

Quality, Safety & Experience Committee

Wed 03 June 2026, 09:00 - 12:00

Virtually via Teams

Agenda

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

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Committee Chair*

09:05 - 09:10 **2. CONSENT AGENDA BUSINESS**
5 min

The Committee Chair will ask if there are any items from the Consent Agenda (Section 6) that Committee Members wish to bring forward to the main agenda for discussion

09:10 - 09:25 **3. GOVERNANCE/COMMITTEE BUSINESS ACTIVITY**
15 min

3.1. Action Log - To follow

Discussion *Carolyn Donoghue, Committee Chair*

3.2. Matters Arising Not Contained within the Action Log

Discussion *Carolyn Donoghue, Committee Chair*

3.3. Committee Annual Report

Decision *Carolyn Donoghue, Committee Chair*

-  3.3a Cover Report QSE Committee Annual Report 25 26 QSEC 3 June 2026.pdf (3 pages)
-  3.3b Draft QSEC Annual Report 2025-2026 QSEC 3 June 2026.pdf (10 pages)

09:25 - 11:25 **4. IMPROVING CARE**
120 min

4.1. Outcome reports – Board Member Patient Safety Walkabouts -To follow

Discussion *Richard Hughes, Executive Director of Nursing*

4.2. Highlight Report for People’s Experience Activity February – April 2026

Discussion *Clare Ibbs, Interim Head of Corporate Nursing and People’s Experience*

-  4.2 Peoples Experience report QSEC 3 June 2026.pdf (7 pages)

4.3. Report from the Clinical Executives

Discussion *Richard Hughes, Executive Director of Nursing*

 4.3 Clinical Exec Directors Update Report QSEC 3 June 2026.pdf (13 pages)

4.4. Care Group Highlight Reports

Discussion *Care Group leads*

4.4.1. Unscheduled Care Highlight Report

Discussion *Deborah Matthews, Unscheduled Care Nurse Director*

 4.4.1 USC Quality Safety Highlight Report QSEC 3 June 2026.pdf (20 pages)

4.4.2. Planned Care Highlight Report

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

 4.4.2 Planned Care Highlight Report QSEC 3 June 2026.pdf (9 pages)

4.4.3. Primary & Community Care Highlight Report

Discussion *Zoe Ashman, Interim Care Group Nurse Director*

 4.4.3 PCC Highlight report QSEC 3 June 2026_FINAL.pdf (9 pages)

4.4.4. Mental Health & Learning Disability Highlight Report

Discussion *Lloyd Griffiths, Head of Nursing*

 4.4.4 MHLQ QSEC Highlight Report QSEC 3 June 2026.pdf (11 pages)

4.4.5. Children & Families Highlight Report

Discussion *Suzanne Hardacre, Director of Midwifery and Nursing*

 4.4.5 Children & Families Care Group Highlight Report QSEC 3 June 2026 FINAL.pdf (8 pages)

4.4.6. Diagnostics, Therapies, Pharmacy and Sciences Highlight Report

Discussion *Gary Howell, Clinical Director of Therapies*

 4.4.6 DTPS Highlight Report QSEC 3 June 2026.pdf (13 pages)

4.5. Quality Dashboard Report

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

 4.5 Patient Safety Experience Dashboard Report QSEC 3 June 2026.pdf (26 pages)

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

Discussion *Louise Stait, Interim Assistant Director of Governance & Risk*

 4.6a Organisational Risk Register QSEC 3 June 2026.pdf (9 pages)

 4.6b QSEC_P1_ORR_Summary QSEC 3 June 2026.pdf (5 pages)

 4.6c QSEC_P1_ORR QSEC 3 June 2026.pdf (7 pages)

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

Discussion *Richard Hughes, Executive Director of Nursing*

 4.7a HIW Tracker Cover Report June 2026 QSEC 3 June 2026.pdf (7 pages)

 4.7b HIW Inspections Recommendations Tracker_QSEC 03.06.2026.pdf (7 pages)

4.8. Highlight Report from the Harm Free Care Agenda

Discussion *Becky Gammon – Interim Deputy Executive Director of Nursing*

 4.8 Highlight Report Harm Free Care agenda QSEC 3 June 2026.pdf (6 pages)

4.9. Mortality Indicators and Mortality Reviews

Discussion *Dom Hurford, Executive Medical Director*

 4.9 Mortality Reviews and Mortality Indicators QSEC Report 3 June 2026.pdf (11 pages)

4.10. Redress Case Management

Discussion *Lead for Legal Services*

 4.10a Redress Case Management Report QSEC 3 June 2026.pdf (9 pages)

5. SUSTAINING OUR FUTURE

11:25 - 11:35
10 min

5.1. Commissioning Quality Arrangements and Individually Commissioned Packages of Care

Discussion *Richard Hughes, Executive Director of Nursing*

 5.1 Commissioning Paper QSEC 3 June 2026.pdf (7 pages)

6. CONSENT AGENDA

11:35 - 11:40
5 min

6.1. FOR APPROVAL

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

Decision *Carolyn Donoghue, Committee Chair*

 6.1.1 Unconfirmed Minutes Public QSEC 24th March 2026.pdf (13 pages)

6.1.2. Unlicensed Medicine Policy

Decision *Dom Hurford, Executive Medical Director*

 6.1.2a Unlicensed Medicines QSEC 3 June 2026.pdf (4 pages)

 6.1.2b Unlicensed Medicine Policy QSEC 3 June 2026.pdf (45 pages)

6.1.3. Ventilation Policy

Decision *Sally May, Executive Director of Finance*

 6.1.3a Ventilation Policy QSEC 3 June 2026.pdf (5 pages)

 6.1.3b Ventilation Policy EST10 FINAL 02-04-2026.pdf (15 pages)

6.1.4. Pharmaceutical Needs Assessment - To follow

Decision *Dom Hurford, Executive Medical Director*

6.2. FOR NOTING

6.2.1. Non-Routine Committee Business (Forward Plan)

Information *Carolyn Donoghue, Committee Chair*

 6.2.1 CTMUHB QSEC Non Routine Bus QSEC 3 June 2026.pdf (4 pages)

6.2.2. Annual Cycle of Business

Information *Carolyn Donoghue, Committee Chair*

 6.2.2 QSEC Cycle of Business QSEC 3 June 2026.pdf (9 pages)

6.2.3. Cancer Services Annual Report

Information Dom Hurford, Executive Medical Director

 6.2.3 Cancer Services Annual Report QSEC 3 June 2026.pdf (12 pages)

6.2.4. Bi-Annual Report CTM Radiation Safety Committee

Information Lauren Edwards, Executive Director for AHP's and Health Sciences

 6.2.4 Radiation Safety Committee QSEC 3 June 2026.pdf (6 pages)

6.2.5. Antimicrobial Stewardship Report – June 2026 - To follow

Information Dom Hurford, Executive Medical Director

6.2.6. Annual Report of the Decision – Making and Consent Working Group - To follow

Information Dom Hurford, Executive Medical Director

6.2.7. RADAR Programme – Outline of Activities, Areas of Focus and Roles

Information Dom Hurford, Executive Medical Director

 6.2.7 RADAR Report for QSEC 3 June 2026 (v2).pdf (8 pages)

6.2.8. Update: Explosion of Pacemaker at Glyntaff Crematorium

Information Dom Hurford, Executive Medical Director

 6.2.8 Exploding Pacemaker QSEC 3 June 2026.pdf (5 pages)

11:40 - 11:50
10 min

7. CLOSE OUT BUSINESS

7.1. Committee Highlight Report to the Board

Discussion Louise Stait, Interim Assistant Director of Governance & Risk

7.2. Meeting Feedback

Discussion Carolyn Donoghue, Committee Chair

Is there anything we should do more or less of?

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

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

Have we received sufficient assurance from a range of sources?

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

7.3. Any Other Business

Information Carolyn Donoghue, Committee Chair

11:50 - 11:55
5 min

8. Private/Closed Session Business

Information Carolyn Donoghue, Committee Chair

The following items will be received in the Closed In Committee Session:

- Organisational Risk Register - Closed Risks

11:55 - 12:00
5 min

9. Date & Time of Next Meeting

Information Carolyn Donoghue, Committee Chair
The next meeting takes place on Tuesday 21 July 2026 at 9:00am



Agenda Item

3.3

Quality, Safety & Experience Committee

QUALITY, SAFETY & EXPERIENCE COMMITTEE ANNUAL REPORT 2025 - 2026

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Sharon Edwards, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Chair of the Quality, Safety & Experience Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

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	

1. Situation /Background

- 1.1 Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report *"setting out its activities during the year and detailing the results of a review of its performance"*.
- 1.2 This annual report from the Quality, Safety & Experience Committee details the activities and performance for the Committee for the reporting period 2025-2026.

2. Specific Matters for Consideration

- 2.1 The Committee Annual Report at Appendix 1, summarises the key areas of business activity undertaken by the Committee from April 2025 – March 2026 and highlights activity for further consideration over the next 12 months.

3. Key Risks / Matters for Escalation

- 3.1 Please refer to Appendix 1 for the full detail contained within the report.

4. Assessment

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



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

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

5. Recommendation

- 5.1 The Committee are being asked to **ENDORSE FOR BOARD APPROVAL** the Committee Annual Report.

6. Next Steps

- 6.1 Once endorsed, the Annual Report will be submitted to the Board meeting being held on 30 July 2026 for approval.

ANNUAL REPORT 2025-2026

QUALITY, SAFETY & EXPERIENCE COMMITTEE

Sharon Edwards (Cwm Taf Morgannwg - Corporate Governance)
CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

QUALITY, SAFETY & EXPERIENCE (QSEC) COMMITTEE

DRAFT ANNUAL REPORT 2025-2026

FOREWORD

I am delighted to present the Annual Report of the Quality, Safety & Experience Committee for the year 2025–2026. This report outlines the Committee’s activities and achievements up to March 2026, in accordance with its Terms of Reference.

Throughout the year, I have been supported by Kath Palmer, Vice Chair (also Vice Chair of the Committee), together with Hayley Proctor, Patsy Roseblade and Dilys Jouvenat. All have brought considerable knowledge and a wide range of experience, which has made a valuable contribution to the Committee’s work.

I would also like to extend my sincere thanks to all officers supporting the Committee for their commitment and the high quality of their contributions. Their strong engagement and robust reporting have enabled the Committee to discharge its responsibilities effectively.

I would like to acknowledge the support provided by colleagues within the Corporate Governance Team throughout the year, and to record my appreciation for the valuable contribution of colleagues from the Internal Audit team at NHS Wales Shared Services Partnership, Audit Wales, Llais Cymru and Healthcare Inspectorate Wales.

Looking ahead, the Committee will continue to deliver a comprehensive programme of work focused on the quality, safety and experience of care for our population, alongside matters relating to the health and safety of our workplaces.

The Committee remains committed to promoting a collaborative approach that supports learning and the continuous improvement of services for the Cwm Taf Morgannwg community, while further strengthening the Health Board’s governance and assurance arrangements.

Carolyn Donoghue,

Chair of the Quality, Safety & Experience Committee

Cwm Taf Morgannwg University Health Board (CTMUHB)

INTRODUCTION

The Quality, Safety & Experience Committee (QSEC) is chaired by an Independent Member and provides assurance to the Board on the delivery of safe, high-quality and person-centred care for the population it serves.

The Committee's role is to provide oversight of quality, safety and experience matters across the organisation, ensuring that appropriate arrangements are in place to monitor performance, manage risks and support continuous improvement in care delivery. This includes providing assurance in relation to prevention through public health, as well as the delivery of primary and secondary care services.

During the year, the Committee has continued to evolve, with further development of agenda content and reporting formats to strengthen oversight and assurance. This has supported more focused discussion, enhanced scrutiny, and clearer visibility of emerging risks, quality concerns and assurance gaps, enabling the Committee to provide effective assurance to the Board.

The Committee has embedded the Health Board's Strategic Goals into its work programme, ensuring alignment with the "**CTM2030: Our Health, Our Future strategy**" and the Health Board's "**Values and Behaviour**"



The Quality, Safety & Experience Committee meets every other month and has a key role in providing scrutiny on behalf of the Board on all matters relating to quality, safety and experience. Following each meeting, a Highlight Report is produced summarising the key matters discussed, including significant issues, risks, and areas requiring assurance or further action.

This report is submitted to the next public Board meeting to ensure that the Board is sighted on key quality, safety and experience issues, and can provide appropriate oversight and direction where required.

The Committee aims:

- To improve quality, safety and patient experience.
- To protect and improve population health.
- To ensure that the services provided are accessible and sustainable into the future.
- To provide strong governance and assurance.
- To ensure good value-based care and treatment for our patients in line with the resources made available to the Health Board.

The Committee is also responsible for developing an annual report for presentation to the Health Board.

MEMBERSHIP

The membership of the Quality, Safety and Experience Committee comprises of both Independent Members and Executive Directors, enabling the Committee to provide robust scrutiny and independent assurance to the Board, separate from day-to-day management decision-making processes.

The Committee compromises of four Independent Members, including a Chair, and Vice Chair. Additional Independent Member representation is provided through the chair of the Audit, Risk & Assurance and the Chair and /or a member of the Health, Safety & Fire Sub Committee.

Independent membership of the Committee during 2025-2026 was as follows:

Carolyn Donoghue	Chair of the Committee (Chair since July 2023)
Kath Palmer	Committee Vice Chair (Vice Chair since November 2023)
Hayley Proctor	Independent Member (From November 2024)
Patsy Roseblade	Independent Member (From March 2021)

MEETINGS

The Quality, Safety and Experience Committee met bi-monthly during 2025/26. During the year, the Committee reviewed its forward work programme to ensure that key issues were appropriately prioritised and aligned with assurance requirements.

The Public Committee met on six occasions during 2025-2026, on the following dates:

- 20th May 2025
- 22nd July 2025
- 23rd September 2025
- 18th November 2025

- 20th January 2026
- 24th March 2026

A summary of the Independent Membership attendance during 2025- 2026 is outlined below:

Public Meeting Attendance

Attendance Level 2025-2026	20 th May'25	22 nd Jul'25	23 rd Sept'25	18 th Nov'25	20 th Jan'26	24 th Mar'26	TOTAL
Carolyn Donoghue Chair	✓	✓	✓	✓	✓	✓	6/6
Kath Palmer Vice Chair	x	✓	✓	✓	✓	✓	5/6
Patsy Roseblade	✓	✓	✓	✓	✓	✓	6/6
Hayley Proctor IM	x	✓	✓	✓	✓	✓	5/6
Dilys Jouvenat IM *	✓	x	x	x	x	x	1/1

The In-Committee met on four occasions and the attendance is detailed below

In-Committee Attendance

Attendance Level 2025-2026	20 th May'25	22 nd Jul'25	23 rd Sept'25	18 th Nov'25	TOTAL
Carolyn Donoghue Chair	✓	✓	✓	✓	4/4
Kath Palmer Vice Chair	x	✓	✓	✓	3/4
Patsy Roseblade IM	✓	✓	x	✓	3/4
Hayley Proctor IM	x	✓	✓	✓	3/4
Dilys Jouvenat IM *	✓	x	x	x	1/1

*Although not a member of the Committee, Dilys Jouvenat attended the May 2025 meeting to ensure it was quorate.

All of the above meetings were confirmed as quorate.

Attendees

The Committee's work is informed by reports provided by leads within CTMUHB, Llais Cymru (formerly Cwm Taf Community Health Council), Healthcare Inspectorate Wales, Audit Wales and Internal Audit. Although not members of the Committee, colleagues from these areas are invited to attend each meeting of the Quality, Safety & Experience Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

MAIN AREAS OF QSEC COMMITTEE ACTIVITY

The agenda for each meeting has followed a standard format in six main parts:

- Part 1 - Preliminary Matters
- Part 2 - Consent Agenda Business
- Part 3 - Main Agenda
- Part 4 - Staff and Service User Experience
- Part 5 - Setting the Scene – Service Delivery
- Part 6 - Delivering the plan
- Part 7 - Governance & Assurance
- Part 8 - Consent Agenda
- Part 9 – Close Out Business

Part 1 - Preliminary Matters

This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB.

Part 2 - Consent Agenda Business

This section is where the Committee Chair will ask if there are any items from the Consent Agenda that Committee Members wish to bring forward to the main agenda for discussion

Part 3 - Main Agenda

This section has included reports throughout the year which included:

- The Action Log which helps to monitor the progress and any necessary follow up actions needed.
- Matters Arising not Contained within the Action Log

- Committee Annual report

Part 4 – Staff and Service User Experience

This section has included Shared Listening & Learning Stories from Patients and Staff including:

- Maternity Services
- Unpaid Carers
- Domestic Violence
- Mental Health and Patient Experience
- Alcohol Services
- Podiatry Services

Also under this section, the Committee considered matters relating to Executive and Independent Member walkarounds framework. This included discussion on the different approaches adopted, the development of questions to support these walk rounds, and the outcomes arising from these visits.

Part 5 – Setting the Scene – Service Delivery

As part of this section, the Committee received Thematic Spotlight presentations which provided the Committee with assurance and learning in relation to:

- Service Delivery – Spotlight report update on the cluster of incidents within the maternity services at POWH
- Compassionate Care
- Quality Impact of the Health Boards new Escalation Framework
- Winter Wrap Up

The Committee's agenda incorporates structured reporting from Clinical Executive Directors to support strategic oversight of key issues within their respective service areas.

This is followed by Care Group Highlight Reports, which enable the Committee to gain assurance on performance, risks and emerging themes across the organisation's care groups. These reports allow the Care Group Leads with the opportunity to highlight areas that have been identified through the alerts / escalation section of their reports.

Reports are received from the following care groups:

- Primary Care & Communities Care Group
- Diagnostics, Therapies, Pharmacy, & Specialist Care Group
- Mental Health & Learning Disabilities Care Group
- Planned Care Group
- Children & Families Care Group
- Unscheduled Care group

Within this section, the Committee also received updates on key areas of activity and development:

- Stroke Services Reports– Progress and Bi-Annual Update
- Reducing Health Inequalities report

Part 6 – Delivering Our Plan

This Committee receives papers that provide details on:

- Patient Safety, Quality and Experience Dashboard
- Peoples Experience Activity Report
- Overview of the Development & Delivery of the Research & Development Strategy
- Status report on commissioned services (Quality focused)
- CTMUHB's NHS Research & Development Framework Assessment 2026

Links with Other Committees/Boards

A process is in place for any relevant matters to be referred to other Board Committees for scrutiny and or action.

During 2025–2026, the Committee received two updates relating to committee referrals. The associated detailed report was received and considered by the Audit, Risk & Assurance Committee.

The two referrals concerned medical negligence claims, as reported through the Losses and Special Payments Report.

Part 7 - Governance and Assurance

The effectiveness of the Committee is monitored through the following key governance reports, which included:

- Organisational Risk Register – Risks assigned to the Quality & Safety Committee
- Annual Assurance report on Compliance with the Nursing Staff Level (Wales) Act
- Mortality Indicators and Mortality Reviews
- Healthcare Inspectorate Wales (HIW) Improvement Plan Tracker Report
- Highlight Report from the Harm Free Care Agenda
- Annual Presentation of Nursing Staff Levels
- Coroner's Inquest – Case Activity and Lessons Learned
- Internal Audit Review – Duty of Candor
- Health, Safety and Fire Sub Committee Highlight Report
- Clinical Effectiveness Update 2025-2026

Part 8 – Consent Agenda

This section included reports presented to the Committee throughout the year, comprising of items for approval and items for noting, including:

For approval

- The Unconfirmed Minutes of the previous meeting
- The Unconfirmed Minutes of the previous In-Committee meeting
- IM and exec Walkabouts Operating Model

Terms of Reference, Annual reports and Highlight reports for approval:

- Quality, Safety & Experience Committee Terms of Reference
- Organ Donation Sub Committee Highlight report, Annual Report and Terms of Reference
- Putting Things Right Annual Report
- Health, Safety & Fire Sub Committee Highlight report

Policies for Approval:

- Ratification of Chairs Urgent action Medical Gases Management Policy
- All Wales IPFR Policy (2025)
- All Wales Prior Approval Policy (2025)
- Policy for the Development, Review and approval of CTM UHB Policies, Procedures and Other Written Control Documents

For **items for noting**, including:

- Forward Work Programme
- Committee Annual Cycle of Business

Additional items for noting are:

- Clinical Policies Highlight Report
- Cancer Services Annual report
- CTM Clinical Learning Academy Annual report
- Infection, Prevention & Control Annual Report
- Research & Development, Innovation and Improvement Bi-annual Update
- Terms of Reference Annual review
- Annual Unpaid Carer's Report
- Bi- Annual Report CTM Radiation Safety Committee
- Antimicrobial Stewardship report
- Outcome report – Quality, safety & Experience Committee Effectiveness Survey
- Healthcare Inspectorate Wales improvement Plan Tracker Report
- Continuing Healthcare
- Joint Commissioning Committee Quality, Safety & Outcomes Sub Committee highlight report
- CTMUHB National Clinical Audit Programme Update
- Human Tissue Act (2004) Compliance and Progress Report
- Internal Audit Review Service User Experience
- RADAR Update

Close Out Business

This section included reports presented to the Committee throughout the year, including:

- The Committee Highlight Report
- Any other Urgent Business
- Meeting Feedback

GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference & Operating Arrangements
- Committee Annual Report
- Highlight Reports from the Committee to the Health Board meetings
- Annual Committee Effectiveness Self-Assessment Survey
- Annual Cycle of Committee Business

The Corporate Governance Team maintain a “Committee Effectiveness Tracker” to ensure the above activity is undertaken at the appropriate times during the year.

ASSURANCE TO THE BOARD

The Quality, Safety & Experience Committee considers that on the basis of the work completed by the Committee during 2025 - 2026, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2026-2027 and beyond, ensures that the Committee retains scrutiny on key areas of activity.

In addition, the Committee Chair will meet with the lead officers and the Chair of the Board to discuss progress of the work of the Committee.

The Annual Cycle of Committee Business has continued to be presented to each meeting of the Committee during 2025/2026, alongside the Forward Work Programme. This supports and helps identify the key areas of focus for the Committee and is one of the key components in ensuring that the Committee is effectively carrying out its role. It also facilitates the management of agendas and Committee business.



Agenda Item

4.2

Quality, Safety & Experience Committee

Highlight Report for People's Experience Activity
February – April 2026

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Jenny Oliver, Head of People's Experience Clare Ibbs, Interim Head of Corporate Nursing and People's Experience
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Clare Ibbs, Interim Head of Corporate Nursing and People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director 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
NA	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
SMS	Short Message Service
PALS	Patient Advice and Liaison Service

1. Introduction

1.1 This report has been prepared to provide the Quality, Safety and Experience Committee with a high-level overview of People’s Experience activity for the period February – April 2026.

2. Purpose of this report

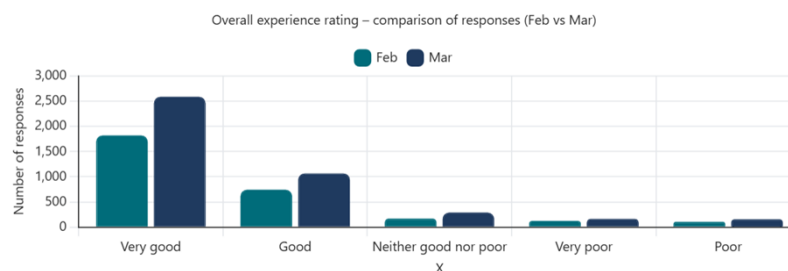
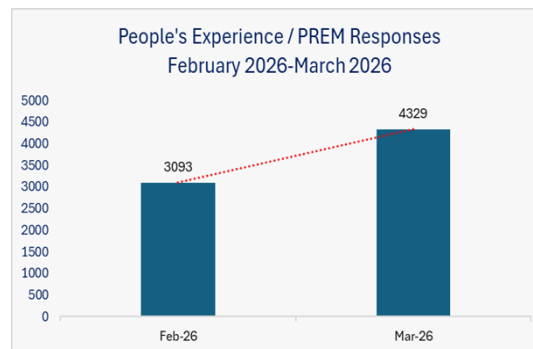
The purpose of this People’s Experience highlight report is to provide the Quality Safety & Experience Committee with a consolidated overview of key intelligence from across the People’s Experience portfolio, supporting assurance on the delivery of safe, effective and person-centred care, in alignment with the All-Wales People’s Experience Framework.

3. Highlight Report

Alert / Escalate	Between February and April 2026, People’s Experience feedback has been maintained through a phased transition to the new Promptly feedback platform. Interim manual reporting arrangements remain in place pending full digital integration, providing ongoing assurance. SMS feedback continues to be received and reviewed, enabling early identification of emerging areas of concern.
	Equality, Diversity and Inclusion – Multi-Faith Facilities: The multi-faith room at Royal Glamorgan Hospital is currently operating at capacity, resulting in challenges in accommodating Friday prayers. This has been identified as an ongoing priority, with work underway with the site management team to explore options for access to a larger or alternative space.
Advise	The proposed redesign of the PALS service into a tiered People’s Experience & Engagement model, is aligned to the All-Wales People’s Experience Framework and Health Board strategy. The introduction of Band 6 Senior People’s Experience & Engagement Officer, together with Band 5 People’s Experience & Engagement Officer roles, will provide clearer leadership, escalation and compliance with all governance arrangements. This redesign of the PALS service will support the shift from a reactive, concerns-focused model to a proactive, engagement and improvement-led approach, supporting early resolutions and ensuring organisational learning is proactively captured,



	addressed and shared across the organisation for wider learning and improvement . The redesigned model strengthens triangulation of people’s feedback, concerns, incidents and people’s stories to inform service improvement and provide assurance to the board by increasing a structured engagement and co-production activity-based approach. This approach will include reaching out to seldom-heard groups and priority service transformation programmes. The redesigned model compliments the current PALS arrangements, with clearer accountability across the People’s Experience portfolio.
Assure	People’s Experience Feedback and Insight Implementation of the All-Wales People’s Experience Survey continues to progress, with a greater than 25% increase in responses received between February and April 2026, providing a broader evidence base. Feedback received demonstrates, predominantly positive experience ratings (very good/good), with recurring themes relating to communication, care experience and service responsiveness. Work is underway to strengthen data triangulation, bringing together people’s feedback, concerns, incidents and lived experience to better inform service improvement and governance oversight. The increasing volume and consistency of people’s feedback is strengthening organisational insight and assurance. While data maturity continues to develop, current information provides early identification of themes and informs improvement activity. Refer to Table 1: Total Responses Feb–April 2026, Table 2: Satisfaction Rates CTM Feb–April 2026



Compassionate, Person-Centred Support Services Chaplaincy and Spiritual Care

High levels of activity have been sustained despite workforce pressures, with significant pastoral and spiritual support provided to patients, relatives/carers and staff.

Services maintain a strong ward presence and inclusive, multi-faith approach, demonstrating flexibility in meeting individual needs, including bedside sacramental care.

PALS (Operational Delivery)

PALS activity levels remain steady, with similar numbers of cases opened and closed in February and March 2026.

Key themes relate to communication, clinical care and overall People's Experience, supporting early resolution of issues and organisational learning.

Positive feedback indicating that core patient-facing services continue to deliver compassionate, person-centred support and provide actionable insight into people's experience, despite capacity pressures.

With the implementation of the new Listening To People process, the PALS service will work in collaboration with the clinical teams



	and remain instrumental to supporting across sites with enquiries and early resolutions. Inclusion, Equity and Community Focus Progress continues through targeted programmes supporting unpaid carers, including a pilot of the Carers Passport and integration into key pathways such as discharge, dementia and falls. Ongoing engagement with the Armed Forces and Veterans community, including preparation for Employer Recognition Scheme submission continues. The revised model with the New People's Experience and Engagement roles will support sustained focus on reducing health inequalities, reaching seldom-heard groups and strengthening third-sector partnerships.
Inform	Engagement and co-production activity continues to expand, including sensory support initiatives and the use of baseline surveys to improve accessibility and inform targeted action based on population insight. Work with Armed Forces & Veterans and Unpaid Carers is progressing through established multi-agency partnerships, including the development of co-produced resources such as the Carers Passport. People's Experience teams are supporting key service redesign activity, including the Women's Health Hub, Pain Service review and Llantrisant Health Park developments, ensuring community voice informs transformation. Compassionate support services, including Chaplaincy, continue to be delivered at scale despite workforce pressures. Portfolio reviews of Chaplaincy and Volunteer services are ongoing, with a focus on improving sustainability, aligning provision to population need and modernising operating models The People's Experience team have been awarded silver status in Cultural competencies and are working towards gold status.



4. Assessment

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



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

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

4.3

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	1. Richard Hughes- Executive Director Nursing, Midwifery and Patient Care 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director of Allied Health Professions (AHPs) and Health Science 4. Philip Daniels, Executive Director Public Health
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	1. 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 4. Philip Daniels, Executive Director Public Health
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 4. Philip Daniels, Executive Director Public Health

Pwrpas yr Adroddiad / For Noting



Report Purpose

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

EPMA	Electronic Prescribing and Medicines Administration
CTM UHB	Cwm Taf Morgannwg University Health Board
POW	Princess of Wales
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
HCID	High Consequence Infectious Diseases
PPE	Personal Protective Equipment
IPC	Infection Prevention Control
HEIW	Health Education and Improvement Wales
GMC	General Medical Council
ED	Emergency Department

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
- Philip Daniels- Executive Director for Public Health

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

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

2.1 Nursing & Midwifery-Richard Hughes

This section of the paper provides an overarching update on the remit of the Executive Director for Nursing, Midwifery and Patient Care.

Welsh Ambulance Services NHS Trust (WAST) Quality & Safety data reporting

Committee members have previously raised concerns regarding the quality and safety oversight arrangements for the Welsh Ambulance Services NHS Trust (WAST), particularly at points of transition into the Emergency Department and regarding delays experienced by patients awaiting ambulance responses in the community.

Assurance can be provided that there has been demonstrable improvement in patient experience and safety at the point of handover into the Emergency Department, supported by strengthened operational grip and joint working arrangements.

In parallel, concerns relating to prolonged community waits continue to be recognised and actively addressed.

CTM teams are aligned with WAST colleagues through established processes for joint reviews when quality or safety concerns are identified, including incidents arising from ambulance delays. These arrangements support shared learning, transparency and a whole-system approach to risk mitigation.

The Executive Director of Nursing, Midwifery and Patient Care is formally writing to the Chief Executive of WAST to outline these concerns and to reaffirm a

commitment to working in partnership to ensure that quality and safety monitoring arrangements are aligned across organisations.

This includes strengthening candour, information sharing and assurance to Board members.

Active discussions are already underway with the Deputy Director of Nursing for WAST to progress this work.

In addition, the Executive Director of Nursing, Midwifery and Patient Care and the Executive Medical Director are working with the Chief Operating Officer to establish an Urgent and Emergency Care Oversight Group. This group will align CTM activity to NHS Wales priorities and provide an integrated focus on quality, safety, patient flow and operational performance, including the targeted application of improvement science.

WAST-related issues will be incorporated within this oversight framework, with formal reporting through to the Executive Management Board.

Bi-annual update on coroners' inquests - activity & lessons learnt

Over the six-month period from November 2025 to April 2026, new inquest activity has remained relatively constant within Cwm Taf Morgannwg University Health Board (UHB). During the time period, 141 new inquests were received, which remains consistent with the long-term average trend of 23 opened each month.

During the same period, there was a notable increase in the number of cases closed. This activity is partly attributed to a targeted cleansing exercise undertaken jointly with the Coroner's Officer during April 2026, which has supported the resolution and formal closure of historic cases. Whilst this demonstrates improved oversight and alignment between the Health Board and the Coroner's Officer, it should be noted that this does not reflect Inquest hearing activity.

As of May 2026, there are 272 open inquests, with activity predominantly concentrated in Unscheduled Care (84 cases) and Planned Care (58 cases), alongside notable volumes in Mental Health (50) and Community (47) services.

The current open inquest caseload requires 497 statements, of which 78% have been submitted.

Compliance with the timescales for submission of statements continues to be a challenge, with the Coroner's Officer issuing schedule 5s as a result of the delays.

A review of the Health Board process for managing Inquests has been undertaken, along with detailed guidance to support clinical teams throughout the inquest process.

To support this, a training programme jointly delivered by the Coroner and Health Board is being rolled out, with the first session delivered on 5th May 2026.

Although activity has remained stable, the complexity of cases continues to increase, with shorter timescales for submitting information to the Coroner.

This is in addition to a greater expectation on the Health Board to produce internal investigation reports, as well as to source and provide expert evidence.

The increasing complexity is reflected in the current inquest caseload, where **38** cases have been RAG-rated as **Red (21)** and **Amber (17)**.

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, 58 cases have been referred to Legal & Risk due to the anticipated need for specialist representation and expert evidence.

In the six-month period, the Coroner has issued three Regulation 28 reports following the conclusion of an inquest involving Cwm Taf Morgannwg University Health Board. These relate to:

- a) **Issued to Welsh Government:** Missed opportunities to identify the co-ingestion of clarithromycin with simvastatin in the community
- b) **Issued to All Health Boards:** Delay in locating adrenaline during resuscitation due to lack of standardisation of crash trolleys across Wales
- c) **Issued to CTM UHB, Cardiff & Vale UHB and Welsh Government:** absence of clear guidance and protocol for when a referral should be made by the local hospital to the tertiary centre in respect of Hepato-Pancreato-Biliary (HPB) related matters.

Maternity Nationally Reportable Incidents

A cluster of four nationally reportable maternity incidents occurred between March and May 2025 across Princess of Wales Hospital and the Tirion Freestanding Midwifery Unit. In response, investigations were undertaken in line with the nationally reportable incident framework, including internal reviews, one external investigation, and a commissioned independent review of all cases by external midwifery and obstetric reviewers. The review applied a tabletop approach, assessing clinical records, relevant policies and RAPID review documentation to determine whether care processes were safe and effective.

The independent review found no common concerns regarding individual staff members involved in care. All four cases were identified as involving suboptimal care, in which different management approaches may have influenced outcomes. The RAPID review process identified issues, although some were not evident at the earliest stage. Contributory factors included delays in updating clinical guidelines, variation in escalation and documentation practices, and broader system pressures arising from the recent suspension and reopening of maternity services.

An improvement programme is in place with oversight through a maternity and neonatal oversight board. Key recommendations include reinforcing escalation arrangements when transferring women between settings, ensuring timely use of emergency call systems, and returning to detailed clinical documentation while

digital solutions are developed. Further actions include updating all clinical guidelines within agreed timescales, introducing staff rotation to support clinical acuity and teamwork, strengthening business continuity planning using learning from these incidents, and reviewing the future configuration of maternity services.

The Committee is asked to note that Duty of Candour, claims management, and organisational learning processes are in place, and that delivery of these actions is subject to established governance and oversight arrangements

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. Electronic Prescribing and Medicines Administration (EPMA) Princess of Wales Hospital (POW) Roll-out
2. Successful Appointment to Care Group Medical Director for Mental Health & Learning Disabilities

EPMA POW Roll-out

The successful roll-out of the Electronic Prescribing and Medicines Administration (EPMA) system at Princess of Wales Hospital represents a major milestone in CTM's digital transformation programme. Following comprehensive system testing, staff engagement, and training, the site-wide go-live has been delivered with strong clinical and digital support in place to ensure a safe and effective transition. The move to a fully electronic prescribing system will enhance patient safety through improved prescribing accuracy, reduced medication errors, and better clinical decision support. This achievement provides a strong foundation for further digital innovation and standardisation of medicines management across the Health Board.

Appointment of Care Group Medical Director – Mental Health and Learning Disabilities

We are pleased to confirm the successful appointment of Sarah Argent as Care Group Medical Director for Mental Health and Learning Disabilities on a 6-month interim contract. This is a key leadership position within one of the Health Board's most complex service areas and represents a significant strengthening of the senior medical leadership team. Sarah will provide strong clinical leadership, supporting service development, workforce priorities, and delivery of high-quality

patient care across the Care Group. We extend our congratulations to Sarah on her appointment and look forward to the impact of her leadership in driving forward improvement and stability within the service.

Areas of Focus

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

1. Bare Below the Elbow Compliance – POW
2. Resident Doctor Contract Implementation
3. Prince Charles Hospital Emergency Department (Training and Supervision)

Bare Below the Elbow Compliance – POW

From a recent point prevalence study, infection prevention and control compliance at Princess of Wales Hospital identified particular concerns in hand hygiene and PPE practice. While Bare Below the Elbows compliance is generally strong, a number of wards show low hand hygiene adherence, indicating inconsistent application of core IPC measures. The most significant risk relates to PPE, where widespread inappropriate use, poor removal practices, and failure to change between patients were observed across multiple areas.

This inconsistency increases the risk of cross-contamination and healthcare-associated infections. Targeted intervention, strengthened leadership oversight, and behavioural change work are required to improve compliance and ensure safe, consistent practice across the site and leadership teams are working to put these actions into practice.

Resident Doctor Contract Implementation

Progress with Resident Doctor Contract implementation remains broadly in line with the planned programme, with rota review booklets issued, high-risk specialties prioritised, and engagement across Care Groups and clinical teams ongoing. Consolidated feedback has been received and discussions are progressing to finalise implementation plans, supported by a standardised assurance framework to strengthen consistency and governance. However, further work is required to finalise rota compliance across all specialties, particularly where gaps, recruitment requirements, and financial implications remain unresolved. Additional focus is needed on workforce modelling, study leave funding pressures, and delivery of Facilities Charter requirements to ensure safe, sustainable implementation ahead of formal rollout in August 2026.

Prince Charles Hospital Emergency Department - Training and Supervision

Following a targeted visit by HEIW and engagement with the GMC, a number of concerns have been identified in relation to training and the clinical environment within the Emergency Department at Prince Charles Hospital.

