat-Neo services in PoW has now re-opened - Will revisit this work , contact made with recruitment to meet in April 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	June, August, October, December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. March 2025 - There have been challenges with attendance in Safe to Start meetings during the PoW temp closure due to the acuity and timing of the sessions which clash with handover and essential safety briefings in maternity. this will be revisited in a meeting arranged for 25th 2025, Senior on-call midwifery managers attend daily and weekend site escalation meetings.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	5. The health board must develop a policy in line with best practice guidelines that ensures the safety, privacy, dignity and rights of patients can be maintained throughout the mixed gender wards as well as keeping patients of the same gender safe in dormitories.	Healthcare Inspectorate Wales (HIW)/2024/235/MD5/2	The Health Board has developed a Single Sex accommodation policy. The draft version Is currently going through the Health Board's ratification process.	Mental Health & Learning Disabilities	30.04.2025	31.03.2026	In progress	March 2026 Update - No update against this recommendation action has been received on this occasion. December 2025 Update - New revisited date of completion 31/03/ 2026 .
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	7. The health board must develop a policy to provide guidance to staff regarding patients' use of electronic equipment, mobile phone devices and access to the internet.	Healthcare Inspectorate Wales (HIW)/2024/235/MD7/1	There is an all Wales Social Media Policy and a Health Board policy that supports use of mobile phones within hospital settings. Both policies are out of date. A request has been made to update the Health Boards policy.	Mental Health & Learning Disabilities	30.06.2025	31.03.2026	In progress	March 2026 Update - No update against this recommendation action has been received on this occasion. December 2025 Update- Revised date 31/03/2026.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	9. The health board must ensure that a mental health pharmacist is allocated to the ward to support staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD9/1	Pharmacy provision to form part of the wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. The mitigation includes; Ysbyty Cwm Cynon pharmacy teams screen medication charts and supply medication to the wards and the Principle Pharmacist for Mental Health supports the ward on an ad hoc basic with reviewing medication incidences.	Mental Health & Learning Disabilities	31.12.2025	31.12.2025	Partially complete (Overdue)	March 2026 Update - No update against this recommendation action has been received on this occasion. December 2025 Update - Ward 7 YCC, now have Pharmacy support. Pharmacist visits the ward weekly. Pharmacy technician visits the ward daily Monday to Friday. The ward is also able to contact Pharmacy and have support for any urgent issues. completed and evidence attached needs sign off at next QSE meeting in January.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	11. The health board must ensure that a dietician is allocated to the ward to support staff and meet the needs of the patients.	Healthcare Inspectorate Wales (HIW)/2025/241/MD11/1	Dietetic provision to form part of wider strategic programme on Older Adult inpatient redesign work. The risk remains on the risk register with mitigation appropriately in place. Mitigation includes; all patients have a risk assessment which determines the level of risk. There is a scoring mechanism in place from 0-7+ based on nutritional risk. If the score is 7+ then the patient requires referral to Dietetic service. In this scenario the Advanced Nurse Practitioner (ANP) or Doctor also prescribe supplements, advise on diet plan and nursing staff would complete weekly weights.	Mental Health & Learning Disabilities	31.12.2025	31.03.2026	In progress	March 2026 Update - No update against this recommendation action has been received on this occasion. December 2025 Update - Inpatient redesign will look at inequities across the region with regards all AHP provision. Extended completion date 31-3-26
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	12. The health board must ensure that policies are reviewed to ensure they are current.	Healthcare Inspectorate Wales (HIW)/2025/241/MD12/1	The policies identified within the inspection that were; Mental Health policies • Management of violence and behaviours that challenge, no review date (this has been completed) Corporate / Health Board policies • Health and safety policy, review date August 2024 • Consent to examination or treatment, review May 2024 • Policy for safe support and supervision of patients, review date October 2018 • PPE, review date March 2021 The Health Board is undertaking a policy review project this year with the scope and objectives as outlined below: Project Scope To undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. This review will focus on Non-Clinical Written Control Documents, however, at appropriate intervals there will be engagement with the Assistant Medical Director Quality & Clinical Effectiveness, who leads on Clinical Written Control Documents to ensure consistency and flow. Project Objectives: 1. To establish a baseline compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. 4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents. To review the "Policy on Policies" and develop a simplified document supported with clear process maps.	Mental Health & Learning Disabilities	31.12.2025	31.03.2026	In progress	March 2026 Update - No update against this recommendation action has been received on this occasion. December 2025 Update - Revised completion date 31-3- 26.
Healthcare Inspectorate Wales (HIW)/2025/241	27.01.2025	Appendix C - Improvement Plan_ Ward 7, Ysbyty Cwm Cynon Hospital	13. The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HIW)/2025/241/MD13/1	It has been agreed that a priority for the Older Adult Mental Health Directorate is to complete a pan CTM inpatient redesign review which will scope a widespread multi-disciplinary establishment review.	Mental Health & Learning Disabilities	31.12.2025	31.03.2026	In progress	March 2026 Update - No update against this recommendation action has been received on this occasion. December 2025 Update - Staffing establishment will be reviewed through inpatient redesign and in line with CTM establishment review. Date extended 31-3-26
Healthcare Inspectorate Wales (HIW)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	The employer must ensure that: •The current DRLs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HIW)/2025/261/MD2/3	CTM DRL group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRLs. The DRL group will feed into CTM image optimisation team and radiation safety committee.	Diagnostic, Therapies, Pharmacy and Specialities	05.06.2025	05.06.2025	Partially complete (Overdue)	October, December 2025, March 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)	2. The employer must ensure that training and competency is evidenced prior to duty holder entitlement.	Healthcare Inspectorate Wales (HIW)/2025/264/MD2/1	Review existing practitioner and operator duty holders training and competency evidence. Ensure that practitioner and operator training and competency prior to entitlement is assessed for specific tasks e.g. Cardiologists practitioner training to justify imaging in theatre. Duty holder competency will be assessed by ongoing referral form audit i.e. accurate completion of request form; signature, adequate clinical information, date.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. October 2025 Update - Documentation ready for sign off, awaiting training records as evidence.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	6. The employer must ensure that the non-medical referrers who were clinically evaluating are appropriately entitled and that the entitlement is supported by relevant training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD6/2	Scope of practice for clinical evaluation and entitlement by Radiology CD will be sent to existing NMRs on receipt of evidence of training and competency. Policy for NMRs will be updated to include entitlement for clinical evaluation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	Complete November 2025. October 2025 Update - Scope of practice sent. NMR policy to be updated.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/2	Retrospective audit of CT forms justified by a Radiographer to ensure exposures have been justified appropriately.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Fully complete (Awaiting approval)	Complete October 2025. October 2025 Update - Discussion required as to audit approach.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/3	To be discussed at CT modality user group meeting, pan-CTM to clarify justification or authorisation process for Radiographers.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	Complete November 2025. October 2025 Update - CTMUHB CT user group to meet November 2025.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	7. The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD7/4	If authorisation as an operator is agreed, guidelines will be issued by an individually named practitioner. Authorisation agreed - practitioner named and documents displayed.	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	Rejected (To be resubmitted)	October, December 2025, March 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)	8. The employer must ensure that individuals outside radiology performing practitioner and operator tasks are appropriately entitled. The entitlement should be underpinned with the appropriate training and competency.	Healthcare Inspectorate Wales (HIW)/2025/264/MD8/1	Review duty holder entitlement outside of Radiology. Identify any gaps and entitle, where appropriate, following confirmation of training and competency.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Partially complete (Overdue)	December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. October 2025 Update - Documentation complete, awaiting evidence of training before entitlement sign off.

HIW Inspections Recommendation Actions Tracker as at 02/03/2026
(for Quality, Safety and Experience Committee 24/03/2026)

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 Specialties	31.10.2025	31.10.2025	Partially complete (Overdue)	October, December 2025, March 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)	15. The employer must review the gaps in the QC records and the inconsistencies in baselines between the policy and manufacturer recommendations.	Healthcare Inspectorate Wales (HIW)/2025/264/MD15/2	Meeting with MPEs to review baselines and manufacturer recommendations. Will review policy and amend. Ongoing	Diagnostic, Therapies, Pharmacy and Specialties	29.07.2025	29.07.2025	Partially complete (Overdue)	October, December 2025, March 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)	18. The employer must ensure that staff are reminded of the intellectual task of justification and exposure and how this differs to authorising under authorisation guidelines.	Healthcare Inspectorate Wales (HIW)/2025/264/MD18/1	CPD session to be delivered on changes to employers procedures to include the difference between justification and authorisation.	Diagnostic, Therapies, Pharmacy and Specialties	30.09.2025	30.09.2025	Partially complete (Overdue)	December 2025, March 2026 Update - No update against this recommendation action has been received on these occasions. October 2025 Update - To be scheduled.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	19. The employer must ensure that: • The MRI 'putting things right' leaflets are also available in Welsh in the reception (H&CD) – Communication and Language) • The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.	Healthcare Inspectorate Wales (HIW)/2025/264/MD19/3	Feedback Friday to be implemented i.e., staff will actively ask patients to give feedback. Once feedback has been gathered 'you said, we did' board will be displayed.	Diagnostic, Therapies, Pharmacy and Specialties	31.08.2025	31.08.2025	Partially complete (Overdue)	March 2026 Update - New patient feedback system being launched. December 2025 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20. The department must continue to highlight the business case to the employer and ensure that a decision is made in a timely manner.	Healthcare Inspectorate Wales (HIW)/2025/264/MD20/1	A case has been submitted for additional radiography staff that supports the future workforce model and demand as part of the IMTP investment priorities for 2025-26 across the sites. This will continue to remain the priority for Radiology. To date, no source of funding has been identified. Additional staff have been rostered out of hours at RGH temporarily while services from POW are temporarily relocated.	Diagnostic, Therapies, Pharmacy and Specialties	30.04.2026	30.04.2026	Partially complete	February 2026 Update - Business complete.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/9	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Wellbeing champions to be established.	Diagnostic, Therapies, Pharmacy and Specialties	31.07.2025	31.07.2025	Partially complete (Overdue)	February 2026 Update - Chaired all sites again. October 2025 Update - Scoped well being champion role - staff to be appointed.
Healthcare Inspectorate Wales (HIW)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.	Healthcare Inspectorate Wales (HIW)/2025/264/MD22/11	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Preceptorship programme to be developed for Band 7 team leaders.	Diagnostic, Therapies, Pharmacy and Specialties	31.12.2025	31.12.2025	Fully complete (Awaiting approval)	February 2026 Update - Complete.
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 positionally.	Healthcare Inspectorate Wales (HIW)/2025/276/MD2/1	All Wales self-administration policy is currently distributed for comment, once ratification the organisation will support implementation.	Children & Families	30.04.2026	30.04.2026	In progress	December 2025, March 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	In progress	March 2026 Update - work has started however, some delays have been experienced due to media resources availability. In view of media resources delay due change amended. 15 steps challenge completed in PoW to ensure patients perspectives have been completed, action plan attached and all actions completed. Information on how to access the unit is shared community midwives in the interim. Following the reopening f POW hospital signs are now in place.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	6. Fully implement BSOTS, including dedicated telephone advice lines, comprehensive staff training, and consistent triage processes.	Healthcare Inspectorate Wales (HIW)/2025/276/MD6/2	Staff to receive BSOTS training.	Children & Families	30.11.2025	30.11.2025	Fully complete (Awaiting approval)	December 2025 Update - all core staff in MPU have received BSOTS training.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	6. Fully implement BSOTS, including dedicated telephone advice lines, comprehensive staff training, and consistent triage processes.	Healthcare Inspectorate Wales (HIW)/2025/276/MD6/4	Undertake data collection and complete clinical audit to monitor compliance of BSOTs.	Children & Families	28.02.2026	28.02.2026	Fully complete (Awaiting approval)	March 2026 Update - Completed action. BSOTS audit complete and demonstrated 90% adherence to BSOTS. over 90% of women in PoW were seen within 15 mins of arrival. clinical audits will continue to ensure compliance.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	8. Review and address any outstanding theatre estates concerns and theatre staffing levels and skill mix.	Healthcare Inspectorate Wales (HIW)/2025/276/MD8/2	Undertake Birthrate Plus workforce review.	Children & Families	31.01.2026	31.01.2026	Fully complete (Awaiting approval)	March 2026 Update - Birth rate plus report now complete. Business case in development, currently in draft - action changed to complete as commissioned report completed, however, business case yet to be presented at DMB.
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	30.04.2026	In progress	March 2026 Update - due date extended, unable to complete due to the implementation of badgerNet. 'go live' date for CTM is 17/3/26. all digital priority remains on badgerNet currently, therefore due date extended after implementation date. In the interim, the service has created a teams channel to support information sharing. SCBU SharePoint page has now been completed and feedback from staff is positive.
Healthcare Inspectorate Wales (HIW)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	12. Ensure that established investigation processes are implemented consistently when needed.	Healthcare Inspectorate Wales (HIW)/2025/276/MD12/1	The Maternity Governance team to undertake an engagement event to celebrate the rebranded title of – quality assurance team.	Children & Families	31.01.2026	31.01.2026	Overdue	March 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.
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	Overdue	March 2026 Update - Assist Me Back completed in draft. Document shared for comment and due to be prewarded at the next SWAG meeting in March.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	2. The health board should ensure that staff remain mindful of the need to actively engage with certain patients / patient groups when time permits.	Healthcare Inspectorate Wales (HIW)/2025/277/MD2/1	CTMUHB acknowledges the findings and the importance of ensuring that all staff are mindful of the needs to ensure engagement with all patients. We recognise that effective communication and engagement are crucial to providing patient centred care to promote positive outcomes. Ensuring our patients are actively engaged with is a whole team approach. Patient feedback is gathered on a weekly basis where feedback is collected and reviewed. Feedback from both service users and carers is utilised to support service and environmental improvements. All staff are regularly reminded to introduce themselves to patients, informing them of their name and their role and to repeat this information regularly as needed. "You Said", "We Did" promotes an inclusive culture and engagement with all patient groups, the CTMUHB Patient Experience group are reviewing this information with a view to clearly displayed it within the department. The ED has been supported by a volunteer group over the past 18 months. Under nursing direction, the team undertake shift working to support peoples experience within in the ED. Volunteers may carry out a combination of the tasks listed below as required: • Provide support and companionship for patients. • Support patients to contact relatives and loved ones either using patient's personal device, CSCO phone or tablet where appropriate. • Support staff by liaising with patients relatives and friends by other departments within the hospital. • Provide refreshments for patients (with staff guidance, checking for any allergies or diet/liquid restrictions) • Help at mealtimes to hand out food and drinks, check cutlery and utensils are suitable for patients, clear away etc. and fill up water jugs. • Check in on patients and visitors in waiting areas. • Replenish stock. • Direct, and accompany where appropriate, patients/visitors to other areas of the hospital (not where patients require a clinical escort). • Encourage and assist patients and family/friends to complete feedback survey. The Department has use of the Reminiscence Interactive Therapy Activities (RITA) system for patients attending the ED. This is digital tablet-based therapy tool for patients with Dementia, cognitive impairment, and other conditions. The RITA system provides music, games, films, photos and historical news to stimulate memories, promote engagement and helps to reduce anxiety and agitation. The ED has improved training compliance in undertaking Equality and Diversity online training compliance is currently 88%. Targeted area to improve training compliance by January 2026. Additional Information: • Raise further awareness to staff of the RITA system. A written memo will be completed to share widely with our teams. • Develop a patient experience group within the ED to promote quality improvements towards the experience for our patients. • FCH ED has shared the Dementia improvement work undertaken there with RGH to promote shared learning and commence plans to implement improvement work undertaken.	Unscheduled Care	31.01.2026	31.01.2026	Partially complete (Overdue)	February 2026 Update - All actions completed, can be finally approved. January 2026 Update - - memo to be uploaded to provide evidence communication of raising awareness of the RITA system. Will add document to action - update required from Senior Nurse regarding patient experience group meeting - Provide update of Dementia Training compliance
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	3. The health board should explore the availability of washing or showering facilities for patients who are accommodated in the ED for significant periods of time, or whose medical condition / presentation might necessitate it.	Healthcare Inspectorate Wales (HIW)/2025/277/MD3/1	Cwm Taff University Health Board recognises the current unavailability of washing and/or showering facilities within the ED. All patients attending the ED are offered wash facilities by the way of disposable wash bowls, individual soap sachets also providing a stock of toothbrushes, toothpaste and hair combs. For our patients who are accommodated in the ED for a longer period of time, we have explored departments located around the ED to identify facilities which may be considered as an available option to our patients. The Radiology Department which is adjoined to the ED has showering facilities. Since the HIW visit, we have discussed the option of the use of the showering facilities with radiology colleagues who have confirmed that showering facilities within the radiology department can be utilised. This agreement enables staff to offer suitable patients to access washing and showering facilities during their stay within the ED. - Environmental audit / risk assessment of washing facilities to ensure suitable for patients. - Review staffing allocations where patients may require supervision or support with personal care. Additional Information: • Share the above agreement with the nursing team to raise awareness of accessible facilities for our patients who can be offered to shower during their stay at ED.	Unscheduled Care	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	January 2026 Update - Information Memo complete. Memo to be updated to documents. December 2025 Update - Agreement arranged with the radiology department regarding use of showering facilities. Memo to be uploaded.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	4. The health board must continue to be highly cognisant of the footprint of the department and its ability to remain fit for purpose in the context of current demand, capacity and usage.	Healthcare Inspectorate Wales (HIW)/2025/277/MD4/1	CTMUHB recognises the requirement to continually the ED footprint and its ability to remain fit for purpose in the context of current demand and capacity. Following service reconfiguration as a result of the Critical Incident in Princess of Wales Hospital, a comprehensive review of the current ED footprint will be required to ensure it aligns with evolving service needs. This review should consider patient flow, workforce requirements, infrastructure limitations, and future growth projections to ensure the department remains responsive, safe, and sustainable.	Unscheduled Care	31.03.2026	31.03.2026	In progress	January 2026 Update - Ongoing discussions - for IMTP. December 2025 Update - Ongoing discussions - for IMTP.
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	5. The health board must ensure that the length of time a patient in seated for is appropriate in the context of the patient criteria and clinical need.	Healthcare Inspectorate Wales (HIW)/2025/277/MD5/1	CTMUHB recognises that assurance must be provided to acknowledge the importance of ensuring that patients sitting in chairs are appropriate in the context of clinical need and are not in chairs for extended periods of time. To address this, a 12-hour action card is being developed, in its infancy stages, to identify and support prioritisation of patients who have been within the department in excess of 12 hours which can include prompts to review the length of stay experienced within a chair and prioritisation for a suitable flat space. The nursing team including a newly developed role of the 'Helicopter Nurse' will conduct regular assessments of patients in chairs to determine appropriateness and highlight patient prioritisation. The NIC ensures appropriate escalation, ensuring daily discussions as part of the formal "Safe to Start" meetings undertaken at 08:00 hours and 14:30 hours, recognising risk to patients, risk of pressure damage and patient experience. The number of patients waiting in chairs is also highlighted at the three daily HB conference calls. Recent patient experience improvement work has been undertaken to offer suitable patients ear plugs and eye masks within busy fit to sit areas to promote rest and sleep. The ED utilises Reprose pressure relieving aids which are offered to patients who are identified as at risk of developing pressure damage. The ED huddles which occur 3 times daily include focus on patient safety and quality, which includes escalation for patients who are seated for prolonged length of time and who are at risk of developing pressure damage. A recent Pressure Ulcer prevalence audit has been undertaken within the ED where feedback has been presented. The audit recognises the requirement to continue to supply a sufficient stock of reprose pressure relieving cushions for our patients who are seated in chairs. Next Steps: • In addition to the steps already undertaken an amendment will be made to the ED Safe to Start proforma to include details of patients who have spent a prolonged wait in a chair. The 4-hour performance metric should support the reduction in length of time waiting in chairs and this needs to be supported by effective patient flow out of the Emergency Department.	Unscheduled Care	31.10.2025	31.10.2025	In progress	January 2026 Update - - Safe to Start proforma updated to include chair waits - electronic safety huddle implemented Dec 2025. December 2025 Update - - S2S proforma updated including patients who have spent a prolonged wait in chair which is discussed as a priority at S2S - prolonged waits included in ED safety huddle reporting - electronic safety huddle commences launch 15th Dec 2025. This will provide facilitation of communication, improve situational awareness, and enhance patient safety and operational awareness highlighting long wait in ED
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	6. The health board must consider the recommendations of RCEM (December 2020) regarding security and restraint and ensure that ED staff can access a consistent site security presence.	Healthcare Inspectorate Wales (HIW)/2025/277/MD6/1	CTMUHB acknowledges the findings regarding the requirement to ensure consistent access to on site security presence. The ED regularly receive Violence and Aggression (V&A) Modules B - Personal Safety & De-escalation and Module C - Breakaway & Escape Techniques. Historically CTMUHB Emergency Departments have not been trained in Module D - Physical Restraint Techniques (PMVA) and the onsite security team are trained to assist with restraint. Since the introduction of Right Care Right Person by South Wales Police, ED staff cannot guarantee support from South Wales Police to attend incidents of violence. Datix incident analysis over the past few years shows security porters have been required to manage restraint incidents without back up support from South Wales Police. There are two security porters available to manage violence at any given time and this is to support the hospital site. Next steps: The facilities team are currently undertaking a review of the security team establishment and a training needs analysis to support the increase of security availability at the hospital site. The facilities team are undergoing improvement work to review the current establishment of the security team and implement a training plan for PMVA training.	Unscheduled Care	31.03.2026	31.03.2026	In progress	January 2026 Update - - facilities team progressing the review of the security team with a view to increase establishment for cross-site security support - Task and Finish Group commenced with a plan to review training and develop a training package. Meeting includes Security, Facilities, Safeguarding and Corporate Nursing Education. Training will focus on how to support, team lead, and advocate for adult and child patients who require restraint with appropriate escalation and de-escalation. -A training package will be developed to allow staff to advocate for the patient during those times - plan to work towards the training package by April 2026 - Senior Nurse for Education in ED will be co-chairing the task and finish group to create this package of training. December 2025 Update - - facilities team progressing the review of the security team with a view to increase establishment for cross-site security support - training analysis being supported by Violence and Aggression Case Manager including the safeguarding team and ESDs to implement a training plan for PMVA training
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	8. The health board should replace torn seating to maintain effective cleaning and IPC standards.	Healthcare Inspectorate Wales (HIW)/2025/277/MD8/1	CTMUHB recognises the importance of ensuring that all equipment and seating are maintained effectively to ensure effective cleaning and adhering to IP&C standards. We recognise that torn or damaged seating can pose a risk to IP&C and compromise the cleanliness of the department. A walk-through in the department has been undertaken on the 24th September 2025 by the ED Band 7 management team to identify both condemned and torn seating. This enables us to prioritise the replacement or repair of our chairs. AMaT audits are undertaken which incorporates IP&C environmental audits to ensure regular maintenance of our chairs are implemented to enable us to efficiently address damaged or torn seating. Next Steps: • Received quote for new chairs to replace condemned furniture. This quote has been submitted for approval.	Unscheduled Care	31.10.2025	31.10.2025	Fully complete (Awaiting approval)	January 2026 Update - - New chairs arrived and installed on 12/2/2026 - condemned chairs have been removed December 2025 Update - - quote received - order submitted via Oracle. - awaiting update of authorisation to progress with order
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	9. The health board must ensure that staff accurately assess and document pressure and skin tissue damage in clinical notes.	Healthcare Inspectorate Wales (HIW)/2025/277/MD9/1	CTMUHB acknowledges the importance of providing assurance that staff assess and document pressure and skin tissue damage. The nursing team are able to provide assurance of awareness that a skin assessment must be undertaken within 6 hours of arrival as per Health board policy. The ED Nursing documentation includes relevant risk assessments and documents to allow contemporaneous documentation following a skin assessment. This includes initial skin assessment with body map, Purpose T assessment and repositioning charts. The role of the 'Helicopter nurse' is to undertake documentation checks which is documented within a checklist on the back of the ED nursing pack to support live auditing and timely actions to be undertaken. As addressed previously, a recent Pressure Ulcer prevalence audit has been undertaken within the ED and feedback has been presented. Should an incident occur relating to Pressure, ED attends the pressure assurance panel which runs weekly. The Pressure Ulcer Prevention Champion collates lessons learned following panels to include within the training programme as described in next steps. The ED displays a Governance Board on the main corridor of the ED which includes incident reporting data, lessons learned, learning from excellence and trends identified. Current ED training compliance for Pressure Ulcer Training is 71%. A trajectory of improvement of training compliance has been made. The Band 7 Practice Development Nurse (PDN) will work alongside the ED Pressure Ulcer Prevention Champion to target training compliance improvement by December 2025. Next Steps • The audit recognises the requirement to update the ED nursing documentation pack to include a formalised care plan which has been supported by our Tissue Viability Nursing (TVN) team. The updated ED nursing pack is currently in draft and with a view to implement across the 3 ED's in CTMUHB. The ED has recently supported the enthusiasm of Band 6 RN to become the ED Pressure Ulcer Prevention Champion who is currently working on an internal training programme collaboratively with the TVN to incorporate education, the good work being undertaken and areas for improvement.	Unscheduled Care	31.12.2025	31.12.2025	Fully complete (Awaiting approval)	February 2026 Update - All actions complete (January update by Lead Nurse DS), await final approval. January 2026 Update - - Updated ED nursing pack working through final stages to agree and roll out across the 3 sites
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	10. The health board must ensure that multifactorial risk assessments and relevant care plans are completed promptly when identified as necessary.	Healthcare Inspectorate Wales (HIW)/2025/277/MD10/1	CTMUHB recognises the importance of completing multifactorial risk assessments and care plans in a timely manner to ensure that our patients receive the highest quality of care which is patient centered. We recognise the importance in completing these assessments and plans to promote patient safety. The ED nursing documentation pack includes relevant risk assessments and care plans to support our patients. To ensure that our assessment processes are efficient, effective and timely, we are planned to undertake a review of the current ED nursing pack across the 3 EDs in CTMUHB. Following a review and implementation of the updated ED nursing pack, we will ensure nursing staff are trained and competent to complete the multifactorial risk assessments. As identified previously, the role of the 'Helicopter nurse' is to undertake documentation checks which is documented within a checklist on the back of the ED nursing pack to support live auditing and timely actions to be undertaken. In the event of implementing new/updated documents, we ensure that all staff are briefed both via verbal and written memos, by utilising internal social media page, emails, weekly ED newsletter and uploaded on the ED SharePoint page on the Health Board Intranet.	Unscheduled Care	31.12.2025	31.12.2025	Fully complete (Awaiting approval)	February 2026 Update - ED Nursing documentation has been implemented across the 3 sites and includes Falls Assessment in line with the action. January 2026 Update - - Updated ED nursing pack working through final stages to agree and roll out across the 3 sites - Awaiting date of Task and Finish group to commence. Led by corporate nursing
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 5-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)	January 2026 Update - - Update required from PEM group December 2025 Update - - RCPCH benchmarking underway with Paediatric team - CTM PEM group commenced
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	15. The health board should consider incorporating an audit of the condensed nursing bundle into existing departmental audit processes to ensure its appropriate use and effectiveness.	Healthcare Inspectorate Wales (HIW)/2025/277/MD15/1	CTMUHB acknowledges the importance of auditing the ED nursing pack to measure appropriateness of its use. To ensure that our assessment processes are efficient, effective and timely, we are planned to undertake a review of the current ED nursing pack across the 3 EDs in CTMUHB. Following a review and implementation of the updated ED nursing pack, we will ensure appropriateness and effectiveness of its use. • Following a review of the ED nursing pack and agreement of the updated documentation, we plan to meet with the AMaT team to discuss implementing an electronic audit which can record usage and effectiveness of the ED nursing pack. • An audit review will allow monitoring of the use of the ED nursing pack and highlight what is working well and which areas require improvement.	Unscheduled Care	31.12.2025	31.12.2025	Fully complete (Awaiting approval)	February 2026 Update - Actions completed. January 2026 - - Updated ED nursing pack working through final stages to agree and roll out across the 3 sites - Awaiting date of Task and Finish group to commence. Led by corporate nursing

Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	16. The health board should also ensure that staff are reminded of the organisation-wide processes available to them for raising concerns, including the option to do so anonymously.	Healthcare Inspectorate Wales (HIW)/2025/277/MD16/1	CTMUHB recognises the importance of ensuring that all staff are aware of the organisational availability to raise concerns including the option to raise concerns anonymously which promotes an open culture. The ED has set up a process for staff to have the opportunity to post written feedback on small cards that can be placed in a sealed box or via a QR code to a Microsoft form (ideas and concerns) which is collected and reviewed on a weekly basis. Following feedback review, we will ensure that we feedback to the team on actions we can support, progress or which may require further discussion. The ED band 7 managers undertake 1:1 wellbeing session with staff. The wellbeing session is an informal meeting offering the nursing team to have dedicated time with their line managers to discuss what is going well, areas of concern and allows a confidential session to discuss the staff members wellbeing. • A memo will be circulated to the ED team via our information sharing platforms to remind staff of the process on how concerns can be raised and the opportunity to raise a concern anonymously. • The 'Dealing with Anonymous Concerns Procedure' is accessible via the intranet page. We will ensure a link is provide on the ED SharePoint page to raise awareness and allow ease of access to this information. The 'Dealing with Anonymous Concerns Procedure' details how the organisation will act upon any information received anonymously, in accordance with existing protocols, policies and procedures, and aims to ensure that: • Anonymous allegations or concerns are taken seriously; and • CTMUHB provides a consistent approach in dealing with anonymous communications. The ED senior team will ensure that the policy is accessible to all staff to raise awareness of the support offered by the organisation.	Unscheduled Care	31.10.2025	31.10.2025	Fully complete (awaiting approval)	February 2026 Update - - memo and comms shared with the wider teams - memo to be uploaded to documents. December 2025 Update - updated policy received and circulated with the wider team to raise awareness on the process to raise anonymous concerns - memo to be uploaded
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	17. The health board should consider the training suggestions provided by staff in response to our survey, such as, Advanced Life Support, Paediatric Advanced Life Support, and Advanced Trauma Life Support.	Healthcare Inspectorate Wales (HIW)/2025/277/MD17/1	CTMUHB acknowledges that compliance for mandatory resuscitation training is not where we want it to be. The ED currently has 46 staff booked on various resuscitation courses, compromising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTLS = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An Ba Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all 99s 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	February 2026 Update - see progression in actions - no further update this month. January 2026 Update – - training compliance to be updated - inhouse training sessions commenced
Healthcare Inspectorate Wales (HIW)/2025/277	05.08.2025	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	18. The health board must review staff compliance with all Immediate and Advanced Life Support training for both adult and paediatric patients, ensuring that improvements are made promptly.	Healthcare Inspectorate Wales (HIW)/2025/277/MD18/1	CTMUHB acknowledges that compliance for mandatory resuscitation training is not where we want it to be. The ED currently has 46 staff booked on various resuscitation courses, compromising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTLS = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An Ba Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all 99s 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	February 2026 Update - progression of action as described in January 2026 update. January 2026 – - training compliance to be updated - inhouse training sessions commenced

Agenda Item
4.8

Quality, Safety & Experience Committee

MORTALITY INDICATORS AND MORTALITY REVIEWS

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026	
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable	
Awdur yr Adroddiad / Report Author	Esther Flavell – Clinical Lead for Mortality Review Mark Townsend –Head of Clinical Audit and Quality Informatics Matthew Smith –Mortality Review & Learning Manager	
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director	
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director	
Pwrpas yr Adroddiad / Report Purpose	For Noting	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	02/03/2026	Minor amendment made to Mortality Board membership
Acronyms / Glossary of Terms		
CTMUHB	Cwm Taf Morgannwg University Health Board	
HMR	Hospital Mortality Review	
RGH	Royal Glamorgan Hospital	
PCH	Prince Charles Hospital	
POW	Princess of Wales Hospital	

1. Situation /Background

1.1 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.

1.2 The table below outlines the number of Medical Examiner (ME) referrals received (as of 13th February 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	**4820**	**100 (2%)**	**83 (2%)**	**106 (2%)**	**4530 (94%)**

Learning from Mortality Reviews

1.3 Medical Examiner Service is now reviewing all of CTMUHB, in-hospital deaths and deaths in the community setting since September 2024.

1.4 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.

The table below shows the number of cases identified for HMR since 2022-23 (as of 24th October), the number where the review has been completed and the percentage completed within 28 days of screening panel.

	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	370 (98%)	63%
2025-26	244	149 (61%)	19%

1.5 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.

1.6 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.

1.7 Any patients with a known Learning Disability that die in a hospital setting are also automatically reviewed at HMR level.

1.8 There are currently 103 HMR cases outstanding. The table below is a breakdown of these cases:

	Number	Percentage
Coroner's Inquest/Investigation	30	29%
Hospital Acquired Covid	7	7%
Hospital Acquired Influenza	27	26%
Inappropriate Discharge Concerns	15	15%
Learning Disabilities Patients	7	7%
Other	17	17%

1.9 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.

1.10 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%

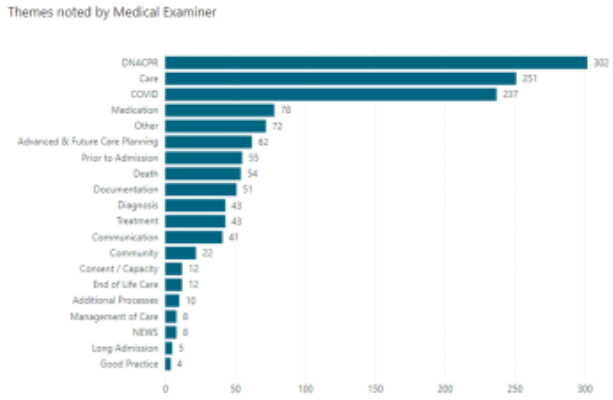
Mortality Rates per DGH:
PCH – 1.74%
POW – 1.72%

Mortality Rates per Locality:
Merthyr – 1.93%
Bridgend – 1.81%

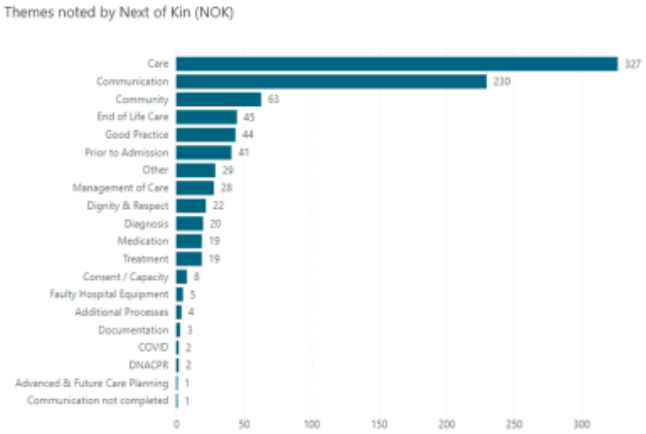
RGH – 2.34%

Rhondda – 2.58%

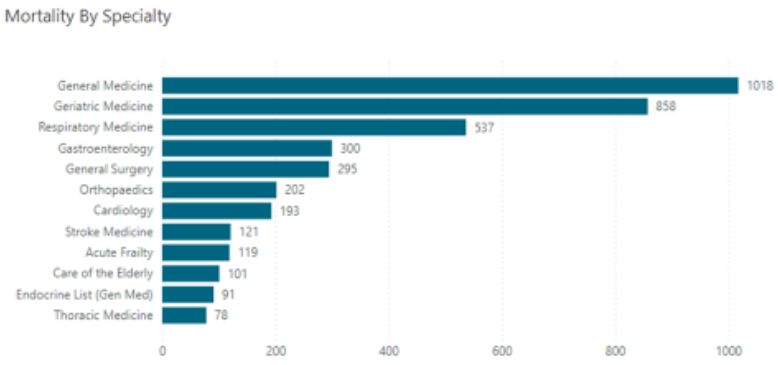
Themes noted by ME



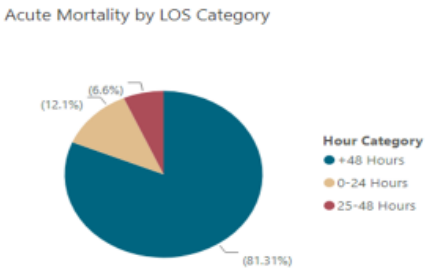
Themes Noted by NOK

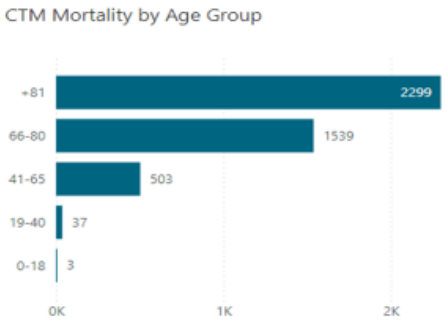


Deaths by Specialty (Top 10)

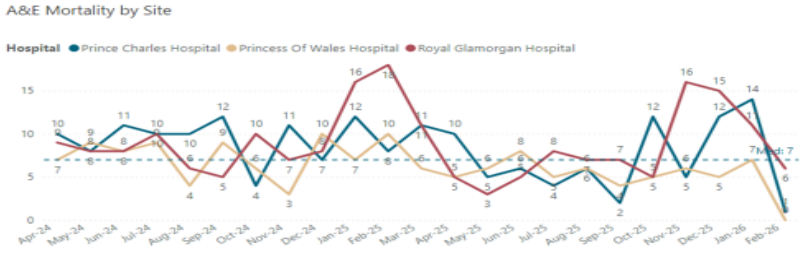


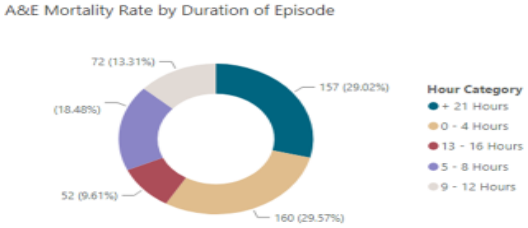
CTM Mortality



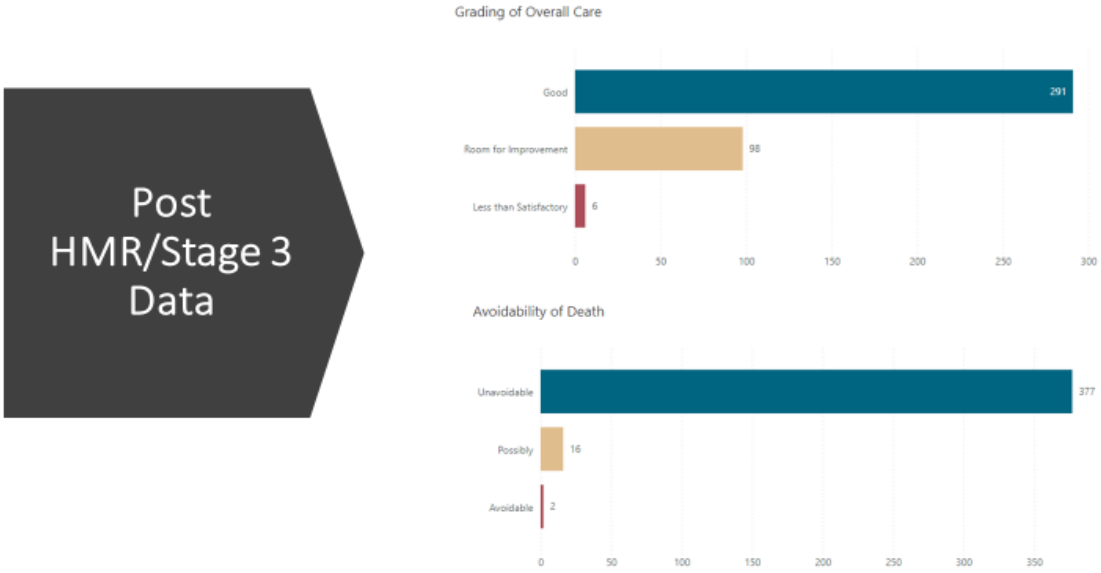


A&E Data

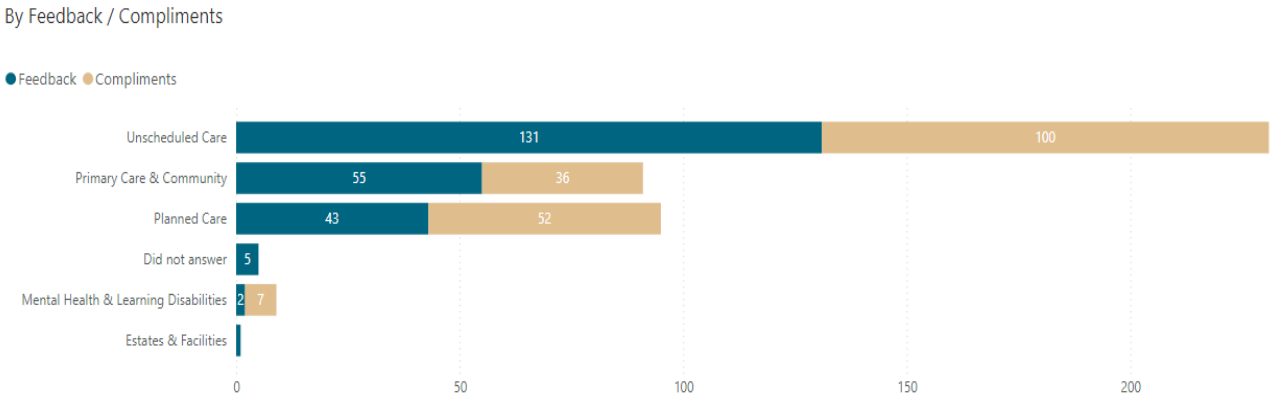




1.11 Current CTMUHB Mortality Review data shows that there is room for improvement in care in around 26% of deaths.



1.12 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.



Mortality Board

1.13 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 Directors, 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 People's Experience, Operations Lead, AHP Representative and Medical Examiners Service Representative. Representation from the Public Health Team has also recently been included.

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

Initial actions required with timescales:

- SOP for Screening Process – Awaiting formal approval
- Governance meeting template for Specialties completed
- Approval of Mortality Review Dashboard – awaiting IT sign off

Ongoing Development

1.14 Whole Mortality Data - Work continues to develop a Mortality Database to collate all information related to Mortality across the Health Board. This is currently in development in partnership with colleagues in Cardiff & Vale and developers from AMaT (Audit Management and Tracking). Current plans are for this to function alongside the existing Datix Mortality module

1.15 Use of an external company to provide peer matched data to compare trends and causes of death on different sites and specialties. This will help to identify outliers and target in-depth analysis of cases and themes. The care groups will take ownership of this analysis and will report to the mortality board.

1.16 QR codes for notifying deaths to both the coroner and the medical examiner service have just been introduced. These aim to reduce the time taken to notify and therefore, reduce waiting time for families.

Baseline Population Numbers

1.17 The population CTM health board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf (RCT) 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 2021 for population of local areas to CTMUHB

Area	Estimated pop 2021	People/km 2021
Bridgend	145,500	580
RCT	237,700	560
Merthyr	58,800	528

1.18 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.

1.19 The following table shows the number of deaths per area for each month of 2024 for each local authority area. Again, the data sets are from the ONS using their 2024 datasets.