In response, a comprehensive action plan has been developed by the ED Clinical Lead, Directorate leadership team, and the Unscheduled Care Group. This focuses on strengthening clinical supervision, improving training opportunities, enhancing rota sustainability, addressing recruitment challenges, increasing leadership engagement, and optimising patient flow. Progress against these actions is being actively monitored through established governance arrangements, with ongoing engagement with HEIW to provide assurance and demonstrate sustained improvement.

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.

Recognition

Operating Department Practitioners Day

The work of Operating Department Practitioners (ODP) was celebrated on the 14th of May 2026.

A Healthcare Scientist profession within Wales, ODPs make a vital contribution to patient care through perioperative care, anaesthetic support, surgical assistance, and post-operative recovery.

ODPs are a Health and Care Professions Council (HCPC) registered profession and are crucial to providing safe, high-quality surgical care across CTMUHB.

Cardiac and Respiratory Physiology - student feedback

The work experience offer from the cardiac and respiratory service has received excellent feedback. The wide range of learning opportunities across both cardiac and respiratory physiology, including observing ECGs, echocardiograms, pacemaker clinics, and lung function testing was highlighted. The team were described as welcoming, supportive, and knowledgeable, with time taken by staff to explain procedures.

This positive experience made a real impact on a student who has now accepted an offer to study Cardiac Physiology at Swansea University; a fantastic outcome.

Pathology

Pathology Training leads across Wales held a Virtual Work Experience opportunity in May 2026. This unique learning opportunity enabled students to learn about

NHS laboratory careers in a variety of pathology disciplines and is vital in raising awareness of the profession and encouraging people from within the CTM footprint to consider it as a career.

Awareness

Chief Allied Health Professional Officer

Interviews have been held for the vacant Chief Allied Health Professional Officer (CAPHO) role within Welsh Government.

The successful candidate will work across the health system, and with local authorities to oversee the strategic direction and leadership of the AHP professions that are regulated by the Health and Care Professions Council (HCPC), together with associated staff groups and support workers.

Occupational Therapy

Four Welsh Universities that deliver Occupational Therapy courses have reduced commissioning numbers for 2026/27, raising concerns around the future workforce supply and the ongoing viability of courses.

Concerns have been escalated to Executive Directors of AHP and Health Science, recognising the potential future impact on service provision.

Assure

National Programme Updates

At May's monthly meeting of the CTM Allied Health Professions & Health Science Professional Leadership Group, colleagues received updates from both the National Allied Health Professions and Health Science Programmes.

The updates focussed on achievements of 2025/26 and priorities for 2026/27 ensuring CTM staff are fully informed on national developments allowing for local alignment where appropriate.

Audiology

During October and November 2025, all Adult Hearing Rehabilitation Services in Wales were audited externally against the latest version of the Quality Standards for Adult Hearing Rehabilitation Audiology (2025).

The compliance targets for the 2025 audit were 80% for each individual standard and an overall target of 85%. Audiology at CTMUHB met the 80% target in all nine individual standards and the Service also met the overall target of 85%.

As previously reported, 3 out of 82 individual criteria were identified as low scoring with accessing the service/maximum waiting time being one of these low scoring components. To help to address current waiting times, the Audiology service in CTM is prioritising adult waiting times by maximising available capacity through reduction in meeting attendance, maximisation of room availability, and use of bank staff.

2.4 Public Health Update-Philip Daniels

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

Sexual Health Test and Post Service Update:

In November and December 2025, Public Health Wales identified some operational issues in the Sexual Health Test and Post Service. These included:

- Safeguarding processes for people using the online and community test-and-post sexual health service which were not effective and did not meet required legislative standards. This meant that Public Health Wales reported safeguarding information to health boards, rather than to local authorities.
- Some data handling processes, involving personal data, which were not effective and did not meet required standards.

Public Health Wales undertook a risk assessment to ensure the service was safe to continue, changing the internal safeguarding processes for people who contact our Sexual Health Test and Post Service to ensure that the correct safeguarding processes and procedures are followed. Cases were reviewed and where needed directed these cases to the relevant local authority for the appropriate management and support.

There were occasions when test results were sent to the wrong health board, were incorrect or delayed. PHW have made changes to their data handling procedures and have reported the data incidents to the Information Commissioners' Office.

As part of the detailed review of the service an issue was identified with some of the Hepatitis C tests for those living with HIV. This has meant that some people who have self-declared that they are living with HIV and who have asked for a Hepatitis C test through the Sexual Health Test and Post Service have not been tested for Hepatitis C. This applies to test results received from the Test and Post Service between May 2020 and 25th February 2026 and was the result of a technical issue.

Public Health Wales has been contacting those affected to offer them a test and set up a helpline to support individuals.

Public Health Wales will be commissioning a full independent external review into these issues.

Hantavirus Overview:

The Health Board has attended the national Hantavirus Incident Management Team (IMT) meetings and has set up two CTM Hantavirus IMTs to assess preparedness for a Hantavirus contact within CTM. Attendance has been across care groups and with local authorities and PHW to ensure preparedness against all aspects of the Hantavirus Care and Wellbeing plan. The team has also taken the opportunity to review CTM preparedness for High Consequence Infectious Diseases (HCID), with the HCID plan due to be signed off in June 2026.

Environment, ventilation, patient access and flow, decontamination and workforce readiness were assessed for all three acute sites.

PCH is the preferred CTMUHB receiving site for suspected or confirmed HCID subject to time-limited use, specialist escalation and recognition of very limited medical capability.

RGH and POW do not currently have negative pressure rooms, though these have been funded and development is ongoing. Therefore, RGH/POW capability remains HCID recognition, immediate isolation and escalation only.

The new HCID PPE training across all sites was reviewed with gaps identified in some sites and in medical staff. Training options have been identified and will be rolled out as soon as possible.

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / 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) /	No - Not Applicable
	If more than one applies please list below:



**Environmental
/Sustainability Impact (5Rs)**

Impact Assessment

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

Resource Impact
(People / Financial)

4 Recommendation

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

5 Next Steps

5.1 Members of the Quality, Safety & Experience Committee will continue to receive regular 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

4.4.1

Quality, Safety & Experience Committee

Unscheduled Care Group Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Sarah Follows, Operational Director for Unscheduled care. 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 <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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	03/06/2026	

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 Care Group Quality, Safety, Risk and Experience meeting.
- 1.2 Key highlights from the meeting are reported in section 3.



2. Purpose of this Meeting

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

Highlight Report

Alert / Escalate

Gastroenterology Services

The Consultant rota has been fragile since the critical incident at POWH, but due to the sudden loss of a Locum Consultant in Planned Care and other issues impacting it has been agreed to temporary transfer the service from POWH to the RGH from Tuesday 5th May 2026 for 6 months.

There has been an immediate MDT approach to ensure Patient Pathways are in place with good communication. In order that we monitor patient safety and experience, the Patient Safety Team are setting up a dashboard, like that is established within the stroke service. There is a potential risk of unintended consequences, including a deterioration in Emergency Department quality and operational performance, notably in relation to the 12-hour standard and ambulance handover times.

Key areas of monitoring will include:

- Patient delays in ED POWH
- Patient delays in ED RGH due to the prioritisation of Gastroenterology patients in POWH ED that require direct transfer to Ward 5 RGH. This may potentially impact on equity of care for patients remaining in ED that may be for Gastroenterology or another defined speciality.
- Patient harm indicators, including pressure damage, falls, medication errors and other associated deconditioning risks.

The details of the findings will be reported in the next QSEC, September 2026.

Nursing Recruitment

A recent "Deep Dive" into recruitment processes across the Unscheduled Care areas has identified inconsistencies and variations in practice.



There have been initial discussions with People's Services with the intention of introducing Recruitment Panels in Unscheduled Care from 1st May 2026, to ensure consistent governance arrangements around the approval process for all vacancies. Unscheduled Care will be a "Proof of Concept" for aligned processes re training, education, a pan CTM USC Interview Panel inclusive of the HB's Equality, Inclusive and Diversity Action Plan and validation of Interview Questions in order that we are optimising the quality of staff we recruit.

Hydroxychloroquine (HCQ), related Patient Safety Incidents.

Patient safety concerns have been identified in relation to the prescribing of Hydroxychloroquine (HCQ) and the associated ophthalmology monitoring pathway, and this risk is recorded on the Health Board's Risk Register. While further detailed work is required to fully confirm the position, it is currently understood that approximately 1,000 patients have received HCQ prescribed through Rheumatology Services. The primary patient safety concern relates not to the prescribing of HCQ itself, but to incomplete or absent ophthalmology follow-up and screening in line with national guidance.

To date, two confirmed National Reportable Incidents (NRIs) have been identified, with a further case under active review. In addition, based on initial clinical intelligence, there is potential for harm to 60 or more additional patients where appropriate ophthalmic screening has not taken place, including the risk of early or irreversible retinopathy.

The Planned Care Clinical Services Group (CSG) is in the process of establishing the required screening arrangements and will provide direct reporting through its Care Group governance structures. The issue has been formally escalated to the Executive Team, with mitigating actions agreed and progress against these mitigations subject to ongoing executive oversight and assurance.

Advise

Fundamentals of Care; Nutrition, Hydration and Oral Hygiene

An update from March QSEC, **231 cases** maintained on an informal Action Log maintained by Speech & Language Therapy (SALT) have been reviewed and No Harm has been identified. Please note 1 case requires further investigation as more detail is required. Actions have progressed with the key issues identified from the Multi-Disciplinary Team (MDT) review:

- Multiple issues with completion of Yale swallow screen including not completing the form completely and reassessing when there was no need to.
- Oral care concerns.



- Capacity assessments and correct use for discharge processes and feeding decisions.
- What constitutes a 'swallow screen' to satisfy SSNAP audit requirements (does not specify Yale) and how MDT agreement is made whether in certain cases are accepted as a pass on a screen that was not a Yale screen – this will be discussed in the Stroke MDT for clarity.
- Inconsistent documentation in medical notes - for example "eating and drinking well" when patient was Nil by Mouth (NBM) and on PEG/NG feed.

There has been increased education awareness for SALT in terms of adhering to the HB's internal Governance Framework and "what is an incident" and formal reporting mechanisms.

With the Support of the Head of Quality, Stroke has introduced a "Variation Meeting" to be held once a month; to date 2 meetings have been held and includes, Nursing, Therapies, Medical and Patient Safety. The meetings to date have proved positive with a Terms of Reference being developed. It is the intention that these assurance panels will be rolled out across the HB as we do with pressure damage, falls and medication errors.

There is enhanced reporting in relation to nutrition, hydration and swallowing on the Stroke Unit, reflecting the presence of a dedicated, unit-based Therapy Team. As a result, reporting in these areas is proportionately higher when compared with other areas across USC and should be understood in the context of strengthened clinical oversight and assurance rather than an increased incidence of concern.

Stroke

There has been an agreement in Executive Management Board on 1st May 2026 to maintain the temporary position of the Stroke Services in the RGH for a further 12-month period; until 31st March 2027. Staff and the Trade Union colleagues have been met with on the 7th May 2026.

SSNAP performance HB wide below notes a deterioration in performance in March 2026 on both targeted KPIs.

Admission to Acute Stroke Unit (ASU)

- In March 2026, 36% of stroke patients admitted to ASU were transferred from PCH and POW and therefore were subject to ambulance transfer delays.
- In March 2026, 57% of stroke patients attended outside of normal working hours and therefore experienced delays in medical clerking prior to admission to ASU.



- In March 2026, 26.9% of patients presenting to RGH were admitted to ASU within 4 hours (compared with internal performance target of 60%).
- In March 2026, 3.8% of patients presenting to RGH had a CT scan within 20 minutes, but 46.2% of patients had a CT scan within 45 minutes and 57.7% within 60 minutes (internal performance target of 80% within 45 minutes).

Stroke Quality Improvement Measures					
Summary Compliance 2025 / 26					
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes					
October	November	December	January	February	March
10.80%	13.00%	8.90%	7.76%	12.16%	5.60%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 30mins					
October	November	December	January	February	March
0%	25.00%	0.00%	0.00%	0.00%	0.00%
% of applicable patients who have direct admission to an acute stroke unit within 4 hours					
October	November	December	January	February	March
8.50%	18.60%	14.90%	20.61%	22.20%	15.50%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours					
October	November	December	January	February	March
28.40%	34.10%	35.60%	32.29%	34.20%	33.70%
% of patients who are assessed by at least one therapy within 24 hours					
October	November	December	January	February	March
64.90%	71.20%	76.80%	67.90%	76.90%	69.10%
% of patients discharged with ESD / Community Therapy MDT					
October	November	December	January	February	March
49.70%	48.70%	47.40%	41.90%	43.90%	44.60%

The Improvement Team are supporting the transformation work with process mapping, digital touchpoints, and performance reporting. Daily huddles continue with multidisciplinary clinical engagement, as the improvement Programme remains a priority:

- 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.
- Standard Operating Procedure (SOP) to support clinical pathway.
- Clinical Nurse Specialist (CNS) based in ED 6/7.
- Daily and weekly performance reporting.

Resuscitation Training

For assurances improving compliance, update below, previous escalation in QSEC March 2026 with the training plan in place described. The improvement work is monitored in the monthly Workforce Meetings.

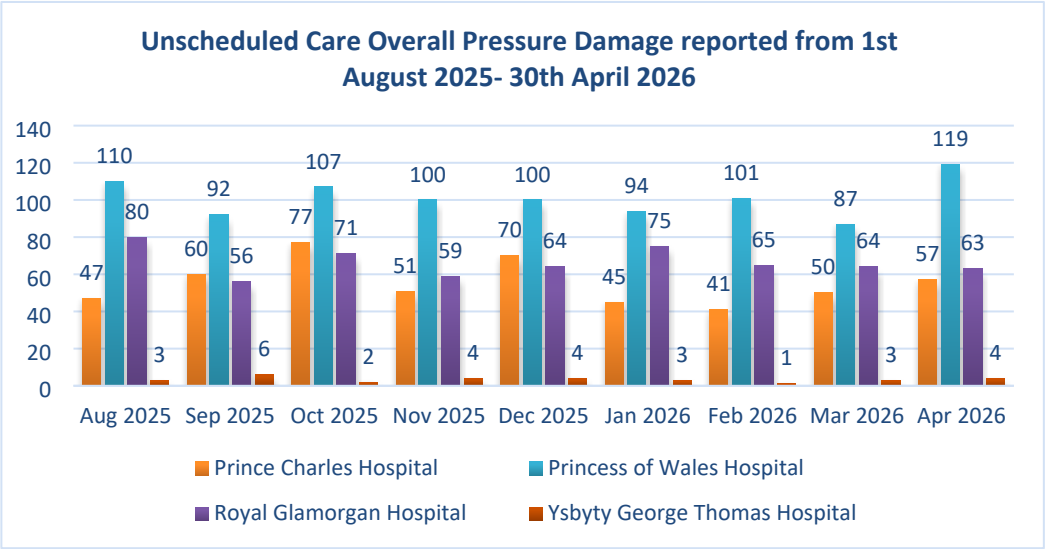


	Unscheduled care Group		
		Previous reported	April 26
	Overall compliance	44%,	46.76%↑
	Level 1 -ESR module	59%	57.87%↓
	Level 2 - Adult Basic Life Support	49.39%	56.10%↑
	Level 2 - Paediatric Basic Life Support	17.71%	19.89%↑
	Level 3 - Adult Immediate Life Support	47.30%	47.94%↑
	Level 3 - Paediatric Immediate Life Support	25.19%	28.02%↑
Assure	CTMUHB continues to deliver safe and compassionate care across the Unscheduled Care Services. Incident reporting has increased from 670 in February 2026 to 775 in April 2026, with no identified trends or statistically significant increase in severe harm events this quarter. However, system pressures, particularly within USC 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. This is a key Ministerial Priority this year to reduce and improve patient experience. Ambulance handovers remain good, CTMUHB remaining the best 3 or 4 in Wales. 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.

Below outlines the number of incidents reported between 1st August 2025 – 30th April 2026 and includes all Unscheduled Care inpatient areas and the ED’s.

Graph 1
Overall Pressure Damage Incidents reported 1st August 2025 – 30th April 2026



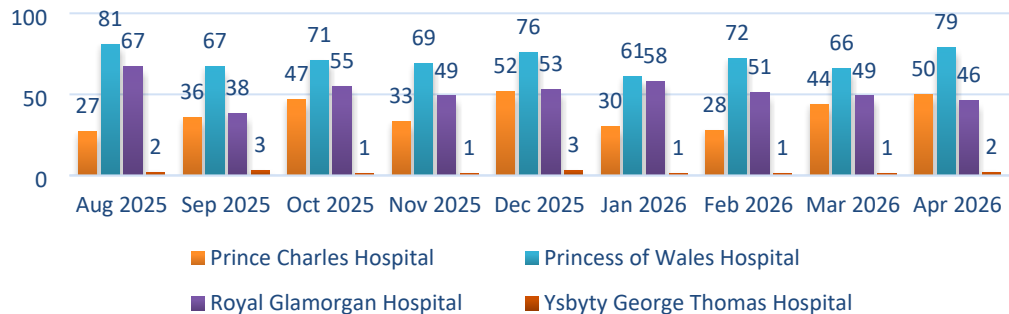
There is no significant difference in the numbers reported month on month, noting April higher numbers in POWH, with POWH consistently the highest.

Graph 2
Pressure Damage Present Before Admission Incidents reported 1st August 2025 – 30th April 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.



Unscheduled Care - Pressure Damage Present before admission from 1st August 2025- 30th April 2026.

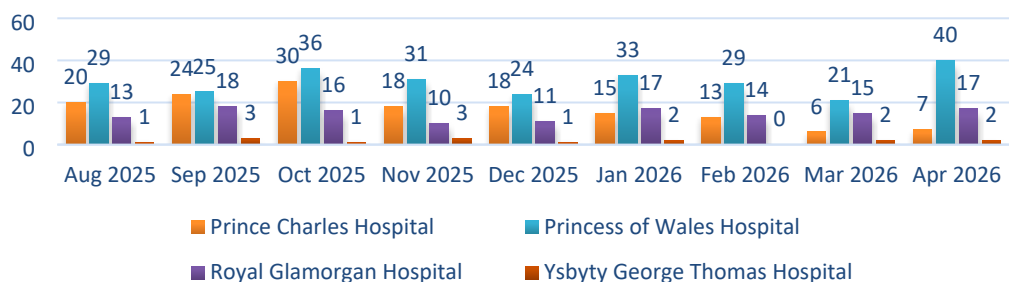


Graph 3

Pressure Ulcers Developed or Worsened During Care reported 1st August 2025 – 30th April 2026.

The numbers remain consistent however there has been a small increase in April at POWH. However currently they do not reflect any significant trend. All pressure damage is reviewed in weekly assurance panels and wider learning implemented as part of the collaborative and locally based on identified themes.

Unscheduled Care - Pressure Damage- PU developed or worsened during care. Incidents report from 1st August 2025-30th April 2026.



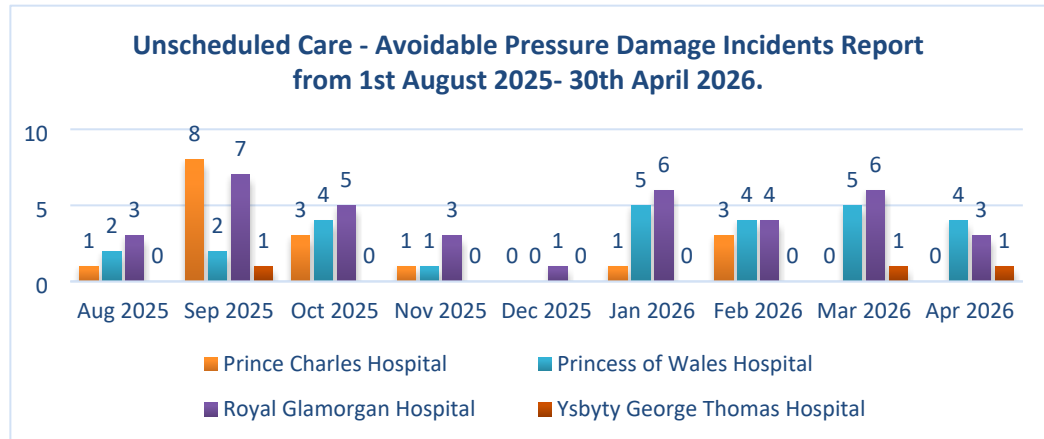
Graph 4

Avoidable Pressure Damage Incidents reported 1st August 2025 – 30th April 2026.

Avoidable pressure damage incidents reported between 1 August 2025 and 30 April 2026 demonstrate low overall numbers with some month-on-month variation across sites. An increase is observed in September 2025 for both PCH and RGH. A further rise is evident in January 2026, during the period of extended Business Continuity Incident (BCI), with POWH and RGH reporting the highest numbers. Across the remaining



months, incident levels remain relatively stable, with occasional small increases at individual sites.



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.
- Tissue Viability Nurses (TVN's) supporting with specific equipment reviews.

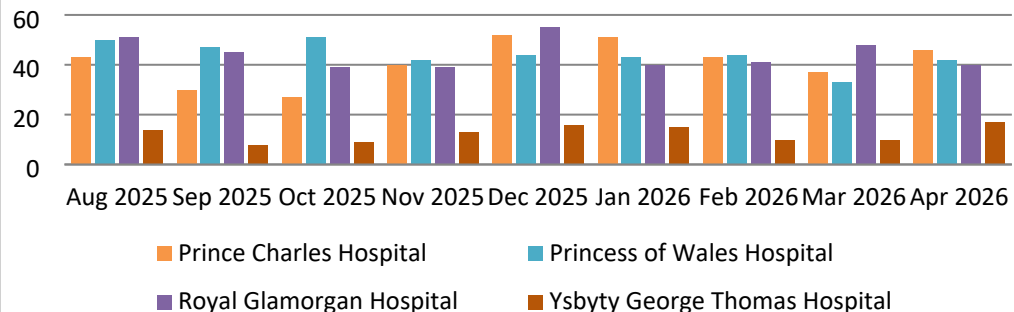
Graph 5

Patient Falls reported 1st August 2025 – 30th April 2026.

Patient falls reported between 1 August 2025 and 30 April 2026 remain broadly consistent across all sites, with a slight reduction observed in October 2025. RGH and POWH generally report higher numbers, while YGT remains lower throughout the period. Overall, no significant sustained upward or downward trend is evident



Unscheduled Care- Patient Falls Reported 1st August 2025-30th April 2026.



Themes identified include:

- No Lying and standing Blood Pressure (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.

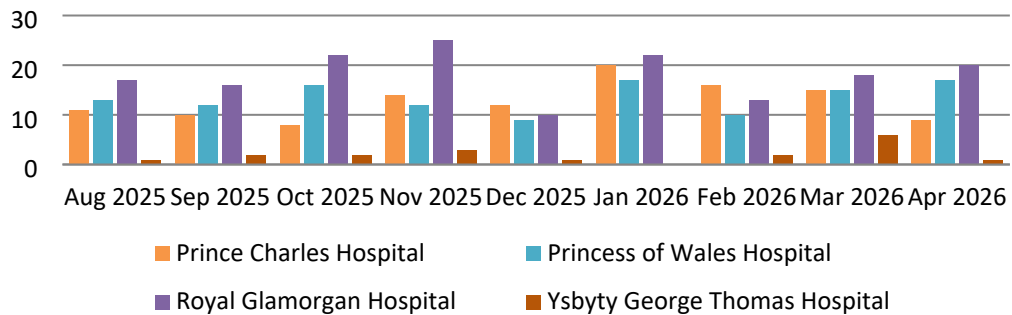
Graph 6

Medication Incidents reported 1st August 2025 – 30th April 2026.

Medication incidents reported between 1 August 2025 and 30 April 2026 show month-on-month variation across sites. RGH consistently reported the highest numbers, peaking in November 2025, with all sites showing an increase in January 2026. YGT reported comparatively low numbers throughout, with a slight rise in March 2026. Identified themes are reviewed via the Medicines Management Committee to support shared learning, alongside targeted local training.

Unscheduled Care- Medication Incidents Reported 1st August

2025- 30th April 2026.



A review has identified themes across medicines documentation, prescribing and administration. These include incomplete recording of allergies on medication charts, controlled drug stock discrepancies and inappropriate storage of patients' own medicines; prescribing issues relating to the discontinuation of variable rate intravenous insulin infusions (VRII); and administration incidents such as wrong-patient errors, omission of intravenous fluids, inappropriate crushing of medicines, and failure to remove existing transdermal patches.

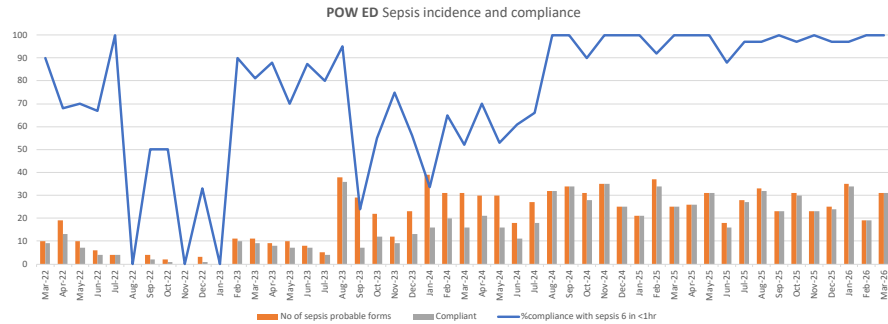
In response, strengthened governance and assurance arrangements have been implemented, including targeted audit and review, formal escalation to specialist services for complex patients, and the embedding of Endocrine Pharmacist support within the Stroke Unit to provide expert oversight and proactive risk mitigation.

Sepsis Compliance

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

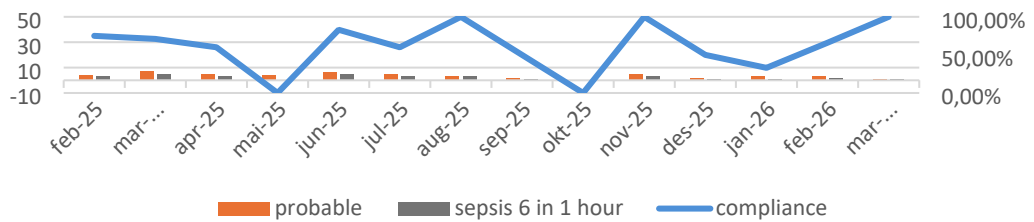


POW ED

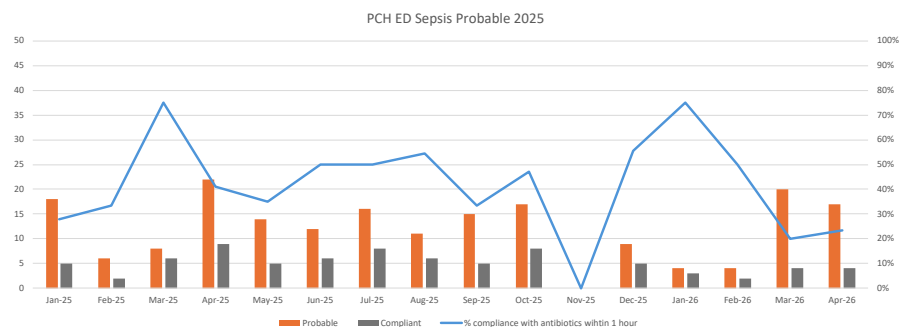


- Compliance 95-100%
- Number of sepsis probable consistently >2035

RGH ED Sepsis Probable Compliance



PCH ED



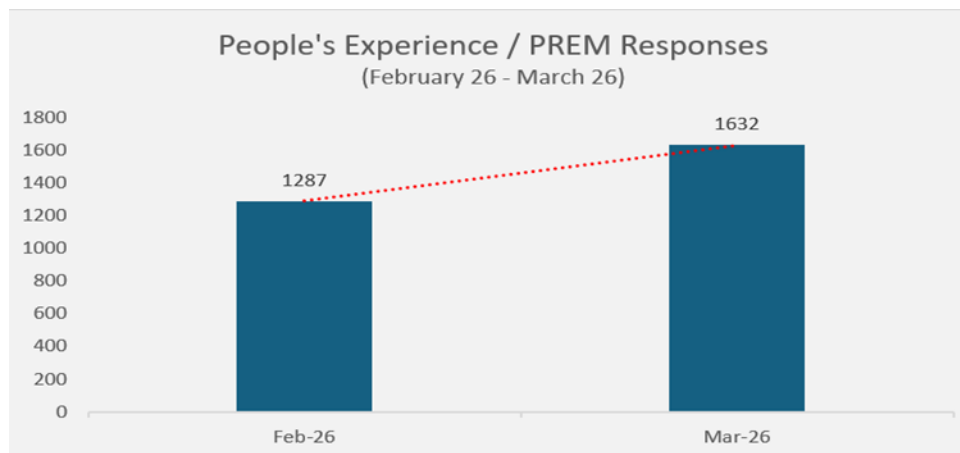


Sepsis Audit and Improvement Plan

Aspect	Current Status	Next Steps
Sepsis Audit Process	Robust process in place with feedback mechanisms	Share audit and feedback process with other EDs (RGH/PCH)
Compliance with Timely Antibiotics	95-100% compliance	Maintain and monitor compliance levels
Sepsis Form Utilization	Lower in PCH/RGH, compliance variable (20-100%)	Improve form submission rates and consistency
Sepsis Team Formation	In planning stage for RGH/PCH	Establish sepsis teams in RGH and PCH
New Sepsis Tool Implementation	Revised per NICE CG 253, to be introduced this year	Introduce updated sepsis data metrics and tools
Education Program Updates	Aligned with new sepsis tool, NICE guidelines	Update education programs for staff
Sepsis Awareness Campaign	Planning stage, includes safety netting	Launch awareness and safety netting campaigns
Staff Induction Education	Include sepsis education for new staff (medical/nursing)	Ensure sepsis education part of induction process

Patient Experience

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

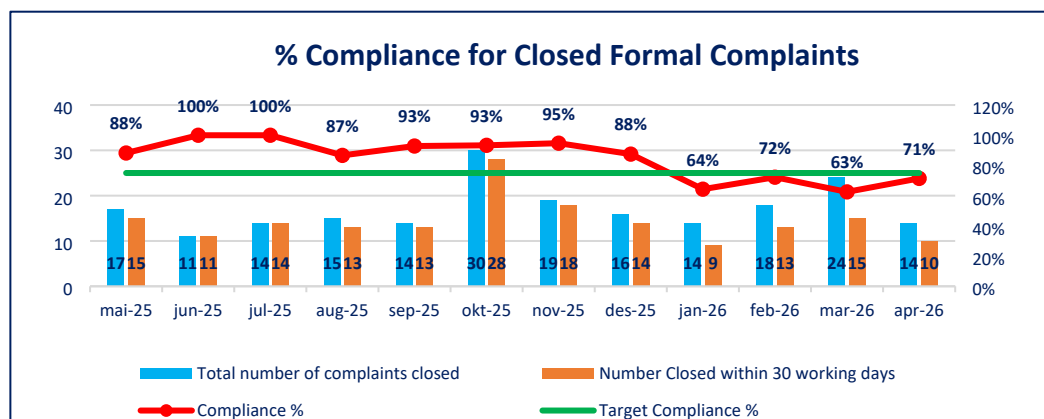




waiting grateful
uncomfortable nurse agreed
delivered pain ward
stop leave helpful
happy care great kind

There were 30 formal complaints received in March and April 2026:

- Primary themes: communication issues, care and treatment and delays in treatment.
- 71% 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.

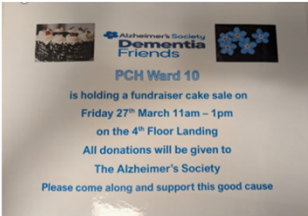


The implementation of the Listening to People (LTP) framework has been supported within care groups, with early indications suggesting a positive impact. Complaints triangulation shows a clear link between emergency department delays and dissatisfaction. Improvement work is aligned to patient flow initiatives.

NRI's

There are currently five nationally reportable incidents open: four 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.



	<table><tr><th colspan="2">NRI status – as at 01/05/2026</th></tr><tr><td>Total Open NRIs</td><td>5</td></tr><tr><td>Total Open NRIs Overdue</td><td>1</td></tr></table> External Stakeholders There have been no formal concerns raised in this period from HIW or LLais. Formal communications to LLais in relation to Temporary Gastroenterology Service Change 6th May 2026. 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. HCQ-combined risk with Planned Care – 5797 risk score 16.	NRI status – as at 01/05/2026		Total Open NRIs	5	Total Open NRIs Overdue	1
NRI status – as at 01/05/2026							
Total Open NRIs	5						
Total Open NRIs Overdue	1						
Inform	Celebrations Below are just a few examples of positive work our teams are delivering across Unscheduled Care supporting our patients, families, carers and each other, and demonstrating team working at its best. Ward 10 PCH cake sale for Dementia £400 raised 🙌 						



Nutrition and Hydration Week PCH Ward 10



Patients thoroughly enjoyed the options for drinks. The additional drinks round in the afternoon will continue and is built into the nurses routine of the day.

Stroke Unit Nutrition and Hydration Week

Nutrition and Hydration Week RGH



Nutrition and Hydration Week 2026 Malnutrition CPD Day		
Venue - RGH - Seminar Rooms 1 and 2		
Time - 09.15 - 15.30		
Time	Topic	Presenter
9.15-10.00	Welcome and introductions Importance of good nutrition care	Rhian Thomas Dafydd
10.00-12.00	Workshop 1 - Nutritional screening Workshop 2 - The Importance of fluid balance Workshop 3 - Oral/Nutritional supplements Workshop 4 - Enteral feeding pumps and tube care	Rhian Thomas Dafydd Emily James - critical care Claire Warr - Abbott representative Charlotte Bassett - Abbott Nurse Advisor
12.00-13.30	Break	See
13.30-15.00	Break and LUNCH	See
15.00-16.00	Dysphagia Awareness	Courtney Jones Speech and Language Therapist
16.00-17.00	Patient safety	Kath Honeysuckle
17.00-18.00	Summary, Questions and Feedback	Rhian Thomas

CPD day being repeated on 27th July 2026.

Feedback score: **4.92/5**
majority of sessions being rated as excellent



ED RGH

The team have been awarded the **Wildlife Garden Package** supporting staff wellbeing.



Stroke RGH

A "Patient Story" was shared at Public Board in March 2026, and following the detail shared, the Stroke Team have progressed and arranged a "**Carers Café**" for stroke victims and their carers. The first



	meeting was held on the 6th May 2026, and has facilitated the opportunity to network and support each other but also for the carers to have some time out to think about what their needs are. The meeting was also supported by the Stroke Association. The feedback was positive with good attendance, and it was amazing to see how patients have progressed in their recovery. 
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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality	Leadership
	If more than one applies please list below:



<i>(Duty of Quality Statutory Guidance (gov.wales))</i>	
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Person Centred If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reuse If more than one applies please list below:

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

4.4.2

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
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 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	
SDEC	Same Day Emergency Care
USC	Unscheduled Care
ITU	Intensive Therapy Unit
POWH	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital

PU	Pressure Ulcer
USC	Unscheduled Care
PCH	Prince Charles Hospital
CTM UHB	Cwm Taf Morgannwg University Health Board
T&O	Trauma & Orthopaedic
ED	Emergency Department
DTPS	Diagnostic, Therapies, Pharmacy and Sciences
HON	Head of Nursing
YCC	Ysbyty Cwm Cynon
SOPS	Standard Operating Procedures
NRIs	National Reportable Incidents

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 20th April 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.

Mitigation & Assurance

- Care Group implementation of 'Optimal Trauma Reset Fortnight' 23rd February – 6th March involving different ways of working, processes and pathways with key stakeholders including Occupational Therapy, Physiotherapy and Orthotics.
- Trauma Board implementation for Planned Care and Community & Primary Care to focus on community patient pathways (1st meeting held on 28th April)
- Exploring opportunity of creating a Trauma SDEC model within Fracture Clinic at RGH
- New elective surgical clinical model implemented in RGH. With plans to commence this in October 2026 in PCH to support the Winter Pressures and demand.

Gastrointestinal Services

Temporarily consolidate POWH inpatient Gastroenterology services at the Royal Glamorgan Hospital site, on an interim six months. This will allow Planned Care and USC to maintain safe emergency and inpatient care, including the management of gastrointestinal bleeds and other urgent conditions, while the Care Groups continue longer-term work to rebuild workforce resilience.

General Surgery

The POWH Critical Incident, resulted in interim changes to surgical capacity across RGH and POWH, combined with the centralisation of in-patient arthroplasty has resulted in changes to the acute surgical intake at POW and has prompted a further review of the general surgical on-call model.

Due to these changes, the majority of the acute general surgical workload and Resident Doctor workforce has shifted to RGH, whilst PoWH now mainly manages lower-risk patients via a Day Surgical model and Category 1 Surgical emergencies only, this is creating inefficiencies and transfer delays between the two sites.

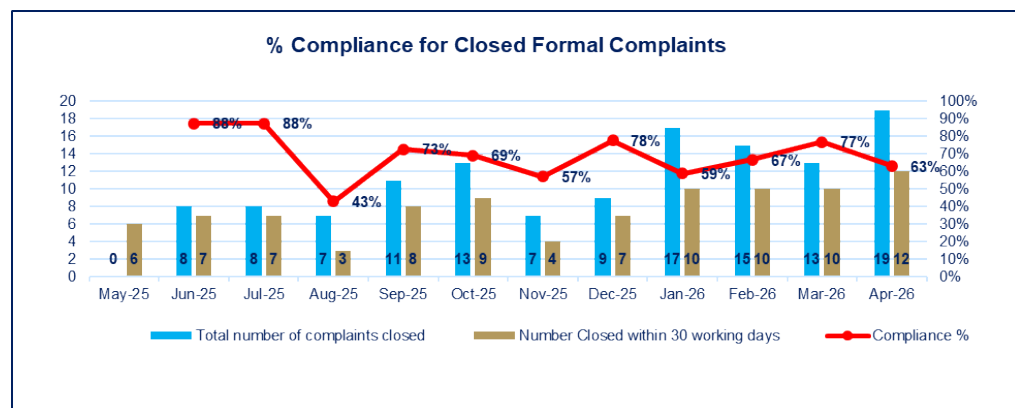
Previously, CTM UHB operated an acute general surgical intake across three acute sites, but this placed unsustainable pressure on Consultants and Resident Doctors, adversely affecting elective care, workforce recruitment, retention, and training.



The current arrangement of maintaining multiple full on-call teams is becoming increasingly challenging to sustain and has limited-service modernisation. Experience since the incident suggests that most major complex acute surgical admissions can be safely managed on a single site in the South with workforce consolidation also supporting better use of staff, improved training opportunities, greater service standardisation, and more effective use of Same Day Emergency Care and elective capacity.

Advise

Concerns



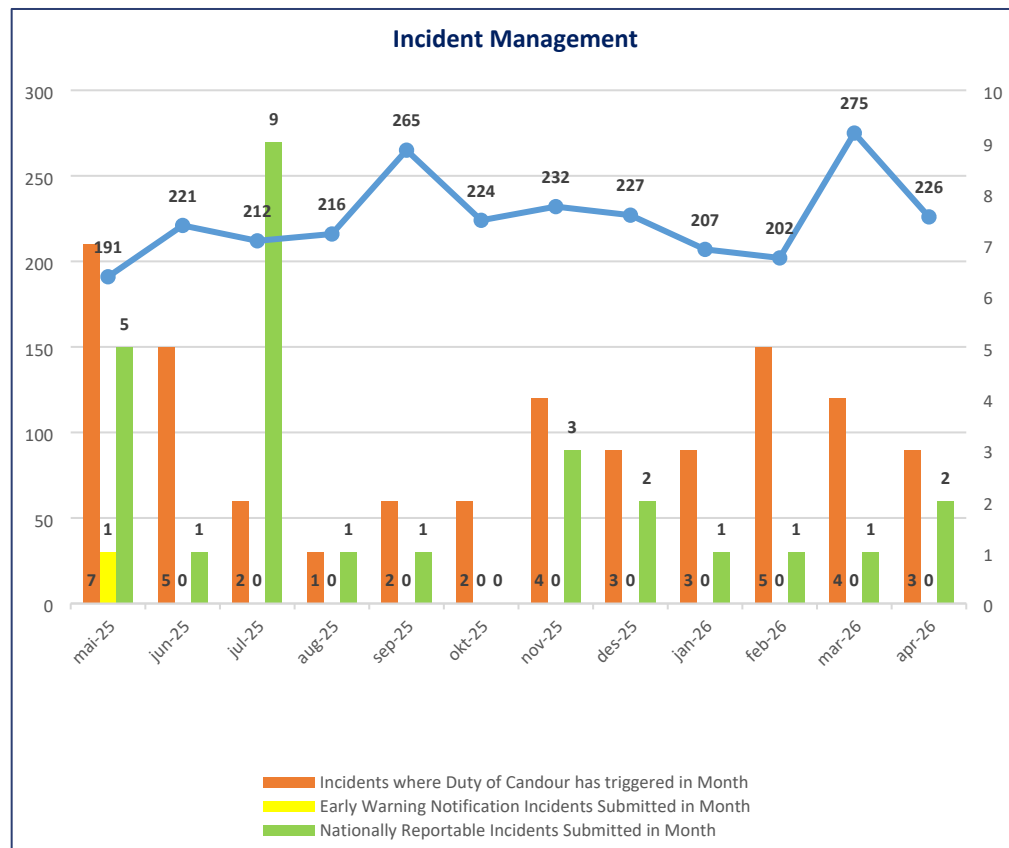
- Concerns Lead commenced in role December 2025. Reduction in Early Resolutions within Planned Care from 156 in December 2025 to 3 at time of producing this report.

Themes and trends

- Trauma theatre capacity
- T&O waiting list
- Adherence to clinical pathways within Trauma and General Surgery
- Delays in administering pain control within General Surgery



Incident Management - end April 26



The spike in March was due to incidents being submitted relating to:

- Reduced Dietetics and Psychology support being provided in the ITUs. This has settled in April as support has increased from a Dietetics perspective. However, a detailed review of Critical Care Psychology Services is being undertaken by the DTSPS Care Group.
- Complex patient in ITU, where there was a need to submit an incident form to ensure correct governance reporting when a controlled 4:1 restraint was required. (March and into April).

Nationally Reported Incidents (May 2026)

- 4 NRIs open at time of report with 1 of these overdue.

Falls

No avoidable falls across Planned Care in Feb & March 2026

Key themes from unavoidable falls

- Inaccuracy with Enhanced supervision documentation
- Significant improvement within T&O regarding the performing of Lying & Standing Blood pressure recording, which has reduced the amount of falls.

Pressure Damage (Feb & March 2026)

- 4 Avoidable Pressure Ulcers reported:



- 3 x General Surgery
- 1 x PCH

Key Themes include:

- Failure to escalate in timely manner lack of availability of appropriate mattress.
- Repositioning not representative of individualised care plan

Actions – So What?

- Monitor nursing compliance with Pressure Ulcer training compliance
- Ward Manager feedback in Ward Meetings
- Sharing for learning per site via the HoN Professional Focus Group meetings
- Explore opportunity to roll out the 'PU pink form,' which has been designed and is being used in PCH and across the other 3 sites.
- Ward 8 in PoW have created a visual repositioning board and have subsequently reduced the number of hospital acquired PUs to 1 in both February & March, both of which were deemed unavoidable.

Optimal fortnight for Trauma Unit (TU) in RGH

Aim was to understand via daily 'deep dives' and where possible address delays in T&O discharges in RGH with an aim to improve discharges and reduce length of stay.

Outcome of optimal fortnight

- Reduced time in Occupational Therapy first review of patients on TU from 12 days to 1 day
- Lead Nurse attendance at a daily Trauma Consultant Huddle to support review of all in-patients and patients in ED in RGH and PoW. This includes plans for re-admission, transfer, alternative pathways for review and treatment (e.g. Trauma clinic).
- Clinical Director and Lead Nurse scoping implementation of Trauma SDEC with RGH Fracture Clinic in RGH initially and then PCH Fracture Clinic in the Autumn when the Fracture Clinic returns from YCC. The aim will be to care for patients who could be treated daily via this unit rather than requiring admission onto the ward. In the process of creating SOPs and clinical Pathways.

	Exit block more clearly understood and 'easy wins' outlined. This will also define clear actions for the newly created Trauma Board, being led by the Planned Care Group.
Assure	Pre-Assessment – Task and Finish Group - One Stop Pre-Assessment (PA) Clinics started in RGH to bring on-line with PCH. Aim to improve efficiency of patients waiting PA before being given a definitive date for surgery. - Pre-Assessment standardised, single, pan CTM Pre-Assessment Pathway created to ensure improved efficiency within PA clinics in POW, PCH and RGH.
Inform	Good News - Ward 15 in RGH have 100% in their NEWS 2 audit in March - Practice Educator commenced in post on TU in RGH in February 26. - PCH Ward 6 – News 2 and Pain Champions - PCH Ward 5 &6 – Award for their IPC management - Critical Care PCH recognised for 100% compliance with PVC and Urinary Catheter bundle and management 
Appendices	



2. Assessment

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

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



<i>Have you undertaken a Quality Impact Assessment Screening?</i>		
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐ Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	No: ☐ If no, please include rationale below: 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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	

3. Recommendation

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



Agenda Item

4.4.3

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Zoe Ashman, Interim Care Group Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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	13/05/2025	Noted

Acronyms / Glossary of Terms

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

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

1. Situation /Background

- 1.1 This report has 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 13th May 2026.
- 1.2 Key highlights from the meeting are reported in section 3.

2. Specific Matters for Consideration

- 2.1 The purpose of the Care Group is to provide assurance to the Committee on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.
- 2.2 The Primary Care and Community Care Group QSRE Board will:
- Put the needs of patients, carers and the public at the centre of all its business.
 - Provide evidence based and timely advice to the Primary Care and Community Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.



- Provide assurance to the Primary Care and Community Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

Alert / Escalate

District Nursing

The Care Group is experiencing ongoing low staffing levels within the Community Nursing service due to several staff on long term sickness and vacancies resulting in reduced clinical capacity. Aligned to the HB escalation policy RCT and Merthyr Tydfil areas are green (able to meet demand) the Bridgend locality remains within amber escalation. Mitigation work has continued with recruitment into the 9 vacant posts within the locality and proactive management of sickness absence.

Quality improvement activity is in place to review district nursing caseloads, activity and demand which will inform future models of care aligned to high quality care and efficiencies.

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. OOH GPs are recruited through 'rota master' where they can book 'shifts' they chose to work, sometimes on an ad hoc basis. Many of the experienced GPs do because they work elsewhere during the day or in the week.

The inability to recruit is leading to significant reduction in shift fill and this is a concern on weekends and bank holidays, resulting in key gaps in rota, e.g. home visiting. This will impact many of our housebound and palliative care/end of life patients and will result in more being admitted into the Emergency Department (ED) who would otherwise be supported at home. This is impacting not only GP OOHs but the navigation hub during daytime and weekends.

Wound Care

Staffing deficits challenge delivery of the current model. The waiting list is currently 3 weeks; this is having an additional impact on district nursing for those not accommodated within



wound clinic. The Senior Nurse is undertaking daily review of staffing to monitor the situation, ensuring minimal clinic cancellations.

A review of the Supplementary Service (the commissioned service with GPs) has commenced, within the Supplementary Service Review Group, with the collaboration of the Local Medical Committee (LMC). This will inform future delivery model with consideration of a virtual and in person structures.

Increasing Security Risks at Community Sites

There have been increased security incidents recorded in community sites over the past 9 months which have included:

- Aggressive behaviour of school children at Ysbyty Cwm Cynon (YCC)
- Threatening language toward a member of staff from a patient's family resulting in police involvement.
- Attendance of a patient experiencing a mental health crisis OOH in Ysbyty Cwm Rhondda (YCR) where police did not attend.
- Intoxicated male entered community hospital site and caused criminal damage and stole food from canteen.
- Staff assaults by patients (23 incidents in total)

The cumulative risk of these incidents has highlighted the lack of on-site security support equivalent to acute sites as well as suitable Standard Operating Procedure (SOP)/policy to support security incidents, mitigation and oversight in community sites. A review of the lockdown procedure and action cards is required. Roles and responsibilities need to be aligned to acute sites where there are consistent security presence and 24/7 site management.

The Care Group is holding a workshop on the 20th of May with all key stakeholders and deputies to review recent community site security incidents, outline expectations, responsibility and accountability. A concise report with recommendations will be fed back to a future meeting.

A request was made at Operational Management Board (OMB) to add this to the Corporate Risk register; the risk will therefore be assessed and considered for the July iteration of the ORR.

Advise

Specialist Palliative Care

A paper outlining the outcome of the engagement period alongside seeking approval to progress to implement the



redesign of model of care will be considered by the Board on 21st May 2026.

Continuing Health Care (CHC)

Implementation of Direct Payments (DP) for CHC has commenced, since implementation <5 requests have been made to the HB. Informal conversations ongoing with Local Authority (LA) to discuss how they can support with the process for paying of the direct payment and the potential training of social care needs.

All Wales Retrospective Review process, currently have 62 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 LAs, 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. A quality improvement approach has been commenced to review the CHC processes within the HB, the outcomes will inform future delivery models.

Vaccination Outreach at University of South Wales, Pontypridd Campus

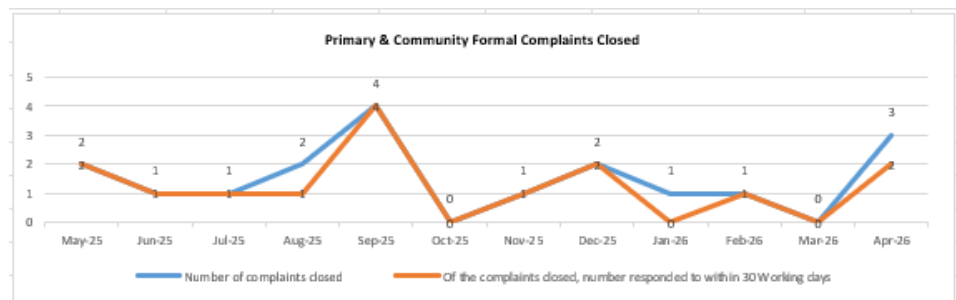
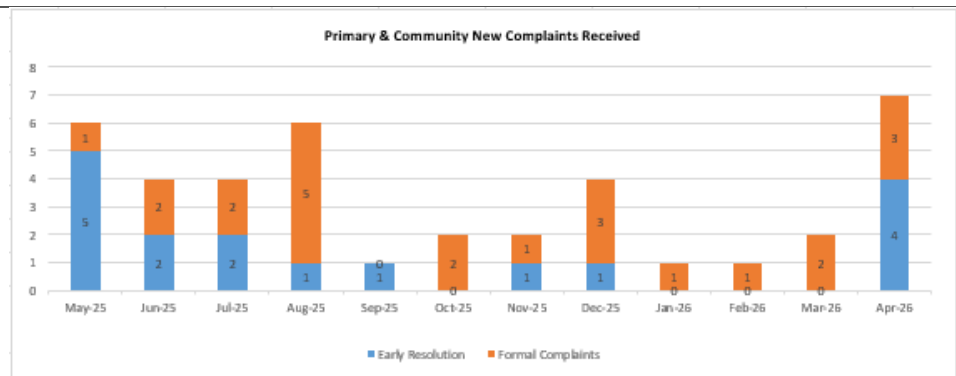
A new outreach programme has undertaken at a 'pop up' clinic in the University over a weekend in May 2026, aimed at maximising the opportunity to offer teenagers vaccinations they have missed. In total, 196 teenagers were vaccinated. Vaccines provided included routine immunisations such as MMR, HPV, meningitis and tetanus/diphtheria boosters.

General Dental Services (GDS) Contract

Since implementation on 1 April, no further contract hand backs have been received. While numbers on the Dental Access Portal (DAP) have increased to 8,531, they remain below expected



	levels. Primary Care continues to allocate all new patients from the DAP to practices. In March, 830 patients were allocated, in April 1,837. The Care Group is proposing to allow the new contract to embed over the coming months prior to commissioning additional activity, to have a clearer understanding of demand and to ensure there are enough on the DAP to allow practices to meet their 3% NP annual target. 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.
Assure	Paediatric GA Risk Paediatric Dental Service continues to see the benefit of additional lists to address the backlog. Due to the reduced numbers on the historic GA Assessment list, the service has been able to merge waiting lists into one. There are now 650 children on the combined list either waiting assessment or triaged ready for GA. An issue is arising with no access to clinical holding for some special care patients, treatment is being delayed due to no availability of a holding team for children. Meeting with SBUHB to discuss temporarily commissioning sessions to support this work. Longest wait = 100 weeks Lymphoedema service Improvement programme of work being undertaken, with implementation phase commenced February 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 Patient Reported Experience Measures (PREMS) have been positive for the service provided, improvement programme commenced March 2026.
Inform	Community bed base: Model for community bed base has been agreed by Executive Management Group, the care group is working through the timeline for implementation. Concerns management In line with Listening To People (LTP) a larger proportion of concerns are managed as early resolution, thus ensuring that concerns raised by patients or families reach an early resolution with mutual agreement.



Open redress 8

Learning from Events Reports (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 Patient Reported Outcome Measures (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.



**GIG
CYMRU
NHS
WALES**

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

	Total number of answers Always Usually (All) (Inv) Number of Answers Did you feel well cared for? Total number of answers Always Usually (All) (Inv) Number of Answers Were you treated with dignity and respect? Total number of answers Always Usually (All) (Inv) Number of Answers Were you involved as much as you wanted to be in decisions about your care? Total number of answers Always Usually (All) (Inv) Number of Answers Were things explained to you in a way you could understand?
Appendices	

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies, please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies, please list below:
	Ageing well Dying Well Growing Well
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies, please list below: Culture and valuing people Leadership
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies, please list below: Efficient, Person centred, Equitable, Timely, Safe



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

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

5. Recommendation

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



Agenda Item

4.4.4

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Lloyd Griffiths Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Lloyd Griffiths Head of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	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
CAMHS	Child and Adolescent Mental Health Services
CDAT	Community Drug and Alcohol Team
CMHT	Community Mental Health Team
CTM	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
FACS	Forensic Adolescent Consultation Service
HB	Health Board
HCSW	Health Care Support Worker
HIW	Healthcare Inspectorate Wales
JCC	Joint Commissioning Committee
KPI	Key Performance Indicator
LPMHSS	Local Primary Mental Health Support Service
MDT	Multi-Disciplinary Team
MH	Mental Health
MHLD	Mental Health and Learning Disability
NG	Naso-Gastric
NHSPI	National Health Service Performance and Improvement
NRI	Nationally Reportable Incident
ORT	Opioid Replacement Therapy
OPMHS	Older Peoples Mental Health Services
PICU	Psychiatric Intensive Care Unit
PMVA	Prevention and Management of Violence and Aggression
POW	Princess of Wales Hospital
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
RGH	Royal Glamorgan Hospital
RN	Registered Nurse
SLT	Senior Leadership Team
SS	Specialised Services

1. Situation / Background

- 1.1 This report had been prepared to provide the Committee with details of the key issues considered by the MHL D Care Group at its QSE meeting on 22/04/2026.
- 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 MHL D Care Group QSE Board will:
- Put the needs of patients, carers and the public at the centre of all its business.
 - Provide evidence based and timely advice to the MHL D Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
 - Provide assurance to the MHL D Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
 - Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
 - Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Key Risks / Matters for Escalation

Alert / Escalate

- On 13/04/2026 CTMUHB was notified that a private provider who had been awarded a contract to provide Opioid Replacement Therapy (ORT), such as Methadone and Buprenorphine, to those CTM residents leaving prison custody could not meet the requirements of the contract due to registration issues with HIW.

In order to maintain the prescribing for these individuals the only viable option was for the CDAT service to temporarily take over the prescribing and administration of the ORT until the provider received its HIW registration. There are around 150 CTM residents affected.



	The CAMHS and SS directorate are holding daily meetings with partner agencies to provide updates and a further daily meeting is held with clinical staff to resolve any operational issues. To date the service has been maintained but there is no current date for the private provider to take over. In the short term CDAT are able to continue without an adverse effect to their existing caseloads. • The Care Group currently provides a Memory Assessment service at HMP Parc through a part-time Band 6 nurse. While this resource enables a level of provision, it is not sufficient to meet the expectations or emerging needs of the prison population. A scoping exercise undertaken over the past 18 months has identified a clear requirement for enhanced Older Adult Mental Health (OAMH) support within the prison, which cannot be adequately delivered within existing capacity. Discussions are therefore ongoing to determine the most appropriate and sustainable model for a Memory service, with emerging plans focused on the introduction of regular memory clinics alongside dedicated follow-up clinics delivered as an in-reach service.
Advise	• The Care Group has been advised that replacement personal alarms for staff working on the POW mental health wards can no longer be procured, as key components of the existing system are now obsolete. As a result, the installation of a new alarm system will be required. Information on available options and the associated costs for an upgraded system has been requested to support consideration by the Adult Mental Health Directorate. In the interim, there are currently sufficient alarms in use across both wards, and arrangements are in place to monitor the ongoing availability and functionality of devices to maintain staff safety. • Following a series of reviews undertaken by the Joint Commissioning Committee (JCC), Llanarth Court, a privately operated mental health hospital providing secure inpatient services for adults, has experienced a downgrade in its quality rating across all services. This outcome reflects concerns identified through the review process and signals the need for sustained improvement and strengthened governance and assurance arrangements to ensure the consistent delivery of safe, high-quality care.; • Care Planning and Risk assessments



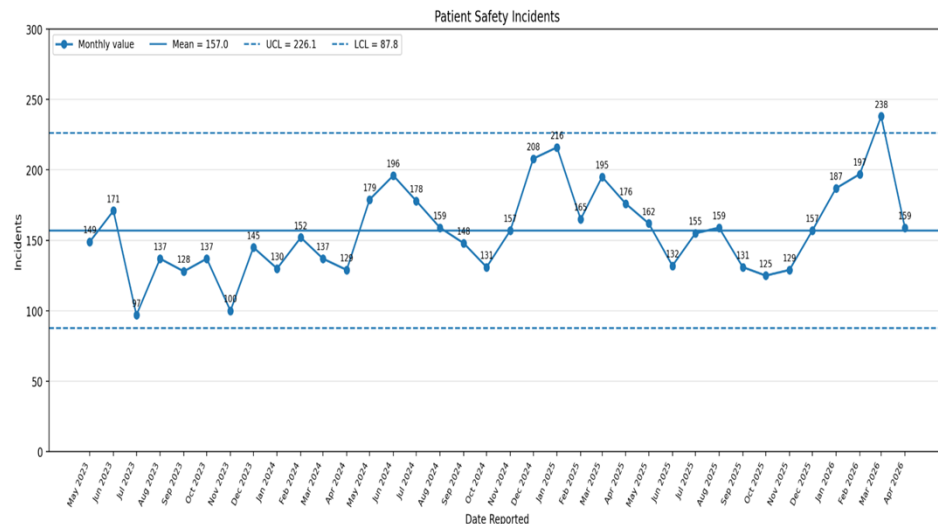
	• Insufficient and timely documentation to support patients leave from the ward. • Breaches in procedural security. CTMUHB currently has seven patients placed at the site. All patients have been subject to recent review by the Mental Health Commissioning Team and continue to be actively monitored and managed. Oversight arrangements are in place, including regular clinical review and discussion through weekly multidisciplinary team meetings. • HIW conducted a 2 day unannounced inspection of Wards 21, 22 and PICU at RGH on 13/04/26. The feedback on the whole was very positive, particularly in regard to documentation, leadership and staff/patient interactions. However, the following Immediate Assurance was requested; • There were a number of environmental, estates and IPC issues, including damaged fixtures, fittings, doors and lights. There was multiple long-standing issues that had been reported • Mandatory training compliance • Lack of oxygen cylinder training The Immediate Assurance Improvement plan was submitted to HIW on time and has been accepted. The full report and further action plan is expected in the next 6 weeks.
Assure	• The number of Early Resolution complaints received by the Care Group during this reporting period (12 in March and 13 April) was consistent with the yearly monthly mean of 13 and the 2 year monthly mean of 18. The number of formal complaints received during this period (3 in March and 3 in April) was 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 (Highest last report) 2. Appointments (Third highest last report) 3. Communication Issues (Second highest last report) The Adult Community Directorate has the highest number of 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 10 open complaints in the MHL D Care Group, all of which were received during this reporting period and are in date.

- Patient Safety Incidents



- In March there was 238 patient safety incidents reported on Datix which is higher than in recent months and more than the 3-year mean of 157 per month. Of these 238, 214 were assessed as being low or no harm by the reporter.

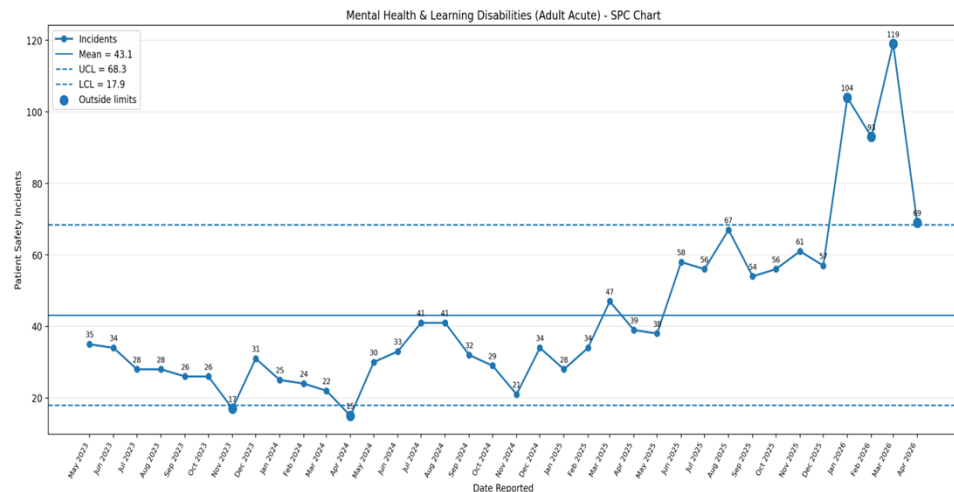
Of these 238 incidents 119 were reported by the Adult Acute directorate as is to be expected given the nature of MH wards, however it is above the 3 year mean of 68.

Of the 6 Adult Wards, Ward 14 POW has seen a noticeable increase in incidents (76 in March). The Adult Acute Directorate were asked to present a deep dive into this increase at the MHL D Care Group QSE. There are no discernible themes at this point other than the continued use of surge capacity and a small cohort of patients who accounted for a large number of low and no harm incidents, for example of the 76 incidents in March, 59 were attributed to 3 patients.

In April the total number of incidents for the MHL D Care Group fell to 159 which is in line with the 3 year mean. This correlated with a reduction in reported incidents in the Adult Acute Directorate where the total number of incidents fell to 69, this

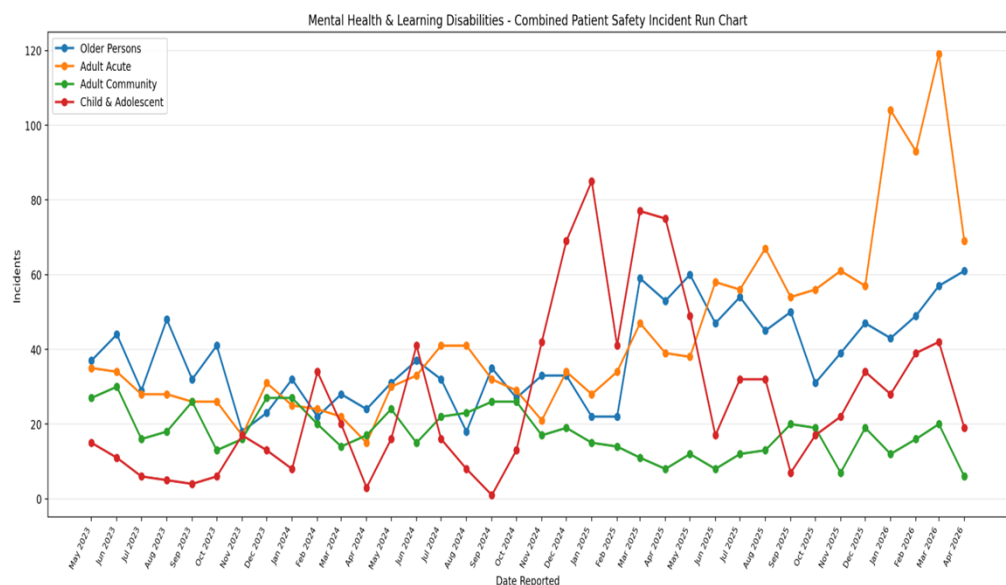


is still higher than the 3 year directorate mean of 43 but back to the upper control limits for the directorate.



The higher than mean numbers continue to be driven by Ward 14, although in April the number of incidents there fell to 41 from the 76 reported in March, with 2 out of the 3 patients mentioned above being discharged.

The Adult Acute Directorate will continue to monitor incident rates and report themes and trends to the MHL D QSE.



- **Restrictive Practices**

During the last committee a query was raised around restrictive practices in MH and the difference between care planned and not care planned restrictive practices. The terms "care planned"



and “not care planned” come from Datix where the various forms of restrictive practice are subdivided into care planned and not care planned.

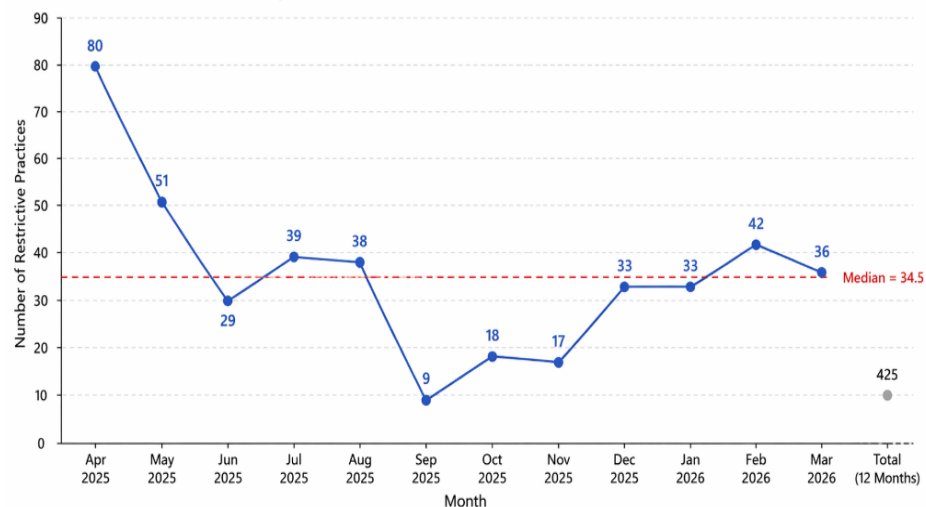
In MH restrictive practices typically fall into 2 Datix categories;

- Physical restraint event - Care planned
- Physical restraint event - Not care planned

A “Physical restraint event - Care planned” incident would be a planned treatment intervention which would require a person to be physically held to receive treatment, this would typically be done under the MHA, examples of this would be in Ty Llidiard where people receive NG feeding under restraint where it is clinically indicated or in adult services where a person might require depot IM medication against their will. A “Physical restraint event - Not care planned” is a category used for unpredictable events where restraint is required, for example in incidents which occur where there is a risk to self or others.

MHLD Restrictive Practices

April 2025 – March 2026 (Grand Total: 425)



The vast majority of the Care Groups incidents of restrictive practices occur in Ty Llidiard and involve NG feeding. This can fluctuate greatly in line with patient mix and need where in some cases an individual might require a “Physical restraint event - Care planned” 3 times per day.

It is important to point out that a restrictive practice is usually the outcome of an incident, for example, an incident of aggression on a ward might be resolved through the use PMVA techniques, when it comes to Datix reporting it is the restrictive practice that will be the main category not the antecedent cause.



- There are 2 open NRIs which is below with the 2-year mean. One is overdue but in the final stages of approval.

There was 1 new NRI reported during this period.

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

Project	No. audits	Current compliance
Health & Safety	1	 100.0%
Health and Care Standards	1	
Infection Control	16	 90.1%
Medicines Management	2	 94.1%
Patient Safety	28	 88.3%

In the Patient Safety category, the overdue actions have gone up from 37 to 51 as more audits have been added. Of the 51, 47 of are RAG rated green with 4 RAG rated as amber and 0 as red (down from 2), the 4 Amber all relate to Senior Nurse Spot checks on the OA wards and are due to a change in the Senior Nurse post, they will be rectified this month. Performance against these audits is monitored in the individual directorate's QSE meetings.

- The HIW improvement Plan for the recent Taf Ely CMHT inspection was submitted on time and has been accepted by HIW, with a further update required in 3 months time.

Inform

- As part of the National Mental Health P+I strategic goal 3, Ward 14 was selected as one of five pilot wards across Wales to participate in the Safe Wards programme.

Following the success of the pilot, NHSPI have confirmed a national rollout across all acute wards will begin and a two-day training programme has been scheduled for May and June 2026 which 4 more CTM MH wards will complete.

NHSIP has confirmed that this phase will be fully funded and supported by the National Safe Wards Team.

- The FACS team hosted a national interest group meeting 26/03/26 in Llandudno. The title of the day was:



	<i>'Young People and Counter-Terrorism in Wales: Beyond the Headlines'</i> They hosted a number of speakers from Prevent, Police, Youth Justice and legal advocacy alongside FACS staff to explore current trends in FACS referrals and the complex intersections between safeguarding, vulnerability and counter-terrorism.
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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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



Agenda Item

4.4.5

Quality, Safety & Experience Committee

**Highlight Report from the
Children & Families Care Group**

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Suzanne Hardacre, Director of Midwifery & Nursing Carl Verrecchia, Service Director Mohamed Elnasharty, Medical Director
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre, Director of Midwifery and Nursing
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 / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
ANP	Advanced Nurse Practitioner
APCP	Advanced Paediatric Care Practitioner

BLOOM	B uilding L ives & O ptimising O utcomes in M idwifery
BCBC	Bridgend County Borough Council
BSOTS	B irmingham S ymptom-specific O bstetric T riage S ystem.
CTM	Cwm Taf Morgannwg
DoN/M	Director of Nursing & Midwifery
EWN	Early Warning Notification
HCWP	Healthy Child Wales Programme
HV	Health Visitor
IA	Industrial Action
MNPB	Maternity and Neonatal Programme Board
MNSB	Maternity and Neonatal Safety Board
MatNeo	Maternity & Neonates
MCBC	Merthyr County Borough Council
NRI	Nationally Reportable Incident
QSRE	Quality, Safety, Risk & Experience
RCM Cymru	Royal College of Midwives Cymru
RCPCH	Royal College of Paediatrics & Child Health

1. Introduction

- 1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Children and Families Care Group at its meeting on 23rd April 2026.
- 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, Risk and Experience Meeting (QSRE) 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 Visitor Industrial Action (IA)– Notified on 5th May 2026 that Unite intend to continue industrial action until 17th July. Care Group Directors visited Health Visitors at their hubs on 15th May to support wellbeing, listen to concerns. Executive Director attendance being arranged. Wellbeing & Chaplaincy support in place. Community Midwives and community children's nursing continuing supporting to maintain safe care. Daily strike action cell meetings are continuing to ensure any issues are identified and immediately actioned. Risk assessment updated to reflect latest period of IA. RISK ID 6475 (Risk score 16). • As a result of the ongoing IA, the Care Group are working with Primary and Community Care Group colleagues around the resilience to participate in the forthcoming "Fluenz" programme in September. A plan is being developed between the two care groups and the Health Protection team in the event that Health Visitors will not be able to undertake "Fluenz" vaccinations. • The project to refurbish the Gynaecology Hub in RGH remains paused due to delays in procurement and new contractor issues. Decant was done in March to enable the work to start in earnest at the end of March for a period of 12 weeks which is now significantly delayed.
Advise	• Recent inquest resulted in Section 28 notice all Wales to standardise resuscitation trollies for adults and paediatrics, also requirements for 'CPAP' standardised checklist. Health Board meetings being held, CTM also included in All Wales meetings / conversations. • Birth rate + midwifery staffing report under review. The report suggests additional staffing within clinical and specialist workforce. Meeting with Heads of Midwifery (HoMs) 18th May to discuss business justification case. • Special school nursing (RISK ID 5753) remains a high risk (20) in Children and Families – There is currently 1 wte vacancy. Senior team have been 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 Programme. A meeting was held with the special school leads in the education authorities in March and a review of the service level agreements between CTM and Rhondda Cynon Taf (RCT), MCBC and BCBC is underway then we will regroup to progress discussions.



- Listening to People: Care Group systems in place, learning events held across directorates. Quality and Safety Lead Nurse attended Care Group QSRE meeting to deliver training 23rd April.
- Badgernet – Community booking live from 16th March. Number of workarounds taking place to ensure integration with other IT systems. Monitoring via Badgernet Programme Board. Second phase (all records transferring to Badgernet) on track for June 9th. Both Princess of Wales (PoW) and Prince Charles Hospital (PCH) will go live at the same time due to the potential risk of information being lost in the event that a woman requires transfer between hospital sites.
- 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. Current wait is at just under 102 weeks, the target of no patients waiting over 104 weeks was met at the end of April 2026. Funding allocation for 2026-7 has been received, the team have developed a plan to deliver the capacity needed.

Assure

Risk Register

There are currently three risks scoring high with 16 or more 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
6475	Health Visiting industrial action impacting on services to families across CTM	16

- Of these risks, two are currently escalated to the Organisational Risk Register, namely Risk ID 5753 and Risk ID 6475.
- Modernising school nursing model to work to Health Child Wales Part 2 (HCW2) School Aged Children, progressing well with staff engagement. Risk Assessment in place.
- Scoping work underway to review the environment to provide BSOTS care within the Maternity Priority Unit. This is a requirement from the national Maternity and Neonatal Safety Support Programme.