Deaths per region 2024(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Bridgend	169	142	164	158	147	117	138	143	117	147	132	
RCT	294	257	227	248	240	202	250	216	179	264	210	
MCT	53	65	67	67	65	70	62	67	54	52	59	

ONS data for deaths per month for Wales 2024

Month	Deaths	Involving COVID	Covid Proportion of Deaths
Jan	3032	86	2.8
Feb	3072	93	3.0
March	3574	44	1.2
April	2891	27	0.9
May	3195	41	1.3
June	2710	36	1.3
July	2649	78	2.9
August	3043	102	3.4
September	2360	38	1.6
October	2679	56	2.1
November	3292	67	2.0

2. Specific Matters for Consideration

2.1 The Committee is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

Extrinsic:

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths
- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)

- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins
- Discussions with other health boards and ME services to improve communication and feedback

2.2 **Intrinsic:**

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues
- Continue to involve clinicians at an early stage for reflection
- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.

3. Key Risks / Matters for Escalation

3.1 Limited clinical reviewers with appropriate MR experience available in each Care Group remains challenging., and the biggest risk to the non-completion of the MR process.

4. Assessment

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

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

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

5. Recommendation

5.1 That the Committee **NOTE** the contents of the paper

6. Next Steps

6.1 Continuation of current Mortality Review Process
6.2 Continued development of Datix Mortality Module at an All-Wales Level.
6.3 Continued development of CTMUHB Mortality Dashboard and use of the data from the external company

6.4 Monitoring of the use of the QR codes for notification to reduce delays for families

6.5 Continued development of Whole Mortality Database

Agenda Item
4.9

Quality, Safety & Experience Committee

CTMUHB's NHS R&D Framework Assessment 2026

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Professor John Geen, Assistant Director for R&D Rhian Beynon, R&D Manager
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Rhian Beynon, R&D Manager
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Approval

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

Acronyms / Glossary of Terms	
AD for R&D	Assistant Director for Research and Development

CTIMP	Clinical Trial of an Investigational Medicinal Product
CRP	Clinical Research Portfolio
CTIMP	Clinical Trial of an Investigational Medicinal Product
CTMUHB	Cwm Taf Morgannwg University Health Board
GCP	Good Clinical Practice
HCRW	Health and Care Research Wales
HDRC	Health Determinants Research Collaboration
HEIW	Health Education and Improvement Wales
IMTP	Integrated Medium Term Plan
MHRA	Medicines and Healthcare Products Regulatory Agency
MRC	Medical Research Council
NIHR	National Institute for Health and Care Research
QS&EC	Quality, Safety and Experience Committee
QS&RE	Quality, Safety, Risk and Experience
SBRI	Small Business Research Initiative
SOECAT	Schedule of Events Cost Attribution Tool
STP	Scientific Training programme
R&D	Research and Development
VPAG	Voluntary scheme for branded medicines pricing, access and growth
W&OD	Workforce and Organisational Development

1. Situation /Background

1.1 The delivery of high-quality clinical care is supported through the delivery of high-quality research, enabling patient access to treatments and technologies and providing the evidence needed to improve and transform clinical services.

1.2 Research-active organisations demonstrate better patient outcomes, relating to morbidity and mortality, compared with those conducting less research. Research activity also strengthens organisational capability, supporting workforce recruitment and retention, enhancing reputation, and creating financial benefits through cost avoidance and the generation of research income.

1.3 The Health and Care Research Wales NHS R&D Framework was co-developed by key stakeholders, including NHS Research and Development (R&D) and was published in 2023.

1.4 The Framework outlines, "what research excellence looks like" within an NHS Organisation, "where research is embraced, integrated into services, and is a core part of the organisation's culture".

1.5 The features of a supportive organisation are organised under ten key pillars: Strategy, Governance and Leadership, Partnerships and Collaboration, Research Support, Research Delivery, Finance, NHS Workforce, Public Involvement and Participation, Communications and Engagement and Research impact.

1.6 CTMUHB completed the Health and Care Research Wales NHS R&D Framework baseline assessment in the Autumn of 2023. The contents of the baseline assessment were discussed at the annual review meeting with Welsh Government and Health and Care Research Wales on 7th March, 2024, which was attended by the Executive Lead for R&D, the Assistant Director for R&D, the Independent Member Research Champion, Executive Director for Public Health, Executive Director of Allied Health Professions (AHPs) and Health Science, and the R&D Manager.

1.7 The NHS R&D Framework Assessment template and accompanying technical guidance have been updated for 2026, following a Health and Care Research Wales discussion and consultation with the NHS R&D Directors/Leads, and a workshop held in November 2025 with representatives from NHS R&D.

2. Specific Matters for Consideration

2.1 CTMUHB's completed NHS R&D Framework Assessment 2026 template outlines CTMUHB's progress made against the NHS R&D Framework since the last assessment in 2024.

2.2 Assessment outputs will be gathered nationally and shared across the NHS Organisations, as well as informing the basis of the discussions at the upcoming annual review meeting with Welsh Government and Health and Care Research Wales (date to be confirmed).

3. Key Risks / Matters for Escalation

No Risks relating to the submission of the CTMUHB NHS R&D Framework assessment have been identified.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	Inspiring People, Creating Health, Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	Dying well, Growing Well, Living Well, Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	A Prosperous Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People
	Data to Knowledge, Leadership, Learning, Improvement and Research, Whole-systems perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	Efficient, Equitable, Person Centred, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable
	If more than one applies please list below:

Environmental /Sustainability Impact (5Rs)	

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate):	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	This is a self-assessment submitted externally for review. The internal view is that this is a positive assessment and will continue to support a good external profile of R&D activity within CTM. Yes (Include further detail below)	
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.	
	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Quality, Safety and Experience Committee are asked to **approve** the submission of CTMUHB's NHS R&D Framework Assessment 2026 to HCRW.

6. Next Steps

6.1 CTMUHB's NHS R&D Framework Assessment 2026 will be submitted to Science, Research and Evidence Division, Health, Social Care and Early Years, Welsh Government on Tuesday 31 March 2026.

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

NHS R&D Framework Assessment 2026

Purpose

This R&D Framework Assessment Template should be completed by NHS organisations as a way of assessing progress against the implementation of the NHS R&D Framework https://www.gov.wales/sites/default/files/publications/2023-07/research-and-development-framework.pdf, 2 years since its publication. It also sets out priorities and plans aligned to the broader NHS planning framework.

Please read the Technical Guidance document before completing this assessment template.

This assessment template should be submitted electronically to the Science, Research and Evidence Division, Heath, Social Care and Early Years, Welsh Government (Claire.Bond@gov.wales) **by 17:00 on Tuesday 31 March 2026.**

If you would like to discuss your application prior to submission, please contact Claire Bond (Claire.Bond@gov.wales).

Name and job title of person coordinating completion	Professor John Geen, Assistant Director for R&D Rhian Beynon, R&D Manager
Name of NHS organisation	Cwm Taf Morgannwg University of Health Board

COMPLETION OF TEMPLATE

[Please outline your NHS organisation's internal process for completing this assessment template, including which departments/ teams contributed to its completion]

Discussions were undertaken between the Executive Lead for R&D and the Assistant Director for R&D (AD for R&D) to inform the completion of this assessment. A draft was completed and shared with the Executive Lead for R&D for review and comment. The finalised draft was shared with the Quality, Safety and Experience Committee (QS&EC) for approval, for which the Independent Member Research Champion serves as Chair.

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

1. STRATEGY (max one page in total (inc 2023 summary)

Brief summary of your 2023 baseline assessment return (max 250 words):

CTMUHB R&D Strategic Delivery Plan was in the process of being developed at the time of the 2023 submission, following the release of key national documents published by Heath and Care Research Wales. The baseline assessment described how the draft would be circulated across the UHB for feedback, with the final version submitted to Board following ratification by the R&D Group. The R&D Department encourages all departments to include research related programmes of work within their IMTP, and additional guidance and requirements for Care Groups and operational areas has been incorporated into the IMTP planning guidance to ensure that all areas of CTMUHB consider R&D as part of their planning process.

Progress since baseline assessment:

CTMUHB's R&D Strategic Delivery Plan 2025-30 has been developed, outlining how CTMUHB will meet its strategic vision to *"embed research as a core function in all that we do and harness the potential of research to address the health challenges of our population and the development of our workforce, to transform future clinical service delivery".*

- Extensive consultation undertaken and feedback received (including HCRW and Welsh Government R&D Division) on the CTMUHB R&D Strategic Delivery Plan.
- CTMUHB R&D Strategic Delivery Plan developed to ensure alignment with key national and Health Board policy and strategic documents and objectives, and can be accessed at: R&D Strategy 2025-30 - Cwm Taf Morgannwg University Health Board
- The R&D Strategic Delivery Plan has seven strategic objectives encompassing primary, secondary, community and social care and population health and they are applicable to all specialties and professions (clinical and non-clinical).
- Developed strategic and departmental (R&D) action plans outlining key local and national performance indicators to aid in monitoring and reporting on the delivery of the strategic delivery plan to the R&D Group and a committee of the CTMUHB Board.

Achievements since the 2023 return:

- The CTMUHB R&D Strategic Delivery Plan was endorsed at the Quality, Safety and Experience Committee on July 22nd 2025, approved by the Board on 31st July 2025, and launched at the CTMUHB's R&D Conference held on 26th November 2025. CTM UHB Research & Development Conference 2025 - Cwm Taf Morgannwg University Health Board https://healthandcareresearchwales.org/about/news/new-five-year-research-strategy-launched-cwm-taf-morgannwg-university-health-board

- An R&D Strategic Delivery Plan summary page (see link above) has been developed, to help Care groups, Directorates and Departments identify their potential areas of contribution to the CTMUHB strategic research objectives in their IMTP planning cycle.
- The Executive Lead for R&D, AD for R&D, and Executive Director of Strategy and Transformation met in January 2026 to develop a plan and process for the inclusion of R&D in the organisation's current and future IMTPs.
- Recognition and support from the CTMUHB Planning team ensures that R&D is an integral component of the IMTP process. R&D strategic action plan on a page included in this year's IMTP, with key R&D priorities also documented.

Challenges and Solutions since the 2023 return:

- Changing the culture to ensure that R&D is not a competing priority but integral to service delivery and planning. Constructive discussions between R&D and Strategic planning team to progress the inclusion of R&D in all IMTP submissions. 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.

Plans for the next 1-3 years:

- Continue to monitor and report progress against the R&D Strategic Delivery Plan metrics detailed in the R&D strategic and departmental action plans.
- Work with Strategic Planning colleagues to monitor the inclusion of R&D in all submitted IMTPs.

2. GOVERNANCE AND LEADERSHIP (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

The 2023 return described CTMUHB's R&D leadership being provided by the Executive Lead for R&D and AD for R&D. An Independent Member champions R&D at Board level, alongside the Executive Lead. The R&D Group was meeting three times per year to discuss and agree the research agenda and provide assurances to Board via the Population and Health Partnership Committee that appropriate strategic monitoring arrangements are in place. The process was for an annual report to be submitted to Board via the Population and Health Partnership Committee, with plans in place for the AD for R&D to present the NHS R&D Framework at a Board Development session. The R&D Department compiles an R&D section for CTMUHB's public facing annual report, summarising KPIs, external funding successes, key projects, infrastructure developments and the annual R&D conference.

Progress since baseline assessment:

- Executive Director of Allied Health Professions (AHPs) and Health Science appointed as the new Executive Lead for R&D in November 2025 and

regularly meets with the AD for R&D (1:1, and with other Executives as required).

- Independent Member continues to champion R&D at Board and other internal and external forums.
- The R&D Group meets tri-annually to discuss progress against the strategic direction of the UHB's research agenda, oversee R&D departmental performance, and assure the CTMUHB Board via the Quality, Safety and Experience Committee (QSEC) on the safe, effective strategic management and delivery of R&D activities across the UHB.
- Membership of the CTMUHB R&D Group is developing, and includes representatives from the Clinical Executives, Care Groups, academic partners and the Health Determinants Research Collaboration (HDRC).

Governance Organisational Chart

- Reviewed and approved new governance reporting route for R&D business through the QSEC.
- The R&D Department submits bi-annual reports to the QSEC and annually at Board.
- Presentations to Board members since last assessment include:
  - 29th February 2024: AD for R&D and R&D Manager delivered a presentation on CTMUHB's strategic objectives, the NHS R&D Framework and R&D activity at a Board Development session.
  - 3rd April 2024: AD for R&D delivered a presentation on CTMUHB's strategic objectives and the NHS R&D Framework and R&D activity at the Improving Care Board.
  - 19th March 2025: AD for R&D presented a draft of CTMUHB's R&D Strategy 2025-30 to the Operational Management Board (OMB).
- The R&D Department contributes to the CTMUHB's corporate public-facing annual report, outlining research activity, key performance indicators, successful funding applications, research infrastructure, and the annual R&D Conference.

Achievements since the 2023 return:

- Maintaining continuous Executive Lead role despite changes in personnel and therefore maintained the profile and visibility of R&D at Board level.
- Excellent engagement from the Board and other senior leadership groups across CTMUHB and Research partners.

Challenges and Solutions since the 2023 return:

- Delay in confirming public and patient representation on the R&D Group and so the R&D Department are in discussion with Llais to secure representation.

Plans for the next 1-3 years:

- Recently agreed by the Chief Operating Officer that R&D activity and updates will be presented bi-annually at the Improving Care Board.
- Standalone public-facing R&D annual report will be produced, detailing research activity, income, and key achievements for the 2025-26. Report to be published in June 2026.
- Research activity reports will be circulated to the UHB's Care Groups on a quarterly basis to facilitate internal R&D discussions.
- Continue to promote and present on the national and local research agenda to include the CTMUHB's R&D Strategic Delivery Plan 2025-30 to continuously raise the profile of research at all levels.

3. PARTNERSHIP AND COLLABORATION (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

CTMUHB's R&D, Innovation, and Education Departments work closely as part of the key pillars in maintaining UHB status. CTMUHB promotes interdisciplinary working and supports collaborative projects across care settings, as well as with academic, industry, and third-sector partners e.g. presenting at external academic events, inviting industry partners to sponsor the annual R&D Conference, and involving academic partners as exhibitors, scientific chairs, or conference judges. Following a joint funding initiative with Cardiff Metropolitan University, the UHB agreed to provide £15k per annum for the R&D Department to release a funding call for joint NHS/Academic research projects to promote collaborative working with 9 collaborative projects were awarded funding during 2022/23.

Progress since baseline assessment:

- The AD for R&D continues to contribute to national programmes of work e.g. member of the Embedding Research in the NHS Steering Group and the Leadership Team of the National Cardiovascular Research Network (NCRN), contributed to the Priority Project, and development of the HEIW Research & Innovation for Healthcare Science Professionals in Wales: A 5 Year Strategy

2025-2030. Provided comments on the questionnaires for the Developing Clinical Academics Project" with HCRW.

- AD for R&D and R&D Manager and clinical colleagues attended the Cadarn National meeting on 13th November 2025.
- As the peer representative, AD for R&D co-ordinated a letter from all NHS R&D Directors, supporting the NCRN successful submission to the NIHR funding call: *Fewer Lives Lost – Research Consortium to Prevent Cardiovascular Disease.* This initiative has £50million available across the UK, in support of cardiovascular research.
- The R&D Department continues to develop and undertake collaborative research projects with its academic and industry partners.
- Following an NIHR award of £5million to Rhondda Cynon Taf Local Authority in collaboration with Cardiff University, CTMUHB R&D and Interlink as part of a Health Determinants Research Collaboration (HDRC), continue to collaborate with Rhondda Cynon Taf Local Authority to develop their research infrastructure, with a view to undertaking joint research studies at the health and social care interface. Principal Researcher for Public Health continues to represent CTMUHB at HDRC operational group meetings, as well as ad hoc meetings with the HDRC team.
- CTMUHB have agreed to host an NIHR programme development grant, *"Living with ADHD: Developing a nationwide platform for ADHD".* Failure to have an NHS organisation to host the grant would have resulted in the loss of this research funding (£250k) from Wales.
- CTMUHB are the only NHS recruiting site for the MRC funded (£3.2M) LIONNS study, in collaboration with Cardiff University

Achievements since the 2023 return:

- Burdett funded project exploring barriers and facilitators to secondary-care nurses discussing smoking cessation with patients in collaboration with the University of South Wales.
- A UK Stroke Association funded study investigating biomarkers and stroke risk in collaboration with Cardiff Metropolitan University. A second study is in discussion.
- CTMUHB's Workforce and Organisational Development Directorate undertook a collaborative project with Cultech investigating the effects of a probiotic on the general wellbeing of UHB staff, and a second phase of the study is in discussion.
- The Surgical and Clinical Biochemistry teams are undertaking an SBRI funded study with CanSense Ltd, investigating the use of AI and blood biomarkers to reduce colonoscopy demand on cancer pathways. Key project detailed in the Wales Cancer plan.
- 2024/25 CTMUHB R&D Collaborative funding supported 6 projects with Cardiff Metropolitan University, University of South Wales, and Swansea University in the fields of infection, laboratory Sciences/ICU (long covid), Parkinson's disease, paediatric diabetes, breastfeeding provision for CTMUHB's workforce and Vitamin D binding protein and stroke.

Challenges, solutions since the 2023 return:

- Aligning collaborative work with academic partners who may hold differing research priorities and end goals. Sharing the CTMUHB Research Strategic Delivery Plan with academia and having them sit on our R&D group, will help align priorities and objective and opportunities where commonality arises.

Plans for the next 1-3 years:

- Development of grant applications in progress include a second phase of a project investigating predictors in stroke, in collaboration with Cardiff Metropolitan University
- Study to investigate fibroscan as a resource for engaging individuals using substances in health promotion, in collaboration with Public Health Wales and Swansea University.
- AD for R&D to attend and present at the Research and Innovation Group meeting at the University of South Wales to discuss CTMUHB's strategic approach and how CTMUHB and USW could collaborate more closely.

4. RESEARCH SUPPORT (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

CTMUHB's R&D Department provides support for the set-up, delivery and quality assurance of research. The R&D team assesses organisational capacity and capability for both hosted and sponsored studies and allocates Research Nurse, 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 research estate includes the Clinical Research Centre at the Royal Glamorgan Hospital and administrative bases at Princess of Wales Hospital, Prince Charles Hospital and Keir Hardie University Health Park.

Progress since baseline assessment:

- Two additional Research Nurses have been appointed to support the commercial and non-commercial portfolio.
- Recruitment in process for a fixed term Research Nurse and Clinical Research Fellow to support the developing CTMUHB commercial reseach portfolio, funded by CTM commercial research income.
- Development of a secure future research contact database, comprising of participants who have been enrolled in an existing approved research study, for the purpose of seeking their consent to be approached about future research opportunities.

- The R&D Department funds software packages “NVivo” and “Analyse It” to assist CTMUHB’s researchers in the analysis of qualitative and quantitative research data.
- CTMUHB underwent an MHRA GCP Investigator Site Inspection from 26th to 28th August 2025 in relation to a non-commercial CTIMP being undertaken in Princess of Wales Hospital

Achievements since the 2023 return:

- Procurement of the electronic site file platform (FLORENCE) to streamline the management of investigator site files and study monitoring activities.
- Continued support in the set up and delivery of research involving applications and digital tools e.g. Raman spectroscopy, Virtual Reality, Point of Care, Artificial Intelligence.

Challenges, solutions since the 2023 return:

- The growing interest and positive attitude towards expanding research activity in CTMUHB exceeding the available research support capacity. Concerns over capacity are being explored through continued discussions with HCRW and WG RS&E division regarding core funding. The R&D team are seeking to increase commercial research activity and increase this income stream in addition to ensuring all grants are fully costed for research delivery staff to help deliver large scale projects and excess treatment costs (ETCs) are reimbursed centrally.
- Challenging to secure sufficient capacity to meet all priorities set by HCRW to include delivering commercial, cancer, non-commercial research and national programmes of work. Prioritising the work of the R&D team is necessary.

Plans for the next 1-3 years:

- Support the acquisition of research clinical and additional administrative space at both Prince Charles Hospital and Princess of Wales Hospital.
- Maximise research opportunities resulting from the development of the Wales National Data Repository.

5. RESEARCH DELIVERY (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

The R&D Department was working closely with HCRW to implement national research delivery and streamlining initiatives, to include the prioritisation of urgent public health covid-19 research during the pandemic, the NIHR Restart Framework, adoption of the single national costing and contracting model. CTMUHB representation is included in national R&D forums. The R&D Department provides comprehensive support for portfolio and commercial studies in line with national and local priorities. The

department oversees all research undertaken within the UHB, monitoring recruitment to time and benchmarking through national data platforms.

Progress since baseline assessment:

- The R&D Department continues to support the set up and delivery of studies aligned to national and local health priorities to include cancer (Canfit, BrCa-SPECT, PATHOS), stroke (PREDICT-EV), mental health (dementia) (CONNECT, SANDBOX), population health (Think Quit, Evaluweight), cardiovascular (PROTECT-HF, CYCLES 1&2), physiotherapy (TIP-TOE, OPAL, INITIATE), dietetics (LIGHTWAY).
- CTMUHB's R&D Department contributes to multiple national HCRW forums to include Research and Delivery Operational Group, R&D metrics Task and Finish Group, Site ID Task and Finish Group, Training Alliance and Research Systems Advisory Group, All -Wales Pharmacy Research Group.
- As part of the implementation of UK-wide process for Commercial Site identification, the R&D Department is developing CTMUHB's market profile to highlight the organisation's research strengths, infrastructure and track record in the delivery of research, to attract potential research sponsors to utilise CTMUHB as a research site.

Achievements since the 2023 return:

- Increasing number of Clinical Research Portfolio (CRP) studies and participants recruited, from 65 and 1395 respectively in 2023/24 to 72 and 1680 in 20-25/26 (part-year).
- Increasing pipeline of commercial research.
- During 2023/24, 2024/25 and 2025/26 (part-year), 100% of CRP and commercial studies have closed having met their recruitment time to target.
- CTMUHB was highest recruiting additional site for the QuicDNA study.
- CTMUHB is the highest recruiting NHS organisation for the Tiptoe Study (one-site Wales).
- CTMUHB recruited 1st patient in Wales for MH-EF Clinical trial.
- CTMUHB recruited 1st UK patient for the Shells study.

Challenges, solutions since the 2023 return:

- Meeting the 150-day metric for commercial clinical trial set-up is essential in attracting repeat commercial research and strengthening both our national and local reputation. Will be supported by filling a current band 5 vacancy to support the existing team in delivering this metric.
- Being unable to meet HCRW's expectation to support commercial and non-commercial research activity on existing limited capacity, affecting our ability to meet the performance metrics. The AD for R&D and R&D manager are continually reviewing the R&D team infrastructure and available resources (to include income streams) to optimise staff numbers, to include the employment

of band 3 research assistants. The Executive Lead for R&D, AD for R&D and R&D manager are encouraging and promoting the use of existing clinical and non-clinical staff to support research via the embedding process, to include plans to demonstrate and deliver this in the Care Group and Directorate IMTPs.

Plans for the next 1-3 years:

- Increase the number of open CRP studies and participants recruited to CRP studies by 5% per year.
- R&D department to work closely with the Wales Cancer Research Network (WCRN) to increase cancer research across CTMUHB, which will be facilitated by the identification of a CTMUHB champion for Cancer research.

6. FINANCE (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

The AD for R&D, R&D Manager and R&D Senior Finance Analyst meet regularly to ensure all research funding budgets, costs and associated spending plans are monitored appropriately and in line with the All-Wales Finance Policy. This includes budget setting and forecasting to ensure that there is minimal financial risk to the UHB. A key priority is securing external commercial and non-commercial funding. The team actively shares grant opportunities and supports researchers with costing, SOECATs and applications, encouraging early engagement to ensure all NHS costs are included.

Progress since baseline assessment:

- Initial meeting with CTMUHB's charitable funding team has taken place to explore the potential use of this funding to support research.
- Continued prioritisation to increase the commercial research activity, with support being provided to research active colleagues in Rheumatology, Dermatology, Endocrinology, Podiatry, Dietetics, Physiotherapy and Psychiatry (Dementia) to develop their commercial research portfolios.

Achievements since the 2023 return:

- Successful collaborative grant applications since 2024:

Project Title	Funder	Collaborator	Amount
The 'ThinkQuit' Study	Burdett Trust	University of South Wales	£97,667
CAN-FIT: use of AI and blood testing to reduce colonoscopy demand on cancer pathways	SBRI Centre of Excellence	CanSense Ltd (Swansea University)	£125,626

Arteriovenous Fistula Stenosis and Failure: Identifying individuals at risk and exploring their perspectives. A sequential mixed-methods study	Kidney Research UK Allied Health Professional Fellowship (Clinical)	Cardiff University	£181,467.50
Maximising the Impact of Speech and Language Therapy for children with Speech Sound Disorder Phase 2	HCRW Wales Integrated Funding Scheme	Cardiff Metropolitan University	£295,887.00
Reducing preterm births by improving antenatal infection screening pathways in a high-risk population	SBRI Centre of Excellence	Llusern/University of South Wales	Tbc
Scaling Innovative Pelvic Health Support for Women and Girls in Wales	SBRI Centre of Excellence	Get U Better Ltd	£124,130
Supporting Prudent Antibiotic Use with CRP Point of Care Testing for LRTI's in Wales (SPARROW).	Welsh Govt and INEOS Oxford Institute synergy grant.	Oxford Institute and Welsh Govt	Welsh Govt £734K £115K (CTM) INEOS: £500K

The outcome of a further 4 grant applications is awaited, and two applications are currently in development.

- £170,000 VPAG funding for equipment for commercial research awarded to CTMUHB January 2025 and £20,916.64 awarded in October 2025.
- Two successful VPAG Workforce Fellowships 2025/26 to the sum of £4784 (Audiology) and £1507 (Pharmacy).

Challenges, solutions since the 2023 return:

- Static HCRW Delivery budget impacting capacity and will affect ability to meet all performance metrics. CTMUHB continues to maximise alternative sources to secure additional external R&D funding i.e. grant and commercial income.
- HCRW delivery funding excludes pay award funding for 2018-2021, for posts that were not in existence during those years. A £62k shortfall was met by the Health Board in 2024/25 and met in part from the HCRW R&D funding in 2025/26, through not covering maternity leave and the delay in appointment of vacant posts, which affects departmental capacity. The shortfall has been discussed with the Science, Research and Evidence Division in Welsh Government.

Plans for the next 1-3 years:

- Secure additional research funding from all non-commercial sources (cost recovery, excess treatment costs, grant funding, charitable funding, government funding schemes and third sector) to £1 million by 2028.
- Increase the number of grant applications submitted by CTM researchers, with a target of reaching 10 applications per year by 2030.
- Increase the UHB's generation of commercial research income to meet a 50% increase target from 2025 to 2030.
- Re-investment of commercial research income into the CTMUHB research infrastructure to continue to develop self-sustaining delivery posts.

7. NHS WORKFORCE (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

The AD for R&D continued to promote CTMUHB's and the national research strategy across a wide range of internal and external staff groups, highlighting the importance of embedding research within job plans, job descriptions and PADRs. Plans were progressing to include R&D in CTMUHB's nurse induction and offer a research placement for nursing students. The R&D Department promotes national research training and supports staff at all levels who wish to undertake research. Joint healthcare/academic posts had been explored with partner universities to strengthen impactful research aligned with NHS and academic priorities.

Progress since baseline assessment:

- Importance of protected time for research continues to be highlighted in all R&D reports, presentations and meetings with senior UHB staff e.g. Assistant Director of Workforce and OD, Head of Psychology, Lead Nurse for Corporate Services, Service Manager for Gastroenterology and Endoscopy.
- The UHB has continued to fund 0.2 wte consultant sessions for research following a previous Moondance award.
- The R&D Department continues to support the enrolment of staff on the Associate Principal Investigator (API) Scheme. 8 APIs supporting research currently and 25 have completed their training to date since 2021.
- The R&D Department recently supported two applications for the HCRW Research Doctoral Fellowship Award (in Haematology and Public Health), and the outcomes are currently awaited.

Achievements since the 2023 return:

- Presentations delivered to promote research include:
  - 9th November 2023 CTMUHB's Health Psychologists
  - 26th February 2024, 14th July and 6th December 2025 Band 6 Nurse Development Programme
  - 2nd May 2024 CTMUHB's Pharmacy Researcher Community of Practice Launch Event at Cardiff Metropolitan University
  - 5th June 2024 Mental Health and Learning Disability QSRE Board

- 17th July and 4th December 2025 Band 7 Development Programme
- 6th March 2025 F1 Doctors
- 31st July 2025 Enhanced, Advanced and Consultant Forum
- 23rd September, 2025 Dietetic Showcase Event at Coleg y Cymoedd, Nantgarw

- R&D hosted placements to date include one/two-week placements for University of South Wales student nurses, two-week placement for a Trainee Clinical Scientist, three-day placement for a Cardiff University student midwife and two-day placement for an Audiology Trainee Clinical Scientist (STP) trainee.
- Research listed as a priority within CTMUHB's Allied Health Professions and Healthcare Science Delivery Plan.

Challenges, solutions since the 2023 return:

- Current financial constraints have prevented further progression of joint posts with our academic partners. Conversations remain ongoing, with exploration of opportunities as they arise.

Plans for the next 1-3 years:

- AD for R&D has been invited to present the CTMUHB's R&D Strategic Delivery Plan to the Public Health Team in April, 2026, The Grand Round in May, 2026 and the Research and Innovation Group meeting at the University of South Wales (date TBC).
- Explore opportunities to include research as part of the UHB's induction process and mandatory training.
- R&D Manager to attend the Advanced Clinical Practitioner (ACP) Panel to support and signpost the ACPs to help support them to meet the requirements of the research pillar of advanced practice.
- Progress activity aimed at increasing medical SPA sessions dedicated to research, with a target of 15% SPA sessions ringfenced for research by 2030.
- Increase the number of Chief Investigators hosted by CTMUHB, having a target of 10 Chief Investigators by 2030.
- Routinely record the profession of the lead researcher as part of study set up.
- Continue to promote and support the Associate Principal Investigator Scheme.

8. PUBLIC INVOLVEMENT AND PARTICIPATION (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

CTMUHB's R&D Department continued to actively promote patient and public involvement (PPI) throughout the research process, encouraging the appropriate inclusion of public involvement in grant application, sufficient funding for their time, and ensuring representatives are named as co-applicants. The R&D Department has

welcomed previous public representation at the R&D Committee to agree the strategic direction of the UHB's research agenda and will circulate the Strategic Delivery Plan following its development. The R&D Department signposts researchers to Involving People and the research public involvement toolkit and promotes public involvement training across the UHB. CTMUHB is represented by the Deputy R&D Manager on the HCRW Public Involvement Alliance and members of the R&D team attend the HCRW Public Engagement and Involvement Forum events.

Progress since baseline assessment:

- The requirement for appropriate PPI is flagged in all discussions relating to the development of a research proposal or grant applications.
- CTMUHB's R&D Strategic Delivery Plan 2025-30 has been circulated to Llais for distribution among its members.
- Deputy R&D Manager continues to represent CTMUHB in the HCRW Public Involvement Alliance.

Achievements since the 2023 return:

- Public involvement has been sought in the development of research through multiple forums e.g. Involving People, ITU Survivors clinic, Special Interest Groups.
- Public facing calls for recruitment have been shared through the UHB's communications as appropriate e.g. National Centre for Mental Health Research, SWELL (Skills for Adolescent Wellbeing) and Neptune (Non-Invasive Prenatal Testing Wales).

Challenges, solutions since the 2023 return:

- The team continues to work to balance the need for the UHB to allocate sufficient budget for public involvement alongside ongoing investment required to develop and maintain research delivery infrastructure.

Plans for the next 1-3 years:

- The R&D Department will utilise the R&D web page to signpost access to CTMUHB's research portfolio to enhance participation.
- Public representation on CTMUHB's group to be confirmed.
- Continue to support and make the CTM workforce and our collaborators aware of research funding opportunities to include the HCRW Faculty.

9. COMMUNICATIONS AND ENGAGEMENT (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

CTMUHB's R&D Department continued to work with the Communications Teams at CTMUHB and HCRW to promote recruitment to studies, share good news stories within the UHB and to the public. The R&D Department is exploring research opportunities for underrepresented groups e.g. mental health and wellbeing in the prison population within CTMUHB.

Progress since baseline assessment:

- CTMUHB's R&D Department shares examples of research best practice/impact, successful grants awarded and the annual R&D Conference, both internally and externally to the UHB.
- The R&D Department participates in national campaigns e.g. Red for Research and Clinical Trials Day.
- The R&D Department maximises opportunities to exhibit an R&D stand at conferences and events e.g. CTMUHB's acute hospital sites for Clinical Trials Day, CTMUHB Antenatal Baby Shower Event, HCRW Conference and upcoming HDRC Conference.
- The R&D Department continues to circulate and signpost all research training, funding and conference opportunities across the UHB and highlights specific calls for recruitment through the UHB's Sharepoint site and staff bulletins.
- The R&D Department is exploring ways to further support the set up and delivery of research in under-represented populations in CTM. Recent examples include a research project exploring the barriers and facilitators to breastfeeding infants among the gypsy and traveler population, and a research project exploring attitudes to vaccination in prisons.

Achievements since the 2023 return:

- Examples of recent public facing research communications involving CTMUHB include:
  - 2025 | New research on long-COVID offers hope for patients living with condition | Cardiff Metropolitan University
  - CTM researchers running study to improve bowel cancer diagnosis - Cwm Taf Morgannwg University Health Board
  - CTMUHB delivering QuicDNA lung cancer study - Cwm Taf Morgannwg University Health Board
  - https://ctmuhb.nhs.wales/news/latest-news/think-quit-empowering-nurses-to-help-patients-quit-smoking/
  - Rapid diagnostic testing for bacterial infections to be rolled out in primary care | GOV.WALES
- The R&D Department undertook an investigation into the demographic and socio-economic profile of participants recruited to research studies supported by the delivery team in secondary care in CTMUHB in 2023-24. Results indicated that participants were representative of CTM's population in terms of age, gender and deprivation quintile.

Challenges, solutions since the 2023 return:

- The potential to share good news stories can be impacted by the R&D capacity available to draft and co-ordinate the communications required.
- Recent loss of designated local communications support has impacted progress in developing an R&D specific communications plan. Review of the R&D team's roles is underway and may help identify opportunities for inclusion of communications development, in support of developing an R&D communications plan.

Plans for the next 1-3 years:

- Develop a formalised communications plan in partnership with the communications teams at CTMUHB and HCRW.
- Finalise the content of CTMUHB R&D webpage, in line with the template shared by HCRW in December 2025.
- Evaluate the demographic profile of participants recruited during 2024-25 and investigate the potential of recording additional data for analysis e.g. ethnicity, health status.
- Finalise CTMUHB's market profile for inclusion in the national commercial Site identification process.

10. RESEARCH IMPACT (max one page in total (inc 2023 summary))

Brief summary of your 2023 baseline assessment return (max 250 words):

CTMUHB's R&D Department organises an annual R&D Conference; a celebratory event to showcase the multi-professional and multi-disciplinary research being hosted and undertaken across the UHB. The R&D Department plans to collate research and service development findings, publications, outputs and impact for inclusion in a research repository and to measure R&D successes.

Progress since baseline assessment:

- The R&D Department encourages and supports CTMUHB's researchers to publish their research findings in open access, high-quality peer reviewed journals and advises researchers to include dissemination costs as part of grant funding applications.
- Research publications and presentations at conferences are collated by the R&D Department and reported to the R&D Group.
- The R&D Department has resumed collecting data on drug cost savings and avoidance generated through clinical trials and has shared the method of collection with the Senior Research Impact Manager at HCRW.
- The R&D Department has started to collate equipment provided by study sponsors for individual research projects.

- The R&D Department met with the Executive Director of Strategy and Transformation and National Director of Support and Delivery, HCRW on April 16th 2024 to explore the potential for research capacity to be incorporated into the development of the diagnostics provision at Llantrisant Health Park. A further meeting was held the R&D Department and Llantrisant Health Park's Clinical Operations team on 9th December 2024.
- Continued support for the set up and delivery of collaborative research with local life science companies e.g. Cultech, CanSense, providing opportunities to generate commercial and social impact for the local population.

Achievements since the 2023 return:

- Annual CTMUHB R&D Conferences were held on Tuesday 26th November 2024 and Wednesday 26th November 2025 at the Vale Hotel, Hensol.
- 2024 conference featured 10 oral and 60 poster presentations with 224 delegates. In 2025, the conference featured 10 oral and 63 poster presentations and 256 delegates. Delegates included CTMUHB staff as well as partners and colleagues from across the NHS, Welsh Government, industry and academia. Both events were sponsored by industry partners with exhibition stands from our academic partners, industry, HCRW and the HDRC. There was strong representation from CTMUHB Board members.
- The intervention developed through the "Think Quit study" was launched in November 2025, which is a feedback loop providing nurses with feedback on the results of their referrals, helping them feel confident and empowered to start these conversations with patients.
- The ctDNA blood test, evaluated as part of the QUicDNA study in which CTM UHB was a key recruiting site, has been formally incorporated into the Optimal Lung Cancer Diagnostic Pathway for England and Wales.

Challenges, solutions since the 2023 return:

- There is no funding available to cover the cost of publications for own account research. Researchers are encouraged to include dissemination costs in their funding applications, to help facilitate publication of their findings.
- Capturing all the financial, workforce, health, commercial, resource, and reputational benefits and impact of research.

Plans for the next 1-3 years:

- CTMUHB will increase the number of research publications year on year.
- The R&D Department will share information on publications and conference presentations with the library services and as part of the quarterly Care Group research activity reports.
- Planning underway for the next R&D conference, which will be held on Wednesday, 25th November 2026 at the Vale Hotel, Hensol. A call for abstracts will be released in May 2026.

- Collate research findings and any resulting changes in clinical service delivery such as treatments and pathways.

HCRW (HCRW) SUPPORT

Please outline ways in which HCRW, the Science Research and Evidence Division in Welsh Government and/or other key stakeholders (please specify) can support your organisation with the implementation of the Framework.

- The re-introduction of ring-fenced development funding from HCRW would enable the R&D Department to support more up and coming researchers.
- Meetings between HCRW and NHS organisations to discuss priorities would help to facilitate stronger alignment of the research activity undertaken by the HCRW funded centres and units and the NHS priorities.
- To raise the profile of research at Executive level, research could be included as an agenda item on an IQPD meeting held between Welsh Government and Health Boards.
- HCRW, through Welsh Government, could consider recommendations on the amount of SPA/sessional time allocated for research across the organisation's workforce. This will help facilitate embedding research in the NHS.
- Increased Government investment directly into NHS research delivery at Health Board level would facilitate the increase in research delivery capacity and continued development of patient focused research across the NHS in Wales

Optional SWOT Analysis (see guidance)

S Strengths	W Weaknesses	O Opportunities	T (R) Threats and/or Risks
Positive research attributes that your NHS organisation has	**Areas for improvement and internal factors that are challenging for your NHS organisation**	**External factors that could give your NHS organisation an advantage**	**Factors that could harm research and/or risks to research in your NHS organisation. Please include ways in which risks will be mitigated**
Diverse population of 450,000, with a wide range of socio-economic status and high disease prevalence, e.g. cardio-vascular, respiratory, metabolic, MSK, mental health and cancer	Need for clinical and additional administrative space at PCH and POW hospital sites to facilitate the provision of equitable research support and access to research across the UHB.	Several key academic partners to create and develop research opportunities that align with the UHB's strategic priorities.	Levelling of the NHS delivery funding and investment from HCRW in recent years will impact local NHS research infrastructure, research delivery and performance.
3 acute hospitals sites, community hospitals and primary care, prison	Variable engagement in research across specialties and disciplines	Working with our commercial partners will generate income that can be reinvested to develop research infrastructure, as well as increase access to novel	Risk of failing to meet the 150-day set-up metric for commercial clinical trials, potentially affecting CTMUHB's reputation with industry partners

		therapies for CTMUHB's population	
Fully equipped Clinical Research Centre at Royal Glamorgan Hospital (reception area, 3 clinic rooms, small laboratory with temperature-controlled sample processing and storage as well as temperature-controlled refrigerators and freezers for pharmaceutical storage)	Increasing service delivery pressures can result in teams having insufficient time to consider undertaking and maximising research opportunities.	The Health Determinants Research Collaboration (HDRC) provides an opportunity to develop research at the interface of health and social care, further strengthening collaboration with our academic and third sector partners	Ongoing estates changes at Prince Charles and Princess of Wales hospitals and competing priorities with Clinical service delivery could potentially impact the available clinical and administrative space for R&D activity at these major sites.
Dedicated support services time for research (Clinical Trials Pharmacist, Clinical Trials Pharmacy Technician, Research Radiographer, Clinical Research Scientist, Medical Laboratory Assistant)	Availability of specialist Comms advice is impacting the pace of development of a CTMUHB R&D communications plan.	Potential to increase research capacity for imaging and endoscopy associated with the development of Llantrisant Health Park	

Dedicated R&D Senior Finance Analyst time to support management of all research income and project costing.			
Joint clinical roles in Physiotherapy, Pathology and Rheumatology			
Recently developed Strategic Delivery Plan 2025-30 with strong Board support for R&D.			
CTMUHB hosts the National Imaging Academy, with access to Senior grade Radiologists and Radiographers			
Reputation for the successful delivery of research, having met recruitment to time and target for 100% closed commercial and non-commercial research during 2023/24, 2024/25 and 2025/26 (part-year)			
R&D Department funds and provides access for CTMUHB			

staff for software packages (Nvivo and Analyse It) for the analysis of qualitative and quantitative research			

Agenda Item	5.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 20 January 2026 09:00
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Committee Chair
	Kath Palmer	Committee Vice Chair
	Patsy Roseblade	Independent Member
	Hayley Proctor	Independent Member
In Attendance	Gethin Hughes	Chief Operating Officer
	Richard Hughes	Interim Executive Director of Nursing, Midwifery and Patient Care
	Lauren Edwards	Executive Director of AHPs and Health Science
	Philip Daniels	Executive Director, Public Health (In part)
	Emma Walters	Head of Corporate Governance and Board Business
	Gaynor Jones	RCN Convenor
	Alex Brown	Care Group Medical Director – Unscheduled Care (In part)
	Sallie Davies	Deputy Medical Director (In part)
	Carl Verrecchia	Care Group Service Director, Children & Families
	Becky Gammon	Interim Deputy Executive Director of Nursing
	Hannah Wilton	Director of Pharmacy & Medicines Management (In part)
	Chris Beadle	Assistant Director of Health Safety and Fire
	Lloyd Griffiths	Interim Nurse Director, Mental Health & Learning Disabilities
	Deborah Matthews	Nurse Director, Unscheduled Care
	Kyle Newton	Alcohol Care Team Lead (In part)
	Dee Lowry	Assistant Director of Value & Efficiency (In part)

	Zoe Ashman	Interim Care Group Nurse Director, Primary Care & Community
	Gary Howell	Clinical Director of Allied Health Professionals
	Clare Thompson	Executive Director of Strategy & Transformation
	Sharon O'Brien	Care Group Nurse Director – Planned Care
Meeting Observers	Sophie Bassett	Interim Head of Mental Health and Learning Disability
	Sharon Edwards	Corporate Governance Officer
	Victoria Healy	Head of Quality & Safety (In part)

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	C. Donoghue welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its hybrid form was also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Dom Hurford, Executive Medical Director • Stephen Sarasin, Consultant Orthopaedic Surgeon • Cally Hamblyn, Assistant Director of Governance & Risk
1.3	**Declarations of Interest**
	There were no interests declared.
2.	**CONSENT AGENDA BUSINESS**
2.1	C. Donoghue reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 8) that the Committee Members wished to bring forward to the main agenda for discussion. H Proctor advised that she would welcome the opportunity to raise a question regarding agenda item 8.1.6 and added that she would be happy to raise this question under any other business.