	• The path to safer beginnings in Wales - A national assurance assessment of Maternity and Neonatal care and services was published in February 2026. Heads of Midwifery, Clinical Director and Perinatal Safety Support Manager working through local improvement plans. A bi-monthly Assurance and Oversight Board will commence in June replacing Maternity and Neonatal Safety Board and will be chaired by the Executive Director of Nursing and Midwifery to ensure progress against the national recommendations. • A review of the Menopause service has concluded. The review has shown that provision in CTM requires further work to meet demand in accordance with national guidance. Additional medical support allocated, working with Primary Care colleagues to ensure patients re reviewed and supported within the Women's Health Hub (opened February 2026). • Transition work for Children into Adulthood with complex conditions is progressing steadily. The Ready Steady Go approach is an app-based aid and will be introduced in June 2026. (awaiting Information Governance (IG) advice). Further dialogue with Adult long term condition teams is required and children who will most likely need to be considered for this are being identified. • 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 have been supporting a review of the cases of long term sickness with the Heads of Midwifery.
Inform	• BLOOM team- (Building Lives & Optimising Outcomes in Midwifery) The Bloom service launched in Bridgend (pilot) will provide dedicated, continuity-based midwifery care for families facing significant challenges, including mental health issues, domestic abuse, substance misuse, and late engagement with maternity services. The Bloom team will also work closely with a range of partner services, including safeguarding teams, mental health specialists, and local authority programmes, ensuring a coordinated and holistic approach to care. • Advanced Paediatric Care Practitioner (APCP) from Royal Glamorgan Hospital (RGH) recently won Paediatric Advanced Nurse Practitioner (ANP) of the year at the Royal College of Paediatrics and Child Health (RCPCH) St David's day Conference • Infant Feeding Specialist Health Visitor (HV) has successfully achieved lactation consultant award. This will provide added



	expertise and support to breast feeding mothers in the HV service. • Positive feedback from a family End of Life Care team for dignified, compassionate care provided by the community children's nursing team to a child. • Robust teamwork, communication and support provided by the community midwifery teams for health visiting colleagues during this period of industrial action. • Successful Epilepsy Awareness Sessions held in paediatric units, with money also raised for Epilepsy Action. • International Day of the Midwife (IDM) celebrated on 5th May with colleagues from RCM Cymru. Over 300 nominations were submitted and 20 winners awarded with trophies and flowers. • Approval received to upgrade baby tagging security systems at PoW, standardising systems and security measures across acute sites. Delivery date awaited. • 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 Operational Capital Management Group (OCMG) May 2026. • Awaiting start dates in 2026 for medication room refurbishment in the paediatric ward at PoW. • New risk identified for paediatric areas for high flow oxygen equipment required for transport between ED, radiology and childrens ward. The current items are end of life. Statement of Need (SON) raised and approved through Capital management group and agreement has been reached to purchase. Risk mitigations in place. • Fire risk assessment conducted in February 2026 across paediatrics at PCH. Good compliance noted with a few ongoing actions recommended to include removal of trailing extension leads, improving completion rates for staff fire safety training and evacuation and installation of a fire exit override mechanism on a secured door in ward 30 (which has been escalated to estates team).
Appendices	• N/A



4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: - Improving Care - Sustaining our Future - Inspiring People
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:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Safe
	If more than one applies please list below: - Timely - Efficient - Equitable - 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	Yes: ☐	No: ☒



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

5. Recommendation

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



Agenda Item

4.4.6

Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Gary Howell, Clinical Director of Therapies
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health 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
CDAT	Community Drug and Alcohol Team
CT	Computed Tomography
DHCW	Digital Health and Care Wales
DI	Designated Individual
DRL	Diagnostic Reference levels

DTPS	Diagnostics, Therapies, Pharmacy and Sciences
FUNB	Follow Up Not Booked
HB	Health Board
HMPPS	His Majesty's Prison and Probation Service
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
MHLD	Mental Health & Learning Disabilities
MHRA	Medicines and Healthcare Products Regulatory Agency
OOH	Out Of Hours
PACS	Picture Archiving and Communication System
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QSRE	Quality, Safety, Risk & Experience
RISP	Radiology System Information Project
RGH	Royal Glamorgan Hospital
SDEC	Same Day Emergency Care
SLT	Speech and Language Therapist
SLA	Service Level Agreement
TCLe	Trakcare Lab Enterprise
UAT	User Acceptance Testing
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
HO	Home Office

1. Introduction

- 1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy and Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 27th April 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 and 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

Pathology **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 to Executive Leadership Group (ELG) in February 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. There is a significant clinical risk to the health board if the Blood Transfusion service is disrupted through loss of LIMS or failure to meet legal requirements of MHRA.
- Microbiology deployment is now delayed until mid-June, likely to have further impact on deployment of blood sciences and blood transfusion.
- Project presents a significant financial risk to the Health Board due to unbudgeted costs of the delayed project timeframe.



- A further briefing is being prepared for the Chief Operating Officer (COO) and Senior Responsible Officer (SRO) in preparation for w/c 11th May.

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 was 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) that 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 outside of the Health Board. 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) and this would mean that no samples from a patient with highly suspected or confirmed VHF would be able to be processed in CTM and would be sent elsewhere for testing.

Historic Kell Positive Blood Transfusion Incident

A further historic incident has been identified where anti-Kell antibodies were detected in an antenatal booking sample sent to Welsh Blood Service (WBS). WBS identified that two units of Kell positive blood had been incorrectly issued to a woman of childbearing potential at PCH in 2022. BSH (British Society for Haematology) 'Guidelines for pre-transfusion compatibility procedures in blood transfusion laboratories', state that females of child-bearing potential should receive Kell antigen negative red cells unless they are unavailable in an emergency. This is to minimise the risk of subsequent complications in pregnancy, such as HDFN (haemolytic disease of the foetus and newborn).

A RAPID review for this incident was held on 15/04 where it was graded as moderate harm. The midwifery team was contacted to support with informing the patient of the incident and the patient's partner has since been tested and found to be Kell negative and this eliminates the risk of haemolytic disease of the foetus (HDFN). Harm level was reduced to low as a result.



A paper was submitted to QSEC in September 2025 relating to previous Kell positive incidents. This recent incident predates preventative actions outlined in this paper however, as a further action the Blood Transfusion Clinical Lead has requested a review of the Telepath LIMS system to provide assurance of no further cases. Currently, this can only be done manually and will be a significant task for the Blood Transfusion Team

Healthcare Science

Bed Management

There is a reduced number of dynamic mattresses available across the Health Board due to full hospital sites and a high number of mattresses /pumps being condemned as they are deemed beyond repair, including dynamic mattresses used in the prevention and management of pressure ulcers.

Short-term mitigations are being pursued, along with long-term considerations for a full rolling-replacement programme. There is a substantial revenue cost to replace this equipment which is beyond the budget levels held to maintain and repair existing equipment stock.

Audiology

Waiting lists

There are long waits on Audiology waiting lists for adult hearing aid pathways, paediatric assessment pathways, and diagnostic waits. Adults are now waiting 40 weeks for their hearing aids, resulting in complaints. Paediatric hearing aids are prioritised and no children are waiting beyond the 6-week target.

Each month, the number of breaches increase as the department provide life-long care and each year hearing aids are fitted to around 3500 new patients. Recent additional pressures include the ENT weekend overtime clinics increasing demand for audiology diagnostic services, and the retirement of two medical leads from paediatric Audiology, with a current loss of 6 clinics per week lost capacity.

The service has a number of mitigations in place to reduce the waiting lists, including the work of the PIT board, change in ENT clinic cover with a 50% reduction in cover to utilise unused capacity, and a whole-service waiting list focus until the end of August.

Radiology

Radiology Information System Project (RISP): Some supplier dependencies remain. Philips system configuration is still outstanding, and access to legacy Fuji data is incomplete. As a result, continued reliance on suppliers is required to fully stabilise the solution.

	Operational inefficiencies persist due to mismatches between the RIS and PACS systems. These issues require manual reporting workarounds and result in increased staff workload. Performance visibility remains limited. Constraints within Power BI and NOUS reduce confidence in reported activity levels. Manual cleansing of data underway. RISP: Biotronics: An interim Standard Operating Procedure (SOP) has been implemented as no formal contract is currently in place. As a result, stroke imaging requires manual transfer to Bristol. Images are first sent via PACS to Swansea Bay and then forwarded to Bristol, resulting in additional delays. Procurement of the Biotronic software and licence is in progress. An update from CTM Digital on the status of the contract procurement is being actively followed up by the Radiology Directorate Manager. RISP Qaelum: The dose management system is no longer functioning at POW following the implementation of RISP. This has made it difficult to complete dose audits and implement new Dose Reference Levels (DRLs). A manual workaround is currently in place, and the issue is being actively addressed with Philips. <u>Medicines Management</u> A national NHS network outage on 25/03 affected access to SystmOne, resulting in an inability to access drug charts and administer medication at HMP Parc. The incident has been appropriately debriefed and escalated within Primary Care and Community Care Group. The lack of a shadow backup for SystmOne has been identified and will be added to the HMP Parc risk register.
Advise	<u>Pathology</u> HTA Reportable Incidents In January and March 2026, two security breaches were reported at the Royal Glamorgan Hospital Mortuary. In April 2026, one security breach was identified at the Prince Charles Hospital Mortuary. These were all accidental access resulting from doors being unlocked. All have been classified as unauthorised access and are HTA reportable. The HTA have assessed the first incident and categorised it as a near miss. The investigation is ongoing for the other two incidents, and they will be reported back to the next HTA board on the 24th June 2026. These three incidents occurred within office hours with Mortuary staff in situ and there was no immediate breach of patient security or dignity. All immediate remedial actions have been undertaken to prevent a reoccurrence. We await feedback from the HTA regarding the second and third incident. Cellular Pathology Service Capacity Concerns:



There are currently risks recorded on the risk register in relation to Cellular Pathology laboratory space and staff resource. There is insufficient space to safely support the existing outsourcing activity undertaken by the department, and therefore no capacity in terms of space to take on any additional workload. This presents a significant concern as there are ongoing discussions regarding the repatriation of the POW Cellular Pathology workload that is currently being processed by Swansea Bay.

Cellular Pathology Misdiagnosis Incident Review:

There have been four recent incidents where previous skin biopsy samples have been reviewed due to a re-occurrence at the same site on the body. Upon further review, the initial skin biopsy reports were found to be incorrectly reported. All cases were pre-2020, when the Cellular Pathology service was being supported by locum histopathologists. A skin dissection SOP is now in place (since 2022), and the risk of further similar incidents is deemed unlikely.

Health Sciences

Allied Health Professionals

Physiotherapy:

The current on-line self-referral form for accessing Musculo-Skeletal (MSK) Physiotherapy in CTM is outdated and poses a clinical risk. The issues with the self-referral form are 1) it does not comprehensively screen for red flags that indicate a need for an emergency or urgent medical opinion and 2) the absence of a branching logic function prevents necessary changes to make it safe and fit for purpose, failing to signpost 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. MS Forms has now been approved as the digital platform for self-referral, and we are currently working with the Digital Team and awaiting deployment.

Medicines management

Primary Care: Due a situation arising as a result of the retendering of the Police and Crime Commissioner / HMPPS co-commissioned Dyfodol Substance Misuse Contract, CTM's Community Drug and Alcohol team (CDAT) has had to step in to undertake prescribing for prison leavers and existing community service users, resulting in some disruption within Community Pharmacy service and HMP Parc. Primary Care Medicines Management are fully involved in mitigations in daily ops meetings until planned resolution is complete.



	HMP Parc- The Pharmacy Manager PMR system hardware failed in February, resulting in loss of dispensing data. DHCW have been engaged and supported the installation of a replacement system. Pharmacy Manager is now backed up daily and DHCW are managing and supporting the system.															
Assure	<u>Health Sciences</u> <u>Audiology</u> Cochlear Implant referral CTM has submitted data for the CIRCA -2 Audit. CIRCA 2 – INTEGRATE. It involves referral analysis by postcode and deprivation index to work towards ensuring equal access to this life-changing technology. Dissemination at Audiology Cymru 2026 and other national conferences is planned. Deaf awareness Deaf awareness videos have been developed by the Audiology Patient Reference Group, with thanks to staff from both audiology, medical illustration and patient representatives. Deaf Awareness Week <u>Medicines Management</u> CD audits: Target= 100%. Current figures for completion of CD audits are: <table><tr><th></th><th>RGH</th><th>PCH</th><th>POW</th><th>YCR/YCC</th></tr><tr><td>Current compliance with CD ward Audits %</td><td>95</td><td>100</td><td>100</td><td>100</td></tr><tr><td>Previous months compliance %</td><td>98.7</td><td>100</td><td>82</td><td>100</td></tr></table> <u>Pathology</u> SHOT Transfusion Safety Standards Gap Analysis: Following the publication of the Infected Blood Inquiry (IBI) Report and its recommendations in May 2024, an oversight group has been tasked with monitoring 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 through monthly meetings; some actions are being escalated to the BHNOC transfusion safety group for possible national approach or advice from other Health Boards. Good Progress:		RGH	PCH	POW	YCR/YCC	Current compliance with CD ward Audits %	95	100	100	100	Previous months compliance %	98.7	100	82	100
		RGH	PCH	POW	YCR/YCC											
	Current compliance with CD ward Audits %	95	100	100	100											
	Previous months compliance %	98.7	100	82	100											

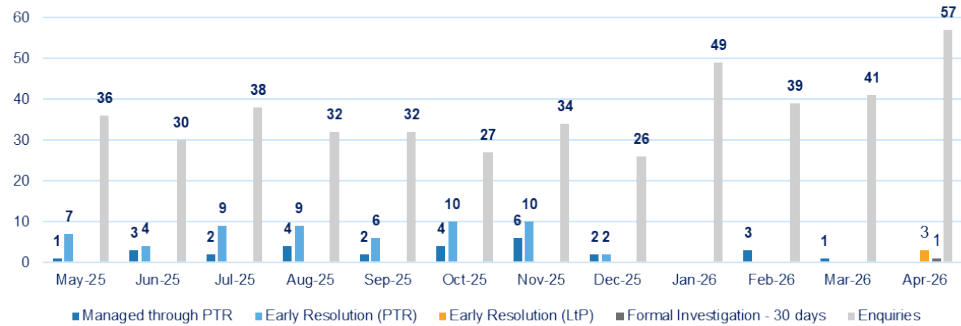


	- Following Cellular Pathology TCLe go live, a meeting has been arranged to review costs/implementation of the Talking point solution. This solution will provide automatic/electronic transmission of Cellular Pathology reports from outsourcing providers directly to Cell Path LIMS (TCLe), eliminating the risk of manual transcription error leading to incorrect reports being received. - Biochemistry Pre-analytical errors: there has been a strong focus on reducing specimen reception incidents through the SimplyDo ideas initiative and targeted training/competency assessments in relation to highlighted incident trends. Over 80% of Biochemistry errors occur in the pre-analytical phase (before the sample reaches the analyser), so these initiatives will reduce error rate ensuring patients receive timely and accurate results. - Mortuary and Bereavement: there has been significant improvement in death certification turnaround time in comparison to Q1 in 2025. There is an All-Wales agreement that F1 doctors will be able to sign death certificates from August 2026 which should result in further improvement. <u>Radiology</u> RISP - CTMUHB has delivered all local obligations and continues to operate the system safely. Current constraints are predominantly national or supplier-related, not due to local delivery failure. Mini C-arm - Employers Procedures have now been written and implemented. Ultrasound Governance Group – has been established, strengthening clinical oversight and assurance.
Inform	<u>Pathology</u> Point of Care Testing (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. The CRP testing devices were received in November 2025 and all 27 primary care sites who expressed an interest were live by Feb 2026. Representatives from the CTM POCT Team presented the project outline at the Roche Head Quarters in Mannheim, Germany, the efforts of CTM received an overwhelmingly positive and congratulatory response.



DTPS Complaints Received and Compliance

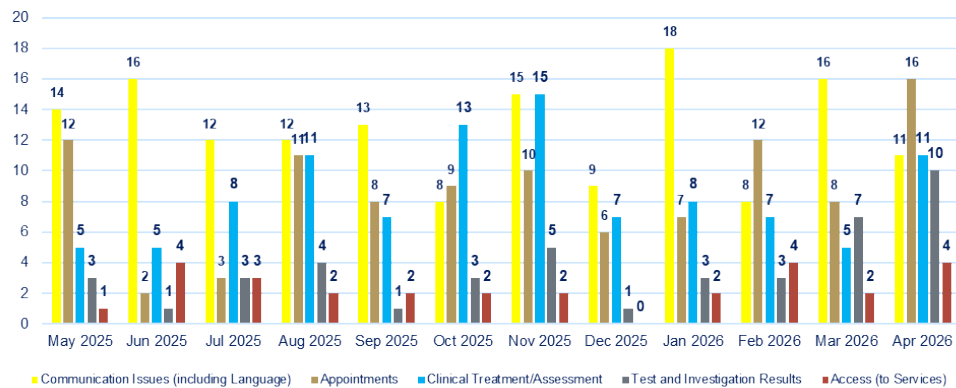
Total Complaints & Enquiries Received

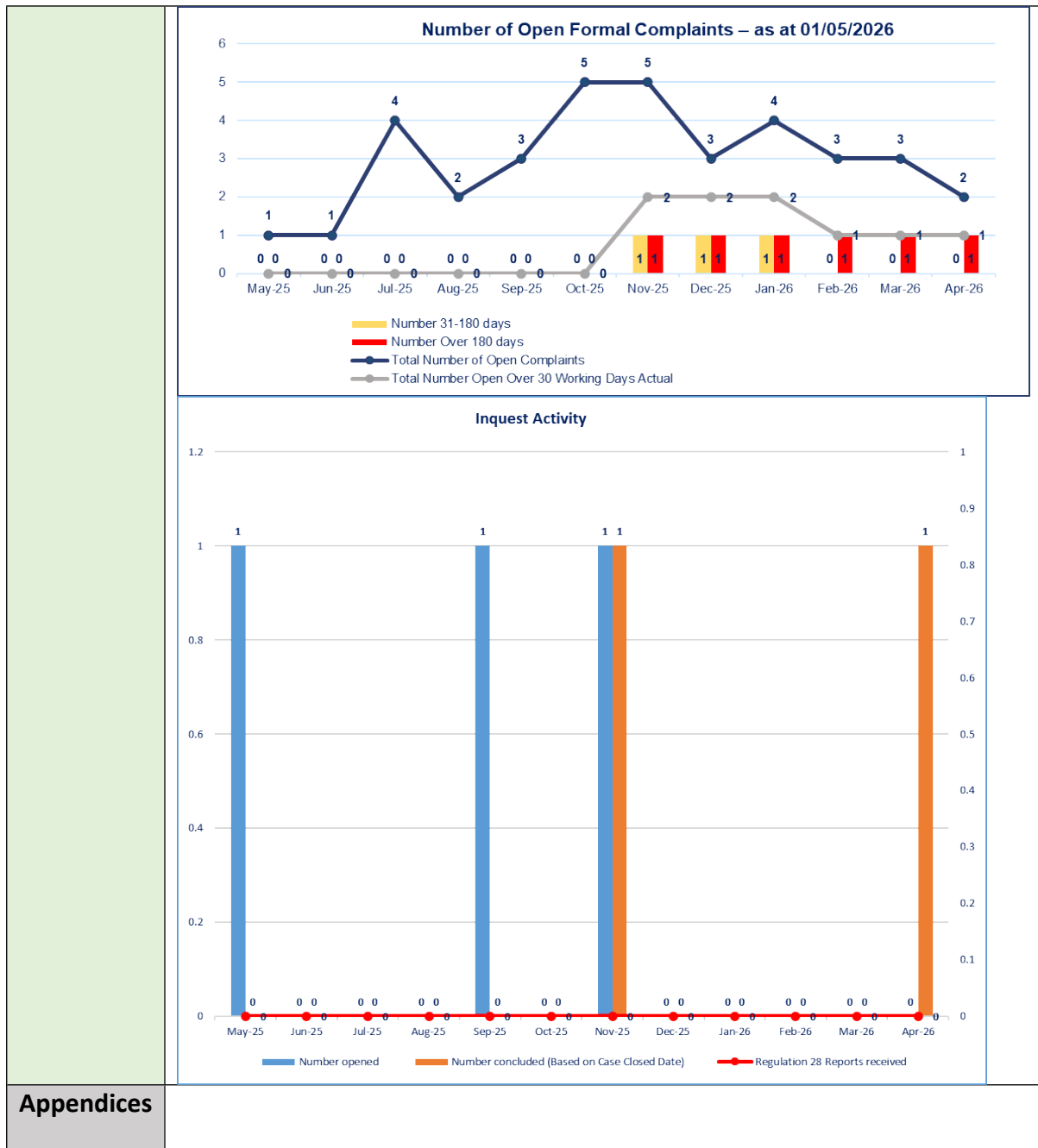


% Compliance for Closed Formal Complaints



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





3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	Living Well



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

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



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

4. Recommendation

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



Agenda Item

4.5

Quality, Safety & Experience Committee

Quality, Safety & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, 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 Services Ombudsman for Wales

PALS	Patient Advisory Liaison Service

1. Situation /Background

The report provides an overview of patient safety, quality and experience performance for the period 1 March to 30 April 2026, highlighting both areas of improvement and ongoing risks requiring assurance.

2. Executive Summary

2.1 Transition to Listening to People

- The introduction of Listening to People (LTP) on 1 April 2026 is beginning to shift practice towards earlier resolution and improved engagement.
- There has been a notable increase in early resolution cases (36 → 53) and a reduction in formal complaints (57 → 41), indicating positive early impact of the new approach.
- Early resolution performance under LTP is strong, with 93.33% resolved at that stage.

2.2 Complaints and Feedback Profile

- The Health Board received high volumes of enquiries (565 → 625), continuing an upward trend in demand.
- Themes remain consistent:
 - Clinical treatment and assessment
 - Communication
 - Appointments

2.3 Ombudsman Activity (Public Services Ombudsman for Wales (PSOW))

- There are 43 open PSOW cases. A reconciliation is planned with PSOW.
- Activity includes new investigations, enquiries and early settlements, alongside completed recommendations in final report cases.

2.4 Patient Safety Incidents

- 5,016 incidents reported, an increase of 437 compared to the previous period, reflecting sustained reporting levels.
- The most common incident types remain:
 - Pressure damage
 - Accidents/injuries
 - Behaviour
 - Medication

- Maternity incidents

- 38 Nationally Reportable Incidents (NRIs) remain open, with 20 overdue, representing a key risk area requiring continued focus.

2.5 Learning from Harm and Incident Review

- The majority of incidents are 'low' or 'no harm', with evidence of robust review processes:
 - High levels of downgrading following clinical review
 - Minimal progression to severe or catastrophic harm post-investigation
- Work continues to improve accuracy and consistency in harm assessment.

2.6 Duty of Candour

- Increase in Duty of Candour: 20 (Jan-Feb 2026) → 31 (Mar-Apr 2026); with continued high compliance in:
 - In-person notifications
 - Written follow-up
- Ongoing monitoring via live dashboards and data validation supports assurance.

2.7 Inquests and Claims

- 48 new inquests were received and 98 closed.
- 50 new clinical negligence claims received, with 16 progressing to settlement stage.

2.8 Key Quality Metrics

- Medication incidents increased (360 vs 328), though 90% are 'low' or 'no harm'.
- Patient falls decreased slightly (516 vs 535).
- Ongoing improvement programmes are in place for:
 - Falls
 - Pressure damage
 - Mental health safety

3. Specific Matters for Consideration

3.1 Patient / Service User Feedback

The legislation governing how NHS Wales's organisations respond to concerns has changed, with the *Putting Things Right* framework being replaced by the new *Listening to People* approach from 1 April 2026. This shift reflects a national move

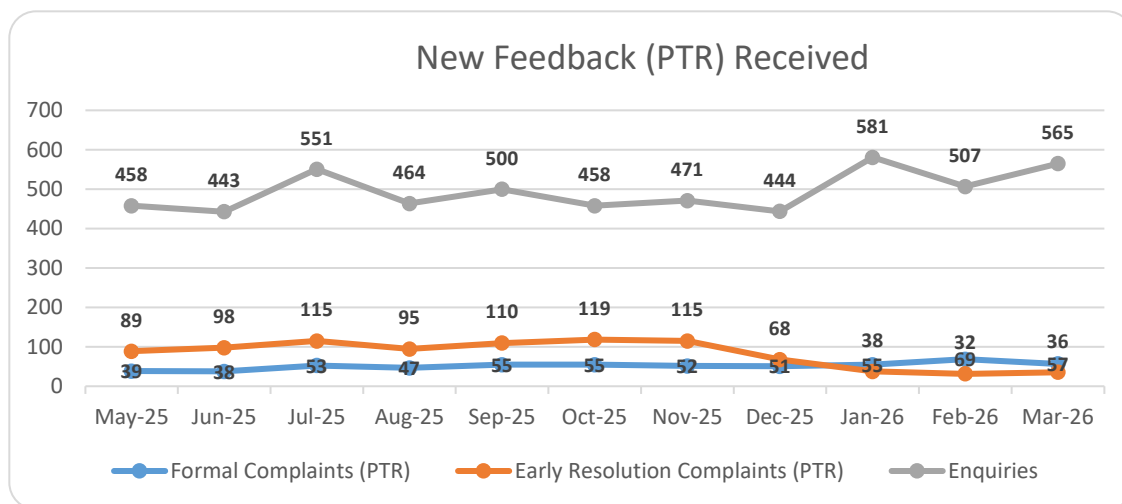
toward earlier engagement, stronger communication, and a greater emphasis on understanding people’s experiences before issues escalate. The new legislation places listening, empathy, and early resolution at the centre of practice, ensuring that individuals feel heard and supported at the earliest opportunity rather than only after something has gone wrong.

Complaints & Enquiries

New Complaints Received

Putting Things Right

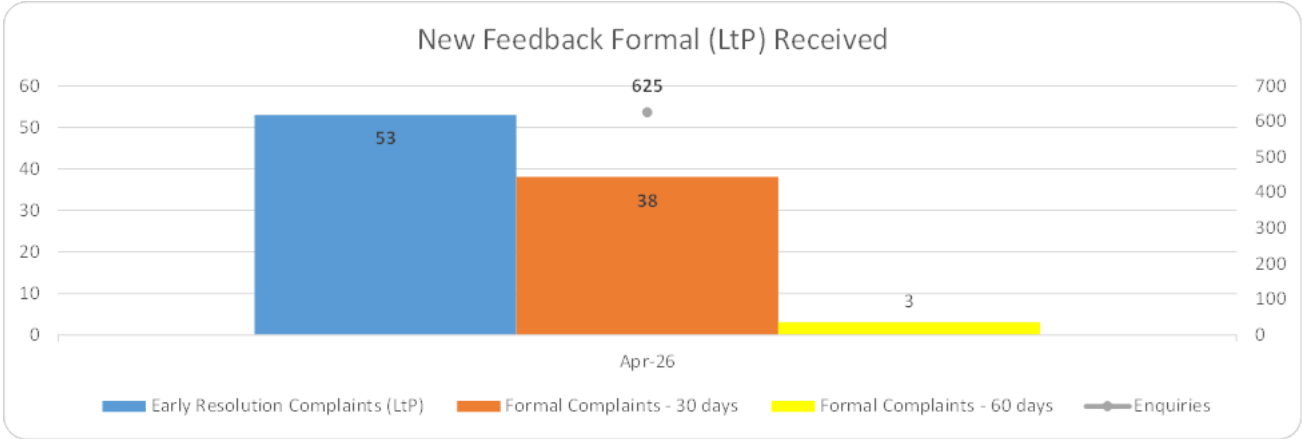
Between the 1 March to 31 March 2026 the Health Board received a total of 93 complaints and 565 enquiries. Of the 93 complaints received 36 were managed as early resolutions and 57 were managed as formal complaints.



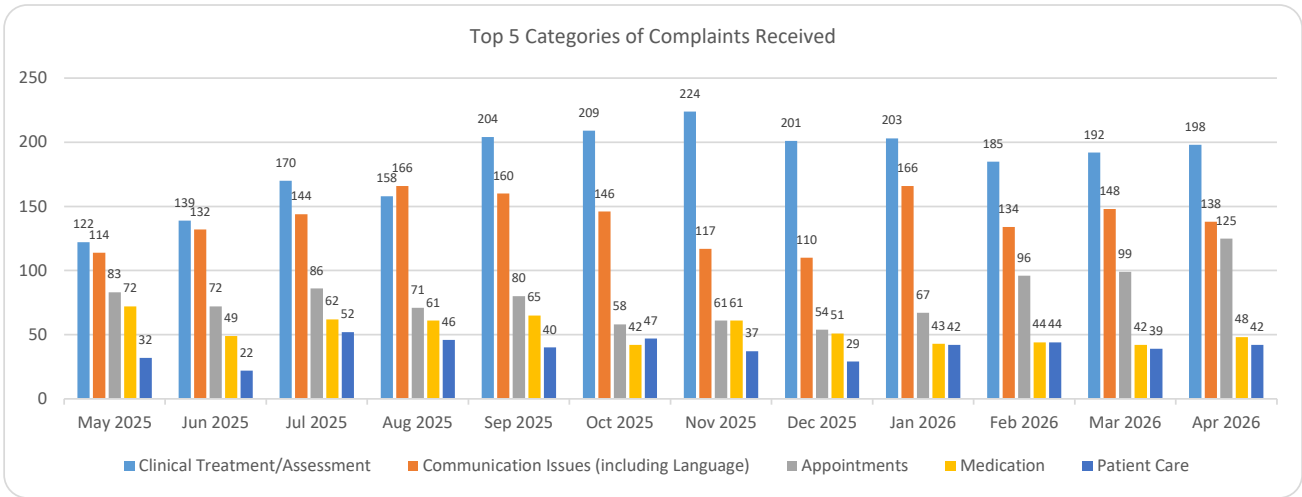
Listening to People

Between the 1 April to 30 April 2026 the Health Board received a total of 94 complaints and 625 enquiries. Of the 94 complaints, 53 have been managed under the new early resolution process and 41 are being managed in the formal process.

We have seen a clear increase in the number of cases being managed under early resolution from 36 (March 2026) to 53 (April 2026) and a reduction in the number of cases managed formally from 57 (March 2026) down to 41 (April 2026), which correlates with the move to early resolution through the new LTP process.



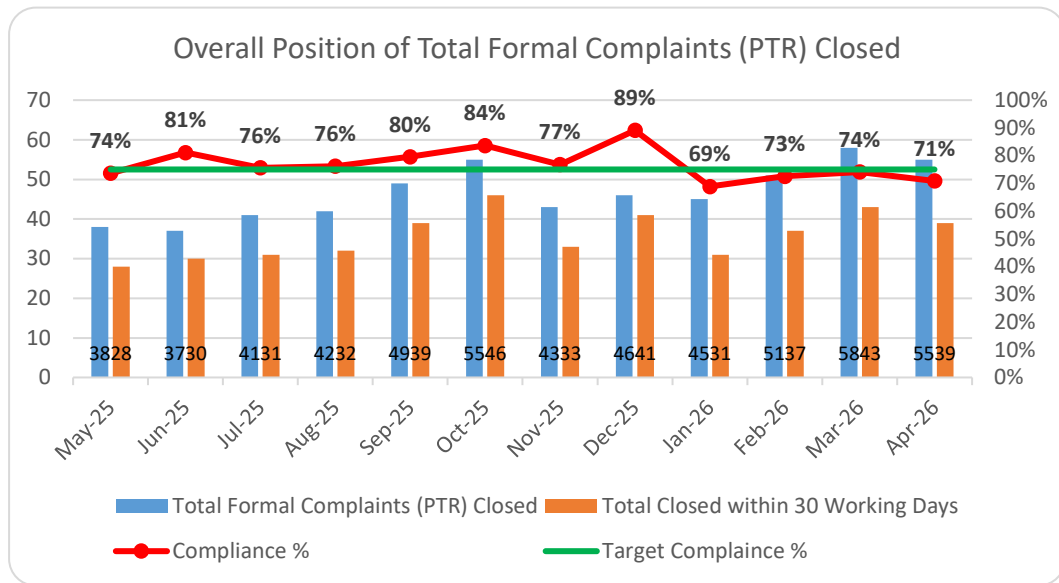
For all feedback (Complaints and Enquiries) received between the 1 March to 30 April 2026, accounting for 63% of the feedback received, the top 3 types remain consistent with previous months. These relate to Clinical Treatment / Assessment (390), Communication Issues (including Language) (286) and Appointments (224).



Closed Complaints

Putting Things Right

Within the period of the 1 March to 30 April 2026, the Health Board closed a total of 113 formal complaints (Managed through PTR).



Listening to People

As of 30 April 2026, the Health Board had logged 60 complaints as Early Resolutions (LTP) since the 1 April 26. Of those complaints (60) received since the 01 April 2026 that were triaged as Early Resolution (LTP), 4 have been transferred to Formal Investigations (LTP). Therefore, 93.33% of those complaints triaged as Early Resolution (LTP) were managed as Early Resolution (LTP).

Public Services Ombudsman for Wales (PSOW)

Open cases

The Health Board has 43 open PSOW cases. Of these, 30 are awaiting a response from the PSOW. A reconciliation with PSOW is planned for next month.

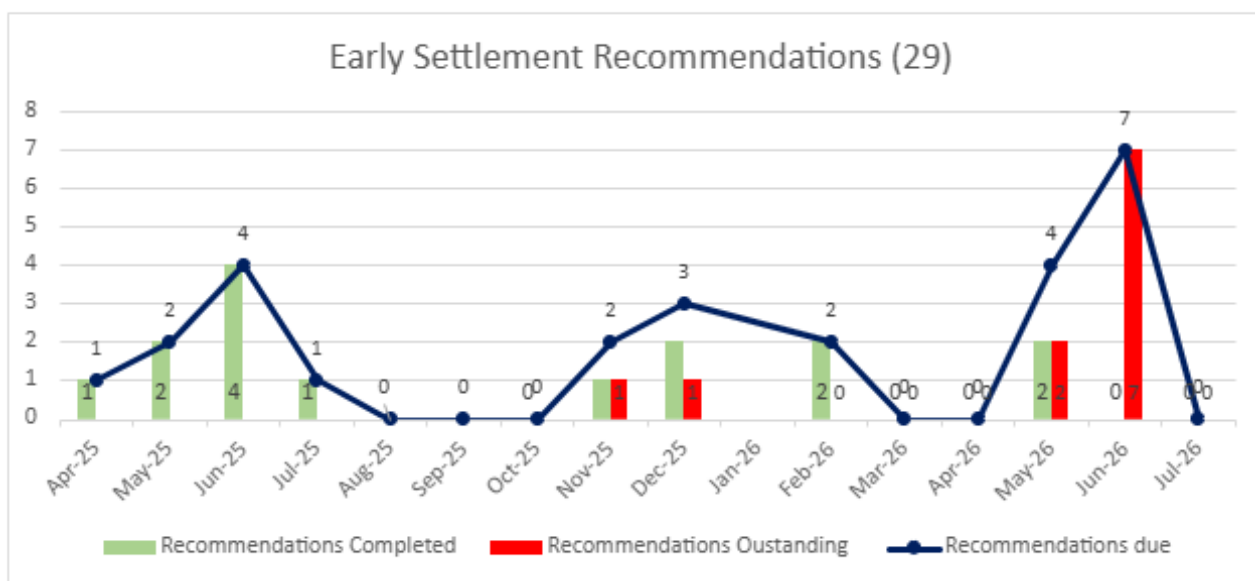
New PSOW Cases Received

The Health Board received notification of 18 new referrals to the PSOW between the 1 March and 30 April 2026. Of the 18, 8 were received as enquiries, 5 new investigations and 5 early settlements.

Early Settlement Recommendations

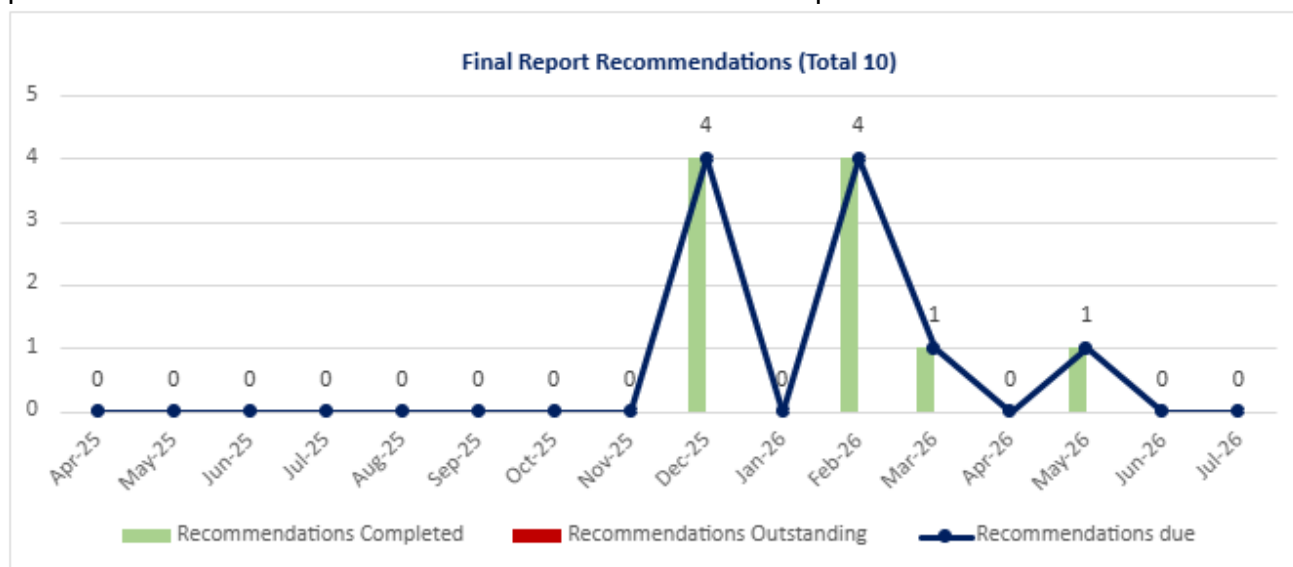
There are 4 actions due which remain outstanding:

- 1 redress case being progressed
- 1 complex case - complex case management group being progressed
- 1 letter with 2 actions is in QA process



Final Reports

The Health Board has 10 cases which are currently in the final report stage of the PSOW process. All of these recommendations have been completed

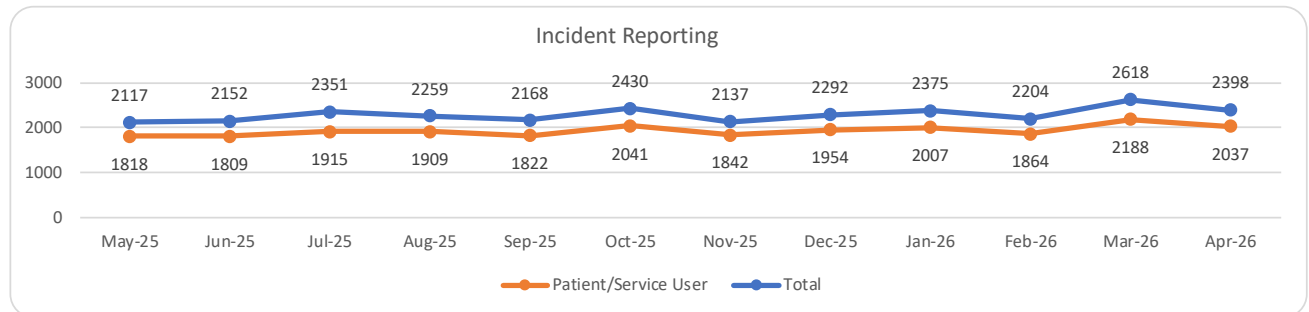


3.2 Patient Safety Incidents

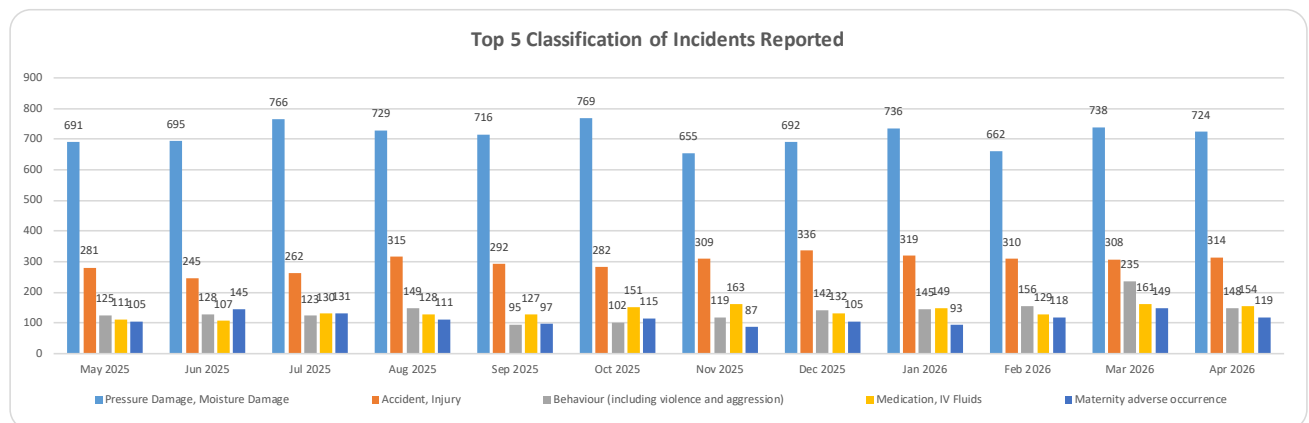
Total Patient Safety Incidents

A total of 5,016 incidents were reported as occurring between 1 March and 30 April 2026, this represents an increase of 437 when compared with the previous 2 months (4,579). The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 5,016 incidents

reported, 84% (4,225) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

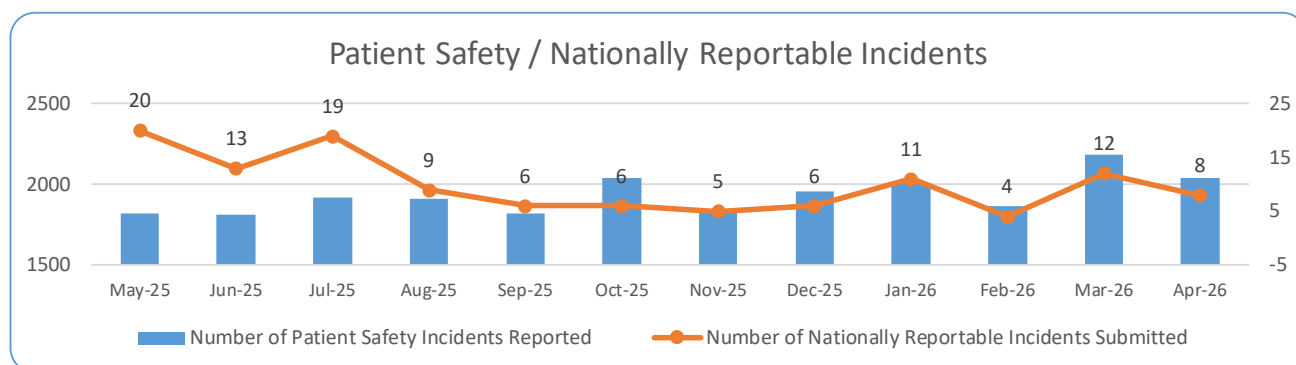


The top 5 classification of incidents reported as occurring in March and April 2026, linked to a patient affected incident are: Pressure Damage /Moisture Damage (1,462), Accident, Injury (622), Behaviour (including violence and aggression) (383), Medication, IV fluids (315) and Maternity adverse occurrence (268). 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

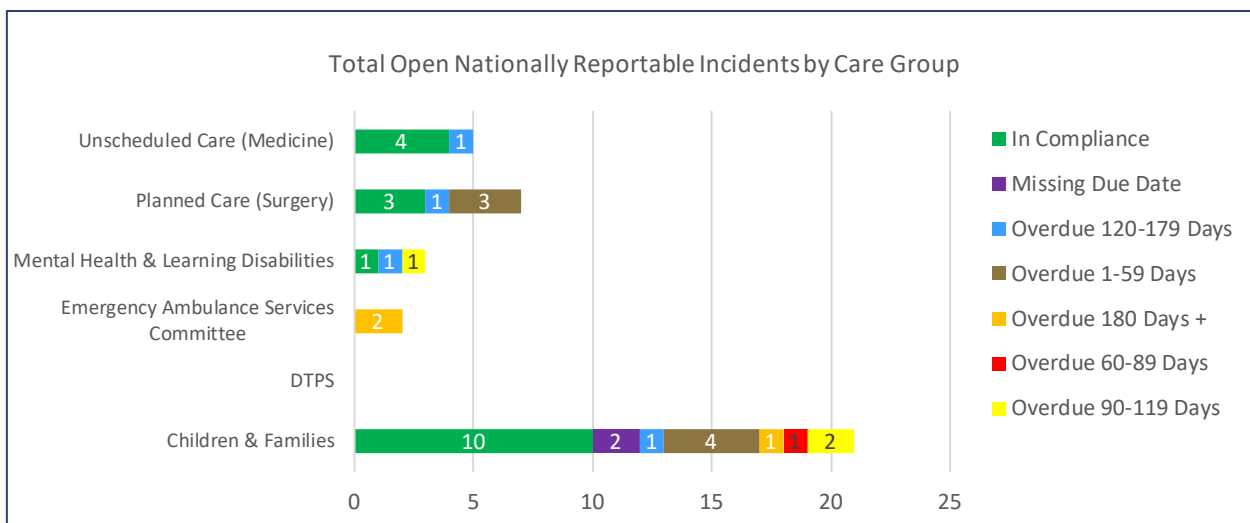
Between 1 March and 30 April 2026, 20 Nationally Reportable Incidents were submitted to the NHS Performance & Improvement Team. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



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:

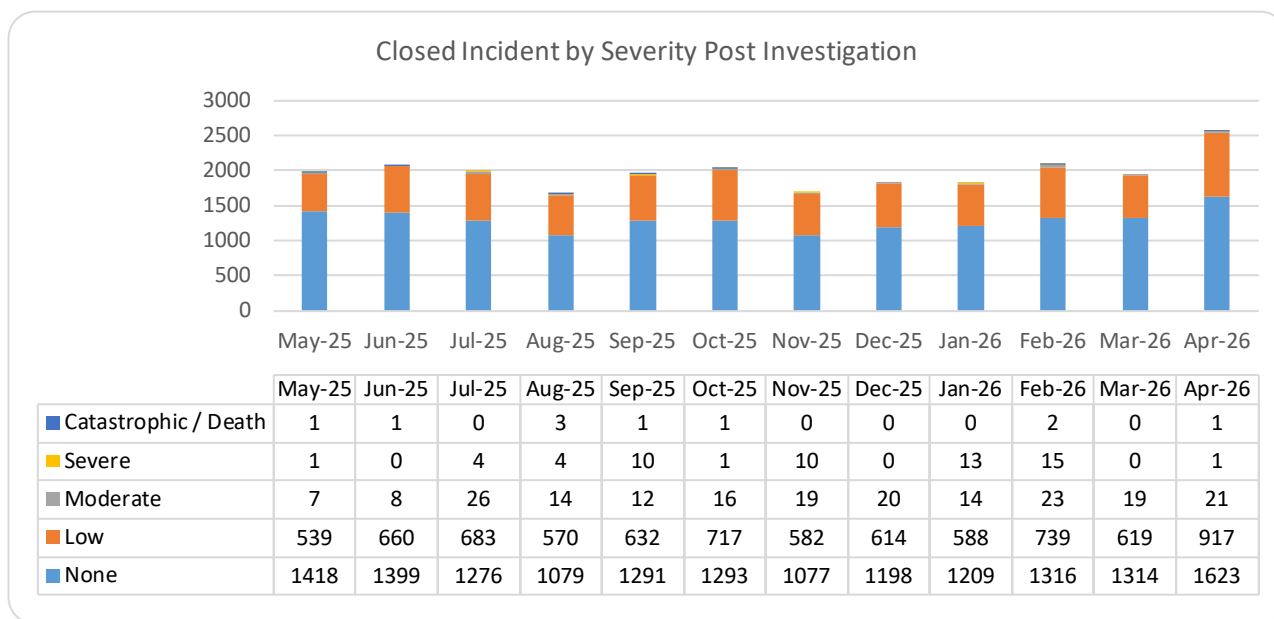
	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	Total
Access, Admission	3	1	0	0	0	0	0	0	0	1	1	0	6
Assessment, Investigation, Diagnosis	2	0	2	0	0	0	1	1	3	0	1	1	11
Behaviour (including violence and aggression)	0	0	0	0	0	0	0	0	0	1	0	0	1
Infection Prevention and Control	2	0	0	0	1	0	0	0	0	0	0	0	3
Maternity adverse occurrence	5	2	0	5	1	5	0	1	4	0	2	4	29
Medication, IV Fluids	0	0	0	0	0	0	0	0	0	0	1	0	1
Patient/service user death	1	1	1	1	1	0	0	0	3	0	0	0	8
Pressure Damage, Moisture Damage	7	6	15	3	3	1	2	4	1	2	6	3	53
Transfer, Discharge	0	2	0	0	0	0	1	0	0	0	0	0	3
Treatment, Procedure	0	1	1	0	0	0	1	0	0	0	1	0	4
Total	20	13	19	9	6	6	5	6	11	4	12	8	119

As at the 5 May 2026, the Health Board currently has 38 open Nationally Reportable Incidents, of which 20 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

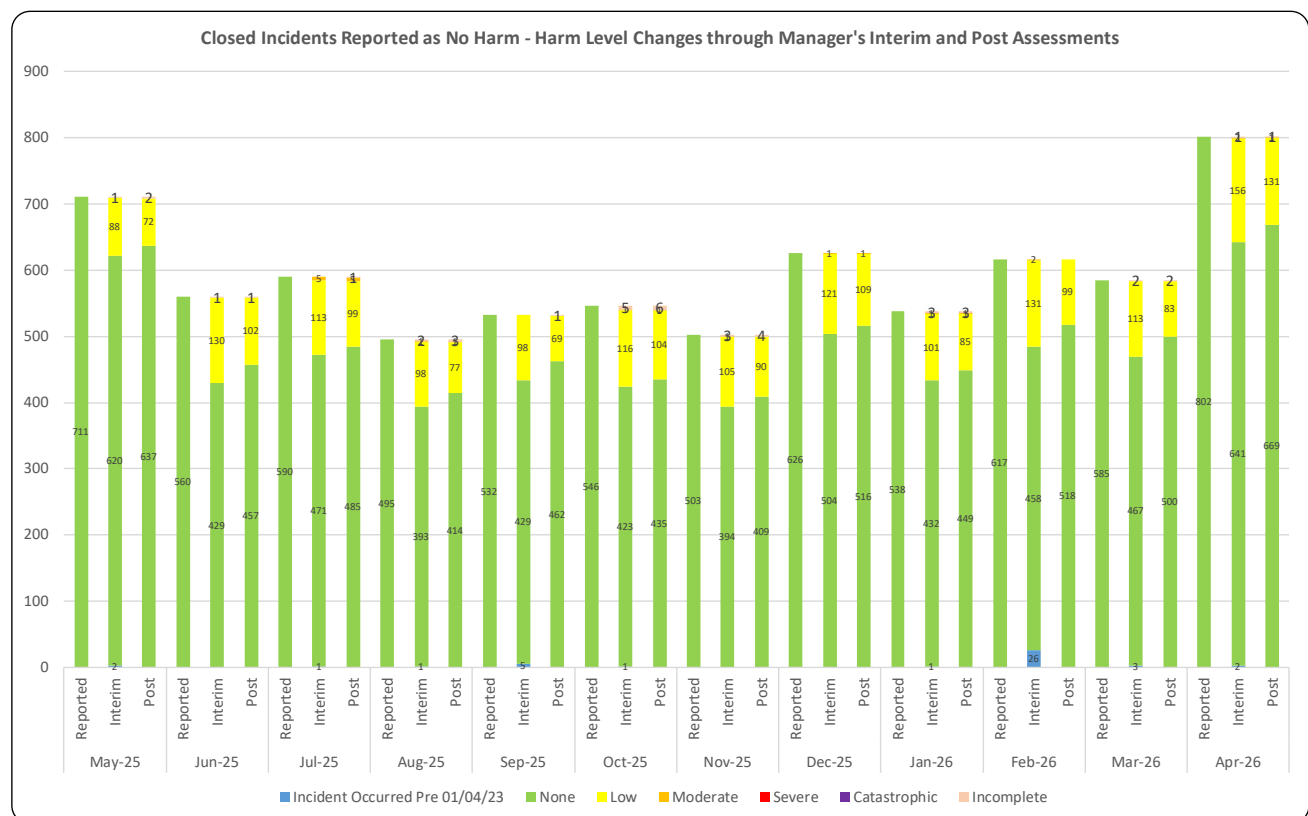
Between the 1 March and 30 April 2026 a total of 4,515 patient safety incidents were closed. The 12 month trend is reflected in the table below.



Of the 4,515 patient safety incidents closed, 1 was closed with severity post investigation of severe harm and 1 incident of catastrophic/ death. A breakdown of incidents is provided in the table below:

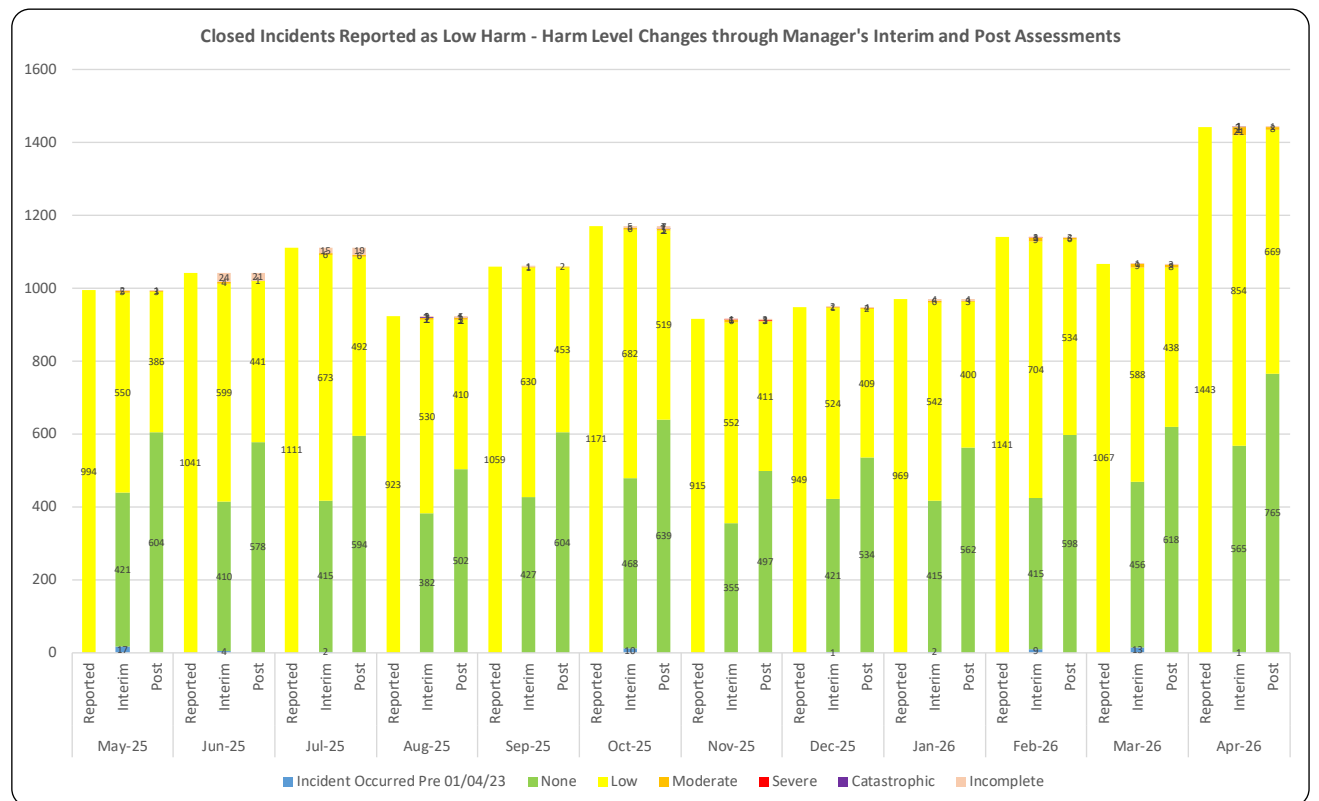
	Unscheduled Care	DTPS	Total
Assessment, Investigation, Diagnosis	0	1	1
Infection Prevention and Control	1	0	1
Total	1	1	2

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:

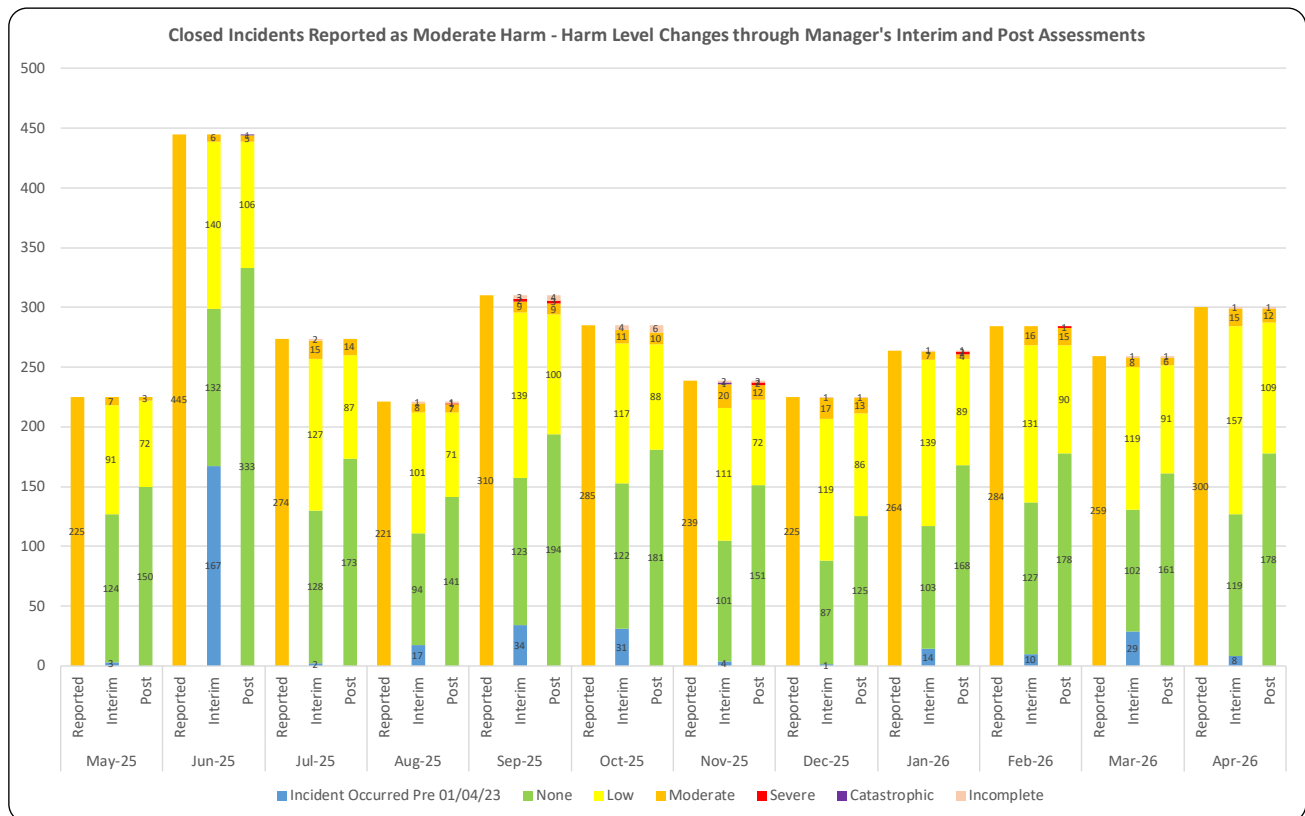


Between 1 March and 30 April 2026, a total of 1,387 incidents were initially reported as 'No harm', representing an increase of 232 compared with the previous two-month period (1,155). Across the period, approximately 20% of incidents were upgraded to a higher harm level at the interim stage, reducing to around 16% at post-review. No incidents were classified as severe or catastrophic, and incomplete reviews remained minimal (3

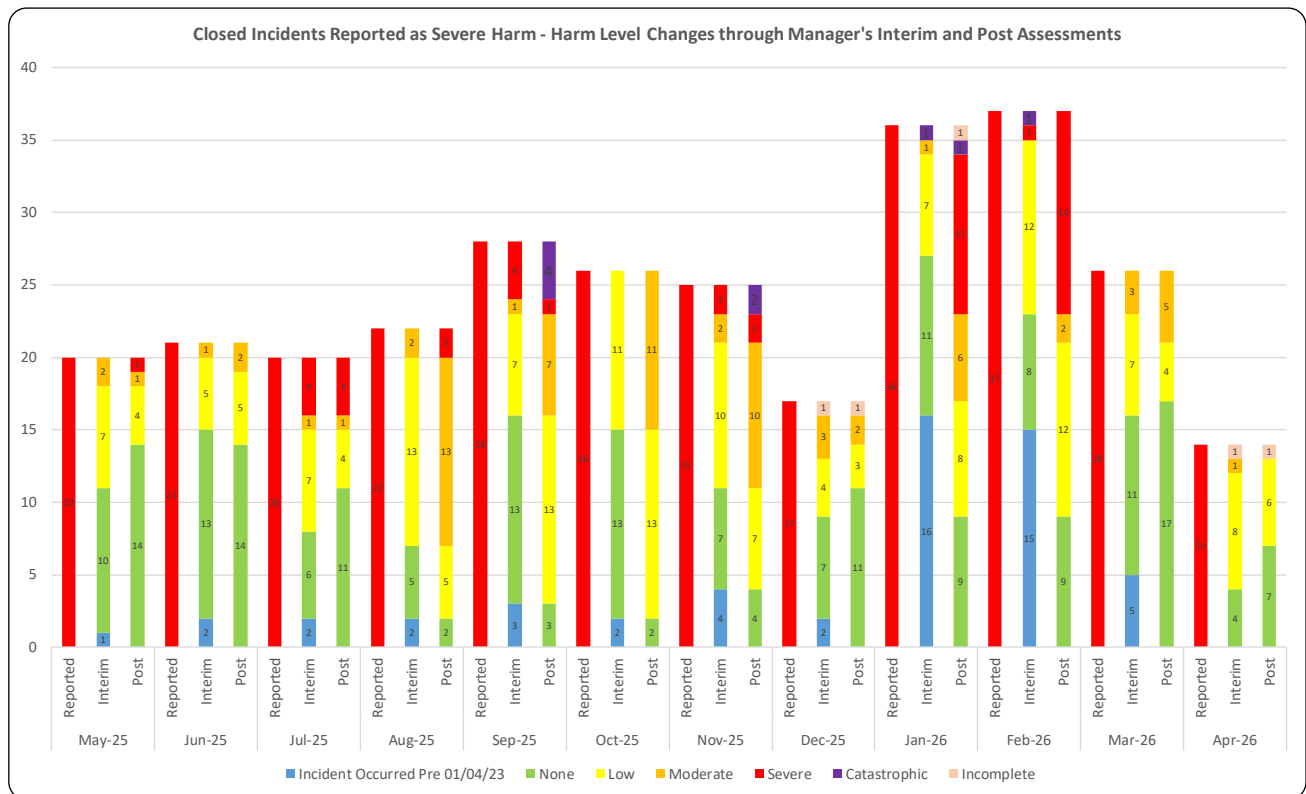
at interim and 3 at post across the period). The trend in harm level changes is reflected in the chart above.



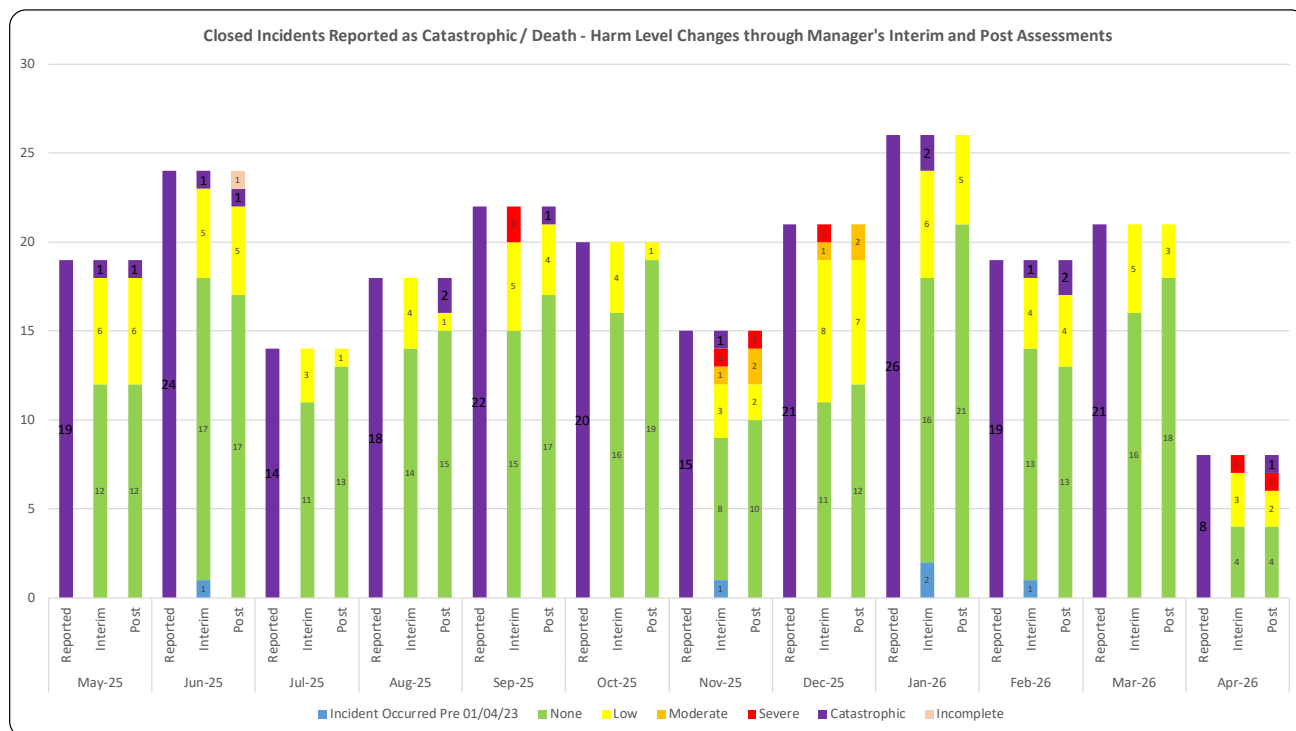
Between 1 March and 30 April 2026, a total of 2,510 incidents were initially reported as 'Low harm', representing an increase of 400 compared with the previous two-month period (2,110). Following review, most incidents were reclassified to 'No harm', with a smaller proportion remaining as 'Low' or being reassessed as 'Moderate'. Across the period, approximately 1.2% of incidents were upgraded to a higher harm level at the interim stage, reducing to around 0.6% 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 1 March and 30 April 2026, a total of 559 incidents were initially reported as 'Moderate harm', representing an increase of 11 compared with the previous two-month period (548). Following review, most incidents were downgraded at the interim stage (95.5%), primarily to 'Low' (49%) and 'No Harm' (40%), with a smaller proportion recorded as 'Incident Occurred Pre 01/04/23' (7%). By post-review, downgrade levels remained high (96.4%), with the majority recorded as 'No Harm' (61%) and 'Low' (36%), and none recorded in the 'Incident Occurred Pre 01/04/23' category. Upgrades to higher harm levels were not observed across the period. The trend in harm level changes is reflected in the chart above.



Between 1 March and 30 April 2026, a total of 40 incidents were initially reported as 'Severe harm', representing a decrease of 33 compared with the previous two-month period (73). Following review, 97.5% of incidents were downgraded at the interim stage, with most incidents reclassified to lower harm levels. By post-review, downgrade levels remained high (97.5%), with most incidents reassessed to 'No', 'Low', or 'Moderate' Harm. No upgrades to higher harm levels were recorded across the period. The trend in harm level changes is reflected in the chart above.



Between 1 March and 30 April 2026, a total of 29 incidents were initially reported as 'Catastrophic harm', representing a decrease of 16 compared with the previous two-month period (45). Following review, all incidents were downgraded at the interim stage (weighted 100%), primarily to lower harm categories. By post-review, downgrade levels remained high (96.6%), with most incidents reassessed to 'No', 'Low', or 'Moderate' harm. No incidents were upgraded beyond the original category, and incomplete reviews were not identified across the period. The trend in harm level changes is reflected in the chart above.

Duty of Candour

The Duty of Candour regulations were implemented from the 1 April 2023. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at a glance along with the introduction of weekly data validation audits.

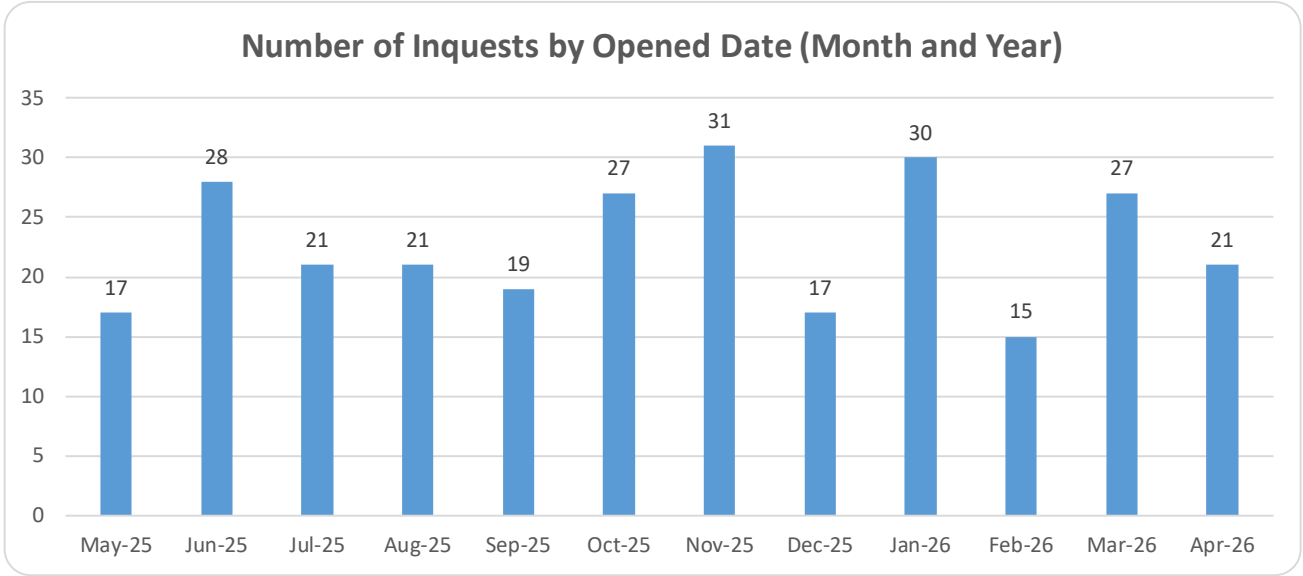
Number of Incidents	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026
Where Duty of Candour Triggered	22	19	9	12	13	28	10	17	11	9	16	15

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

3.3 Inquests Case Activity

New Inquests Received

Between 1 March and 30 April 2026, the Health Board received notification of 48 inquests. Whilst this is a slight increase when compared with the previous 2-month period (45) new inquest activity remained relatively constant as reflected in the trend graph below of the inquests opened during the previous 12 month period.



Of the 48, the highest number of inquests were received for the Primary Care and Community (22). A breakdown of inquests received by Care Group is provided below.

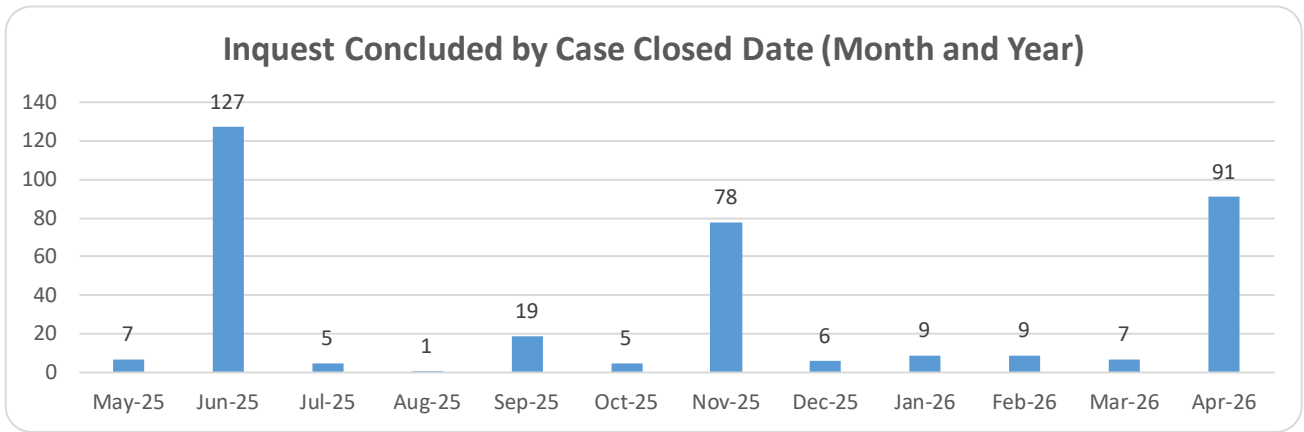
Care Group	Number Received
Children and Families	0
Primary Care and Community	22
Mental Health and Learning Disabilities	0
Planned Care	11
Unscheduled Care	15

DTPS	0
Not Specified	0
Total	48

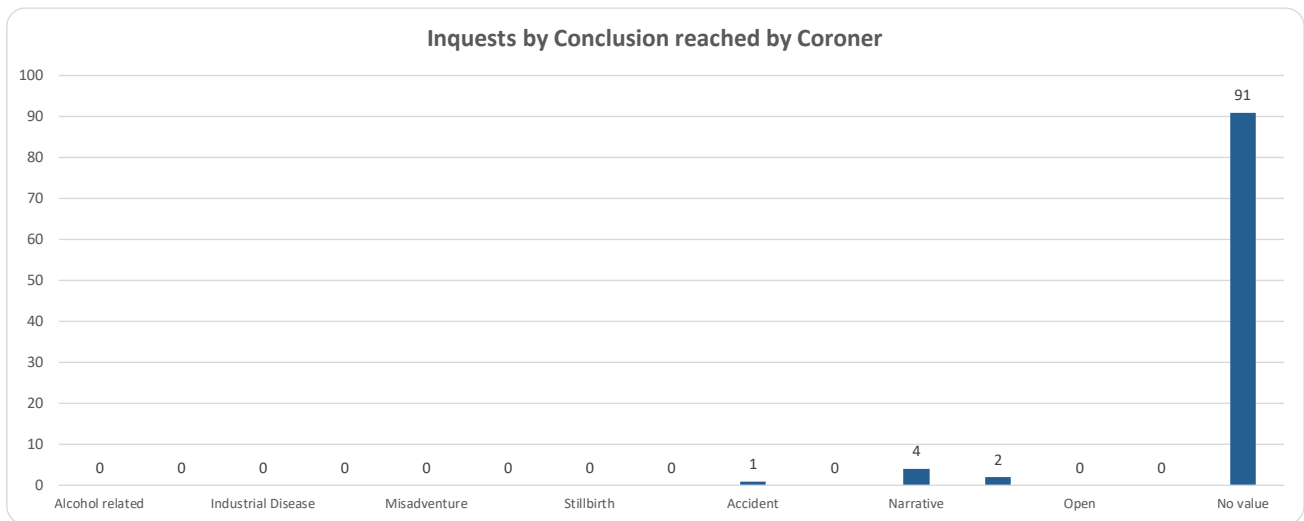
Inquests Concluded

During the same period, there was a notable increase in the number of cases closed with 98 inquest cases closed on the Health Board’s Datix system. This activity is partly attributed to a targeted cleansing exercise undertaken jointly with the Coroner’s Officer during April 2026 which has supported the resolution and formal closure of historic cases. Whilst this demonstrates improved oversight and alignment between the Health Board and the Coroner’s Officer, it should be noted that this does not reflect Inquest hearing activity.