3.	**MATTERS ARISING**
3.1	**Action Log**
	P Roseblade raised concerns regarding the proposed closure of the action relating to the Welsh Ambulance Services Trust (WAST) joint investigation framework thematic review, noting that the Clinical Executive Directors report referenced ongoing challenges in relation to achieving 15-minute handover performance, with the Health Board currently working at 45 minutes handover performance. R Hughes recognised this as a fair challenge and advised that he would consider the framing of this action outside the meeting. C Thompson highlighted the need to ensure duplication was not being experienced in relation to discussing ambulance handover performance within Committee environments, noting that the Operational Delivery Committee also received updates on ambulance handover performance, and queried whether a cross-committee referral was required in this regard. P Roseblade advised that whilst she recognised this, there was a quality and safety aspect that required discussion within this Committee. C Donoghue advised she would welcome the suggestion made by R Hughes to review the framing of this action to determine what information needs to be presented to the Committee moving forward. All other actions proposed for closure were supported.
Resolution:	The Committee **NOTED** the Action Log
Action:	R Hughes to consider the framing of the action being proposed for closure in relation to the WAST joint investigation framework thematic review.
3.2	**Matters Arising Not Captured on the Action Log**
	No further matters were raised
4.	**STAFF AND SERVICE USER EXPERIENCE**
4.1	**Shared Listening & Learning Story – Alcohol Services**
	K Newton and D Lowry shared a presentation which highlighted the work undertaken to redesign the Alcohol Care service and a patient video which shared a powerful personal journey made possible through access to the service. Members noted the strong improvements in outcomes, which included better engagement and reduced stigma, significant reductions in length of stay and unnecessary admissions and enhanced consistency via new alcohol withdrawal guidelines. Members praised the service for its person centred approach, measurable impact and national recognition through recent awards. In response to a question raised by P Roseblade as to how learning from the Alcohol Care Team's co-production model and outcomes could be applied to other services, including mental health and substance misuse, D Lowry stated that the service model was built around co-production and lived experience, supported by structured Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs).

	Members noted that learning was already being applied in other settings, including prison health services and value-based healthcare initiatives and noted that further lessons-learned work would be documented and shared with the Committee for information and awareness. C Donoghue extended her thanks to K Newton and D Lowry for sharing the impactful presentation.
Resolution:	The Listening and Learning Story was **NOTED.**
Action:	Lessons Learnt report to be shared with Committee Members for information and awareness once completed.
5.	**SETTING THE SCENE - SERVICE DELIVERY**
5.1	**Thematic Spotlight Presentation – Compassionate Care**
	Before inviting B Gammon to present the report, C Donoghue advised that she fully recognised the pressures being faced by staff at present given the current demand being experienced within healthcare settings and added that balance needed to be taken in ensuring Committee Members were being provided with the appropriate level of detail without placing added pressure on staff. B Gammon presented the report and highlighted the key matters for members attention. Members noted the programme focussed on improving compassionate, and respectful behaviours, with work being undertaken on staff training, reflective practice, "thank you" messaging, and links to speaking-up culture. C Donaghue sought clarity as to how the organisation would know whether the compassionate care programme was having a measurable impact and queried when improvement would be realised. B Gammon stated that impact would be assessed through a range of indicators, including patient experience data and themes from complaints, results from the Staff Survey, as well as reviewing sickness absence, retention and wellbeing indicators. H Daniel advised that in relation to culture and behaviour, behaviours would be more tangible to measure and added that the People Services Team were currently undertaking a review of behaviours, following a listening and learning story received at Board which identified issues with behaviours across a number of staff groups. Members noted that a discussion would be held with the Executive Team and the Board in relation to the types of behaviours that were making themselves evident. C Donoghue welcomed the clear way in which this report had been structured and added that she would welcome future updates to be presented in this way moving forward.
Resolution:	The Committee **NOTED** the presentation.
5.3	**Clinical Executives Directors Update Report**

	R Hughes introduced the report alongside his Executive Director colleagues and highlighted the key matters for members attention. R Hughes extended his thanks to all staff who were caring for patients in difficult circumstances. In response to a query raised by G Jones as to whether senior leaders could undertake visits to community midwifery teams, R Hughes stated that visits to community midwifery teams had already been confirmed, with K Palmer, Vice Chair, already scheduled to undertake a visit. Ongoing Executive oversight of maternity services was also reiterated. In presenting the Medical Directors section, D Hurford advised the Committee that S Davies, Deputy Medical Director would be retiring at the end of January, and he extended his thanks to S Davies for the contributions she had made to this Committee. In relation to ambulance handovers, K Palmer queried if the delays were being measured in terms of quality and harm, and not just hand over times. R Hughes stated that a comprehensive winter wrap up report would be presented to the March meeting of the Committee, focusing on patient flow, timeliness of care, and the quality and safety impact associated with prolonged waits and high demand across urgent and emergency care services. In relation to the Public Health section of the report, P. Daniels provided an update on substance misuse, highlighting that CTM currently had the highest rate of drug-related deaths in Wales. Members noted that a report would be presented to the February meeting of the Strategic Development Committee regarding this matter. In response to a query raised by C Donoghue as to why the Substance Misuse Strategy had lapsed, which had resulted in there being no dedicated Team within Welsh Government leading this work, P Daniels advised that the team was not replaced following episodes of staff sickness and staff departures and added that both Public Health Wales and the CTM Area Planning Board Teams had raised concerns regarding this gap. In response to a query raised by G Hughes as to whether there was a way to map out the roles of the Health Board and the different agencies so that CTM can be clear on its responsibilities versus those of others, P Daniels agreed to prepare a mapped breakdown for discussion with the Executive Team in the first instance. In response to a comment made by K Palmer in relation to linking up alcohol and drugs misuse with the open access service within the Mental Health Transformation Programme, P Daniels advised that this was a complex area which needed to be addressed by the Area Partnerships Board, particularly given the significant role of the Police and Crime Commissioner regarding this matter. P Roseblade raised concerns about public understanding of Physician Associates (PA) roles and national media coverage, and whether patients were aware of when they were being treated by a Physicians Associate, D Hurford explained

	that the national guidance changes had restricted the scope of Physician Associate roles, creating a level of uncertainty for this cohort of staff. Members noted that Physician Associate training was a distinct professional pathway as opposed to medical training and noted that the organisation would not be expanding these roles until national clarity was provided. D Hurford advised that he would prepare a report for a future meeting outlining training, governance and patient communication.
Resolution:	The Committee **NOTED** the report.
Action:	Winter Wrap up Report to be presented to the March meeting Breakdown of the roles and responsibilities of the Health Board and other agencies in relation to Substance Misuse services to be submitted to the Executive Board. Report to be presented to a future meeting of the Committee in relation to Physicians Associates outlining training, governance and patient communication.
5.4	**Care Group Highlight Reports**
5.4.1	**Primary Care & Communities Care Group Highlight Report**
	Z Ashman presented the report and highlighted the key matters for Members attention. K Palmer welcomed the update provided in relation to the 8 care processes and raised a query in relation to dental contracts and whether the impact assessment was taking into consideration those who could not afford private dental care. In response Z Ashman advised that the impact assessment would focus on managing affected patients with mitigations including redistribution to other NHS dental practices. Further updates would be provided at future meetings. In response to a query raised by P Roseblade as to whether there were any shift fill consequences of the GP Out of Hours shortages during the Christmas period, G Hughes advised of the ongoing challenges in filling GP out of hours shifts due to national contract issues and added that recruitment was on hold pending resolution of a financial contractual position from Welsh Government and NHS Employers. H Proctor made reference to the absorption of the Cellulitis service workload and added that she would welcome a further update as to how this was going to work. Z Ashman confirmed that demand and capacity activities were being reviewed and added that she would provide a more detailed update to the next meeting.
Resolution:	The Committee **NOTED** the report.
Action:	Next report to include further updates on the dental contract and the demand and capacity activities of the Cellulitis service workload.
5.4.2	**Diagnostics, Therapies, Pharmacy & Specialities Care Group Highlight Report**
	H Wilton presented the report and highlighted the key matters for Members attention.

	C Donoghue inquired about the absence of cardiac arrest and affray alarms for lone workers in MRI at RGH, to which C Verrecchia responded that refurbishment work is underway to address these safety concerns and added that this matter should be closed prior to the next meeting.
Resolution:	The Committee **NOTED** the report.
5.4.3	***Mental Health & Learning Disabilities Care Group***
	L Griffiths presented the report and highlighted the key matters for Members attention. R Hughes highlighted that Healthcare Inspectorate Wales recently undertook a planned visit to the Community Mental Health Team and an unannounced inspection at Ty Llidiard. Members noted that whilst both visits were largely positive, some learning had been identified which the Team were in the process of addressing.
Resolution:	The Committee **NOTED** the report.
5.4.4	**Planned Care Care Group Highlight Report**
	S O'Brien presented the report and highlighted the key matters for Members attention. In response to a query raised by H Proctor as to whether Hospital at Home services were expected to absorb additional demand related to trauma pressures, S O'Brien confirmed that whilst Hospital at Home formed part of the overall discharge solution, this was not appropriate for all patients. Members noted that focus remained on ensuring patients were placed on the most appropriate pathway and that escalation occurred promptly where barriers to discharge were identified. It was acknowledged that trauma demand had increased significantly, particularly over the winter period, and that this had been compounded by business continuity pressures. Assurance was provided that no cancer or urgent cancer cases had been cancelled during this period. A number of mitigations were outlined, including enhanced daily board rounds, focused oversight of trauma wards, and joint working with community and primary care partners. C Donoghue sought clarification on the progress and impact of elective orthopaedic activity, particularly weekend working. S O'Brien stated that it was reported that a seven day elective arthroplasty model had commenced at Princess of Wales Hospital, supported by Welsh Government funding. C Donoghue sought further details on the impact of insourcing and additional outpatient clinics, and it was confirmed that, between September and December, approximately 11,000 patients had attended additional outpatient appointments delivered through weekend clinics and insourcing arrangements. Members were advised that this had made a substantial contribution to reducing waiting lists and improving access for patients.
Resolution:	The Committee **NOTED** the report.
5.4.5	**Children & Families Care Group Highlight Report**

	C Verrecchia presented the report and highlighted the key matters for Members attention. In response to a query raised by K Palmer as to where updates in relation to the Women's Health Hub would be received, C Thompson advised that a Board briefing would be provided ahead of go-live. C Verrecchia confirmed that quality and safety reporting would flow through both Children and Families and Primary Care and Community Care Group highlight reports. Members were advised that referrals would commence imminently and that early triage activity had already commenced. In response to a query raised by P Roseblade in relation to the Industrial Action and the potential outcome of the ballot being undertaken by Unite with Health Visting staff, H Daniel confirmed that the ballot was ongoing at the time of the meeting and that discussions with trade union colleagues were planned. It was noted that the Health Board had raised concerns regarding the accuracy and legitimacy of the ballot information recognising that this was not solely a local issue, but a national issue. The Committee was assured that partnership working with trade union representatives would continue. In response to a query raised by P Roseblade as to whether BadgerNet was used across the whole of Wales and whether CTM was behind other Health Boards in terms of meeting the Welsh Government deadline, C Verrecchia confirmed that BadgerNet is a Wales-wide system supported by Digital Health and Care Wales and that the Health Board remained on track for the Welsh Government deadline. C Donoghue noted assurance provided that previously escalated nationally reportable incidents within the Care Group had been externally reviewed, with findings confirming that internal investigation processes were robust and learning appropriate. It was confirmed that the associated risk would now be removed from the risk register.
Resolution:	The Committee **NOTED** the report.
5.4.6	**Unscheduled Care Group Highlight Report**
	D Matthews presented the report and highlighted the key matters for Members attention. In response to a query raised by L Edwards as to where the monitoring of the action plans in relation to the quality improvement work undertaken at Ysbyty George Thomas would be undertaken, D Matthews confirmed that this work was being overseen through Unscheduled Care governance arrangements, with close involvement from therapy services and patient safety colleagues to ensure learning was identified and acted upon.
Resolution:	The Committee **NOTED** the report.
5.5	**Stroke Services Report – Bi-Annual Update**
	D Mathews, G Howell and C Thompson presented the report and highlighted the key matters for Members attention.

	K Palmer sought clarity as to how the Health Board were ensuring ambulance crews understand where to take FAST-positive patients and what advice was being given to the public in regard to whether people should call an ambulance or self-present. G Hughes advised that FAST positive patients were always conveyed to Royal Glamorgan Hospital. Members noted that public messaging encouraged calling an ambulance to enable pre-alert processes and rapid CT and noted that internal transfers operate quickly using internal ambulance pathways with improvements at EDs (PCH& POW), meaning all sites now follow standardised pathways for rapid CT access. P Roseblade raised a question on how confident the team were that performance can be sustained. D Matthews and G Hughes acknowledged that the service had faced significant challenge during the transition, however, the current performance reflected genuine system improvement rather than short-term measures. Positive feedback was shared regarding multidisciplinary team functioning, staff engagement and clinical leadership, with clinicians describing the service as markedly improved compared to the early post consolidation period. It was recognised that further work was required, but welcomed the clear governance, quality improvement focus and positive trajectory.. Positive feedback was shared regarding multidisciplinary team functioning, staff engagement and clinical leadership, with clinicians describing the service as markedly improved compared to the early post-consolidation period.
Resolution:	The Committee **NOTED** the report
6.	**DELIVERING OUR PLAN**
6.1	**Patient Safety, Quality & Experience Dashboard**
	R Hughes introduced the report and B Gammon presented the dashboard, highlighting the key matters for members attention. Members noted that the report also included greater detail in regard to Public Services Ombudsman for Wales cases relating to CTM from a compliance aspect and it was noted that further consideration would need to be given to the recommendation contained within the report that stated that actions would need to be monitored via this Committee. C Donoghue advised that further consideration would need to be given to the format this would be presented in. P Roseblade raised the fact that complaints and Ombudsman reports describe individual case actions, queried where the evidence of systemwide learning is and queried the link between incident reporting and Duty of Candour triggers. R Hughes agreed that the Ombudsman report needed more analysis rather than description and proposed revising how learning and improvement were presented. R Hughes advised that Duty of Candour triggers were checked by senior staff before confirmation and a refreshed presentation around Duty of Candour compliance would be brought forward. In response to a query raised by H Proctor as to whether digital systems were contributing to complaint themes such as referral rejections, R Hughes stated that digital dependencies must be considered in thematic learning and that work with Digital Health and care groups was required to understand system-level causes.

	In response to a query raised by K Palmer as to whether the Team still planned to undertake an in-depth review of themes captured within concerns relating to communication issues, B Gammon advised that whilst this had been captured in the Peoples Experience Activity report, she was planning on undertaking a deep dive to interrogate the date further.
Resolution:	The Committee **NOTED** the report.
Action:	In relation to Ombudsman cases, further consideration would need to be given to the recommendation contained within the report that stated that actions would need to be monitored via this Committee with further consideration to be given to the format this would be presented in. More analysis to be provided on the Ombudsman report of how learning and improvement are presented
6.2	**People's Experience Activity Report October - November 2025**
	B Gammon presented the report and highlighted the key matters for Members attention
Resolution:	The Committee **NOTED** the report.
7.	**GOVERNANCE, RISK AND ASSURANCE**
7.1	**Organisational Risk Register – Risks Assigned to Quality & Safety Committee**
	A number of questions were raised ahead of the meeting in relation to this item and are outlined below together with the responses received: ***Planned Care and Commissioning*** ***Question*** *- Risk ID 6280- 'Suspension of the Regional Hepato-Pancreato-Biliary service model'- are discussions scheduled or in progress with JCC ?* ***Response:*** *Yes- we are in close discussions with both C&V UHB and SBUHB who jointly provide this service.* *Models have been proposed and we are responding to the consultation and ensuring the best options are taken forward for our population. We do still have a service in place on a case by case basis in the interim.* *This is a very important service (and by consequence vital we develop the right care) for CTM as we do not have in house teams who can pick these high risk cases up.* ***Unscheduled Care – Care Group*** ***Question:*** *Risk ID 3826 –'Emergency Department (ED) Overcrowding' – Question: are we able to demonstrate the impact of the mitigating actions.?*

Response: *Risk reviewed and remains unchanged, however to note we need to record that patients are not nursed in no clinical areas and we have an escalation and QIA for a handover space on each site.*

DTPS Care Group

Question*: Risk ID 2713 – 'Backlog of Reporting Radiology Examinations' – Question: it would be good to have a verbal update on these in the meeting?*

Response: *Risk will be reduced to 12 as position is improving*

Question*: Risk ID 6379 – 'CT Scanners at RGH damaged by power outage and manual generator/UPS switch over' Question: it would be good to have a verbal update on these in the meeting?*

Response: *New switches fitted to both CT scanners in December. Risk will now close*

Primary Care and Community

Risk ID 6397 'Shortage of GPs to deliver urgent primary care services for escalation'. ***Question:*** *GP OOH and Navigation Hub recruitment I guess may be one we want to highlight to the Board?*

Response *- this will be included in the alert/escalate section of the QSEC Highlight report to March Board*

Children and Family Care Group

Risk ID 6217 'A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity'. ***Question:*** *will this be reduced or removed in light of the outcome of the external review highlighted in the Children and Families Care Group report?*

Response: *Risk now closed*

G Watts presented the report and highlighted the key matters for members attention. C Donoghue advised that she had raised a number of questions outside the meeting regarding some risks and noted that responses would be shared outside the meeting.

K Palmer asked for more detail to be given on the emerging risk around discharge and care homes. C Thompson stated that work is underway with local authority partners to stabilise the sector and added that further work would need to be undertaken by the Regional Partnerships Board on the longer-term plan for the Care Home market.

Resolution:	The Committee **REVIEWED** the risks escalated to the Organisation Risk Register and **CONSIDERED** that all that can be done is being done to mitigate the risks.
Action:	Responses to be shared outside the meeting to the questions raised prior to the meeting regarding the Organisational Risk Register.
7.2	**Clinical Effectiveness Update 2025-2026**
	S Davies presented the report and highlighted the key matters for members attention. P Roseblade stated that current reporting gives reassurance that audits occur, but not assurance about outcomes, and queried whether the committee should have more insight into audit findings. G Watts agreed that reporting must better address the "so what" and the impact of the audit to demonstrate the improvements that have been made. Members noted that this issue would be taken forward in revision of terms of reference and reporting structure.
Resolution:	The Committee **NOTED** the report
Action:	Review the current reporting structure in relation to clinical audit to provide stronger audit outcomes along with a revised terms of reference.
8.	**CONSENT AGENDA**
8.1	**FOR APPROVAL**
8.1.1	**Unconfirmed Minutes of the Meeting held on 18 November 2025**
	The Unconfirmed Minutes of the Committee Meeting held on 18th November 2025 were **APPROVED.**
8.1.2	**Unconfirmed Minutes of the In Committee meeting held on 18 November 2025**
	The Unconfirmed Minutes of the In-Committee Meeting held on 18th November 2025 were **APPROVED.**
8.1.3	**Annual Cycle of Business for 2025**
	The Committee **NOTED** that the Annual Cycle of Business will be presented in March meeting.
8.1.4	**Organ Donation Sub Committee January – December 2025** The report was **APPROVED**
8.1.5	**Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents** The Policy on Policies was **APPROVED.**
8.1.6	**IM and Exec Walkabouts Operating Model** In response to a query raised by H Proctor as to when this new operating model would go live, R Hughes advised that he would review timelines and present an update to the next meeting of the Committee.
Action:	Timelines to be reviewed in relation to a proposed go live date of the new IM and Exec Walkabouts Operating Model.
8.2	**FOR NOTING**
8.2.1	**Non-Routine Committee Business (Forward Plan)**
	The Committee **NOTED** the Forward Plan.
8.2.2	**Health Inspectorate Wales (HIW) Improvement Plan tracker Report**
	The Committee **NOTED** the report.
8.2.3	**Human Tissues Act Compliance Progress Report**
	The Committee **NOTED** the report.

8.2.4	**RADAR Update**
	The Committee **NOTED** the report.
9.	**CLOSE OUT BUSINESS**
9.1	**Committee Highlight Report to the Board – Verbal**
	G Watts advised that this would be drafted by the Corporate Governance Team outside the meeting. Suggested areas for escalation included: • Centralisation of Stroke Services as a positive escalation; • The reduction in risk score for Paediatrics Dentistry as a positive escalation; • The Unite Ballot for Health Visitors as an area of concern
9.2	**Meeting Feedback**
	C Donoghue advised that she would welcome feedback from members and attendees outside this meeting.
9.3	**Any Other Business**
	C Donoghue extended her thanks to S Davies for all the support she had provided to the Committee and wished her well in her retirement. C Donoghue also noted that C Hamblyn was now on a period of extended leave and added that she had found the support that had been provided by C Hamblyn invaluable.
10.	**PRIVATE / CLOSED SESSION BUSINESS**
	C Donoghue confirmed there were no items requiring discussion in closed session on this occasion.
11.	**DATE & TIME OF THE NEXT MEETING**
	Tuesday 23 March 2026 at 9:00am

Agenda Item
5.1.2

Quality, Safety & Experience Committee

All Wales Top-Up Policy

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire Tynan-Preece, Commissioning Manager & Katie Games, Head of Commissioning
Cyflwynydd yr Adroddiad / Report Presenter	Philip Daniels – Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Interim Executive Director of Public Health

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Widespread stakeholder engagement	2009	Supported
Chief Pharmacist Medicine Governance (CTM)	February 2026	Supported
Chair of CTM Medicine Group	February 2026	Supported

Acronyms / Glossary of Terms	
AWMSG	All Wales Medicine Strategy Group
IPFR PIG	Individual Patient Funding Request Policy Implementation Group
CTMUHB	Cwm Taf Morgannwg University Health Board

QSEC	Quality, Safety & Experience Committee

1. Situation /Background

In August 2008, the Minister for Health and Social Services commissioned Professor Philip Routledge, Chair of the 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*.'