A trend graph of inquests concluded for the previous 12 month period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 98 inquests cases closed on Datix, the hearing date or conclusion has been made available by the Coroner to the Health Board for 86 cases. Whilst some of these were discontinued by the Coroner prior to hearing, a percentage proceeded without further involvement of the Health Board. Of the remaining cases (7) a breakdown of the outcome of inquests closed between the 1 March and 30 April 2026 is provided in the chart below.



Regulation 28 Reports / HMC Letter Received

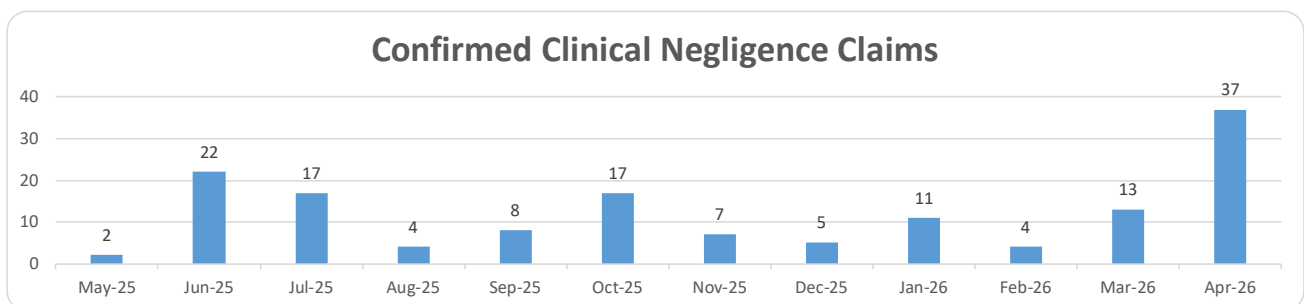
On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. Between the 1 March and 30 April 2026, the Coroner has issued three Regulation 28 Reports following conclusion of an inquest involving Cwm Taf Morgannwg University Health Board. These relate to:

1. Issued to Welsh Government: Missed opportunities to identify the co-ingestion of clarithromycin with simvastatin in the community
2. Issued to All Health Boards: Delay in locating adrenaline during resuscitation due to lack of standardisation of crash trolleys across Wales
3. Issued to Cwm Taf Morgannwg UHB, Cardiff & Vale UHB and Welsh Government: absence of clear guidance and protocol for when a referral should be made by the local hospital to the tertiary centre in respect of Hepato-Pancreato-Biliary (HPB) related matters.

3.4 Clinical Negligence Claims

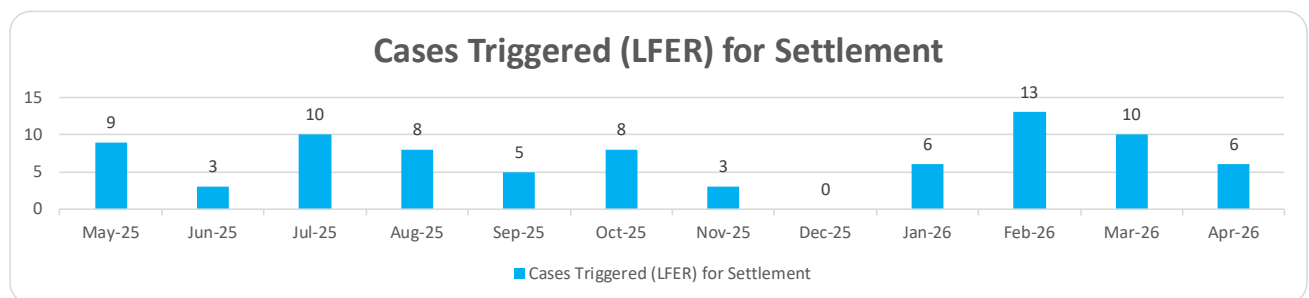
New Confirmed Clinical Negligence Claims

Between the 1 March and 30 April 2026 the Health Board received confirmation of a total of 50 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



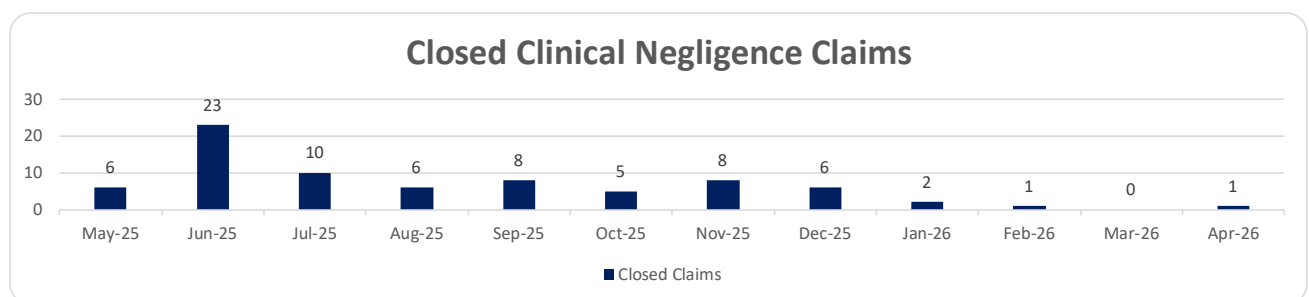
Clinical Negligence Claims triggered for settlement

Between the 1 March and 30 April 2026 in the Health Board, 16 Clinical Negligence Claims were triggered for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



Closed Clinical Negligence Claims

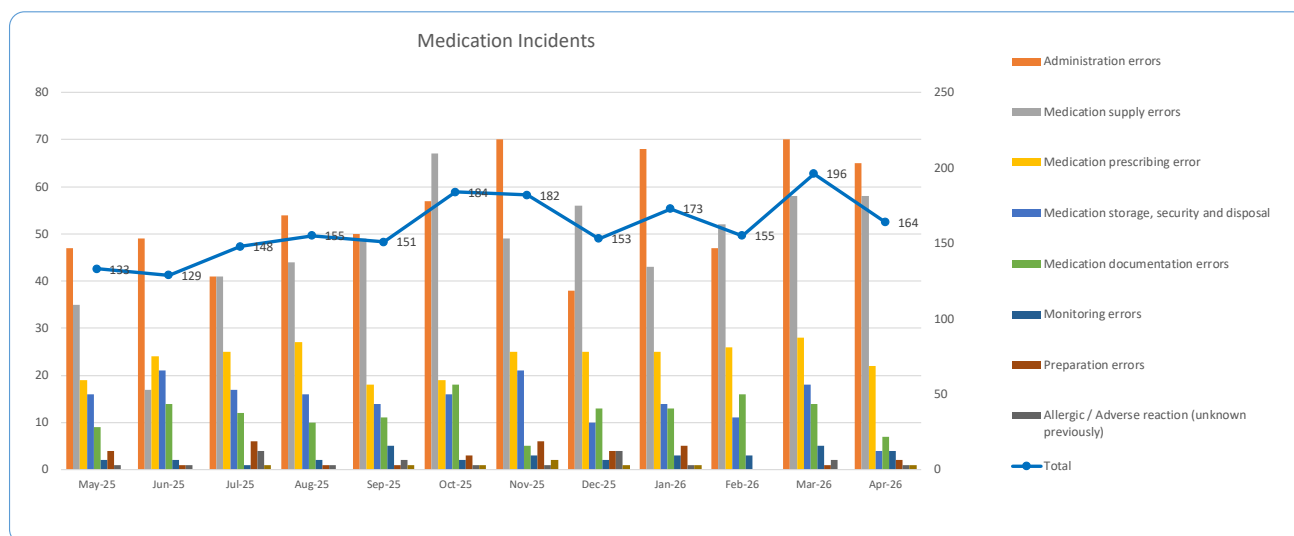
Between the 1 March and 30 April 2026, in the Health Board, 1 Clinical Negligence Claim was closed on the Datix Cymru System. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



3.5 Specific Quality & Safety Metrics

3.5.1 Medication Safety

A total of 360 medication incidents were reported as occurring between 1 March and 30 April 2026. This is an increase of 32 when compared with the previous 2-month period (328). Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (135), medication supply errors (116) and medication prescribing errors (50).

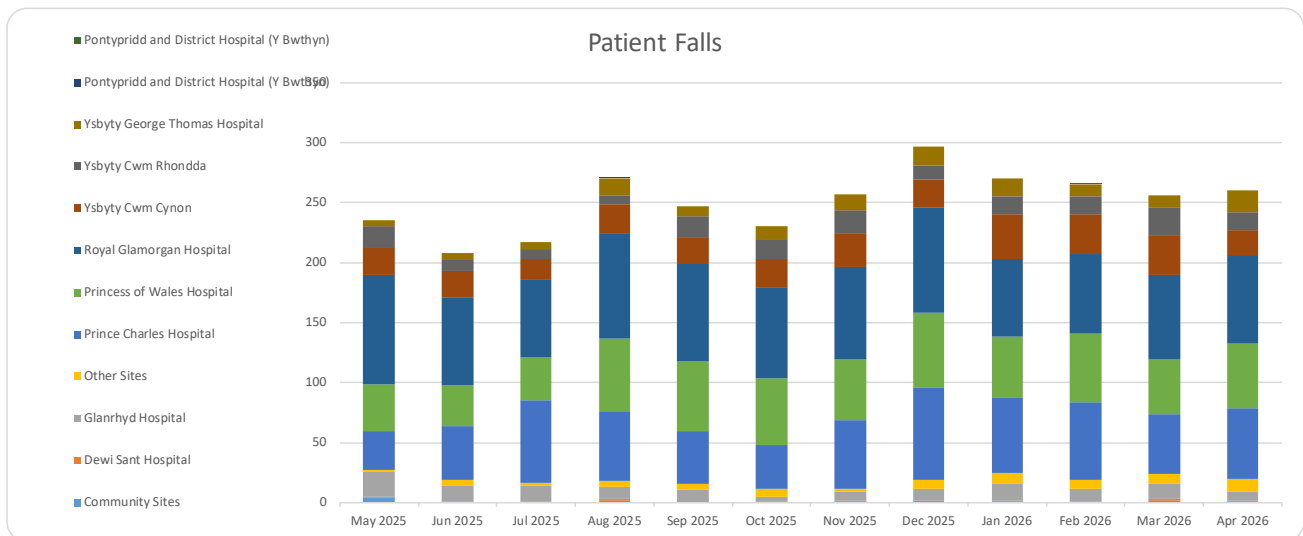


90% of the medication incidents were reported as resulting in 'no' (167) or 'low' (158) harm, with the remaining reported as resulting in moderate harm (30), Severe (4), Catastrophic / Death harm (1). It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

3.5.2 Patient Falls Incidents

A total number of 516 falls, where the person affected was a patient, were reported during March and April 2026. This represents a decrease compared with the previous two months (535).

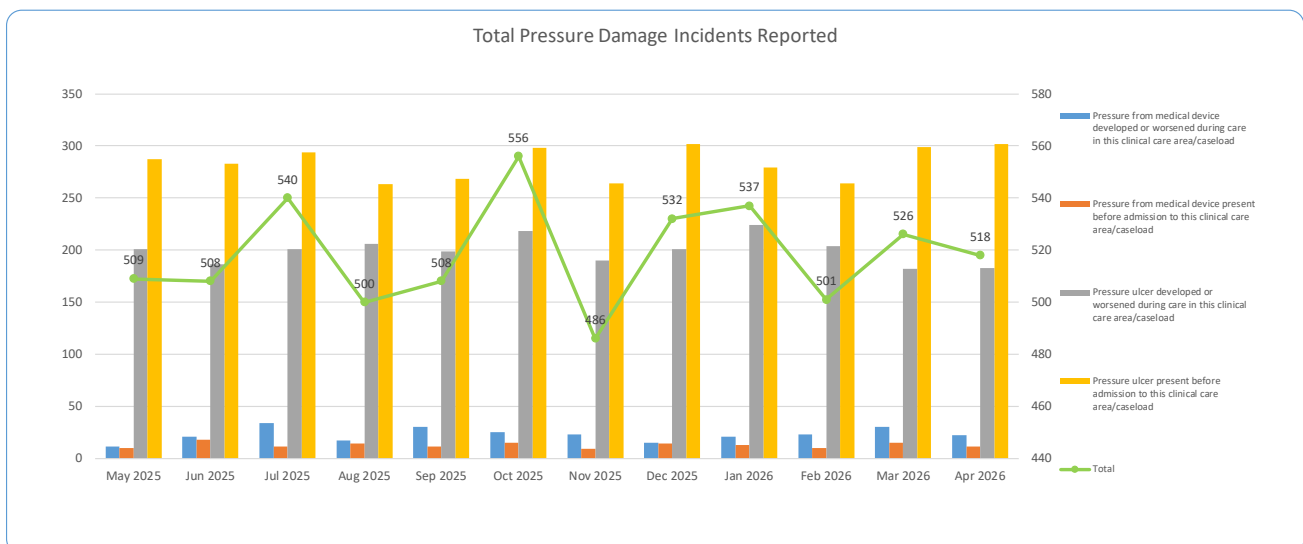
Of the falls incidents within the time period, 94% were reported as no (175) or low (311) harm. The remaining incidents were reported as resulting in moderate (29) and severe (1) harm. No incidents relating to patient falls were reported as resulting in catastrophic harm / death. Once again, it should 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.

3.5.3 Pressure Damage

Between the 1 March and 30 April 2026, a total of 1044 pressure damage incidents were reported, of which 417 were reported as developing or worsening during the current caseload. The remaining pressure damage incidents (627) were reported as being present before admission to this clinical care area/caseload.



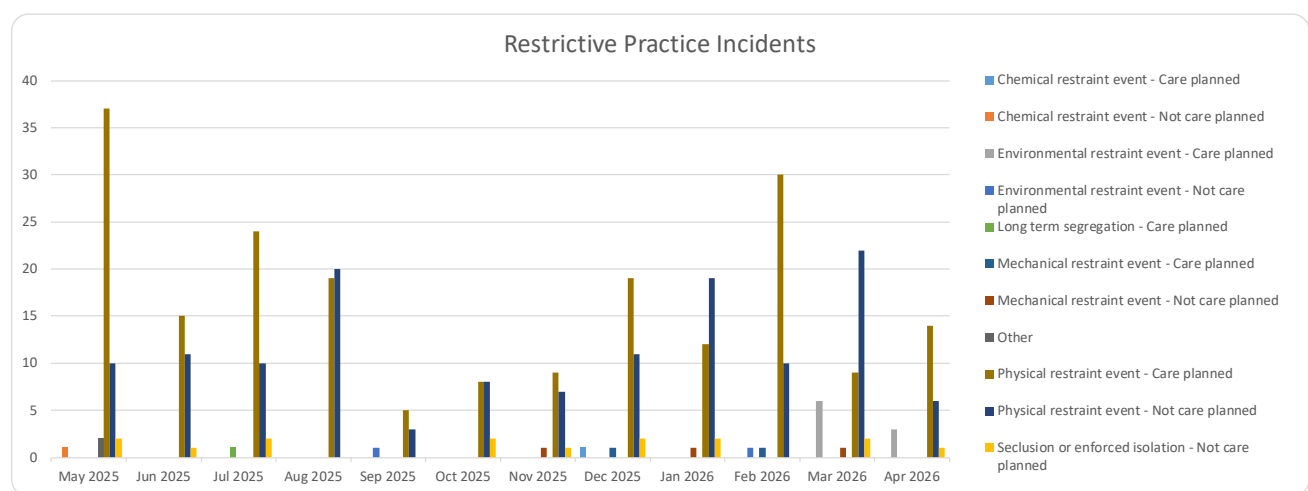
Of the 417, identified as developing or worsening during current caseload, 179 were identified as occurring within the community, which represents a decrease of 63 compared with the previous two-month period (242).

The Pressure Ulcer Steering Group has been established to provide strategic oversight and develop a robust prevention and monitoring programme and ensure learning is shared and embedded where available pressure damage has occurred.

3.5.4 Mental Health Metrics

Restrictive Practices

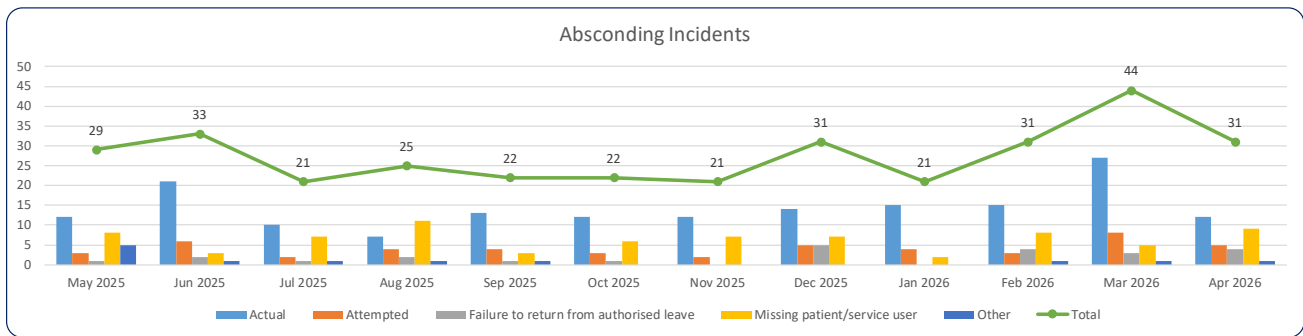
Between 1 March and 30 April 2026, a total of 64 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 12 incidents when compared to the previous two months (76).



Of the 64 incidents, 32 were reported as not care planned (not included in the care and treatment plan for the patient) and 32 were reported as care planned (included in the care and treatment plan for the patient), 0 were recorded as Other. The highest number of incidents were reported as occurring on the Coity Clinic POW (PICU), Princess of Wales Hospital (14).

Absconding incidents

During March and April 2026, a total of 75 incidents were reported under the category of absconding, which represents an increase of 23 when compared with the previous two-month period (52). 39 were recorded as actual absconding, with the remaining recorded as missing patient/service user (14), attempted absconding (13), failure to return from authorised leave (7), and other (2). The highest number of incidents were reported as occurring in the Emergency Care Centre PCH at the Prince Charles Hospital (20).



4 Key Risks / Matters for Escalation

- Maintaining complaints timeliness standards, whilst undergoing the transition into the new operating model within patient care and safety.
- 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.
- Reducing backlog and overdue NRIs
- Timely management of Public Services Ombudsman for Wales Cases
- Responding to Coroner's Inquest requests within timescales
- Managing data and reporting challenges linked to the new operating model

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	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	Learning, Improvement & Research
	If more than one applies please list below:



(Duty of Quality Statutory Guidance (gov.wales))	
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 Board's 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.	

6 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

7 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

4.6

Quality, Safety and Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	3 June 2026
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Louise Stait, Interim Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary
Pwrpas yr Adroddiad / Report Purpose	For review and consideration

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

Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	April 2026	RISKS REVIEWED
Executive Leadership Group	11 May 2026	MANAGEMENT REVIEW AND SIGN OFF RECEIVED

Acronyms / Glossary of Terms

1. Situation / Background

- 1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.
- 1.2 The ORR report is normally produced bimonthly, however it has not been produced since January 2026 due to a key vacancy in the Governance Team. **This iteration of the report therefore reflects more change than usual.**

2. Specific Matters for Consideration

Risk Review

- 2.1. Care Groups and Central leads continue to review and update their assigned risks considering feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews.
- 2.2. The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.
- 2.3. The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.
- 2.4. Risks on the organisational risk register have been updated as indicated in red in Appendix 1.

Risk Training

- 2.5 Risk training, although not a core training requirement under the statutory and mandatory framework, is available via the Electronic Staff Record (ESR).
- 2.6 Due to a vacancy in the Governance Team, the sessions have not yet taken place in 2026. Monthly dates are now scheduled and live on ESR, starting with Thursday 11 June and Thursday 2 July.
- 2.7 The sessions are run by the Interim Assistant Director of Governance & Risk jointly with other colleagues who have expertise and/or lead responsibility for Risk including the Business Manager for the Chief Operating Office. The sessions are held virtually via Teams on a monthly basis for a duration of one hour.
- 2.8 Bespoke team sessions on Risk are also available by arrangement.

Recent Committee Feedback on the ORR

- 2.9 In November 2025, the Audit, Risk & Assurance Committee (ARAC) requested additional context to support interpretation of the Organisational

Risk Register, particularly to understand whether risks are improving, deteriorating or remaining stable over time.

- 2.10 The appended summary of the ORR has been produced in response to this feedback.
- 2.11 In addition, simple trend annotations have been applied to the existing heat map (Section 4 of this report) to indicate direction of travel since the previous reporting period. The use of the heat map may be further reviewed and developed (or indeed superseded by an alternative) with members of the ARAC in the coming months.
- 2.12 Also in November 2025, ARAC members requested clearer evidence and consistency when risk scores are changed. In January 2026, the ODC (Operational Delivery Committee) requested clearer alignment / linkage between emerging risks, performance data, and likely impacts ("the 'so what'")
- 2.13 All the above feedback will be considered during 2026 as part of the ongoing continuous improvement of the ORR.

Internal Audit of Risk Management Arrangements (April 2026)

- 2.14 Internal Audit has recently completed a review of risk management arrangements across a sample of Care Groups and corporate directorates and has concluded reasonable assurance overall.
- 2.15 The proposed actions focus on:
 - increasing consistency in the format, quality and frequency of review of Care Group and corporate risk registers;
 - strengthening escalation arrangements from teams to ensure risks are escalated in line with the Risk Management Policy
- 2.16 These actions will be taken forward and monitored via established governance arrangements.

3. Key Risks / Matters for Escalation

3.1. NEW RISKS AND NEW ESCALATIONS

Planned Care Group

- Datix Risk ID 6451 - Orthoplastic pathway. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.

Children and Families Care Group

- Datix Risk ID 6475 - Industrial action of SCPHN Health Visiting staff members of the UNITE union. Escalated as a risk due to its ongoing duration, reduced workforce capacity and reliance on short term mitigations, creating a growing risk to universal and preventative child health services, despite immediate safety being maintained. Current score of 16.

DTPS Care Group

- Datix Risk ID 5554 - Ability to comply with legal responsibilities for containment level 3 facilities. Existing risk proposed for escalation following confirmation that the CL3 laboratory cannot be sealed or fumigated, with temporary safety mitigations agreed. Risk currently being reviewed to ensure the rating is a true reflection with potential mitigations also noted. Current score of 20.
- Datix Risk ID 6498 - Lack of Dynamic Mattress Systems in UHB due to over 100 units being condemned and not replaced due to cost. Current score of 16.

Cross-cutting risks

- Datix Risk ID 5797 - Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology. New risk – being reviewed for potential merging with another related risk as " Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery" to capture the HB risk as a whole. Current score of 15.

Digital Directorate

- Datix Risk ID 6604 - Misdirected clinical correspondence to GP practices. Longstanding risk escalated following discussion by the IG Group. Current score of 16.
- Datix Risk ID 6605 - Legal compliance with access to records requests. Longstanding risk escalated following discussion by the IG Group. Current score of 16.
- Datix Risk ID 6426 – Access to E-Whiteboards. Due to business sensitivities the details of this risk are captured in the closed session of the Committee. Current score of 16.

People Directorate

- Datix Risk ID 4958 – Fire Safety. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
- Datix Risk ID 4933 – Fire Safety. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.

Executive Director of Therapies and Health Science

- Datix Risk ID 6429 - Physiotherapy MSK Self-Referral Form. Risk score increased from 12 to 16 following longer triage times due to capacity pressures and a recent near miss; immediate mitigating actions have been agreed, with a short-term review scheduled and escalation to the Primary Care Transformation Board, which may enable de-escalation.

Executive Medical Director

- Datix Risk ID 6629: GMC/HEIW Conditions on PCH Emergency Department. New risk: IF the recommendations from the GMC and HEIW on improving the issues with PCH's Emergency Department trainees are not addressed, THEN further action will be taken, RESULTING IN further scrutiny from both the GMC and HEIW, a loss of trainee doctors and potential patient safety issues. Current score of 16

3.2. CHANGES TO RISKS

Risk Score Increased

Planned Care Group

- Datix Risk ID 6294 - Insufficient Consultant Workforce - Endoscopy / Gastroenterology. Score increased from 16 to 20. Consultant workforce shortages continue to impact endoscopy and gastroenterology services, with recruitment ongoing and further mitigations under development to support service sustainability.

Risk Score Decreased or De-escalated (and thus removed from ORR)

Diagnostics, Therapies, Pharmacy & Specialties Care Group Care Group

- Datix Risk ID 2713 - Backlog of Reporting Radiology Examinations. Improvements in radiology reporting have reduced the risk score from 16 to 12 and removed it from the ORR, however the position remains fragile as additional funding ends and is being actively monitored for potential re-emergence.

Children and Families Care Group

- Datix Risk ID 6217 - A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity. De-escalated and removed from the ORR in February 2026 following internal and external assurance and Care Group agreement.

Mental Health and Learning Disabilities Care Group

- Datix Risk ID 4973 - Clinical Medical Cover within CTM Adult Mental Health Services. Risk score reduced to 12 in May 2026, and removed from ORR.

Executive Nurse Director

- Datix Risk ID 1793 - Lack of isolation facilities available- negative pressure rooms. Strategic risk owner changed from END to COO on Datix. Score also reduced from 16 to 12, so will not appear in future ORR reports.
- Datix Risk ID 6229 - Timely development of, management and response to Learning From Event Reports. Score reduced to 12, due to the immediate control measures in place and collaborative working with the Welsh Risk Pool.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Planned Care Group

- Datix Risk ID 5688 - Aging Equipment (Replacement steam steriliser). Closed as equipment has been received, installed and commissioned.

Primary and Community Care Group

- Datix Risk ID 5576 - Palliative Medicine Staffing. Risk closed following interim changes to admission criteria at YCC and alternative medical cover arrangements, pending completion of engagement and confirmation of the long-term service model.

Diagnostics, Therapies, Pharmacy & Specialties Care Group

- Datix ID 6379 - CT Scanners at RGH damaged by power outage and manual generator/UPS switch over. Risk closed and removed from the ORR in February 2026 following completion of CT scanner switch replacements.

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

↑ = score increased since previous report (Jan 2026)

↓ = score decreased since previous report

↔ = score unchanged since previous report

N = new risk identified and added to Datix since January 2026

N↑ = established risk; newly escalated to the ORR following an increase in score.

N↔ = established risk with stable score; newly escalated to the ORR for visibility.

NB: This heat map includes the risks marked as business sensitive / confidential.

NB: This heat map also includes references to the risks marked as business sensitive and confidential

Consequence	5			3337 6451 5797	↔ N↑ N	5276 ↔	



CxL	4			5820 ↔	6318 ↔ 6498 N 6429 N↑ 4417 ↔ 4632 ↔ 4885 ↔ 5045 ↔ 5579 ↔ 5761 ↔	5877 ↔ 6280 ↔ 6397 ↔ 6424 ↔ 6426 N ↔ 6475 N 6604 N 6605 N 6629 N	4491 ↔ 5554 N ↑ 5753 ↔ 5821 ↔ 6052 ↔ 6179 ↔ 3826 ↔ 6294 ↑
	3						6231 ↔ 4672 ↔ 6232 ↔ 4691 ↔
	2						
	1						
	1	1	2	3	4	5	
	Likelihood						

Emerging Risks Identified for possible future escalation

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

- **Planned Care Group** have noted the possible reemergence of a risk regarding the Backlog for Imaging in all modalities (Datix Risk ID 4152). The risk is listed here for awareness – awaiting further update from care group following performance review
- **People Directorate** have noted that subject to board endorsement, there is an emerging risk around shift pattern alignment, including the potential for industrial action, noting that the proposals impact a large proportion of our nursing/ midwifery and HCSW (over 3,000 staff). This is a shared risk owned by the Executive Director for People and the Executive Nursing Director.
- **Unscheduled Care Group** have noted an emerging risk (Datix ID 6618) on potential disruption to invasive coronary angiography (ICA) services due to recall of Kimal supplied manifolds. Mitigations are in place, and the situation is being reviewed on a daily basis.

5. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	The Organisational Risk Register supports delivery of all CTMUHB strategic goals by identifying, assessing and monitoring the principal organisational risks that may impact on their achievement.
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	The Organisational Risk Register provides visibility of risks across all Care Groups and corporate directorates, supporting executive oversight of risks relating to delivery, quality, workforce, finance, estates, digital and enabling functions.



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
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Safe The ORR exists to identify, monitor and mitigate risks that could cause harm. • This includes clinical, operational, workforce, estates, digital and system risks. • Even non-clinical risks (finance, workforce, digital) are framed through their <i>potential safety impact</i>.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	The ORR itself has no environmental impact but includes an environmental sustainability risk (5374) relating to delivery of the Health Board's environmental and social duties and Climate Action Plan.

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



(Pobl /Ariannol) /
Resource Impact
(People / Financial)

See detail captured for each risk

6. Recommendation

6.1 The Committee are asked to:

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

7. Next Steps

7.1 The Organisational Risk Register is currently being submitted to the relevant Committees.

Organisational Risk Register (ORR) – Summary Version – May 2026 – Quality, Safety and Experience Committee Version

This summary shows the ORR divided into two broad categories of risk:

1. **Care Group-led risks**, where the primary accountability for management and mitigation sits within a Care Group, with executive oversight; and
2. **Directorate-led risks**, where the risk reflects a cross-organisational, enabling or system level issue owned directly by an Executive Director and not linked to a specific care group (for example, digital, workforce, finance, estates or commissioning related risks).

The purpose of this summary is to assist navigation of the full ORR (Datix extract), and support oversight and sense checking. It does not replace the detailed ORR and does not alter the existing process.

1. CARE GROUP-LED RISKS

Datix ID	Strategic Risk Owner	Risk Title	Rating Jan 26	Rating May 26	Trend	Notes
Planned Care Group						
6294	COO (Chief Operating Officer)	Insufficient Consultant Workforce - Endoscopy / Gastroenterology	16	20	↑	April 2026: Score increased. Consultant workforce shortages continue to impact endoscopy and gastroenterology services, with recruitment ongoing and further mitigations under development to support service sustainability. (The impact of these mitigations on the score is currently being reviewed)
~~5688~~	~~COO~~	~~Aging Equipment (Replacement steam steriliser)~~	~~16~~	—	↔	April 2026: Closed as equipment has been received installed and commissioned. Will not appear on future reports.
6451 NEW	COO	Orthoplastic Pathway (<i>Business sensitive risk</i>)	12	15	↑	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
4152	COO	Backlog for Imaging in all modalities	16	12	↓	POSSIBLE (RE)EMERGING RISK: For awareness – awaiting further update from care group following performance review
Unscheduled Care Group						
3826	COO	~~Ambulatory Department Overcrowding~~ Emergency Department Overcrowding (<i>change of risk title</i>)	20	20	↔	April 2026: Emergency and ambulatory departments remain overcrowded due to sustained system pressure, with a coordinated programme of urgent and emergency care, acute medicine and patient-flow improvements in place to reduce long waits, improve ambulance handover, and stabilise performance
5045	COO	Access to Neurology Inpatient and Outpatient Services for CTM Residents	16	16	↔	April 2026: Mitigations include the appointment of a Consultant Neurologist commencing May 2026, continued interim arrangements, transfer of waiting-list reporting to CTM, and ongoing work with the commissioning health board to address capacity and long waits. Risk score to be reviewed following the consultant's start.
4632	ED T&HS	Provision of an effective and comprehensive stroke service across CTM	16	16	↔	April 2026: The stroke improvement programme is underway with stabilised medical and nursing workforce, daily multidisciplinary huddles, enhanced senior oversight and performance reporting, and improving timeliness of care, with rollout to additional sites and further performance gains planned.
6618		Disruption to invasive coronary angiography (ICA) services due to recall of Kimal supplied manifolds	tbc	tbc	---	POSSIBLE EMERGING RISK – MAY 2026. Mitigations are in place, and the situation is being reviewed on a daily basis.

Datix ID	Strategic Risk Owner	Risk Title	Rating Jan 26	Rating May 26	Trend	Notes
Children and Families Care Group						
5753	END	Inadequate Special School Nurse Provision	20	20	↔	April 2026: Risk has been reviewed following national guidance and improved engagement with education partners. Service stability has improved and an updated SLA is in development, with a reduction in risk score anticipated once clinical confirmation and formal agreement are in place.
6475 NEW	COO and END	Industrial action of Health Visiting staff members of the UNITE union	---	16	---	NEW RISK opened Jan 2026 Escalated as a risk due to its ongoing duration, reduced workforce capacity and reliance on short term mitigations, creating a growing risk to universal and preventative child health services, despite immediate safety being maintained.
6217	EMD	~~A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity~~	15	15	↔	Feb 2026: De-escalated and removed from the ORR following internal and external assurance and Care Group agreement.
Diagnostics, Therapies, Pharmacy & Specialties Care Group						
5554 NEW	---	Ability to comply with legal responsibilities for containment level 3 facilities	15	20	↑	Feb 2026: Risk escalated following confirmation that the CL3 laboratory cannot be sealed or fumigated, with temporary safety mitigations agreed.
5579	ED PH	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16	16	↔	Apr 2026: Risk reviewed with no change to score. Funding is in place for baseline support, but gaps remain for more complex need and are being addressed through planning.
6429 NEW	ED H&TS	Physiotherapy MSK Self-Referral Form.	12	16	↑	Apr 2026: Risk score increased following longer triage times due to capacity pressures and a recent near miss; immediate mitigating actions have been agreed, with a short-term review scheduled and escalation to the Primary Care Transformation Board, which may enable de-escalation.
6498 NEW	COO	Lack of Dynamic Mattress Systems in UHB due to over 100 units being condemned and not replaced due to cost.	---	16	---	NEW RISK escalated April 2026: A high number of mattresses have been condemned because they are no longer compliant / no longer serviceable, leading to low stock and increased Datix incidents. Plan for resolution under development.
6379	COO	~~CT Scanners at RGH damaged by power outage and manual generator/UPS switch over~~	16	---	---	Feb 2026: Risk closed and removed from the ORR following completion of CT scanner switch replacements.
2713	COO	~~Backlog of Reporting Radiology Examinations~~	16	12	↓	April 2026: Improvements in radiology reporting have reduced the risk score below 12 and removed it from the ORR, however the position remains fragile as additional funding ends and is being actively monitored for potential re-emergence.
Mental Health and Learning Disabilities Care Group						
4973	COO	~~Clinical Medical Cover within CTM Adult Mental Health Services~~	16	12	↔	May 2026: Risk reviewed and score reduced to 12 – will not appear on future ORR reports
6318	COO	Tier 3 SHED (Severe and High-Impact Eating Disorders) Team Service Delivery	16	16	↔	April 2026: Mitigating actions for the Tier 3 SHED Team are in place following joint work with CVUHB, including temporary nurse practitioner cover, drop-in clinics, physical health monitoring and staff training. Current controls and risk score unchanged.
3337	COO & Director of Digital	Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS	15	15	↔	April 2026: Risk Reviewed; no change to scoring or controls

Datix ID	Strategic Risk Owner	Risk Title	Rating Jan 26	Rating May 26	Trend	Notes
4691	COO	~~New Mental Health Unit~~ The Provision of Safe and Appropriate Estate for Inpatient Mental Health Care	15	15	↔	March 2026: Risk title changed April 2026: The inpatient mental health service review and remodelling programme continues under MHLG governance, with no change to current controls or risk scoring.
Primary and Community Care Group						
5877	COO	New Worker Contract for Out of Hour GPs	16	16	↔	Apr 2026: Implementation of the new out-of-hours GP worker contract remains subject to national negotiations, with interim rota management arrangements in place and ongoing work to increase GP recruitment.
6397	COO	Shortage of GPs to deliver urgent primary care services for escalation.	16	16	↔	April 2026: The shortage of GPs to deliver urgent primary care services remains unchanged, with ongoing monitoring, continued recruitment efforts and interim leadership cover where required.
5576	COO	~~Palliative Medicine Staffing~~	16	6	↓	March 2026: The risk score has reduced following interim mitigation, including a temporary change to the YCC unit's designation and admission criteria, and alternative medical cover arrangements due to ongoing vacancies. These measures support current safety but are not a long-term solution. Consideration of the longer term, future service model is being considered by Board at its meeting on 21 May 2026.
Deputy COO Risks						
4491	COO	Failure to meet the demand for patient care at all points of the patient journey	20	20	↔	April 2026: A system-wide programme is in place to reduce the risk of failing to meet patient demand across the whole pathway, through coordinated action on urgent care, patient flow, discharge and planned care recovery, underpinned by strengthened governance and performance oversight
4417	COO	Management of Security Doors in All Hospital Settings	16	16	↔	April 2026: Incident data relating to security door management across hospital sites is under review, with analysis shared with the DCOO to inform an updated assessment and decision on the risk score; COO has requested further review of this risk and its score
Facilities Directorate Risks						
6052	COO	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrakarts).	20	20	↔	April 2026: 16 trollies purchased – due for delivery at the end of May 2026. This risk will be reviewed when trollies are fully operational.
Cross-cutting risks						
5797 NEW		Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology	15	15	↔	April 2026: New escalation – being reviewed for potential merging with another related risk as “Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery” to capture the HB risk as a whole.

2. Summary of Directorate-Led Risks

The following are Directorate-led risks, where the risk reflects a cross-organisational, enabling or system level issue owned directly by an Executive Director and not linked to a specific care group. For example, digital, workforce, finance, estates or commissioning related risks.

Datix ID	Risk Title	Rating Jan 26	Rating May 26	Trend	Status update
ED of Strategy & Transformation					
6280	See below under Executive Medical Director - Regional Hepato-Pancreato-Biliary Service (Jointly owned risk)				
5821	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB)	20	20	↔	April 2026: Arrangements for secondary care immunology remain reliant on external provision, with a commissioning route established for peri-operative referrals and further options being explored through collaboration with other health boards, recognising current funding constraints.
Executive Director of Finance					
No risks under this directorate are included in the QSEC-specific ORR report					
Executive Director of Public Health					
6179	High and increasing prevalence of overweight and obesity in children and adults.	20	20	↔	April 2026: Level 1 childhood obesity services are in place following confirmed funding, however a significant gap remains in Level 3 provision and the risk score remains unchanged
5579	See above under DTPS Care Group - Rising childhood obesity rates				
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding	12	12	↔	Although the normal threshold for the ORR is a current score of 15, this risk is also included due to its novel / contentious nature
Director of Digital					
5276	Failure to deliver replacement Laboratory Information Management System, LIMS 2.0 Programme within project timeframe	20	20	↔	Apr 2026: Risk reviewed; no no change to scoring or controls. Jointly owned risk with the Executive Director of Therapies and Health Science.
6604 NEW	Misdirected clinical correspondence to GP practices	---	16	---	May 2026: New risk raised and escalated following discussion by the Information Governance (IG) Group.
6605 NEW	Legal compliance with access to records requests	---	16	---	May 2026: New risk raised and escalated following discussion by the Information Governance (IG) Group.
6424	Mental Health Subject Access Requests (SARs) (IG/15)	16	16	↔	April 2026: Risk reviewed; no change to scoring or controls
6426 NEW	Access to E-Whiteboards (Business sensitive risk)	16	16	↔	April 2026: Risk reviewed; no change. Existing risk, newly escalated to ORR for visibility. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
4672	Access to a complete, integrated, and coded medical record.	15	15	↔	April 2026: Risk reviewed; no change to scoring or controls.
3337	See above under MH Care Group - Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS				
Executive Nurse Director					
5753	See above under Children & Family Care Group - Inadequate Special School Nurse Provision				

Datix ID	Risk Title	Rating Jan 26	Rating May 26	Trend	Status update
~~6229~~	~~Timely development of, management and response to Learning From Event Reports~~	46	42	↓	May 2026: Initial score of 20 but with the immediate control measures in place and collaborative working with the Welsh Risk Pool the likelihood score has reduced to a 4. The current score is therefore now 12.
6231	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	16	16	↔	April 2026: Arrangements for managing concerns continue to strengthen, with sustained performance, regulatory transition to Listening to People, and delivery of agreed organisational changes. The risk will remain at its current level until the revised staffing model is fully implemented.
6232	Stability of the Legal Services Function	15	15	↔	April 2026: Risk Reviewed; no substantial change.
~~4793~~	~~Lack of isolation facilities available - negative pressure rooms~~	46	42	↓	Feb 2026: Strategic risk owner changed from END to COO on Datix. Score also reduced to 12, so will not appear in future ORR reports.
Executive Director of Therapies and Health Sciences.					
4632	<i>See above under Unscheduled Care Group</i> - Provision of an effective and comprehensive stroke service across CTM				
5276	<i>See above under Director of Digital (jointly owned risk) - Failure to deliver replacement Laboratory Information Management System, LIMS 2.0 Programme within project timeframe</i>				
Director of Corporate Governance / Board Secretary					
4885	Failure to deliver and sustain effective Policy Management System and Process	16	16	↔	April 2026: Controls have strengthened for non-clinical policies following go-live of the new non-clinical policy SharePoint, while clinical policy migration remains at an earlier stage.
Executive Medical Director					
5761	Cross Health Board Data Sharing	16	16	↔	April 2026: Risk Reviewed; no change to scoring or controls
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model	16	16	↔	April 2026: Risk Reviewed; no change to scoring or controls
6629 NEW	GMC/HEIW Conditions on PCH Emergency Department.	---	16	---	NEW RISK escalated May 2026 relating to implementing the recommendations from the GMC and HEIW on improving the issues with PCH's Emergency Department trainees.
~~6217~~	~~<i>See above under Children & Family Care Group</i>~~				Feb 2026: Risk de-escalated and closed.
Executive Director for People					
NOTE: Please see also Risk ID6475 (above): <i>Industrial action of SCPHN Health Visiting staff members of the UNITE union</i> . The risk to service delivery sits with the Care Groups, but the industrial relations element sits with the People Directorate.					
NOTE: Subject to board endorsement, there is an emerging risk around shift pattern alignment, including the potential for industrial action, noting that the proposals impact a large proportion of our nursing/ midwifery and HCSW (over 3,000 staff). (Shared risk owned by Executive Director of People, and Executive Nursing Director)					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan		Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
1	4491	COO	Deputy COO	Business Manager for Chief Operating Office	Safety & Well-being - Patients / Staff / Public	Failure to meet the demand for patient care at all points of the patient journey	IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Specialty specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing undertaken when needed. • The UHB will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The UHB has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and UHB levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified	April 2026: Risk reviewed by COO 30.4.26 and a request to review the risk overall by care groups. April 2026: The Health Board is delivering a system wide programme of control measures and improvement actions to reduce the risk of failing to meet patient demand at all points of the patient journey, from admission avoidance and urgent access, through inpatient flow, to timely discharge and recovery of planned care. This approach recognises that emergency demand is strongly influenced by performance earlier and later in the pathway and therefore requires co-ordinated action across acute, community and partner services. Urgent care have developed an action plan in collaboration with NHS Wales Performance and Improvement Team utilising recommendations from key documents such as, GIRT, SDEC Review, ambulance patient handover guidance, ED Quality Statement and MAG Report April 2026. Ambulance escalation cards are live and ED 12 hour action plan complete. Six Goals for Urgent and Emergency Care programme remains a key driver in place, aligned to national policy and overseen through established governance arrangements. This includes targeted work on admission avoidance, integrated front door models, acute hospital flow, and integrated discharge, supported by weekly performance tracking and escalation processes. Progress within the Productivity, Improvement and Transformation (PIT) and Planned Care Recovery programmes is directly contributing to reduced pressure on emergency pathways by improving outpatient demand management, theatre productivity, diagnostics, and waiting list control, including expanded insourcing, protected elective units, and regional collaboration. These actions reduce inappropriate emergency attendances linked to delayed diagnosis and treatment Targeted action has been taken to stabilise and improve the Eye Care pathway, recognising its contribution to both elective and urgent demand. Cataract surgery has been consolidated to the Princess of Wales Eye Unit, enabling standardisation, high volume low complexity delivery and improved throughput. This is supported by a Regional Cataract Plan In addition, the Health Board continues to receive enhanced assurance reporting on Ophthalmology, alongside other high pressure specialties, enabling earlier identification of access risks and prioritised mitigation where pathway instability could escalate demand elsewhere in the system Recognising the impact of discharge delays on emergency flow, the Health Board has strengthened integrated discharge governance, expanded alternative bed models, and implemented Discharge to Recover then Assess (D2RA) approaches in partnership with local authorities. This is complemented by the mobilisation and scaling of Hospital at Home, enhanced community response services, and improved digital tools to support safe and timely discharge decisions Regular reporting through the Operational Delivery Committee, Quality, Safety & Experience Committee. Performance dashboards, harm reviews, specialty specific reports (including Eye Care), and escalation mechanisms provide ongoing visibility and enable timely corrective action where pressures remain high	20	C4 x L5	12	↔	11/01/2021	01/04/2026	
2	5276	Director of Digital	Digital	Pathology Quality Manager	Service / Business Interruption	Failure to deliver replacement Laboratory Information Management System, LIMS 2.0 Programme within project timeframe	IF: the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in December 2026. THEN: operational delivery of pathology services and the financial position of the Health Board will be severely impacted RESULTING IN: delays in treatments affecting the quality and safety of a broad spectrum of clinical services, potential of system wide disruption associated with loss of Blood Transfusion services and the ability of the Health Board to deliver its statutory responsibilities in respect of financial management.	Currently LIMS 2.0 Programme reports progress against timeline to LIMS 2.0 Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LIMS programme has been completed with findings presented to Collaborative Executive Governance Group (CEG) to inform next steps. Options appraisal presented to ELG March 2026	April 2026: Further escalation of concerns raised to SRO, DCO and COO 17th April Unbudgeted and unexpected costs passed onto CTM for LIMS Programme Delays: As advised at LIMS Programme Board April 2026 1. LIMS2: Programme shortfall for delays: CTM NB allocation of costs £0.57m 2. CCNs: Change Control Notifications for Analyser Interface development costs: CTM allocation £72,326.23 (these costs are being challenged) 3. TCL2016 Legacy Data extract and Sunset Viewer infrastructure: Pending DHCW Work breakdown. Costs to be advised 4. Continued operational support of WAIMS/TCL2016 in the next quarter of 2026: CTM will be billed by the DHCW SLA to continue running TCL2016. Cost breakdown is expected from DHCW for support, licensing and maintenance post Aug/Sep 2026. We are still waiting to hear about the change to Micro Go Live for 18 May. February 2026: There is very real concern within the BT SME community that the BT LIMS 2.0 (TCLx) project will not be delivered within the specified timeframe. This presents both operational and financial risks: Operational: Dedalus have issued an end of life (EOL) notification for the current LIMS system (Telgraph) (attached). This means that past the end of March 2027 the current system will no longer be supported. This presents operational risks in that if there is any hardware or software failure then the supplier would not fix the issue and the blood transfusion lab within the health board would not have a functioning IT system. A lack of a supported LIMS is also in direct contrast with the governance requirements for BT. It must also be noted that the current Telgraph contract extension expires at the end of December 2026. Financial: An alternative solution would be the DLIMS solution supplied by Dedalus. This would allow us to extend the current Telgraph contract up to implementation of the new DLIMS product (as they are both supplied by the same company and Dedalus have confirmed that this is a possibility). The financial risk is significant (quote attached).	20	C5 x L4	5	↔	31/10/2022	01/05/2026	
3	5554		Diagnostics, Therapies, Pharmacy & Specialities Care Group	Clinical and Laboratory Haematology Service Manager	Statutory Duty, Regulation, Mandatory Requirements	Ability to comply with legal requirements for containment level 3 facilities	The Health Board previously been served with an improvement notice from the HSE for the management of the CL3 (containment level 3) facility. Currently the CL3 laboratory does not meet sealability requirements as advised with relation to COSHH. If CL3 standards do not comply with COSHH - Then the responsible persons can be prosecuted under section 37 of the Health and Safety at Work etc Act 1974. Potential fines and/or imprisonment and reputational damage for the Health Board. Resulting in - 27/01/26 Review following fumigation suitability testing by Ellab - room is still not sealable. Ellab have advised that the room is no longer suitable for fumigation. - If the room cannot be sealed: - Then Microbiology will be unable to handle high risk (HCG-HG4*) organisms. - Resulting in the inability to process specimens that potentially contain HCG or HG4 organisms on-site. Specimens may include: respiratory, enteric, blood culture, throat and specimens associated with foreign travel to endemic areas, severely limiting the Microbiology service in CTM. Similar sealability issues have been identified in neighbouring Health Boards, limiting options for referring CTM specimens elsewhere. The Health Board previously been served with an improvement notice from the HSE for the management of the CL3 (containment level 3) facility. Currently the CL3 laboratory does not meet sealability requirements as advised with relation to COSHH. If CL3 standards do not comply with COSHH - Then the responsible persons can be prosecuted under section 37 of the Health and Safety at Work etc Act 1974. Resulting in - Potential fines and/or imprisonment and reputational damage for the Health Board.	Assurances from Ellab that fumigation can be undertaken The facility is still capable of being fumigated under the following conditions - - "Should the room require fumigation the areas from both sets of double doors that comprise the corridor should be sealed and all rooms off that corridor evacuated for the duration of the spillage. During fumigation the volume should be increased by 10% to account for any leakage over the course of the fumigation" 27/01/26 Fumigation as detailed above is no longer viable as per inspection on 02/12/25 (see attached sealability certificate and report). Where clinical details indicate potential high risk organisms, specimens are not processed on-site and referred to Public Health Wales laboratories (currently Glan Clwyd Hospital). Glan Clwyd are only capable of accepting a small number of specimens. TB incidence rate in clinically indicated non-respiratory sites = 1.38% (2024). For respiratory specimens, the positivity rate is 0.39% (2024). It is not safe to send all specimens away as some specimens are clinically urgent and the delay would risk patient harm. Staff training has been updated to include referral of high risk specimens. Ongoing meetings with capital planning to refurbish the laboratory are essential to significantly reduce the associated risk level.	April 2026: COO reviewed 30.4.26 and has advised the score needs to be reviewed, based on the grounds there are mitigation and consideration if this is to be merged with 3567 April 2026: Risk reviewed and remains the same. Now escalated to the Organisational Risk Register. The refurbishment project has been delayed as the updated detailed quotations have exceeded procurement regulations, and so the project needs to go back to tender. However this has proceeded at pace and is in hand. Met with the COO, Executive Director of A&H&S and Health Science, Deputy Director of Allied Health Professions and Health Science, Director of DTPS, and Pathology Directorate Manager to discuss the current CL3 risks and mitigations. Followed up this meeting with a Teams call with the regional H/S lead for Public Health Wales. I was advised that the HSE have supported PHW with advice in the implementation of mitigations to continue testing specimens in CL3 whilst maintaining safety as a temporary measure whilst the CL3 lab is non-sealable. We have adopted these mitigations in CTM as we have the same problems with non-sealability and non-fumigability. See email in document section. March 2026: Risk reviewed and remains the same. Awaiting advice from the Health Board as to whether funding can be provided to make the necessary repairs to the laboratory.	20	C4 x L5	4	↑	19/09/2023	01/05/2026	
4	5753	Executive Director of Nursing	Children & Families Care Group	Senior Nurse Community Children's Nursing Services	Workforce / Organisational Development / Staffing / Competence	Risk to patient safety and children's access to education due to inadequate Special School Nurse Provision	IF: The Health offer towards the current Special Schools Nursing Model is not increased; Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools and education not supporting the use of education staff in delivering delegable tasks to children with health needs Then the Community Children's Nursing (CCN) Service is unable to meet their obligations across the five special schools in CTM and be unable to fulfil their obligation to Rhonda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA Resulting in: Disatisfaction and fractured relationships within RCT and Merthyr LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), children unable to attend school, impact on parents who are having to attend schools to deliver care, impact on Consultant Led clinics, inability of special school nurse to deliver on School Nursing Framework in Wales part 2 - Nursing in Special Schools and Healthy Child Wales (HCW) part 2, lack of access to continual professional development and peer support for the nurses based in Special Schools, continued issues with recruitment and retention of nursing staff into Special Schools	Mitigation - reviewing SLA at pace with LA, high level meetings with EDON, Nursing Director and Directors of education, and supporting staff, sharing risk across SSN schools. During periods of absence or vacancies, access to a school nurse will not be available in person 5 days per week. However, telephone advice and support will be available. These control measures do not meet expectations of Local Authority. Reviewed 19/2/25 due to lack of progress Meetings have been held between Directors of education and Director and Executive Nurse. SBAR has been escalated to Care Group OMB but needs to be escalated to HB OMB (19/02/2025) Engagement between senior nurse and head teachers and support for special school nurses has been given. Community nursing supporting gaps. Service director has asked to meet with education around SLA in January 2026 to agree way forward .	April 2026: The Special School Nursing risk has been reviewed following receipt of national guidance on modernising the school nursing model and improved engagement with education partners. Progress has been made in stabilising the service and clarifying expectations with special schools. An updated SLA with local education authorities is in development, with further assurance anticipated by the end of April. Subject to clinical confirmation, the risk score is expected to reduce from 20 to approximately 15–16, with further reduction dependent on formal SLA agreement and sustained implementation. Coltins, Miss Lucy - Head of Nursing CYW February 2026: Meeting being arranged for 11th March 2026 - invite to be sent SLA to be redrafted	20	C4 x L5	8	↔	16/04/2024	31/03/2026	
5	5821	Executive Director of Strategy and Transformation	Strategy and Transformation	Assistant Director of Transformation	Service / Business Interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	IF: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Control Measures Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GPs have been informed of the challenges currently experienced with immunology provision and delays can be expected	April 2026: Working group continues to meet to look at options. Currently testing to see if any GPs would be interested in developing a special interest as part of service delivery (subject to funding and likely to be paediatric rather than adults). Waiting list is being reviewed to identify any individuals that need review in peri op allergy service as Cardiff and Vale are now accepting referrals via IPR. Discussion on future options to be tabled for next discussion December 2025: Internal working group now meeting monthly and will produce paper to go for executive discussion. New outpatient capacity has been secured to bring adult over 52 weeks waiting list down to zero by 31/3/26 but there remains an issue with follow up appointments. Options are being considered for this. Work on paediatrics continues around gaps in service. Awaiting communications from Welsh Government regarding service development across Wales.	20	C4 x L5	4	↔	11/07/2024	30/04/2026	
6	6052	COO	Facilities Directorate	Assistant Director OSS (Facilities)	Statutory Duty, Regulation, Mandatory Requirements	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultraarks)	Existing fleet of beverage trolleys in CTM UHB require a replacement programme (as per regen trolleys). The current fleet (apart from the Seven assets) are 10 plus years old and maximum life is 10 years old if maintained. The Ultraarks are used for patient breakfast and beverages and then on used on average 5 times a day for beverages so are heavy use. The current models at all district general and community sites are not able to be put on maintenance contracts due to age, hence non-compliant. Several sites are now running with one per two/three wards and the service level is one per ward. VCC have 1 beverage trolley that is non-repairable. If: The patient beverage trolley fleet is not maintained/replaced Then: Patients are unable to be fed breakfast and beverages. This is an essential part of the patient care. Resulting in: Patient hydration and nutrition non-compliance	That could be repeated in 25/26 (subject to funding). Funding discussions ongoing. Welsh Government have commented there is a repair programme in place at each site when equipment is broken. However the beverage trolleys are too old to put on maintenance contracts. Replacement is the only alternative. There is not enough budget in revenue to purchase singularly and the beverage trolleys are manufactured to order (cost decreases with volume). An investment bid has been included in the Facilities MTP (submitted March 2025) An agreed replacement process has been approved, the risk will remain high until such time we have sufficient spares from replaced carts to maintain the existing equipment. Funding for 2 trolleys has been secured 4 additional trolleys are being purchased with a further 12 trolleys to be purchased in 2026/27. Review in 3 months to enable purchased trolleys to be operational and review risk rating (CH 16/03/26) This risk is being mitigated through the purchase of replacement trolleys as funding is identified. The replaced trolleys will be used for spare parts to further extend the life of the existing fleet pending future purchases. The risk will be reduced when the recently purchased trolleys are delivered - estimated as the end of May. Review date amended (CH 5/5/26)	May 2026: 16 trolleys have been procured via revenue they are not due in until end of May from the nominated supplier. Therefore there is currently no change to the score. The service has concerns on the current condition of the trolleys from a food safety, health and safety and IPC perspective (see pictures attached). There is also the customer experience – it is not visually appealing to encourage patients to wait to eat/drink from the trolleys (see pictures attached)). We received another OX10 on 20/04/2026 10:55:56 in relation to a staff trying to move an Ultraark which would not move due to wheels. The procurement status is that the kit is unable to go via Capital due to value and there is not the level of funding in patient feeding budgets to support this level (circa 360k) across the Health Board. Estates have been asked to prepare condition reports on the existing fleet. April 2026: 16 trolleys purchased but as yet no date for delivery. This risk will be reviewed when trolleys are fully operational	20	C4 x L5	8	↔	15/01/2025	05/05/2026	
7	6179	Executive Director of Public Health	Public Health	Assistant Director Public Health	Quality / Complaints / Assurance / Patient Outcomes	High and increasing prevalence of overweight and obesity in children and adults.	IF there is insufficient preventative activity to reduce rates of overweight and obesity Then rates of obesity will remain high in CTM. Resulting in increased activity/acuity/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: -Healthy environments -Healthy settings -Healthy people -Bidership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	April 2026: This risk was reviewed by the LPHIT Strategic group on 31st March and also on 21st April Although a positive update was received that the business case to continue the PPYN service has been approved via the MTP, as there still remains a significant gap in funding to fully support level 1 and 3 services for children, the risk remains the same. The HW roadmap is awaited and will be submitted to board for approval in early 2026	20	C4 x L5	9	↔	06/05/2025	29/04/2026		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan		Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
1	3826	Chief Operating Officer	Unscheduled Care Group	Deputy Clinical Service Group Manager - Acute Medicine and ED	Safety & Well-being - Patients / Staff / Public	Emergency Department Overcrowding	Resulting In: Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of major cases, ambulance arrivals and self presenters. Filling the last reus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases.	April 2026 - Directorate working closely with NHS P&I Team to establish UEC Plans and 12-Hour Action Plan to help improve flow and ease overcrowding in the ED department. Increased number of nursing staff being rostered over and above establishment. Additional respite mattresses have been purchased with associated equipment. Safe to start meeting twice daily to escalate and make plans for deescalation Updated March 21 All patients are triaged, assessed and treatment started while waiting to offload. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST 7 bed call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. - Twice weekly meetings with BDCG colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. - Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21. Note clinical lead position has been removed in re-structuring 2024. Ongoing significant concern re ED crowding and barriers to flow at discharge / community level. Continued highlighting to senior leadership and exec team of patient safety concerns and risks to patients and staff. Continued significant ambulance offload delays impacting on community response times. Ongoing crowding in ED as above. Continued risk of harm to patients and staff.	April 2026 - CTM was the best performing HB in Wales for 45 Minute Ambulance Handover with the Royal Glamorgan top in Wales at 92%. Whilst improving 12-hour ED performance continues to be a priority, an increase from 1871 in February to 2373 in March was recorded. Sustained system pressure continues to impact on operational performance. To address this: ED 12 Hour Action Plan completed - ready for wider CG/HB input and sign off. CTM Safe Transfer of Patient Policy requires sign off alongside action plan Action Plan to review long waits to be seen in ED in development within the Directorate. Unscheduled Care SMT to attend National Urgent and Emergency Care summit 27th April 2026. Urgent Emergency Care Action Plan has been developed in collaboration with NHS Wales Performance and Improvement Team utilising recommendations from key documents such as: G&PFT recommendations SQC Review Ambulance Patient Handover Guidance ED Quality Statement NAG Report (April 2026)	15	C4 x L5	12	↔	24/09/2019	07/05/2026	
2	6294	Chief Operating Officer	Planned Care Group	Directorate Manager for General Surgery and Gastrointestinal Services	Workforce / Organisational Development / Staffing / Competence	Insufficient Consultant Workforce - Endoscopy/ Gastroenterology	Fragility of Consultant workforce, notably on the POW site. Inability to appoint Consultants to replace Consultants that leave. Only two substantive Consultants at POW currently. If the Consultant posts cannot be filled, it will impact on Service Delivery and affect our ability to deliver both diagnostics and clinical services to patients. If the Consultants that are currently in post were no longer in post, this would significantly affect our ability to deliver both diagnostics and clinical services to patients. Furthermore it would impact on ability to support inpatient services at POW. Fragility of the Consultant workforce is contributing to potential gaps within the on call bleed rota, with little redundancy. This could result in a situation in which the on call bleed rota could not be covered.	No possible mitigation currently. Posts remain out to advert. Locum in post for one of the vacancies however he is due to leave in the near future due to other obligations There has been no interest from agencies. Update December 2025: No possible mitigation. Posts remain out to advert. Locum has now left post as of early December (this was earlier than expected, with significant disruption to Endoscopy). Extremely fragile staffing position in POWH. There has been no interest from agencies. 15.4.26 - Locum has since left, vacancy out continuously to advert and current Consultants raising issues with their health	April 2026: Recruitment advert now live, with ongoing development of plans to sustain and support service provision. Currently working through timeline.	20	C4 x L5	9	↑	07/08/2025	01/05/2026	
3	6318	Chief Operating Officer	Mental Health Officer	Directorate Manager - CAMHS and Specialist Services (Mental Health and Learning Disabilities) Care Group	Safety & Well-being - Patients / Staff / Public	Tier 3 SHED (Severe and High Impact Eating Disorders) Team Service Delivery	If: The level of vacancies continues in the C+V UHB service for high risk eating disorder patients (SHED) Then: The service will be unable to fully deliver assessment and treatment interventions for CTM UHB residents. Resulting in: Patient safety concerns for a number of high risk patients (CTM UHB patients - 16) escalating concerns following meetings with CMHT and Dietetic colleagues. concerns relating to lack of engagement by SHED with CMHTS in relation to discharge and lack of timely assessment service. Briefing note developed and forwarded to director of nursing and care group director 24/10/25	There are regular meetings with the SHED team to discuss the caseload. These controls are fragile and could include increased oversight for named pts by CTM CMHT This has been escalated to the MHLD SLT on 29/08/2025, following dialogue with CMHT colleagues increasing concern about communication between SHED and local CMHTS together with lack of timely assessment services and lack of mitigating actions by CVUHB. •The recent appointment of a band 7 practitioner within CTMUHB to help with coordination - Hannah Pritchard would be starting in this role on 15th December for a fixed term until 31st March 2026. The costs for this post would be recharged to CVUHB. •The establishment of fortnightly SHED drop in clinics for adult CMHT staff in CTMUHB. Tracey Larson had helpfully been involved in establishing these regular meetings and initial feedback was positive. •CTMUHB adult CMHT services will continue to provide physical health monitoring arrangements for their patients who have been referred to SHED. •The Consultant lead for SHED, Isabella had agreed to schedule some training sessions for CTMUHB CMHT staff which have been undertaken.	April 2026: The Care Group has met with CVUHB colleagues and implemented a series of mitigating actions including, a temporary appointment of a nurse practitioner, drop-in clinics, physical health monitoring and staff training. April 2026: Meetings scheduled with CAVUHB on 13th and 14th April to discuss medical cover and the 36 degree report action plan. February 2026: The Care Group has met with CVUHB colleagues and implemented a series of mitigating actions including, a temporary appointment of a nurse practitioner, drop-in clinics, physical health monitoring and staff training.	16	C4 x L4	6	↔	29/08/2025	01/05/2026	
4	6498 NEW RISK	Chief Operating Officer	Diagnostics, Therapies, Pharmacy & Specialties Care Group	Care Group Service Director - Diagnostics, Therapies, Pharmacy and Sciences & Children and Family	Safety & Well-being - Patients / Staff / Public	Lack of Dynamic Mattress Systems in UHB due to over 100 units being condemned and not replaced due to cost.	If: there are insufficient dynamic mattresses available, then treatment of patients with pressure ulcers or at risk of developing pressure ulcers will be compromised. Resulting in pressure ulcers developing, possible tissue damage, increased risk of infection, possible increased length of stay and long term health effects, RIDDOOR reporting event and possible litigation for avoidable pressure ulcer damage.	April 2026: COO reviewed 30.4.26, content to agree escalation but would like a clear plan and actions presented to address risk	16	C4 x L4	10c	N/A (new risk)	11/02/2026	01/05/2026		
5	6429 NEWLY ESCALATED TO ORR	Executive Director of Therapies and Health Sciences	Diagnostics, Therapies, Pharmacy & Specialties Care Group	Physiotherapy Manager for Rehabilitation	Safety & Well-being - Patients / Staff / Public	Physiotherapy MBK Self Referral Form	The Physiotherapy Self Referral Form for patients to have open access to physiotherapy was put in place in 2019. At the time Primary Care referrals were lower, and physiotherapy service infrastructure supported the quick triage of patients (within 48-72 hours). It has been highlighted by staff over the past 2-3 years that the self referral form is not fit for purpose, with instances of patients waiting for triage, who should have been seeking urgent medical care. As the Demand for Primary Care MSK Physio self referral has increased beyond triage capacity, we are unable to support the ongoing appropriate governance to ensure the safety of this vulnerable group - this could result in potential serious harm	There have been several attempts to amend the referral form to include branching logic within the question format, to allow the appropriate safety-netting of patients self referring. Healthboard decisions were made to block the use of MS Forms for this purpose over Information Governance concerns. Further options were explored this year, and the form has been developed. However this is unable to progress due to software issues.	April 2026: The risk was reviewed by the COO following meetings on 24 and 30 April 2026. Approval was given to progress with MS Forms to support physiotherapy self referral, implementation is awaiting action by the Digital team. Clinical incidents continue as the process has not yet changed, therefore the risk score remains unchanged. Further actions include commissioning content via the Keeping Me Well website, consideration of short term measures to address backlog pressures, and escalation to the Primary Care Transformation Board. The risk will be reviewed within one month, or earlier if the self referral system is implemented.	16	C4 x L4	1	↑	24/11/2025	06/05/2026	
6	4417	COO	Depty COO	Assistant Director of Operations MH and LD	Safety & Well-being - Patients / Staff / Public	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issued an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. If: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. 29/09/2022 - RTE ILG has recently undertaken a review of all their clinical areas and assessed the risks from patients absconding. An action plan is being developed.	May 2026: COO review 30.4.26, requesting further clarity on progress and actions to date. Business Manager following up with colleagues further. February 2026: The HB are in the process of reviewing incidents reported in the last 6 months, compared to those reported 2 years prior. This will enable the HB to analyse the impact against the original assessment, and review the risk rating.	16	C4 x L4	8	↔	30/09/2020	01/05/2026	
7	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Senior Quality & Safety Manager - Unscheduled Care	Safety & Well-being - Patients / Staff / Public	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care & rehab)	IF: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM THEN: avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care RESULTING IN: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased care burden when discharged to the community. Additionally, the performance targets to monitor improvement of the stroke prevention and care service will be adversely affected, leading to significant challenges for the health board to include noncompliance with Quality Improvement Measures (QIMs).	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • TOR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	April 2026: Stroke Improvement Programme continuing • 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/ICU • Daily and weekly performance reporting. Stroke Performance Summary • Stroke performance continues to improve with daily focused huddles ongoing. Next Steps • Roll out improvement programme to PCH and POWH • Engagement with all stakeholders • Review of baseline data	16	C4 x L4	12	↔	11/05/2021	01/05/2026	
8	4671 Confidential Risk	Director of Digital	Digital	Head of Datacentres and Cloud, Digital & Data	Service / Business Interruption	NHS Computer Network Infrastructure unable to meet demand	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.				16	C4 x L4	9	↔	03/05/2021	05/07/2026
9	4685	Director of Corporate Governance & Board Secretary	Governance	Head of Quality Assurance and Compliance	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process	If: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. Sharepoint Intranet page acts as document library. A risk assessment approach to the prioritisation of reviewing policies and procedures is available to support functions. A suite of support templates along with the policy is published on the Health Board. Policies and procedures are available centrally on SharePoint although many have passed their 3 year review point. Step by Step guides for clinical and non clinical written control documents issued.	April 2026: The new SharePoint site for Non-Clinical Policies is now live. Uploading and archiving access is currently restricted to the Quality Assurance and Compliance team, enabling tight control of approvals and version management. A live master register and shared drive are maintained as a fail safe for all current and archived documents, although this requires significant manual administration. Work is ongoing with Directorates to confirm an accurate baseline of existing policies. Once this is complete, the project will move to the next phase, enabling greater automation and background archiving. Clinical policies remain under development by the clinical team and are not yet ready to migrate to the new SharePoint site.	16	C4 x L4	8	↔	26/10/2021	01/05/2026	
10	6451 NEW ESCALATION		Planned Care Group	Clinical Service Group Manager, Surgery & ACCT, POW	Safety & Well-being - Patients / Staff / Public	Orthopaedic pathway	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.				15	C5 x L3	4	↑	15/12/2025	01/05/2026
11	5045	Chief Operating Officer	Unscheduled Care Group	Directorate Manager Specialty Unscheduled Care	Safety & Well-being - Patients / Staff / Public	Access to Neurology Inpatient and Outpatient Services for CTM Residents	If: there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of CTM; THEN: existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue; RESULTING IN: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients. The waiting lists for RGH and PCH are currently reported by C&VUHB and POW by S&UHB but there has been a request for CTM to take over the RGH and PCH reporting. An SB&H has been drafted and tabled at OMB on 19/02/25 which identifies the resources required to take the waiting over in a reasonable position.	Current Control Measures: An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint 4.3 consultant neurologists within CTM as part of the Neurology Liaison Plan. Mitigating Action Being Taken: Significant concerns have been raised across CTM and the planning team has engaged with key stakeholders to develop a robust commissioning plan. Any development of the service will require investment. A CTM liaison service model paper has been produced and forms part of the USC Care Group IMTP plan for 2025/26. Provision of neurology services to CTM residents has been highlighted as a key risk in the Medicine CSG IMTP in previous years. Approval has been given to recruit to 2x Consultant Neurologists; one post was successfully recruited with a planned start date of April 26. The RGH locum has been extended to end of Dec 26. Once the new appointee starts the risk can be reviewed again and potentially be adjusted to reflect the additional capacity within the neurology service for CTM.	April 2026: • The care group have successfully appointed a Consultant Neurologist (currently working in a neighbouring health board), with a planned start date of 6th May 2026; options for filling the remaining Consultant position are being reviewed in discussion with the new appointment. • The reporting of the neurology waiting list in PCH & RGH will be taken over by CTM on 1st April 2026. The end of March position was 82 patients waiting over 52 weeks for 1st OPA. • Conversations are ongoing with C&V regarding delivery of the commissioned capacity within the Neurology LIA. The risk score will be reviewed following consultant commencing appointment in May.	16	C4 x L4	8	↔	09/03/2022	30/04/2026	
12	5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy & Specialties Care Group	Interim Head of Dietetics	Quality / Complaints / Assurance / Patient Outcomes	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	If there is no children and young persons weight management service... Then the Health Board will be unable to support children and young people to manage their overweight and obesity... Resulting in non compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PIPYN continues to be delivered in Merthyr via PHW budget and pan HB roll out due from April 26 onwards, this will be a phased approach. 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3) Business case developed submitted and submitted for IMTP consideration. BC includes phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Budget agreed for Level 1 PIPYN 26 and onwards. L3 service submitted again as part of this cycle of IMTP. Finance dependant controls: 1) Set up PIPYN and expand to ages 3-10 (from 3-7) from March 26 onwards.	Feb 2026: Risk reviewed. No change. Budget confirmed for HB role out of L1 PIPYN 3-10 from March 26 onwards. L3 still significant gap and put forward again as part of IMTP planning process.	16	C4 x L4	8	↔	13/10/2023	10/04/2026	
13	5761	Executive Medical Director	Medical Directorate	Medical Directorate Manager, YMH	Safety & Well-being - Patients / Staff / Public	Cross Health Board Data Sharing	If... Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then... Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in... Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	Update May 2026 - Same update as Oct 2025. It is raised at the relevant forums (All Wales Medical Director Meetings) regularly.	May 2026: Risk reviewed; no change	16	C4 x L4	8	↔	26/04/2024	05/05/2026	
14	5877	Chief Operating Officer	Primary and Community Care Group	Development Manager - Out of Hours	Service / Business Interruption	NEW WORKER CONTRACT FOR OUT OF HOURS GPs - WTR Risk	If the new worker contract for out of hours GPs is implemented (ambition is for Dec 2025) it will require the application of Working Time Regulations. THEN there will be a significant impact on shift fill rates. RESULTING in the Health Boards ability to fill shifts across the whole roster having a negative impact on both WAST and ED departments.	CTM to consider a local activity threshold to avoid local debarment, unnecessary prolonged length of stay, patient decondition and adverse outcomes to enable an immediate transfer for definitive care.	April 2026- waiting NHS Employers and BMA to conclude their negotiations. Regular oversight of the GP rota, liaising with pool for additional shifts where possible.	16	C4 x L4	8	↔	07/08/2024	01/05/2026	
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	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan		Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
1	6232	Executive Director of Nursing	Executive Nurse Directorate	Deputy Executive Director of Nursing		Stability of the Legal Services Function	If: the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. Then: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. Resulting in: an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Current Control Measures: Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations. Mitigating Action Plan: Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: The Organisational Change Process is near completion, with feedback from team members now catalogued. The benchmarking exercise is complete, and the senior leadership team is reviewing the structure against known demand. Additional workforce in place through recruitment and redeployment to support immediate service needs and overall recovery. September 2025: The recovery programme continues to make progress in standardising and stabilising processes and work plans. The OCP remains delayed as a result of the prioritisation of work and gaps in senior leadership owing to non-work-related absence. April 2026: The OCP is now complete and will be implemented on 5 May 2026. As part of the OCP, additional posts within the Legal Services Team have been approved, with recruitment underway to strengthen capacity and resilience. A new Lead for Legal Services has been recruited to the role. Recruitment of other members of the team is expected to be complete by 31 July 2026. 30/04/26-Executive Director Nursing, Midwifery & Patient Care Richard Hughes reviewed and approved.	April 2026: The risk to remain at its current level until above recruitment (RE: OCP) is concluded and the revised staffing arrangements for the Legal Team are fully in place. Progress will continue to be monitored through routine governance and risk reporting.							
21	6231	Executive Director of Nursing	Executive Nurse Directorate	Deputy Executive Director of Nursing	Statutory Duty, Regulation, Mandatory Requirements	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arr) Regulations	If: the Health Board fails to comply and proactively manage cases that qualify for consideration under NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Then: there will be a missed opportunity to deal with concerns under a single and consistent method for grading, investigating and to actively involve the person raising the concern in an open and engaged manner to put things right. Resulting in: Delays in improving patient safety and experience as a result of identifying how services may have improved as a result of concerns notified and dealt with under these arrangements. Early resolution of cases which provide an opportunity for closure for families and staff as well as effective and efficient learning to be implemented. Avoidable costs should a case proceed to litigation due to failure to comply proactively with the arrangements. Reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned		April 2026: The risk to remain at its current level until above recruitment (RE: OCP) is concluded and the revised staffing arrangements for the Legal Team are fully in place. Progress will continue to be monitored through routine governance and risk reporting.	15	C3 x L5	8	↔	03/07/2025	02/05/2026	
31	6280	Executive Medical Director	Executive Medical Directorate	Directorate Manager for General Surgery and Gastrointestinal Services	Safety & Well-being - Patients / Staff / Public	Suspension of the Regional Hepato-Pancreato-Biliary service model	If... the commissioning of this service is not prioritised as part of the regional commissioning arrangements Then... there will be no Regional service for Severe Acute Pancreatitis Resulting in... sub optimal care for this group of acutely unwell patients	Each case NOW has to be discussed on a case by case basis between neighbouring Health Board Medical Directors which will add delays to an already complex and time sensitive treatment pathway	April 2026: Risk reviewed, no change	16	C4 x L4	9	↔	06/08/2025	24/04/2026	
35	6397	Chief Operating Officer	Primary and Community Care Group	Development Manager - Out of Hours	Service / Business Interruption	RECRUITMENT - SHORTAGE OF GPs TO DELIVER URGENT PRIMARY CARE SERVICES	If the decision to have a 'hold' on the recruitment of GPs into GP DOH and Navigation Hub continues, of engagement and contractual status of Out of Hours GPs THEN there will be a continued reduction in shift fill rates, RESULTING in shifts remaining unfilled (specifically home visiting shifts) and this will lead to more patients (palliative and end of life) being conveyed into the Emergency departments.	Explore alternative engagement routes such as bank and salaried contracting although there are challenges as these do not offer flexible engagement for GPs who have permanent day time and other employment. There are GPs who wish to work GP DOHs and if the recruitment freeze was lifted we may be able to fill some of the shifts to off set the risk.	April 2026: No change with the risk, remains to be closely monitored by the care group. The Care group are reviewing the position to share an appropriate update and mitigation to executives.	16	C4 x L4	12	↔	31/10/2025	01/05/2026	
36	6424	Director of Digital Directorate	Digital Directorate	Information Governance Manager	Statutory Duty, Regulation, Mandatory Requirements	Mental Health Subject Access Requests (SARs) (GIG15)	If... SARs in the Mental Health Team are not processed efficiently due to lack of staff and resources, THEN... we may not be compliant with the law, RESULTING IN... enforcement action from the regulator (ICO), plus increased complaints from requesters and affected parties, adverse press and loss of faith in the organisation	All relevant Exec leads and senior managers have been made aware of the issues faced by the Mental Health Admin Team and the backlog of requests due to staff shortages. The SAR process is in place as it has been for years. Extra recruitment is needed to ensure there are enough staff to process the requests and handle the redaction/checking process.		16	C4 x L4	16	↔	20/11/2025	01/05/2026	
37	6426	Director of Digital Directorate	Digital Directorate	Information Governance Manager	Statutory Duty, Regulation, Mandatory Requirements	IG17 Access to e-whiteboards	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			16	C4 x L4	16	↔	20/11/2025	01/05/2026	
38	6475 HEW	COO and Executive Director of Nursing	Children & Families Care Group	Head of Nursing CYP	Service / Business Interruption	Industrial action of Health Visiting staff members of UNITE Union	If there is sustained industrial action across a long period of time THEN there will be sustained disruption to the expected service offer for the Healthy Child Wales Programme, Flying Start programme and CWTCT programme RESULTING IN reduced health visiting contacts, breach of ALN requirements, reduced opportunity for robust and accurate health needs assessment, reduced data submission to Welsh Government and Local Authority. During Industrial Action (IA), the absence of provision will create immediate risks for: • newborn babies and mothers in the first 42 days post-birth. The first 1,000 days from conception to a child's second birthday represent a critical window for early intervention. Optimal nutrition, nurturing and responsive caregiving, and a safe environment during this period are essential to preventing lifelong and potentially irreversible health, cognitive, and developmental inequalities. Health visiting services play a vital role during this time. • children associated universal reviews, as well as targeted support to meet the	1. Caseload planning in areas where there are staff members taking industrial action 2. Robust risk assessment during caseload planning to ensure those identified as most vulnerable are in receipt of health visiting support 3. Maximising skill mix workforce to support essential services 4. Students without a PSPA will be supported to complete their training by CPE's 5. Informed WG and LA of the industrial action and the impact on data submission 6. Regular close monitoring of the staffing and service delivery plan by the Deputy Senior Nurses to ensure caseload planning reflects the current service position and actions required to maximise service reach to families and children 7. Regular and close monitoring of empty caseloads, caseload numbers and complexity. 8. Allocation of vulnerable families to staff taking industrial action, this will support the universal delivery of the service to non striking staff. 9. Commenced weekly communications updates to all Health Visiting staff (and wider CTM workforce) wef 23rd April to increase transparency and accuracy of information	April 2026: Risk reviewed; no change Feb 2026: The following actions were confirmed at OMB: • high risk families are prioritised • Mitigation plans focus specifically on families and children with the highest level of need or risk. • Daily "strike action call" runs every morning from 8:30am, starting Monday 23 February • Led by senior leaders • Reviews staffing attendance and reallocates available capacity • Additional afternoon calls may be stood up if required • Communications • Formal communications to Local Authorities are being issued • Wider internal and external comms are supported corporately • FAQs are being used to clarify staff responsibilities and expectation	16	C4 x L4	12	N/A (new risk)	21/01/2026	05/05/2026	
39	6604 HEW	Director of Digital Directorate	Digital Directorate	Information Governance Officer	Statutory Duty, Regulation, Mandatory Requirements	IG 18 Misdirected clinical correspondence - NHS to GP	If.... system errors continue to send clinical correspondence to the wrong GP systems due to patient demographic misalignment, Then..... there is potential for clinical risk for the patients due to incorrect or missing data Resulting in.... Potential non-compliance with the Data Protection Act 2018. Significant manual reprocessing by NHS SP, including RPA and scanning intervention. Delayed communication leading to inefficiencies and increased demand on GP and secondary care services. Systemic duplication of effort across Health Boards. Material Risk to Reputation	CTM UHB: • detailed analysis of misdirection causes • reinforcement of demographic update responsibilities for PAS users • API onboarding to enable real-time demographic synchronisation • collaboration with DHCW to mitigate legacy demographic risks • implementation of real-time API consumption of WDS/ENR/NPL demographic updates • reduction of reliance on warehouse refresh cycles • event-driven demographic synchronisation • investigation and resolution of Myddin PAS correspondence routing issue • reconciliation of historic demographic records	May 2026: New Risk Opened following discussion by the IG Group	16	C4 x L4	6	N/A (new risk)	01/05/2026	01/05/2026	
39	6629	Executive Medical Director	Executive Medical Directorate	Medical directorate manager	Safety & Well-being - Patients / Staff / Public	GNC/HEIW Conditions on PCH Emergency Department	If the recommendations from the GNC and HEIW on improving the issues with PCH's Emergency Department training are not addressed, THEN further action will be taken, RESULTING IN further scrutiny from both the GNC and HEIW, a loss of trainee doctors and potential patient safety issue	Following the HEIW Targeted Visit to ED PCH 24/3/26, an action plan with dates has been developed by the PCH ED Clinical Lead, ED Liaison Team (CD and Directorate Manager) and the Unscheduled Care Group Actions address clinical supervision, training opportunities, rota sustainability, recruitment, leadership engagement and optimising patient flow. Progress is being monitored through established governance arrangements with ongoing engagement with HEIW.	May 2026: New Risk Opened	16	C4 x L4	12	N/A (new risk)	12/05/2026	13/05/2026	
39	6605	Director of Digital Directorate	Digital Directorate	Information Governance Officer	Statutory Duty, Regulation, Mandatory Requirements	IG20 Legal compliance with access to records requests	If.... the health board does not improve the compliance for access to medical records requests, Then..... there will be excessive complaints from patients, Resulting in.... complaints to the regulator, potential regulatory action against the health board including investigations or fines. Potential for claims for late records impacting on	Medical Records Team are informing patients that there is an 8 week backlog with the requests. Issues with backlog is due to amount of requests coming in, not enough staff dedicated to access requests only to assist with the work.	May 2026: New Risk Opened following discussion by the IG Group	16	C4 x L4	16	N/A (new risk)	01/05/2026	01/05/2026	
39	6337	COO and Director of Digital Directorate	Mental Health and Learning Disabilities Care Group	Service Director, Mental Health and Learning Disabilities	Safety & Well-being - Patients / Staff / Public	Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS	If: Mental Health Services do not have a single integrated clinical information system that captures all patient details, Then: Clinical staff may make a decision based on limited patient information available that could cause harm. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. To ensure teams are able to access patient information in all localities, a matrix has been developed that informs teams of who they should contact to obtain current information from any of the multiple systems being used. This was introduced to mitigate risk to meet the HW recommendation. 2. Process in place for clinical teams to access information via local authority and health board teams. 3. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 4. Metherby and Cynon and Bridgend CGS leads have confirmed that WCCIS is on their CSG risk register and their updates have been provided within this section, therefore aligned. 5. WCCIS Programme Board establishment for CTM was finalised by the 30th June 2021. Metherby and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Group is established and aligned to this Programme board Programme and is now established. 6. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 7. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 06.09.2023 8. New WCCIS Programme Board and Operational Group established for CTM. The Digital Director and Deputy COO are SROs for the Programme. 9. Project manager has been recruited. This role is leading on the PID and will support the wider project plan. 10. Business Case refresh is underway with a view to present to Board for approval. 11. Workforce capacity impacts on programme deliverables and proposal has been submitted to HEIW for support. 12. Director of Digital, CTMUHB has undertaken a review confirming that WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. 13. WCCIS will become non functional in 2025 therefore, its name has now been removed from the Programme and replaced with Connected Care - HEIW use acronym as All Wales digital system. This is currently in progress (6.2.2024). Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored DHCW annual coding quality audit. 2020/21 funding addressed backlog and proposals made to extend this into 2021/22. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme Information and Technical Standards Clinical audit Gaps in controls Workforce skills & development programme Insufficient resource available to address backlog Digital solutions not yet using snomed-CT/ structurally coded data	April 2026: Risk Reviewed no change March 2026 newsletter attached The Recommendation Report is still with WG for approval therefore the contract award is delayed. Feb 2026: The procurement evaluation has been completed and the Recommendation Report has been drafted and escalated to WG for approval. The contract award is now imminent. Recruitment for key programme roles such as Project Manager, Programme Manager and Business Analyst are complete. It is anticipated that the contract will start in April 2026 and the transition to the system can begin. Griffiths, Mr Lloyd: Head of Nursing - Mental Health (Bridgend LCU) 02/02/2026 10:21:13 Risk reviewed no change, see attached Jan 26 Newsletter for progress. The post of MH&LD Nursing Information Officer has been appointed to	15	C5 x L3	6	↔	07/11/2018	01/05/2026	
39	6672	Director of Digital Directorate	Digital Directorate	Head of Server Management	Business objectives or Projects	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards	If: The Health Board is not able to record information accurately and reliably & does not address the 25000 backlog of uncoded FCS Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored DHCW annual coding quality audit. 2020/21 funding addressed backlog and proposals made to extend this into 2021/22. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme Information and Technical Standards Clinical audit Gaps in controls Workforce skills & development programme Insufficient resource available to address backlog Digital solutions not yet using snomed-CT/ structurally coded data	May 2026: Our strategic partners Teklogy have now started an activity to map Digital and Data activities to meet IMTP initiatives, this work is currently underway and will be reporting to the CTMUHB Board in September.	15	C3 x L5	9	↔	05/06/2021	05/05/2026	
39	6691	Chief Operating Officer	Mental Health and Learning Disabilities Care Group	Service Director, Mental Health and Learning Disabilities	Safety & Well-being - Patients / Staff / Public	The Provision of Safe and Appropriate Estate for Inpatient MH Care	If: Mental health inpatient environments fall short of the expected design and standards, Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting In : Compromised safety of patients , potential avoidable harm , compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation - Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 - 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023. The inpatient review and remodelling programme continues to progress, with Safe Wards interventions and enhanced therapeutic input positively received by staff, patients, and external reviewers. The inpatient renaming of the wards to align with the new model remains paused pending resolution of governance and safety compliance requirements	March 2026: Risk title changed April 2026: The inpatient mental health service review and remodelling programme continues under MHLD governance, with no change to current controls or risk scoring.	15	C3 x L5	6	↔	15/06/2021	01/05/2026	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan		Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
1	5040	Director of Digital	Digital Directorate	Head of Server Management	Business objectives or Projects	DHCW Interdependencies	IF: The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are	Update 06/03/2024: Tactical controls: DHCW digital programme seeks to map out programmes and key phases for delivery over the forthcoming 24 months. CEOs group and Digital Directors peer group provide steer to the programme at strategic level. Majority of the programme is directly funded by WG into DHCW Gaps in controls: No overall governance structure in place that enables Health Boards to prioritise digital developments and adequately assure their delivery and value generation. DHCW operate autonomously to meet their own objectives and priorities as determined by their board, rather than by the provider organisations that they are there to support and enable. Expenditure priorities for digital are often taken in isolation of wider NHS prioritisation process Previous Update: A Myrdin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their fulfilment has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months	May 2026: Following a delay the feeds related to test results and administrative data are now successfully tested and deployed enabling the ePMA programme to progress to an early adopter phase.	15	C3 x L5	9	↔	07/02/2022	05/05/2026	
36	6232	Executive Director of Nursing	Nursing Directorate	Deputy Executive Director of Nursing	Safety & Well-being - Patients / Staff / Public	Stability of the Legal Services Function	IF: the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. Then: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. Resulting in: an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Current Control Measures: Review initiated to understand CTMLHB's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations. Mitigating Action Plan: Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: The Organisational Change Process is near completion, with feedback from team members now catalogued. The benchmarking exercise is complete, and the senior leadership team is reviewing the structure against known demand. Additional workforce in place through recruitment and redeployment to support immediate service needs and overall recovery. September 2025: The recovery programme continues to make progress in standardising and stabilising processes and work plans. The OCP remains delayed as a result of the prioritisation of work and gaps in senior leadership owing to non-work-related absence. April 2026: The OCP is now complete and will be implemented on 5 May 2026. As part of the OCP, additional posts within the Legal Services Team have been approved, with recruitment underway to strengthen capacity and resilience. A new Lead for Legal Services has been recruited to the role. Recruitment of other members of the team is expected to be complete by 31 July 2026.	April 2026: The risk to remain at its current level until above recruitment (RE: OCP) is concluded and the revised staffing arrangements for the Legal Team are fully in place. Progress will continue to be monitored through routine governance and risk reporting.	15	C3 x L5	6	↔	03/07/2025	02/05/2026	
37	5820	Executive Director of Public Health	Public Health Directorate	Assistant Director Public Health	Safety & Well-being - Patients / Staff / Public	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding	IF as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. THEN there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. RESULTING in avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Control Measures: Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps Action Plan: A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation. Update Feb 2025 This risk has been reviewed by the LPHT Strategic Group meeting on Tues 11th Feb 2025. As the uplift in HP funding for 25/26 still does not bring parity to the funding across Wales and is insufficient to deliver the HP strategic plan, there remains a funding gap. Work is ongoing to establish the impact of the gap and the risk consequence score will be updated accordingly as this work completes.	April 2026: This risk was reviewed in the LPHT strategic group meeting on 31st March and 21st April. The uplift in HP funding for 25/26 still does not bring parity to the funding across Wales and is insufficient to deliver the HP strategic plan, there remains a funding gap. A submission to Welsh Government was made in December 2025 highlighting the remaining funding gap and areas this is impacting. Therefore the risk is to remain unchanged and for review upon confirmation of the funding allocation for 26/27	12	C4 x L3	8	↔	10/07/2024	29/04/2026	
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Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
4973	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical Medical Cover within CTM Adult Mental Health Services	If: CTM Mental Health Service fails to implement adequate senior medical cover across adult in-patient and CMHT services Then: the Health Board's ability to provide quality care, a safe environment for patients and a good standard of training for junior doctors will be reduced and potentially compromise the safety of patients and staff Resulting in: sub-optimal care to patients, inability to discharge its legal duties under the Mental Health Act, due to insufficient numbers of suitably skilled and experienced Approved Clinicians. Junior doctor supervision will be reduced which may affect future recruitment, patient safety/experience compromised and staff well being will be poor.	Functional inpatient model in place with 3 consultants to cover. Redeployment out of the service and resignation has led to a further depleted workforce and cover will reduce to two consultants from January 2025 with additional middle grade support. Substantive jobs which are new posts are being developed and advertised Rehabilitation service is at a critically low level with urgent closure of one service needed. Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients. Difficulty recruiting to locum posts due to introduction of rate card and need to have Welsh AC approval. Permission to go out to non-DE has been given by Executive Medical Director and the necessary paperwork submitted. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements.	Substantive jobs which are new posts are being developed and advertised. Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025. Update December 2025 Risk reviewed, no change in the risk rating Due to ongoing respect and resolution related issues medical staffing in RGH has been further pressured in December, to mitigate this further control measures have been implemented. Two Interim Clinical Directors have been appointed. Dr Sally Bolt is also supporting the MHL D Care Group with sessions as Interim	Quality, Safety & Experience Committee Operational Delivery Committee	16		A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity. De-escalated and removed from the ORR in February 2026 following internal and external assurance and Care Group agreement.
1793	Chief Operating Officer	Improving Care	Safety & Well-being - Patients / Staff / Public	Lack of isolation facilities available-negative pressure rooms	If there are no negative pressure isolation facilities available then there will be no appropriate isolation facilities to manage patients with infections transmitted via the airborne route resulting in an increased risk of infection to other patients/ staff/visitors. There are 2 positive pressure ventilated lobby rooms available at PCH. Non compliant with national guidance/ WG expectation.	12/02/2026 - A/W for capital project team to start project 23/10/2025 - No changes, A/W for capital project team Update 19/05/2025 - Capital funding approved for 2 negative pressure rooms, one at RGH and other POW, risk will change once rooms are built Update 13/10/23 - Awaiting executive steer for placement of isolation rooms. Further information required to progress the discussions re. air cleaners. Update 14/04/24 - ongoing. Air purification unit SBAR to be presented in the upcoming IPCC meeting. Two air purification units have been trialled on a ward in POW. Update 24/06/24 - ongoing with regards to executive steer. T&F group set up to operationalize the air purification units. Update - HCID plan being developed with evaluation of capacity on A&E. POW has negative pressure room in A&E but it's location makes it unsafe to deal with HCID. PCH has negative pressure in A&E that can be used in those cases, this capacity does not exist in RGH A&E			12		Feb 2026: A/W for capital project team to start project. Score reduced with care group agreement
6229	Executive Nurse Director		Quality / Complaints / Assurance / Patient Outcomes	Timely development of, management and response to Learning From Event Reports (LFERs)	If: the Health Board fails to achieve timely completion of LFERs, respond promptly to the questions from the Welsh Risk Pool Learning Advisory Panel and provide assurance that learning has been implemented and shared. Then: there is a risk that improvement to quality and safety in healthcare aligned to learning which flows from case investigations, and the LFER (Learning From Event Report)s is not acted upon. Resulting in: reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned. Missed opportunities to improve patient care and safety following identification of areas for improvement. Financial penalties if the Welsh Risk Pool consider withholding reimbursements due to being dissatisfied with the learning and actions taken in a case.	April 2026: An Organisational Change Process across the Quality & Safety and Legal portfolio is now complete and will be implemented on 5 May 2026, strengthening capacity and clarity of accountability for incident investigation and learning processes. LFER Panels have now been established, with the Assistant Director of Quality & Safety chairing the panels from 23 April 2026. Liaison with Welsh Risk Pool continues on a weekly basis in relation to individual LFERs and the overall LFER position, providing ongoing oversight, assurance on timeliness, and support in addressing learning and actions required. 30/04/26-Executive Director Nursing, Midwifery & Patient Care Richard Hughes reviewed and approved.	May 2026: Initial score of 20 but with the immediate control measures in place and collaborative working with the Welsh Risk Pool the likelihood score has reduced to a 4.	Quality, Safety & Experience Committee	12		May 2026: Initial score of 20 but with the immediate control measures in place and collaborative working with the Welsh Risk Pool the likelihood score has reduced to a 4.
5576	Chief Operating Officer	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Palliative Medicine Staffing	If the Health Board are unable to recruit to the vacant Palliative Medicine Consultant post in Ysbyty Cwm Cynon (YCC) for Merthyr/Cynon. Then.. there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant complement. Resulting In.. a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status.	Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant. Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards	Update December 2025 The status for the SPC in YCC has been temporarily changed and removed as a result of implementation of admission criteria for end of life and complex care. This is an interim measure whilst the engagement process is complete around the long term future of the centre enabling the Care Group to commence a redesign of PEOC across the CTM wide footprint. This will be under review as the care group continue the process around the long term future of the centre.	Quality, Safety & Experience Committee Operational Delivery Committee	6		Risk score reduced following interim mitigation, including a temporary change to the YCC unit's designation and admission criteria, and alternative medical cover arrangements due to ongoing vacancies. These measures support current safety but are not a long-term solution. Consideration of the longer term, future service model is being considered by Board at its meeting on 21 May 2026.
2713	Chief Operating Officer	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Backlog of Reporting Radiology Examinations	IF there is consistent backlog of Radiology reports THEN there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes Resulting in impact on patient outcomes, delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place.	There is a significant backlog of reporting radiology examinations, with just over 10,000 X-rays pending. Current mitigation measures include rostering SPRs for extra reporting, outsourcing MSK cases, utilising training posts and the returning from parental leave. We are aiming to address the backlog in the more likely clinical urgent cases (chest x rays) by December as a priority. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee. Operational Delivery Committee	12		Improvements in radiology reporting have reduced the risk score from 16 to 12 and removed it from the ORR, however the position remains fragile as additional funding ends and is being actively monitored for potential re emergence.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
6234	Executive Director of Finance (Executive Lead for Estates)	Sustaining Our Future	Environmental / Estate / Infrastructure	National skills shortage in Estates Roles (Private sector salaries are impacting the CTMUHB's ability to be competitive in the recruitment market) resulting in recruitment and retention challenges throughout the department.	IF: A UK skills shortage coupled with the demand for labour in the private sector has caused recruitment and retention issues throughout the department, this has affected the ability to fill all WTE posts in a timely manner. THEN: The Health Board is at risk of being unable to complete all statutory, mandatory preventative maintenance tasks and help desk request. There is also a risk of being unable to support the delivery of capital projects, and departmental virement works. RESULTING IN: Insufficient staff to deliver the service, significant delays in replacement of staff. Increased revenue costs for overtime and contractor costs to supplement shortfalls. Inability to complete all Statutory and mandatory maintenance activities which could potentially breach legislation requirements Decrease in the maintenance performance figures. Failing estates affecting patient safety and service. Increased risk of claims. Reputational damage.	Performance levels monitored monthly at SMT and weekly at operational estate management level Overtime worked and contractors employed when key risks identified.	Vacancies reviewed at Senior Management team (SMT) meetings on a monthly basis. Age profile developed to manage succession planning. Update January 2026 Risk score reviewed and whilst recognising that there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability. Ongoing activity continues with the support of the People Directorate to explore routes to further promote and attract candidates to roles advertised particularly around the Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge. On the basis of this review the risk likelihood score has been reduced to a 3 and the risk de-escalated from the Organisational Risk Register. The risk will continue to be monitored by the Capital and Estates Directorate.	Operational Delivery Committee & Health, Safety & Fire Sub Committee	12 C4xL3 (Reduced from a 16)	9 (C3xL3)	Risk score reviewed and whilst recognising that there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability. Ongoing activity continues with the support of the People Directorate to explore routes to further promote and attract candidates to roles advertised particularly around the Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge. On the basis of this review the risk likelihood score has been reduced to a 3 and the risk de-escalated from the Organisational Risk Register. The risk will continue to be monitored by the Capital and Estates Directorate.
5417	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	If... Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. Then... the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in... 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 8 wks from assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update December 2025 Prince Charles Hospital additional theatre lists have commenced and now beginning to see the positive impact on the waiting list. October figures show 443 children waiting for assessment for GA. There are also 516 children waiting for a PMBA assessment which may increase the number of children requiring GA once assessed. Following a delayed start to the RGH lists they are now due to commence the 1st week of January, with all lists in place, this should start addressing the backlog issue, however winter pressures does lead to dental GA lists being cancelled so the decrease in numbers may take time to be seen. As a result of the progress being noted to lists, the care group have reviewed and reduced the score to a 12 but will keep under review to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).	Quality, Safety & Experience Committee Operational Delivery Committee	12 Decreased from a 20	9 (C3xL3)	As a result of the progress being noted to lists, the care group have reviewed and reduced the score to a 12 (Likelihood reduced to a 3) but will keep under review in the Care Group to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).
6228	Executive Director of Nursing	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Effective and efficient management of requests from the HM Coroner	If: the Health Board fails to effectively respond and manage requests from the HM Coroners Office in a timely manner. Then: there is a risk that the Health Board will breach 'The Coroners (Investigations) Regulations 2013' in failing to provide documentation on time and take required action in a timely manner to ensure lessons have been learned. Resulting in: poor experience and the wellbeing impact for the families and staff members involved in inquests, reputational impact of the Health Board in terms of trust and confidence in the service, an increase in the number of Regulation 28 / 29 reports on actions to prevent future deaths, an increase in potential enactment of the Coroners powers, including under Schedule 5 - "Power to require evidence to be given or produced".	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests.	Update January 2026 The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12 Weekly coronial meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	12 Decreased from a 16	8 (C4xL2)	The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12