In May 2009, the Minister established an Implementation Group comprising clinicians, pharmacists, nurses, NHS Managers, a health economist, and trade union representative 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 is 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 are currently disadvantaged by not being able to access medicines via the top-up Policy.

2. Specific Matters for Consideration

2.1 What is a Top Up request?

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.

This is available for any patients where their consultant believes that an NHS non-funded medicine may offer a potential clinical benefit despite not being approved as a routine NHS treatment. Top-up is only used when all NHS avenues have been explored, and where the patient and clinician agree that there may still be potential benefit in receiving the top-up medicine.

The top-up Payment to Medicines Policy and Procedure provides a clear and robust framework for the effective management, governance, and monitoring of top-up payments for medicines. Its purpose is to ensure that all top-up activity is undertaken consistently, transparently, and in line with national NHS principles.

All individuals involved in considering, approving, or administering top-up arrangements are required to comply fully with the NHS Wales approved policy and procedural requirements. This ensures equitable decision making, appropriate use of NHS resources, and adherence to the principles of access based on clinical need rather than ability to pay.

2.2 Top-Up policy review

The All-Wales IPFR Network and Policy Implementation Group (IPFR PIG) undertook a review of the 2016 Policy. During the Policy Implementation Group review, All NHS Wales Health Boards and Trusts mutually agreed revisions to the policy that supported local adoption.

The revised Top-up Payment to Medicines Policy and Procedure (Appendix 1) has therefore been streamlined, with clearer governance that includes:

Updates to:

- IPFR application – this is now optional rather than mandatory.
- Top-up patient checklist – this has been updated.
- Agreement to pay form – this has been updated.

Revisions:

- Requirement for upfront payment and one month advance for subsequent treatments.
- Clear directive that does not permit NHS subsidisation of any part of Top-up treatment.
- No reimbursement if the NHS later funds the medicine.
- Emphasis on compliance with Private Patients Policy and professional codes.

The updated policy and procedure was shared with the Principal Pharmacist for Medicine Governance and Chair of the CTM UHB Medicine Group, who are supportive of the new policy.

3. Key Risks / Matters for Escalation

3.1 Equity

The All-Wales top-up policy was not previously adopted or implemented for use in CTMUHB or its predecessor organisations at the time and is the only health board in Wales who does not offer this option to its patients. Therefore, there is a need to formally adopt the top-up policy.

3.2 Current demand for Top-Up

A peer review demonstrated that current demand for top-up requests across all Health Boards appear minimal since its original development and implementation in 2016. This appears to be mainly due to limited awareness of the policy.

Since 2023 the number of requests considered via this policy are:

NHS Wales Organisation	Number of Requests
Aneurin Bevan University Health Board	0
Cardiff & Value University Health Board	0
Powys Teaching Health Board	0
Hywel Dda University Health Board	0
Betsi Cadwaladr University Health Board	2
Swansea Bay University Health Board	11
Velindre University NHS Trust*	20-30 per year

*The number of requests is attributed to the cancer drug utilisation that fall within the parameters of the top-up policy.

3.3 Financial implications

The updated 2025 Top-Up Payment to Medicines Policy and Procedure does not introduce new financial commitments. Instead, it provides clarity for financial governance, including:

- upfront payment requirements,
- advance payment for subsequent cycles,
- strict prohibition on any NHS subsidisation of top-Up treatments.

These measures ensure the health boards recover all associated costs including diagnostics, staff time and medicine access, thereby reducing financial risk and improving cost-control. The policy also reinforces that no reimbursement will be provided if a medicine later becomes available/NHS funded, preventing retrospective financial liability for the organisation.

3.4 Administration of the Top-Up Policy

There is no additional internal funding requirement associated with implementing this policy within CTMUHB.

An assessment of the risk associated with not implementing the original policy along with the very low number of requests received by other health boards across Wales concluded that the administration of the top up policy can be supported by the Commissioning Team. However, demand for top-up requests will be monitored at 6 months and 12 months from the date of implementation.

The Commissioning team, in collaboration with the finance officer and relevant clinicians will act as the administrative lead for patients deemed appropriate for top-up payments.

This is consistent with section 4.1 (Health Board Responsibilities) of the policy (Appendix 1).

3.5 Staff awareness and communication

Staff involved in top-up activity including clinicians, pharmacy teams and administrative staff, will need awareness and understanding of the new processes.

Once the policy has been approved we will cascade out to the Care Groups and include as an agenda item in the next round of Care Group commissioning meetings.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Choose an item. If more than one applies, please list below: Linked to all strategic areas
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Choose an item. If more than one applies please list below: Linked to all wellbeing goals
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Choose an item. If more than one applies please list below: Links to all domains; Effective, efficient, equitable, patient centred, timely and safe The updated policy: • enables individuals to access medication not funded by the NHS. • strengthens governance and consistency. • provides clearer consent and financial safeguards. • patients receive more transparent information about risks, costs and treatment implications.

	• aligns with national standards which reduces risk and variation, also reducing the likelihood of challenge or complaints.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: EQIA undertaken at the time of the original policy
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	The updated (2025) Policy is compliant with the NHS (Wales) Act 2006, the Equality Act 2010 and Welsh Language duties, ensuring the health board continues to meet its legal obligations in delivering equitable and non-discriminatory services across Wales. It reduces legal risk by providing a transparent and consistent process across Wales.	
Enw da / Reputational	Yes (Include further detail below)	
	Adopting the policy ensures equity across Wales	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Where patients request to self-fund medication are supported there will be additional input from health board teams, however, the policy states that any associated costs should be included in the cost of the medication and therefore part of the value re-charged to the patient.	

5. Recommendation

The Quality, Safety & Experience Committee (QSEC) is asked to **approve** and **endorse** the All-Wales Top-Up Policy and Procedure for implementation within the health board.

6. Next Steps

Once the policy is approved the commissioning team will ensure Care Groups are aware of the policy & associated process.

Appendix 1

Top-up Payment to Medicines Policy and Procedure

Reference Number:	**As per individual Health Board**	**Version:**	**Final Nov 2025**
Linked Documents:	**All-Wales Individual Patient Funding Request Policy (IPFR)**		

Executive Summary

Overview	To ensure effective management and monitoring of Top-up payments for medicines, all individuals involved in considering or administering Top-up activity must comply with the Health Boards policy and procedural framework. Reference should be made to the document produced by the National Assembly for Wales, Medicines funding in the NHS October 2011. 11-062-English.pdf (senedd.wales)
Key Messages included within the policy:	**Clinicians and managers are encouraged to exhaust all options for securing NHS funding before proposing a Top-up.** The following **key principles** must always be upheld: • The NHS will continue to ensure timely, appropriate, evidence-based access to cost-effective medicines for all, whilst maintaining its core principles regardless of Top-up arrangements. • Access to NHS services and medicines will be based on clinical need, and not an individual's ability to pay. • NHS services will meet the highest standards and reflect the needs and preferences of patients, families, and carers. • The primary purpose of NHS organisations is to provide clinically and cost-effective services, ensuring fair and efficient use of finite resources. **Definition** - The term Top-up Payment has been defined by the House of Commons Health Committee as follows: *"Payment made by a patient for a medicine (and related care) not approved or funded by the NHS".* **Procedural Framework –** To ensure effective management and monitoring of Top-up payments for medicines, the Health Board requires strict adherence to this procedural framework by all parties involved. Co-operation of consultants is essential for the early identification of patients who may qualify for Top-up payments after all NHS funded options have been exhausted. Consultants should discuss the option of submitting an Individual Patient Funding Request (IPFR) with any patient considering a Top up payment for a medicine not routinely funded by NHS Wales. This process ensures all NHS avenues have been explored and enables the Health Board to obtain the patients formal agreement to cover the relevant charges. Clinicians and NHS Staff must fully comply with the six principles set out in the Health Boards Private Patients Policy.

Contents

Background/Introduction

In August 2008, the Minister for Health and Social Services commissioned Professor Philip Routledge, Chair of the All-Wales Medicine 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.*

In May 2009, the Minister established an Implementation Group comprising clinicians, pharmacists, nurses, NHS Managers, a health economist, and trade union representative 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).

NHS Principles

This policy will be implemented at all times in accordance with the following key principles:

- The NHS will provide a comprehensive service and range of medicines available to all.
- Access to NHS Services and medicines will be based on clinical need and not an individual's ability to pay.
- NHS services will meet the highest standards and reflect the needs and preferences of patients, their families, and their carer's.
- The main purpose of NHS organisations will be to provide NHS services in a cost-effective manner making the most effective, and fair use of finite resources.

Clinicians and managers are encouraged to exhaust all options for securing NHS funding prior to proposing a top-up.

Terminology

The Implementation Report adopts the definition of "Top-up payment" provided by the House of Commons Health Committee:

"A p*ayment made by a patient for a medicine (and related care) not approved or funded by the NHS".*

Under this definition, a Top-up payment enables access to a medicine that supplements or replaces NHS provided treatment for a specific condition.

In Wales, the primary route for accessing new or high-cost medicines are:

- Recommendations from the All-Wales Medicines Strategy Group (AWMSG)
- Appraisal guidance from the National Institute for Health and Care excellence (NICE)
- Individual Patient Funding Requests (IPFR), which allow case-by-case consideration.

The IG Report concluded that Top-up payment may be appropriate where, for clinical reasons, a clinician believes a medicine, despite not meeting approval criteria or being declined via an IPFR, could still benefit the patient.

Responsibilities

Health Board Responsibilities

The Cabinet Secretary for Health and Social Care requires all Health Boards to implement the procedures recommended in the Implementation Group (IG) report.

Accordingly, the Health Board will establish a procedural framework for managing top-up payment cases, covering identification, administration, and recovery of charges.

The Commissioning Manager, in collaboration with the finance officer and relevant clinicians will act as the administrative lead for patients deemed appropriate for Top-up payments.

Clinician's Responsibilities

The Health Board relies on clinicians to identify, at an early stage, patients who may be eligible for Top-up payments. This ensures all reasonable NHS funded options have been explored before advising

that a patient's only remaining option is to self-fund treatment. It also enables the Health Board to secure the patients formal agreement to cover the relevant charges.

The Health Board acknowledges that some patients may choose to purchase medicines via Top-up payments before, or instead of, an Individual Patient Funding Request (IPFR) being submitted. In such cases, clinicians must ensure that:

- the patient is informed of all available funding routes.
- the treatment or indication has not been approved under an Early Access to Medicines Schemes (EAMS) or similar scheme.
- the patient understands that medicines purchased via Top-up will not be retrospectively refunded if subsequently approved through IPFR, routine NHS funding or other mechanisms.

Only after these avenues have been fully explored should clinicians advise that Top-up payment is the sole remaining option.

Consultant and NHS staff must comply with the Procedural Framework, including the completion of the Top-up patient checklist (Appendix 1), in collaboration with the patient and/or their representative.

Top-Up Payment arrangements

Where the Health Board agrees that NHS facilities may be used for the provision of a Top-up treatment, the following principles apply:

- The Health Board will set reasonable charges for the use of its services, accommodation and or facilities.
- Charges will be collected by the Health Board from the patient or an appropriate third party.
- Charges will reflect all associated costs, including diagnostic procedures, laboratory staff involvement, NHS equipment usage, administration of additional treatment, and any related activity

Additional funded care may be provided by the Health Board if required and agreed by the treating clinician. When developing charges for NHS patients receiving care not routinely provided by the NHS, the following principles must be applied:

- Patients must meet any additional direct costs associated with the Top-up treatment, including treatments required to manage side effects.

- Care normally provided as part of standard NHS practice must remain free of charge.
- Where diagnostic or monitoring procedures are required for both NHS and Top-up care, these should be provided once by the NHS as part of the patient's entitlement, avoiding duplication.
- The NHS should manage non-emergency complications arising from Top-up care and must never refuse treatment because the complication is unclear.
- Emergency care must always be provided by the NHS.

Each Directorate undertaking Top-up activity must comply with the procedures outlined in this policy.

The contact details for the Commissioning Manager are detailed below. They should be contacted for any queries relating to Top-up payments.

Commissioning Manager – Cwmtaf.IPFR@wales.nhs.uk

Legal Framework

The Implementation (IG) Report confirmed that there is no legal barrier to a patient using a Top-up payment to access a medicine within NHS Wales. For example, where a medicine has not been approved for use in Wales by NICE, AWMSG or via the One Wales process, or where an IPFR has been submitted and declined, it is lawful for the Health Board to provide the medicine and associated services as part of a Top-up treatment package.

The Health Board also recognises that patients may choose to fund a medicine through a Top-up payment without submitting an IPFR. In such cases, clinicians must comply with their responsibilities as set out in Section 4.2 and adhere to the Top-up payment arrangements detailed in Section 4.3.

Delivery of Care

Care delivery will be determined on an individual basis, following a thorough assessment of clinical need and specific requirements.

Professional Liability and Indemnity Responsibilities

The Health Board is indemnified by the Welsh Risk Pool for all medical and non-medical staff undertaking activities related to Top-up payments, as these activities are considered part of NHS service provision.

The Welsh Risk Pool scheme covers all risks associated with NHS activity in accordance with Welsh Health Circular (2000) 04, (*Revised Welsh Risk Pool Management Arrangements from 1st April 1999)* and WHC's (2000) 12 and 51, (*Insurance in the NHS in Wales*).

For guidance on private patient activities, please refer to the Health Boards Private Patients Policy, as liability and indemnity arrangements differ for private care.

Equality Impact

The Health Boards has reviewed this policy equitable outcomes for all patients. Where potential negative impacts are identified, appropriate solutions or justifications will be provided.

Welsh Government guidelines underpinning this policy have highlighted potential risk of discrimination related to social inclusion and economic barriers. To mitigate these, the Health Board will support any request for Top up payment by ensuring all NHS funded options have been fully explored.

Additionally, if recurring patterns of requests for specific drugs or treatments emerge, the Health Board will notify the Welsh Government via the All-Wales Medicines Strategy Group and request a review the current funding position for those treatments.

Review

This Policy will be reviewed every 3 years, or sooner if required to reflect changes in legislation or guidance. Reviews will be conducted by the All-Wales IPFR Policy Implementation Group in accordance with its Terms of Reference and approved by the responsible Health Board. Any delay in review will not affect the validity or enforceability of this policy.

Acknowledgement

This policy and procedural framework are based on recommendations of the Implementation Group Report, with full acknowledgement of its sources.

Procedural Framework

To ensure effective management and monitoring of Top-up payment activity, the following procedural framework must be implemented and strictly adhered to by all parties involved.

Communication / Information to the patient

Clinicians must demonstrate clear and effective communication when discussing Top-up treatments. Patients should be fully informed about their condition, as well as the potential benefits and risks of the medicines involved in the Top-up arrangement.

All treatment options, both NHS funded and Top-up, must be discussed during the NHS consultation. Clinicians must comply with paragraph 2.9 of the Code for Private Practice which states: -

> *"In the course of their NHS duties and responsibilities, consultants should not initiate discussion about providing private services to NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf".*

The Health Board must ensure patients receive all necessary information and understand the options available to them.

Clinician must complete the Top-up Patient Checklist (Appendix 1) for all cases where Top-up payment is being considered. A copy should be retained in the designated Top-up payment file held by the Commissioning Manager.

The predictable cost of treatment must be clearly outlined and agreed with the patient before treatment commences. Patients will not be liable for costs associated with unpredictable events. However, they must be prepared to pay for non-emergency interventions, planned treatment of scans, essential monitoring, and foreseeable consequences of the Top-up treatment. Patients must acknowledge these risks and accept financial responsibility prior to starting treatment.

The Health Board will not subsidise any element of Top-up treatment package, and this must be made explicit to the patient before commencement. Patients should also be informed that opting for a Top-

up treatment will not confer any advantage regarding NHS waiting list positions. Their status will remain the same as those receiving standard NHS Care.

If a patient becomes unable to continue funding the Top-up package, the treatment will cease. The NHS will not assume responsibility for continuing Top-up treatment.

Charges and payments will be appropriately calculated.

Considering Top-Up Payment

Stage 1 – IPFR application

If the patient and clinician wish to pursue NHS funding, an IPFR application should be completed and submitted for consideration by the Health Boards IPFR Panel.

When assessing an application, the following criteria will be considered, subject to available resources:

- Licensed indication
- Status of drug under NICE, AWMSG or One Wales guidance.
- Clinical evidence supporting use (e.g. clinical trials results).
- Likelihood of significant clinical benefit compared to other patients with the same/similar condition.
- Cost-effectiveness.

For further details, refer to the All-Wales IPFR policy.

If the request is declined, the decision letter will outline the reasons provided to the requesting consultant.

In some cases, patients may choose not to pursue an IPFR application and instead proceed directly to a Top-Up Payment. To do so, they must have the support of their clinician. Both parties must sign the disclaimer at the foot of the Top-up Patient Checklist confirming that NHS funding is not being sought.

Stage 2 – Top-Up Scheme

The clinician must discuss the option of a Top-up treatment with the patient and provide a copy of the Top-up Patient Information Leaflet. At this stage, patients should be advised of the potential risks and benefits of the proposed medicine and encouraged to consult with their family or relatives before making a final decision.

Stage 3 – Second Opinion

Patients considering a Top-up treatment should receive a second medical opinion to confirm that the advice provided is appropriate and that they fully understand the benefits, risks, and safety of the proposed treatment.

The second opinion will be arranged at the Health Boards expenses and provided in a timely manner. It does not need to come from a senior clinician in the same specialty. It may be obtained from another clinician within the treating Health Board.

If the clinician providing the second opinion disagrees with the proposed treatment plan, they must contact the referring clinician to discuss on an appropriate way forward.

Stage 4 Top-Up Checklist

The Commissioning manager must be notified of any the Top-up payment request in coordinate the process. The Top-up checklist must be signed by both the patient and clinician, confirming their understanding of the process. The relevant Top-up Patient Information Leaflet should be provided to the patient by the clinician prior to their final decision. This leaflet is either available from the xxx or from the Health Board website.

The Commissioning manager will liaise with the clinician and pharmacy to ensure all preparatory work for the provision of the Top-up medicine is completed.

Patients will be provided with full details of the costs and advised on payment arrangements in line with the Health Boards payment system. Payment must be made upfront and one month in advance of any subsequent treatments. No treatment will commence until payment is received. Missed appointments without prior notice will be recorded as ‘DNA’ (Did Not Attend) and will not be reimbursed.

Before treatment begins, patients must complete the Agreement to Pay Form for Top- up payments (Appendix 2). The signed form confirms the patient's decision to proceed with treatment under a Top-up arrangement.

The Commissioning manager will maintain a database of all relevant information, ensuring accessibility for the Finance Department.

The Health Board will recover its costs without generating additional profit from Top-up treatments. For medicines supplied under Top-up arrangements, a nominal administrative fee may be applied. As drug acquisition costs are often commercial in confidence, the total charge presented to patients will be include this fee.

Stage 5 – Completion of the Process

To confirm that all required steps have been completed, the Commissioning manager will forward the case for sign off by the requesting clinician and relevant finance lead or other required health board representative as per the Scheme of Delegation.

Local sign off process:

- Upon receipt of a request, the commissioning manager will review the checklist to ensure all sections are completed.
- The request will be forwarded to the required health board representative as per the Scheme of Delegation.
- Outcome emailed to clinician, pharmacy colleagues and finance leads to facilitate the administration and invoicing.

Monitoring and Audit

The Health Board will ensure ongoing monitoring of both Top-up payment care packages and individual patient funding requests.

The Commissioning Manager will conduct an annual review of Top-up payment medicines to identify any patient cohorts that may warrant an All-Wales review of the current funding position.

The Commissioning Manager will ensure compliance with the procedural framework, including completion of the Top-up checklist (Appendix 1).

Standards of Practice for all NHS Staff

All staff must adhere to their professional code of conduct and comply with the Trust Register and Declarations of Interest Policy, which requires them to:

- Prioritise the interest of service users at all times,
- Act impartially and honestly in all official business,
- Use delegated Health Board funds responsibly, ensuring value for money; and
- Declare any incentives offered by companies seeking contracts, so these can be excluded from tender evaluations.

Additionally, staff must not:

- Use their position for personal gain or to benefit family, or friends.
- Seek advantage for any business or interest during official duties.

Training / Implementation

The Commissioning Manager will collaborate with relevant groups to promote awareness and understanding of this policy and its procedural framework.

Appendix 1

Top-Up Checklist

This form **MUST** be completed for all patients choosing to receive a Top-up treatment package alongside their NHS Treatment.

The patient has the right to proceed to the Top-up process without having first accessed IPFR, therefore point 5 and 6 will not be applicable; however, the disclaimer at the foot of the form will need to be completed.

Patient Information			
Patient's name:			
Date of birth:		NHS No:	
Address:			
Postcode:			
Contact telephone number:			
Email address:			

Top-Up details
Details of proposed Top-up treatment:
NHS Provider:
Top-up provider:
Diagnosis/Indication for Treatment:
Optimal start date for treatment:

Checklist	**Clinician**	**Patient**

1.	The patient (or their representative) has received written information about the proposed treatment in addition to a face-to-face consultation.		
2.	The patient (or their representative) has been given full information about the potential benefits, risks, burdens, and side effects of the treatment.		
3.	This information has been recorded on the consent form for the patient's treatment. Informed consent has been obtained in line with GMC guidance and Hospital protocol.		
4.	The patient has received a second clinical opinion		
5.	Funding options with the NHS for the proposed treatment have been explored and are exhausted.		
6.	The proposed treatment has been considered by an Individual Funding Request Panel (If no, please ensure to complete the disclaimer at the foot of this form).		
7.	The outcomes of this treatment with be contributed to relevant national monitoring programmes.		
8.	The outcomes of this treatment will be discussed at multi-disciplinary clinical meetings.		
9.	The patient understands that the additional medicines and any associated costs (e.g. extra tests, monitoring, days in hospital etc) are not being funded by the NHS		
10.	The patient understands that full payment of a treatment cycle is required before commencing the subsequent cycle.		
11.	The patient (or their representative) has received written information about the proposed treatment costs and payment plan		
12.	The patient understands that if they become unable to fund their Top-up package the treatment will stop, and that the NHS are not able to provide the Top-up treatment.		
13.	The patient has signed and returned the Agreement to Pay – PP1//A form		
14.	The patient understands that if the NHS decides to fund this treatment at a future date, including as a result of an IPFR application, the NHS will not refund the cost of treatment already given as part of a Top-up treatment.		

	Signed	**Print name**	**Date**
Patient or representative:			
Clinician:			

Disclaimer – only to be signed if points 5 and 6 in the checklist above are not applicable.

I understand that an application for an Individual Patient Funding Request has not been made – it is my wish to proceed directly to the Top-up process.			
	Signed	**Print name**	**Date**
Patient or representative:			
Clinician:			

Appendix 2

Top-Up Payment

Agreement to Pay

Patient Information			
Patient's name			
Date of birth		NHS No	
Address			
Postcode:			
Contact telephone number:			
Email address:			

Top-Up details			
Details of Top-up treatment			
Dose:		Cost	
Treatment plan:			
Clinician and location:			

Payment details					
Self-funding:	☐	Private Healthcare	☐	Employer or third party sponsored	☐
Insurance Provider (if applicable)					
Membership or policy number (if applicable)					

Financial & Data Protection Declaration
I accept liability for payment of the charges determined by xxx Health Board for the Top-up treatment provided by the UHB as a patient of Mr/Mrs/Miss/Dr/Prof:
I agree to settle the payment of my treatment cycle in full before commencing the next cycle of treatment.
I accept that the UHB reserves the right to request payment of its charges in advance, where advised and agreed prior to treatment commencing.
I consent to disclosure by the UHB of clinical information on my condition and treatment to my insurance company if necessary to approve my claim. I can request a copy of the report before it is disclosed if I so wish.

Signed: **(patient)**		**Date:**
Witness:	**Relationship:**	**Date:**

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

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

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
14 August 2024	Request received by email for this to be presented as a spotlight presentation to a future meeting of the Committee	Senior Nurse Acute Deterioration and Outreach Services	Spotlight Presentation Decision Making around ACP/DNACPR/TEP	Case presentation to highlight the need for more resource in end-of-life education and training	Senior Nurse Acute Deterioration and Outreach Services	Executive Medical Director	25 March 2025	**Proposed for Closure - Superceded** The Committee receives Highlight Reports from the RADAR Committee. The End of Life Care Steering Group has also recently been launched
11 March 2025	Request made by an Independent Member at the January 2025 QSEC for this report to added to future meeting agenda's	Executive Director of Nursing	WAST Produced Quality Report	USC Care Group to provide a report on the joint working with WAST looking at the People's Experience and Quality of care as this is work that is undertaken jointly with the central team and sits within USC portfolio.	USC Care Group Nurse Director	Executive Director of Nursing	20 May 2025 22 July 2025 Now November 2025 **Now June 2026**	**In progress** Following discussion with the Welsh Ambulance Services Trust (WAST) concerning the triangulated data between WAST and the Health Board, a formal response from WAST is awaited. Once received, this will be reviewed and the action progressed accordingly.
22/07/2025	Request made at the July meeting for this item to be brought back to a meeting in 2026	Interim Executive Director of Nursing	Listening & Learning Story - Carers	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed, with further discussion required as to what could be done to address the issues	Carers Lead	Interim Executive Director of Nursing	**July 2026**	**In progress** Date to be confirmed with Carers Lead
7 August 2025	Suggestion made at agenda planning session held on 7 August 2025	QSEC Committee Chair & Executive Lead	Closure Report - Inpatient Mental Health Improvement Programme	Report to highlight progress made since the update presented to the July 2024 meeting	Mental Health & Learning Disabilities Care Group Nurse Director	Mental Health & Learning Disabilities Care Group Nurse Director	23 September 2025 18 November 2025 Deferred to 20 January 2026 **Now 24 March 2026**	**Proposed for Closure – On agenda** An update has been included in the MHLD Highlight Report on the agenda for the 24 March 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	Head of Safeguarding	Executive Director of Nursing	22 September 2026	**In progress** Scheduled for September 2026

				evidence in relation to learning points				
23 September 2025	Request made at the meeting held on 23 September 2025	QSEC Committee Chair	Planned Care - Care Group Highlight Report	Outcome and impact of the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate to be presented to the Committee after the trial period of 12 Months	Planned Care Group Nurse Director	Executive Director of Nursing	22 September 2026	**In progress** Will be presented to the September 2026 meeting
24 September 2025	Email request received from the Assistant Director of Governance Risk following discussion held at the September 2025 meeting	Assistant Director of Governance & Risk	Focussed review on Ambulance Handover times improvement	Report to identify whether the improvement on handover times has not had any adverse effect on quality and safety i.e. increase in incidents, complaints, waiting time performance, patient experience feedback etc.	Unscheduled Care Group Service Director/Nurse Director	Unscheduled Care Group Service Director/Nurse Director	24 March 2026	**Proposed for Closure – On agenda** Will be presented to the March 2026 meeting as part of the Winter Wrap Up report
4 November 2025	Request received from Interim Executive Director of Nursing	Interim Executive Director of Nursing	Spotlight Report - Quality Impact of the Health Board's new Escalation Framework	To be presented to the Committee for awareness	USC Care Group Nurse Director & Planned Care – Care Group Nurse Director	Executive Director of Nursing	Was 20 January 2026 **Now 24 March 2026**	**Proposed for Closure – On agenda** This item will be presented to the Committee in March 2026 as part of the Winter Wrap Up report
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 **Now June 2026**	**In progress** Will be deferred to the June 2026 meeting
16 December 2025	Request made at agenda planning session held on 16 December	Interim Executive Director of Nursing	Winter Wrap Up to include: • Ambulance Handovers and Onboarding Impact • IPC and Infection outbreaks	To be presented to Committee for discussion	Chief Operating Officer and Interim Executive Director of Nursing	Chief Operating Officer and Interim Executive Director of Nursing	24 March 2026	**Proposed for Closure – On agenda** This item is on the agenda for the March 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**	**In progress** March 2026 Care Group Highlight Report states that this is not yet available until later in the year.
28 January 2026	Email request received from the Executive Director of Allied Health Professionals and Healthcare Sciences	Executive Director of Allied Health Professionals and Healthcare Sciences	Research & Development Framework Self Assessment	To be presented to the Committee for approval	Clinical Lead for R&D	Executive Director of Allied Health Professionals & Healthcare Sciences	24 March 2026	**Proposed for Closure - On agenda** This item is on the agenda for the March 2026 meeting

3 February 2026	Committee Referral made at the February 2026 meeting of the Audit, Risk & Assurance Committee	Audit, Risk & Assurance Committee	Audit Wales Report on Eye Care Services	The Committee raised concerns on reading the report with regard to quality and performance issues which were highlighted as requiring urgent attention and given the nature of the concerns it was recommended that a formal cross Committee referral should be made to the Quality, Safety & Experience Committee The Committee have requested that the QSEC reviews and discusses the report and provides assurances back to the ARAC that the issues have been fully examined and the outcomes that have been determined following this.	Care Group Director of Nursing	Chief Operating Officer	24 March 2026	**On agenda** This has been included in the Planned Care Group Highlight Report for discussion
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**
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	**In progress**
5 February 2026	Added to the forward plan following discussion held with the Quality Assurance & Compliance Team	Quality Assurance & Compliance Team	Policy on Policies – Notification of further updates	To be presented to the Committee for approval	Head of Corporate Governance & Board Business	Director of Corporate Governance	3 June 2026	**In progress**
Completed Items								
10 April 2025	Request made at the agenda planning session held on 10 April 2025	Committee Chair	Stroke Services Progress Report	Stroke Services report to be presented to the July meeting of the Committee	Executive Director of Allied Health Professionals & Healthcare Sciences	Allied Health Professionals & Healthcare Sciences	22 July 2025 – 23 September 2025 – **Now January 2026**	**Proposed for Closure** Detailed update on Stroke is on the agenda

								for the January 2026 meeting
23 September 2025	Request made at the meeting held on 23 September 2025	Physicians Associates	Report on the current position regarding the proposed changes to the roles and remits for Physicians Associates	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	20 January 2026	**Proposed for Closure** Update has been included in the Clinical Executives report for the January 2026 meeting
6 October 2025	Email request from the Executive Medical Director	Clinical Effectiveness Update	To be presented to the Committee for awareness	To be presented to the Committee for awareness	Executive Medical Director	Executive Medical Director	18 November 2025 **Now January 2026**	**Proposed for Closure** This item is on the agenda for the January 2026 meeting
10 November 2025	Request received from the Assistant Director of Governance & Risk	Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents	To be presented to the Committee for approval	To be presented to the Committee for approval	Assistant Director of Governance & Risk	Director of Corporate Governance	20 January 2026	**Proposed for Closure** This item is on the agenda for the January 2026 meeting
18 December 2025	Request made at the Board Development Session held on 18 December 2025	IM & Exec Walkabouts Operating Model	To be presented to the Committee for endorsement prior to Board approval	To be presented to the Committee for endorsement prior to Board approval	Interim Executive Director of Nursing	Interim Executive Director of Nursing	20 January 2026	**Proposed for Closure** This item is on the agenda for the January 2026 meeting

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

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

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

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

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

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

Link to: Board Assurance Framework Dashboard

CTMUHB Committee Business:

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

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

Improving Care Strategic Goal aligned to Committee Business Contd.

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

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF
Peoples Experience Activity Report *(to include an annual update on CTM Carers End of Year Progress Report)*	Executive Director of Nursing	All Regular Meetings													X		No	N/A	• Strategic Risk 2
Thematic Spotlights – Learning and Improvement Outcomes	Lead Clinical Executive	All Regular Meetings	Compassionate Care		Quality Impact of the new Escalation Framework & Hospital at Home			Nutrition & Catering	TBC		TBC		TBC		X		N/A	N/A	Will be assigned to a strategic risk dependent on topic
Report from the Clinical Executives *(to include bi-annual updates on Coroners Inquests – activity & lessons learnt)*	Clinical Executives	All Regular Meetings													X		N/A	N/A	It is anticipated that this report will crosscut several strategic risks.
Care Group Highlight Reports	Care Group Nurse Directors/Care Group Medical Directors	All Regular Meetings													X		N/A	N/A	Each Care Group Highlight Report will crosscut several of the strategic risks
Quality Dashboard Report *To include an addendum relating to Ombudsman activity*	Executive Director of Nursing	All Regular Meetings													X		N/A	N/A	• Strategic Risk 2
Ombudsman's Letter & Annual Report	Executive Director of Nursing	Annually														X	EMB	Yes	Strategic Risk 2
Organisational Risk Register *Risks assigned to the QSEC*	Director of Corporate Governance/Board Secretary	All Regular Meetings			Verbal										X		Yes – EMB	No – uploaded to AC for information	Organisational risks aligned to BAF Strategic Risks where applicable.

Improving Care Strategic Goal aligned to Committee Business Contd.

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

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF
Health Inspectorate Wales (HIW) Audit Tracker Report	Executive Director of Nursing	All Regular Meetings			**Main**						**Main**					(to be added to the main agenda on a 6-monthly basis)	Yes - EMB	No	• Strategic Risk 2
Mortality Board Report *(including indicators, reviews and the highlights from the Mortality Board)*	Executive Medical Director	Twice Per Annum													X		Yes - EMB	N/A	• Strategic Risk 2
Infection, Prevention and Control Annual Report	Executive Director of Nursing	Annually													X		N/A	N/A	• Strategic Risk 2
Putting Things Right Annual Report	Executive Director of Nursing	Annually														X	N/A	N/A	• Strategic Risk 2
Safeguarding & Public Protection Report	Executive Director of Nursing	Annually													X		N/A	N/A	• Strategic Risk 2
Nurse Staffing Levels Wales Act	Executive Director of Nursing	Twice Per Annum													X		N/A	Yes	• Strategic Risk 2
Medicines Management *(Including Controlled Drugs Local Intelligence Network (CDLIN) / Prescribing Annual Report) Prescribing errors captured in quality dashboard)*	Executive Medical Director	Annually plus exception reporting														X	N/A	N/A	• Strategic Risk 2
Cancer Services Annual Report	Executive Medical Director	Annually														X	EMB	N/A	• Strategic Risk 2
RADAR Committee Highlight Annual Report *ICB x 2 – Clinical Exception Report then at QSEC*	Executive Medical Director	Annually plus exception reporting														X	Improving Care Board	N/A	• Strategic Risk 2

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

Creating Health Strategic Goal aligned to Committee Business • Reducing Health Inequalities • Equal focus on Mental Health and Physical Health • Supporting our communities • Being a Healthy Organisation																			
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**	**Alignment to Strategic Risks on the BAF**
Health Inequalities Population Inequality Service Inequality *(Quality & Safety impact of services we currently run – differential in quality)*	Executive Director of Public Health	Twice Per Annum													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													X		N/A	N/A	• Strategic Risk 2 • Strategic Risk 8

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

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

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

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

CTMUHB Board Assurance Framework Dashboard

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee
1.	Improving Care, Sustaining our Future  Click Here for Risk 1a Click Here for Risk 1b	**a) Enough capacity to meet elective demand** **b) Enough capacity to meet emergency demand**	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee
2.	Improving Care, Sustaining our Future  Click Here for Risk 2	**Ability to deliver improvements which transform care and enhance outcomes**	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee
3.	Sustaining our Future, Improving Care and Inspiring People  Click Here for Risk 3	**Enough workforce to deliver the activity and quality ambitions of the organisation** *(Including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee
4.	Creating Health, Sustaining our Future  Click Here for Risk 4	**Effective Community and Partner Engagement in service changes and developments**	Director of Communication, Engagement & Fundraising	Strategic Development Committee
5.	Improving Care, Sustaining our Future  Click Here for Risk 5	**Delivery of a digital and information infrastructure to support organisational transformation**	Director of Digital	Operational Delivery Committee and Strategic Development Committee
6.	Improving Care, Sustaining our Future  Click Here for Risk 6	**Ability to maintain a safe and fit for purpose estate infrastructure**	Executive Director of Finance	Operational Delivery Committee
7.	Sustaining our Future, Creating Health  Click Here for Risk 7	**Fulfilling our Environmental and Social Duties and ambitions**	Executive Director of Strategy & Transformation	Strategic Development Committee
8.	Creating Health, Sustaining our Future  Click Here for Risk 8	**Prevention and early Intervention to support Healthy Life Expectancy**	Executive Director of Public Health	Strategic Development Committee
9.	Sustaining our Future  Click Here for Risk 9	**Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)**	Executive Director of Finance	Operational Delivery Committee
10.	Sustaining our Future, Improving Care  Click Here for Risk 10	**Ability to develop a fit for the future estate to reflect our future clinical service model**	Executive Director of Finance	Strategic Development Committee
11.	Creating Health, Sustaining our Future, Improving Care  Click Here for Risk 11	**Delivery of an Integrated Care Model**	Chief Operating Officer	Strategic Development Committee

Agenda Item
5.2.3

Quality, Safety & Experience Committee

Highlight Report from the Organ Donation Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Corinna McNeil & Shaun Miller-Jones, Specialist Nurses Organ Donation David Deekollu, AMD (Q&S)
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
SNOD	Specialist Nurse Organ Donation
CLOD	Clinical Lead Organ Donation
NHSBT	NHS Blood & Transplant
WTE	Whole Time Equivalent
SIGNET	Statins for Improving Organ outcome in Transplantation
ODR	Organ Donation Register
NORS	National Organ Retrieval Service.
DCD	Donation After Circulatory Death
DBD	Donation After Brain Death
NRP	Normothermic Regional Perfusion

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety and Experience Committee with details of the key issues considered by the Organ Donation Sub Committee at its meeting on 5 January 2026 which had been rescheduled from 17 December 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the Organ Donation Sub Committee is to influence policy and practice to ensure that Organ Donation is considered in all appropriate situations and to identify and resolve any obstacles to this.

2.2 The Organ Donation Sub Committee will:

- Ensure that a discussion about organ donation features in all end of life care, wherever located and whenever appropriate, recognising and respecting the wishes of the individuals.

- Maximise the overall number of organs donated, through better support to potential donors and their families.

3. Highlight Report

Alert / Escalate	• No red alerts but please note 'Advise' section
Advise	• The Health Board 100% DBD referral rate and a 92% DCD referral rate for the recent period. • The Bereavement Lead shared information regarding a complex DCD donor case, describing the co-ordination of bereavement support, which enabled successful organ donation discussions and resulted in six recipients benefiting from organ donation. She emphasised the value of collaboration between teams. • Members agreed that the recent NHSBT letter, which contains relevant statistics and benchmarking should be included with the Annual Report submission to QSEC alongside the Annual Report when presented to the Quality, Safety & Experience Committee. • It was noted that there were two missed opportunities referenced in the NHSBT letter, related to best practice adherence and the Sub Committee agreed to clarify these in future discussions to ensure transparency. • Members also discussed specific matters regarding workforce configuration noted in the NHSBT letter in Paragraph 2.3 and it was agreed that the letter should be referred to the Executive Team to consider any workforce implications as it involves operational and funding considerations beyond the Committee's remit • The Sub Committee's Annual Report was approved for submission to the Quality, Safety and Experience Committee (QSEC) for noting at its January meeting – no concerns were received following submission. • The 'Organ Donation, Bolder and Braver' report is forthcoming from a Government Working Group and will set ten actions for the coming year which are likely to impact the Committee's activities.

Assure	• CTMUHB has a well-attended Organ Donation Committee (ODC), which has representation from all relevant internal and external stakeholders, including patient and family representatives. The ODC is the forum in which Health Board performance is reported, missed opportunities discussed, a communication strategy developed, and education sessions are planned. • The Health Board is recognised as exceptional in referral rates for potential organ donors by NHSBT. • CTM Comms Team continue to support the Organ Donation service with community engagement opportunities and outreach into local 3rd sector businesses. Our Comms team are aiming to create a digital package of local donor stories, recipient stories and organ donation key messaging that can be shared across platforms within the HB and into the communities we serve.
Inform	• There has been a change in lead nurse due to maternity leave cover – there will be interim cover for the role, ensuring continuity in the organ donation team. • Members agreed to enhance the draft Action Plan by specifying responsible individuals, timelines and reporting requirements. The updated Action Plan will be discussed at the March Sub Committee meeting.
Appendices	

4. Assessment

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

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

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

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?		
Cyfreithiol / Legal	Yes (Include further detail below)	
	All practices are performed in-line with the Human Tissue Act and Welsh 'Deemed Consent' Law.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	27/01/2026
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 Noting

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

1. SITUATION/BACKGROUND

This report has been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSO) Sub-Committee at its public meeting on 15 December 2025.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted – December 2025)

Status	Update
Alert / Escalate	Risk Management discussions – Concern was raised over thrombectomy (Risk 88) and the absence of a timeline in relation to the business case from Cardiff and Vale University Health Board (CVUHB) in relation to the provision of a 24/7-hour mechanical thrombectomy service in South Wales. Demand for the service was not as high as expected. As such, the capacity in place between CVUHB and UHB is sufficient to meet the current demand and at present the JCC were commissioning more capacity than was being utilised. This would continue to be flagged as an issue with Medical Directors to ensure that it was clear that access to Thrombectomy services was not solely a commissioning issue. In addition, members discussed the interdependencies within specialised services and acknowledged that articulating this was complex. Members remained concerned about St Andrews as the service remained suspended under the National Framework Agreement. Members also raised concern over the issues identified at the Caswell Clinic which led to this service being placed in Escalation Level 3. Members agreed that keeping the Caswell Clinic closed to new admissions pending satisfactory assurances was the correct approach.
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed and referred to the Joint Committee for noting. Director of Commissioning for Specialised Services • That the South Wales Specialist Auditory Implant Device Service had been placed in escalation Level 3 due to waiting list concerns. The JCC had met with the provider and received an action plan which seeks to reduce waiting times by the end of Quarter 4. • Obesity Surgery Services Northern Care Alliance NHS Foundation Trust Salford Royal Hospital Obesity Surgery had served notice. The NWJCC will be seeking an alternative provider for North Wales patients. • That the Neonatal service had been de-escalated. CB highlighted the positive impact on data reporting and coroner's inquests' reports following improvements within the service. • The Thrombectomy risk had been discussed under Item 3.1. Challenges persist with plastic surgery outreach in North

Status	Update
	Wales, PET-CT for prostate cancer, Joint Accreditation Committee of the International Society (JACIE) Accreditation for Bone Marrow Transplantation (BMT) and Chimeric Antigen Receptor T-cell (CAR-T) Services (report still pending), and hereditary anaemias. • Cost savings were anticipated when switching providers for enteral feeds in cases of intestinal failure. • Various events had taken place in relation to Service Innovation and Improvement including Paediatric Oncology, All-Wales Posture and Mobility Service and Intestinal Failure. Welsh Kidney Network (WKN) Report Despite a recent change in governance arrangements (and the Network becoming a part of the NWJCC Specialised Services Directorate), the WKN Report would still be presented as a separate agenda item at the QSO meeting to fully capture work undertaken across the Network. • One Nationally Reported Incident (NRI) had been closed in relation to a Catastrophic fistula haemorrhage resulting in the death of the patient at home. Surgical intervention was delayed due to co-morbidities, anaesthetic complexities, and issues with communication and process. RP assured members that learning was being disseminated across Wales with consideration of changing intervention timelines for these rare but high-risk cases. • One new NRI had been reported, also noted as emerging risk 93. RP outlined the early stages of an independent investigation following the brief but sudden closure of the Cardiff transplant programme, which resulted in missed transplant opportunities. An investigation focused on why and how the unit closed. The WKN has been assured that the service was not vulnerable, and immediate measures have been taken to prevent any further occurrences. Regional collaboration with Bristol and the Southwest will be important, but it was premature to draw conclusions before the investigation concluded. Director of Commissioning for Ambulance Services/111 Report • Phase 2 of the updated ambulance performance framework launched on 2 December 2025, after the team had worked with Welsh Ambulance Services Trust (WAST) and partners to assess and mitigate risks. This led to significantly higher conveyance rates in the orange category. • The Handover 45 initiative, aiming to transfer patients within 45 minutes, had improved performance but results vary by Health Board and hospital, highlighting a need for targeted

Status	Update
	support. Each health board had completed a readiness assessment, currently under review by the National Ambulance Handover Taskforce regarding automatic ambulance release at 45 minutes. • The Non-Emergency Patient Transport Services (NEPTS) service in Wales faced ongoing capacity issues, leading to outpatient and discharge transport cancellations. To address this, the Ambulance Services and 111 Commissioning Team were running weekly forums with stakeholders, aiming for strategic integration and improved discharge efficiency under the NEPTS Future Vision (2030). • WAST had continued its efforts to improve 111 call handling capacity, establishing a dedicated 111 Re-roster Project Board. The Ambulance Services and 111 Commissioning Team remain actively involved, providing support for the strategic priorities and direction of the urgent and emergency care system. This included mapping the various clinical assessment services currently available across Wales to identify duplication and develop proposals for greater efficiency. Anticipated winter-related challenges were also being addressed. • Ongoing discussions with WAST were focused on ensuring that the JCC receives timely and updated reports about incidents and concerns, as well as implementing lessons learned from these outcomes. Director of Commissioning for MHLDVG Report • The St Andrews service remained suspended under the National Framework Agreement and was regularly reviewed through the Enhanced Monitoring process of the Framework. The JCC, together with several agencies, continued to hold oversight meetings and met frequently with the provider. Health Boards were encouraged to closely monitor their patients and there were currently six JCC commissioned medium secure placements within the service. There was a significant increase in interest from both local and national media following the CQC's (Care Quality Commission) latest review of the service released on December 12, 2025. The provider had been rated inadequate across several areas. • The September 2025 review of the Caswell Clinic identified safety and quality concerns. As a result, a decision was taken to Escalate the service to Level 3 and suspend new admissions to the unit due to these safety concerns. An action plan was created, and although some progress had been made, there were still unresolved issues concerning environmental risks and staff risk assessment practices. A member of the NWJCC

Status	Update
	team will offer advice and training on risk assessment and AC has arranged for staff from the Unit to visit another medium secure Unit. • Seren Lodge Perinatal Unit at Countess of Chester Hospital was set to open for admissions on 17 December 2025, with a MHLDVG commissioning team visit scheduled for 9 January 2026. The Incident and Concerns Report highlighted • 4 new nationally reportable incidents, 1 DATIX and 1 early warning notification reported to the Commissioning teams over the period 01/09/2025 – 31/11/2025. • Four incidents were closed in this reporting period. • Thirty-six incidents remained open at the time the report was written. • Six new complaints had been received. • No new referrals to the Ombudsman.
Assure	The Committee received the QSO sub-committee's assigned risks from the NWJCC Operational Risk Register as of 30 November 2025. After QSO scrutiny and review, the JCC will receive the November 2025 risk register at its January 2026 meeting. AF highlighted: • Thirteen risks, with a score of 15 or above, have been assigned to QSOC. All these risks were classified as Specialised Services Commissioning Risks. • Between September 2025 and November 2025 two new risks had been added – Risk 91 Hereditary Anaemia and Risk 92 Women and Children Commissioned Services posts. • One risk has been de-escalated (Risk 3 – plastic surgery but this was a risk assigned to the Planning, Performance and Finance sub-committee and had been highlighted due to the link with the patient story); and • A new section addresses emerging risks. Risk 93 concerned service sustainability for the National Transplant Programme, this risk was reported in more detail under Agenda Item 4.2. The Escalation Trajectories Report was received and is attached at **Appendix 1.** Members noted the changes made to the report and commented that these were helpful. The Regulator Report (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC) was received. An update on regulatory activity was provided. No issues of concern had been highlighted within updates reported upon.

Status	Update
Inform	**Patient Story – Breast Reconstruction** A patient shared her story and personal experiences of the care received from Swansea Bay University Health Board Breast Reconstruction Service. The patient provided an account of her experience with risk-reducing breast reconstruction surgery, detailing aspects such as family history, genetic testing, surgical interventions, complications, and both emotional and logistical challenges. These included extended waiting periods, as each procedure required initiating a new process. Members noted the challenging wait times (partially due to the constraints around the COVID-19 outbreak which was unavoidable) as well as pathway challenges. Members were concerned that patients who required second-stage or revision surgeries were placed back at the start of the waiting list, and this often resulted in lengthy delays with no formal time limits for any subsequent surgeries. Members acknowledged the psychological impact this would have on patients. RT highlighted and praised the support, both emotional and physical, the team provided throughout the patient pathway but agreed that extended waiting times were challenging. All Wales Individual Patient Funding (IPFR) Report A request for IPFR updates to include the financial details of approvals. The finance team were undertaking work in this area. IPFR processes were being used to look at small cohort commissioning. Final approval of the All-Wales IPFR policy was anticipated for January 2026, as some Health Boards had yet to present the updated policy to their Boards for approval. The policy was planned to be implemented across Wales in February 2026.
Appendices	

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** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb	Yes: ☒	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	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 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 IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Amy Lewis
Commissioning Team: Women and Children
Date of last Escalation Meetings: 2/12/25
Date Last Reviewed by Quality Safety, Outcome Committee: 06/10/25

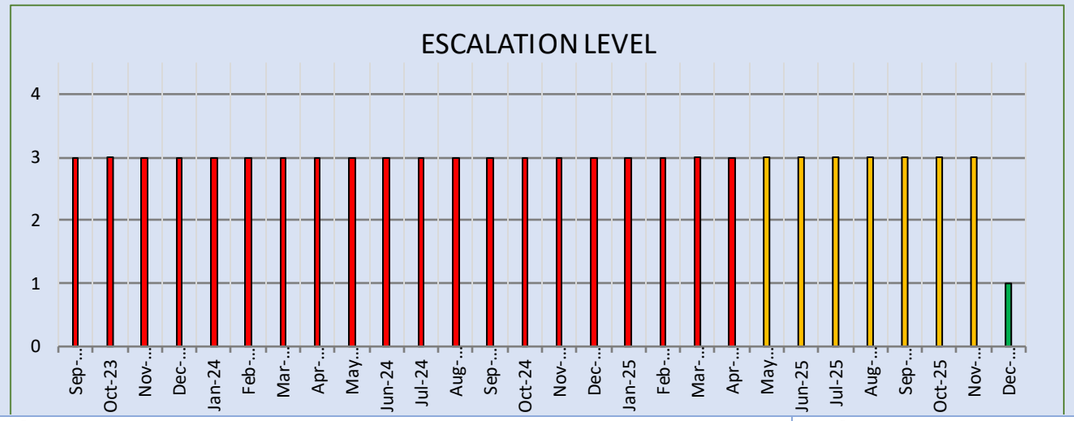
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 1

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2023	**3**

Rationale for Escalation Status:

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

NWJCC assurance and confidence level in developments:
A Paediatric and Neonatal Escalation Reset Meeting took place on the 18th September 2024 to gain an understanding from the health boards perspective of process made and to identify any outstanding actions. Joint Actions/Objectives and monthly meetings have since been agreed.

15th January and 18th March 20th May 1st July escalation meeting and progress acknowledged. Decision made service to remain at escalation level 3 as more data required ensuring that the improved position is sustained prior to considering de-escalation. Conversations ongoing regarding implementing phase 1, both internally in the JCC and with the health board.

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	See comment in development section
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024
Escalation meeting to discuss detail and progress against action plan (every 6 weeks)	Head of Commissioning	-	2nd December 2025

On 4th September the Cabinet Secretary for Health and Social Care has commissioned an all-Wales assurance assessment of maternity and neonatal services to assess the safety and quality of the services. In addition an internal workshop to discuss Phase 1 progression and funding matters took place on the 22nd October 2025. As a result, a decision was made that the work required to progress the cot configuration assessment as part of the escalation process would be stood down and form part of the National work going forward. An escalation meeting with the service took place on the 2nd December and the dashboard data presented noted that the service was no longer an outlier for neonatal infection nor mortality. As a result the service was de-escalated to level 1 and the Health Board was formally informed on 5/12/25.	
Additional Issues/Risks: May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December.	

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Emma King
Commissioning Team: Cardiac
Date of Escalation Meetings:
Date Last Reviewed by Quality Safety Outcome Committee: 6/10/25

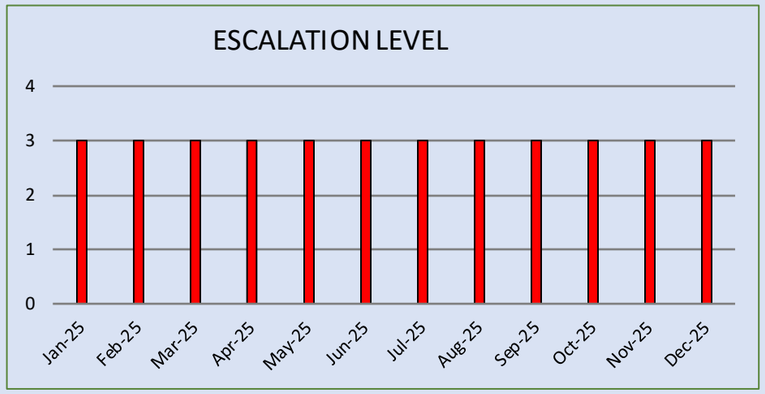
Service in Escalation: Bariatrics

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
January 2025	**3**

Rationale for Escalation Status :

Update April 2025 – The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025. The service has been subject to formal escalation arrangements due to our long-standing concerns with the obesity surgery waiting list and activity levels.

Background Information:

The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025.

NWJCC assurance and confidence level in developments:

Low - A letter was sent to Salford in February informing them of the escalation and process (with no response being received). A chasing communication was sent by the Director of Commissioning for Specialised Services in April 2025. A follow up letter was sent in September 2025 (from the NWJCC Chief Commissioner) to Salford requesting an urgent response to the escalation letter and confirmation of a named Executive Lead from Salford Royal

Correspondence was received from Salford on 25 September 2025 to serve notice of 6 months on the contract for bariatric services. **Work will progress to look**

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Escalation endorsed by SLT	Director of Commissioning	Jan 25	Jan 25
Escalation letter sent to Salford	Director of Commissioning	Feb 25	Feb 25
Follow up email sent to Salford	Director of Commissioning	April 25	April 25
Head of Commissioning for Cardiac has contacted the Commissioning Lead for Obesity Services (Greater Manchester ICB) in NHSE	Head of Commissioning	July 25	July 25

at alternative commissioning options and ensuring patients currently on the waiting list are not adversely affected by this change.	SBUHB to provide service for 15 patients from this catchment area	Head of Commissioning	March 26	March 26
	A follow up letter has been sent to Salford requesting an urgent response to the escalation letter	Director of Commissioning	September 25	September 25
	A letter has been sent to BCUHB informing them of the Salford position.	Director of Commissioning	November 25	November 25
	A formal letter will be sent to the Salford (NCA) requesting a treatment plan for the patients currently on the waiting list; and a further request for the named NCA Executive Lead to continue with NWJCC escalation process.	Director of Commissioning	December 25	December 25
	Explore other commissioning options	Head of Commissioning	December 2025	March 26
Issues/Risks: September 25 – Notice served by Salford requires alternative provision to be sought before 1st April 2026.				

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Krysta Hallewell
Commissioning Team: Neuro sciences

Date of Escalation Meetings: 03/12/25
Date Last Reviewed by Quality Safety Outcome Committee: N/A

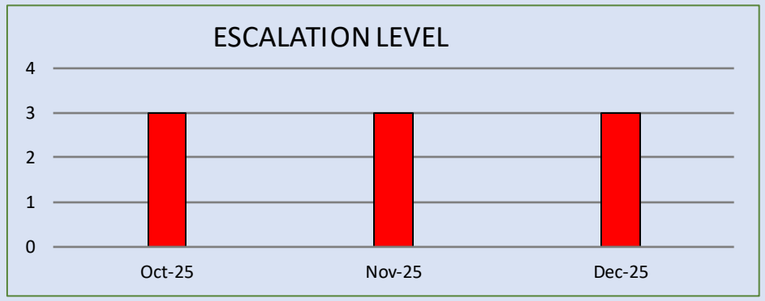
Service in Escalation: Specialist Auditory Implant Device Service

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	**3**

Rationale for Escalation Status : Due to the lack of progress made against the actions monitored through the quarterly Service Performance Management meetings since January 2024, and the RTT position against the specific ministerial target for this patient population, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends placing the service into Level 3 - 'Escalated Measures' as the service requires significant action/improvement requiring Executive level input.

Background Information:

The process for 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.

NWJCC assurance and confidence level in developments:

Low - A letter was sent to Cardiff and Vale UHB informing them of the escalation and process. An action plan, trajectory and timescale will be agreed at the initial escalation meeting on the 3rd December 2025.

There has been a delay in arranging the first meeting. The NWJCC wrote to CAVUHB on the 6th October 25, CAVUHB did not confirm their Executive Lead, delays due to CAVUHB availability.

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Escalation endorsed by SLT	Director of Commissioning	Oct 25	Oct 25
Escalation letter sent to CVUHB	Director of Commissioning	Oct 25	Oct 25

Issues/Risks:

Executive Director Lead: Adrian Clarke
Commissioning Lead: Joanna Dainton
Commissioning Team: MHLDVG

Date of Escalation Meetings:
JCC/Caswell SLT- 16/10/25, 21/11/25
JCC/SBUHB Exec- 03/10/25, 07/11/25, 20/11/25, 5/12/25
Date Last Reviewed by Quality Safety Outcome Committee: N/A

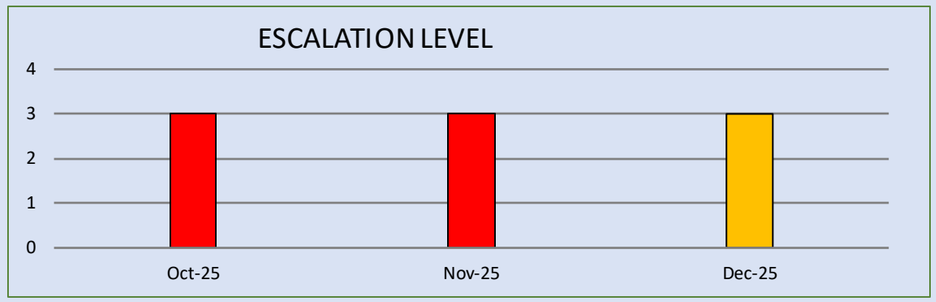
Service in Escalation: Caswell Clinic Medium Secure Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	**3**

Rationale for Escalation Status: Staff and Patient safety issues. Further Quality issues.

A site visit of the facility by NWJCC members in July 2025 identified significant concerns with safety and quality issues. This was reported to the JCC in September 2025 and it was agreed a full service review would be undertaken.
The service review took place between 15th September and 3rd October 2025, assessing service delivery against the recognised quality standards for Medium Secure Units and reviewing individual patients.
The NWJCC review has identified a number of significant safety and quality issues requiring urgent action. Similar issues were identified within a NCCU service review undertaken in November 2022 (1). The NWJCC findings also echo concerns raised within a report produced by an external consultant on the wider Swansea Bay University Health Board Mental Health and Learning Disability Service provision in June 2025 (2) that found provision of safe, effective, respectful, patient centred care was compromised and that performance and leadership structures were not supporting proper oversight of service delivery.

Background Information:

Initial visit to service by Director of Commissioning for MHLDVG and JCC Lay Members raised a number of concerns. Further in-depth review undertaken by JCC MHLDVG review team. Further concerns raised regarding the safety and quality of the service provided at that time. Admissions suspended in order to minimise risk.

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Work with SBUHB executive team & Caswell Clinic SLT to develop an action plan to implement mitigating	Director of	8th December	Finalised action plan agreed on 5th

Full report drafted and disseminated to SBUHB Executive team along with Caswell SLT. Service placed in Level 3 Escalation in October 2025 following endorsement by JCC SLT.

NWJCC assurance and confidence level in developments:

Members of the NWJCC met with Swansea Bay Executive Team in early October to share initial concerns, pending production of a full report. In line with the nature of the concerns and NWJCC quality and governance process, the Caswell Service was placed in escalation Level 3. Weekly service improvement meetings will now be held with Caswell Clinic Senior Leadership Team and that monthly meetings will be held with Swansea Bay Health Board Executive Team.

To support the review findings and service improvement, a detailed plan highlighting specific actions required against recognised standards has been produced. Some of these actions require immediate attention and others will be developed over time.
It is recommended that admissions to the unit are paused until the NWJCC and Swansea Bay Executive Board has received reassurance that the urgent safety issues have been resolved.

December 2025-

Final draft of an action plan received; however further detail has been requested. The mitigations required to support a safe service and in order to reopen the service to new admissions has been received from SBUHB via the action plan. Initial focus is on immediate safety concerns with other mitigations for less serious issues following. Escalation level 3 agreed at executive level within the JCC.

actions in order to minimise risks to staff and patients at the service.	Commissioning		December 2025
Weekly escalation meeting with Caswell SLT & JCC DoC and SBUHB Exec lead every fortnight, to discuss and agree progress against actions/objectives	Asst. DoC/DoC	Ongoing	On completion of all actions
Immediate concerns to be addressed by 8th December 2025 followed by review of completed actions by JCC.	Head of Commissioning	8th December 2025	
Suspension for new admissions to the clinic	JCC	Ongoing	Ongoing

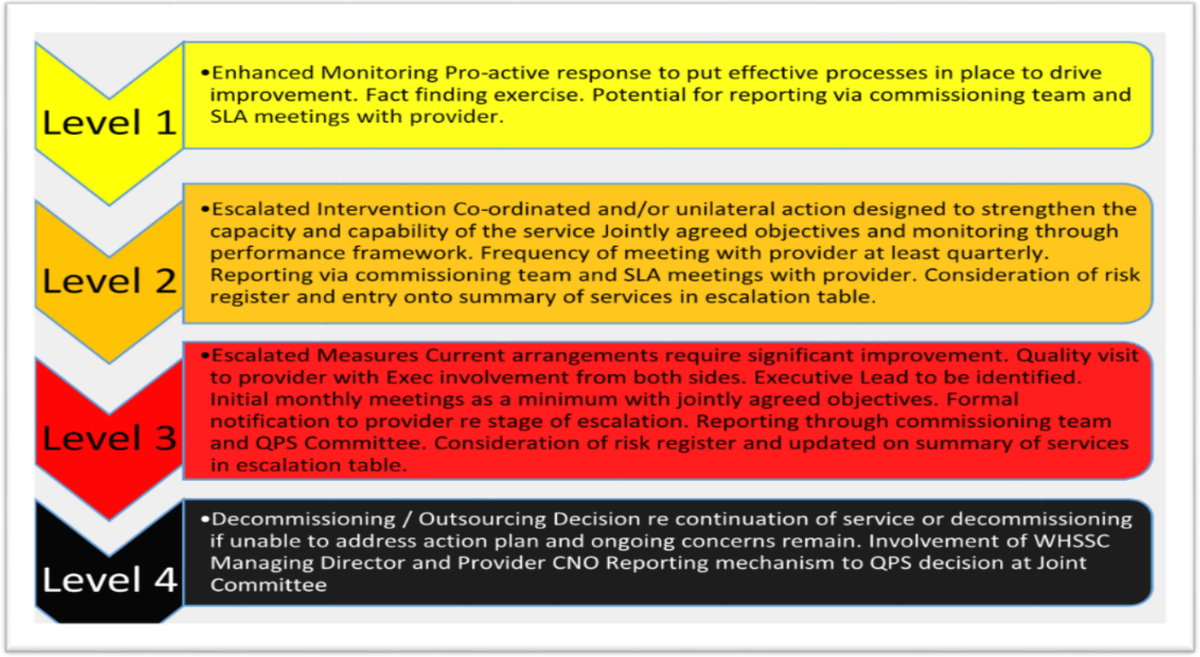
Issues/Risks:

October 25-
Service review raised a number of significant issues that could possibly lead to patient and/or staff safety issues. Following this review, new admissions have been suspended and the service placed in Level 3 escalation.
A number of meetings have been held with JCC and the Service SLT in order to clarify details within the JCC written report and to enable both organisations to come to an agreement on a final action plan which will address immediate, mid- and longer-term issues.

December 25-
Final report and action plan agreed. SBUHB have stated that all immediate concerns that led to admissions being suspended, will have been addressed by 8th December. JCC review team plan to meet with SLT at Caswell clinic on 10th December in order to verify that all mitigating actions are sufficient to reduce identified risks, so that the service can re-open to admissions and escalation level can be reconsidered.

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 I 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 4 **DECOMISSIONING/OUTSOURCING**	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.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position