	A	B	C	D	E	F	G	H	I	J	K
	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
1											
2											
3											
4	6217	Executive Medical Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	A number of Nationally reportable incidents have been raised since February 2025	If - the safeguards and quality systems and processes are not robust Then - mothers and babies may not receive the best evidence based care Resulting in - Potentially less than ideal or negative outcomes.	Rapid reviews have been undertaken on all cases with findings and learning from each. Meetings held with Care Group and executive team to decide on way forward. External review commissioned of the 4 cases. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) Further review once external report received	February 2026: External review received from Cons Obstetrician. No additional issues raised so risk is closed.	Quality, Safety & Experience Committee	Feb-26	February 2026: External review received from Cons Obstetrician. No additional issues raised so risk is closed.
5	5688	Chief Operating Officer		Service / Business Interruption	Aging Equipment	If a replacement steam steriliser is not purchased Then, the department is at risk of not being able to decontaminate medical devices Resulting in patients' operations being cancelled	April 2026: received installed and commissioned.		Quality, Safety & Experience Committee	Apr-26	April 2026: received installed and commissioned.
6	6379	Chief Operating Officer	Improving Care	Safety & Wellbeing Patients / Staff and Public	CT Scanners at RGH damaged by power outage and manual generator/UPS switch over	IF the manual switch over following a power outage is not rectified. THEN the CT scanners/tubes may become damaged RESULTING IN no CT service on site, causing significant delay in patient outcomes, and significant cost to repair (circa £350k per tube)	Discussion with manufacturer and All Wales procurement Discussion with estates team Estates will ensure CT is switched on first, for generator to kick in Regular weekly meeting with GE and estates to monitor	Action plan required urgently to show regular monitoring. If a separate or modified UPS is required then a statement of need for Capital consideration will be required. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee Operational Delivery Committee	Risk closed February 2026	Risk closed and removed from the ORR in February 2026 following completion of CT scanner switch replacements.



Agenda Item

4.7

Quality, Safety & Experience Committee

**HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN
TRACKER REPORT**

Dyddiad y Cyfarfod / Date of Meeting	3 rd June 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

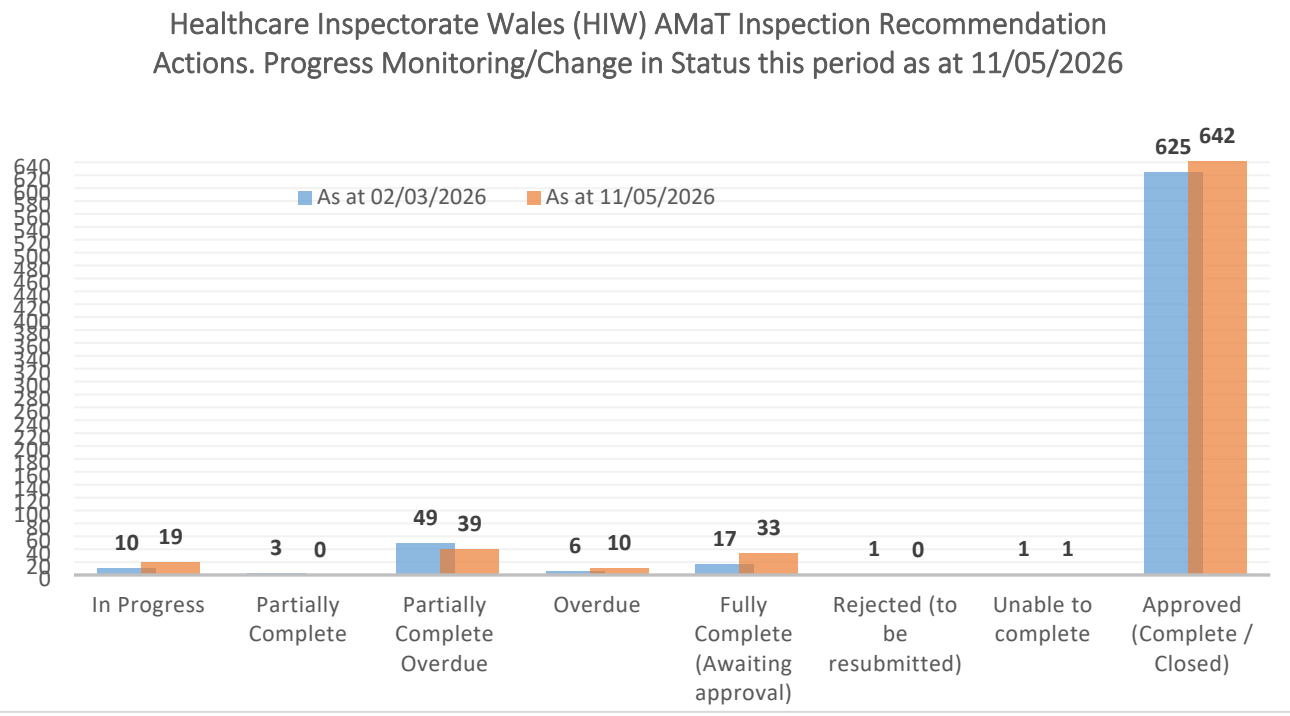
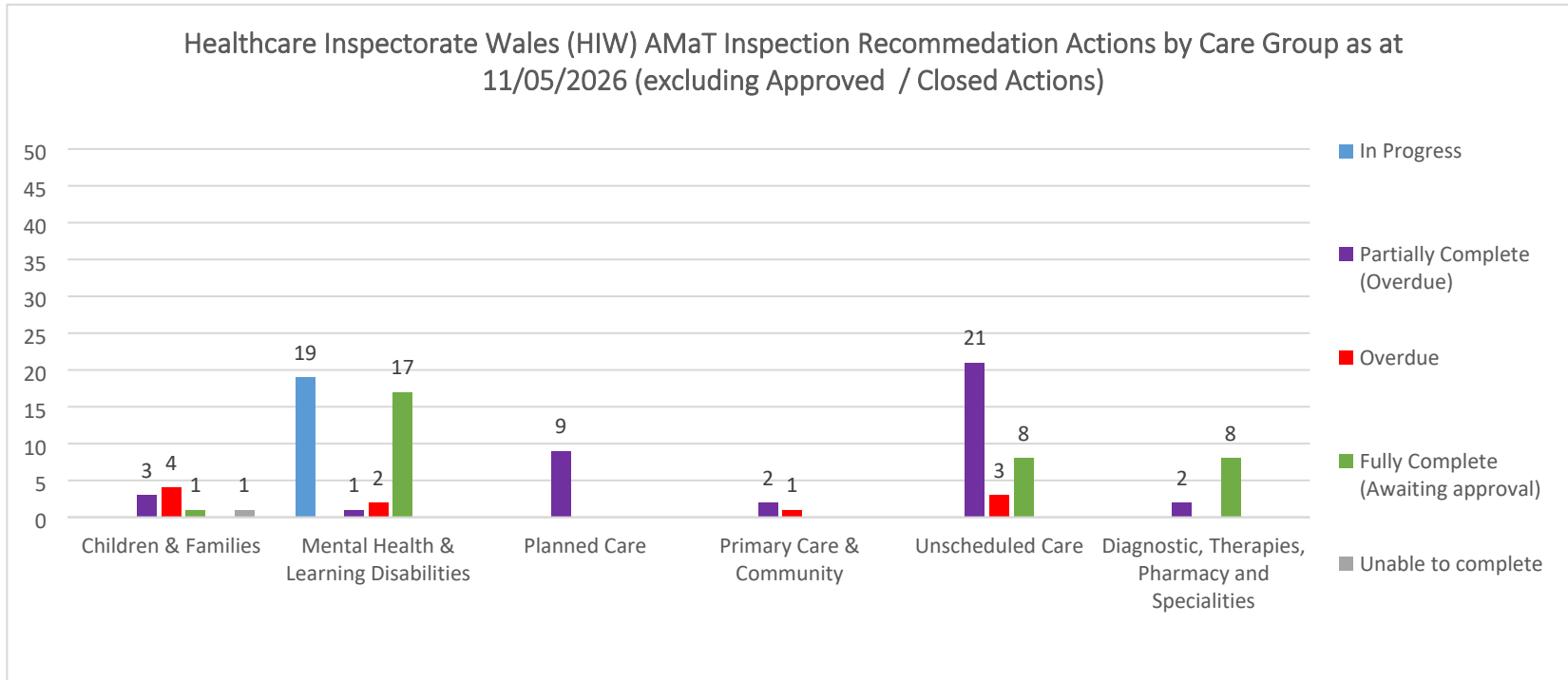
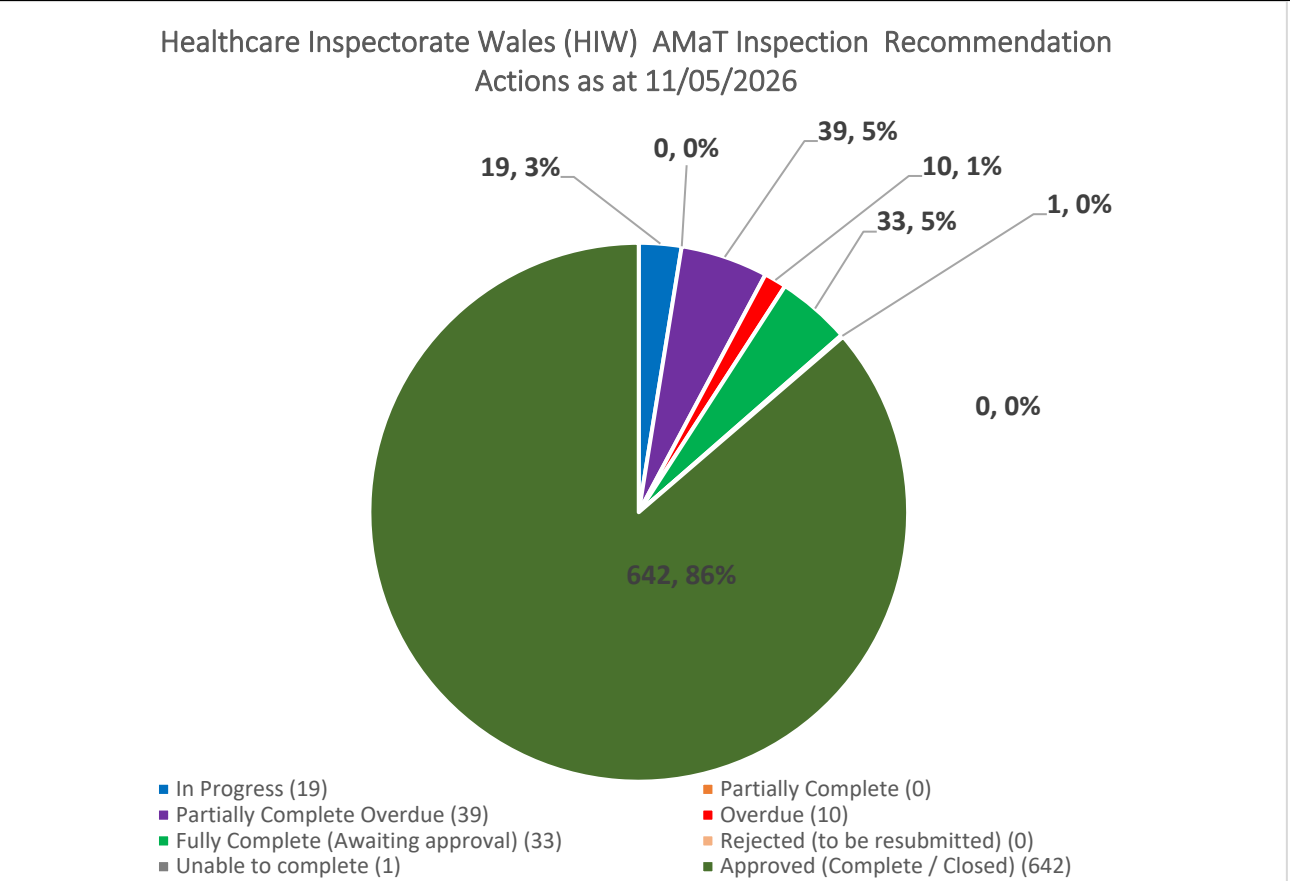
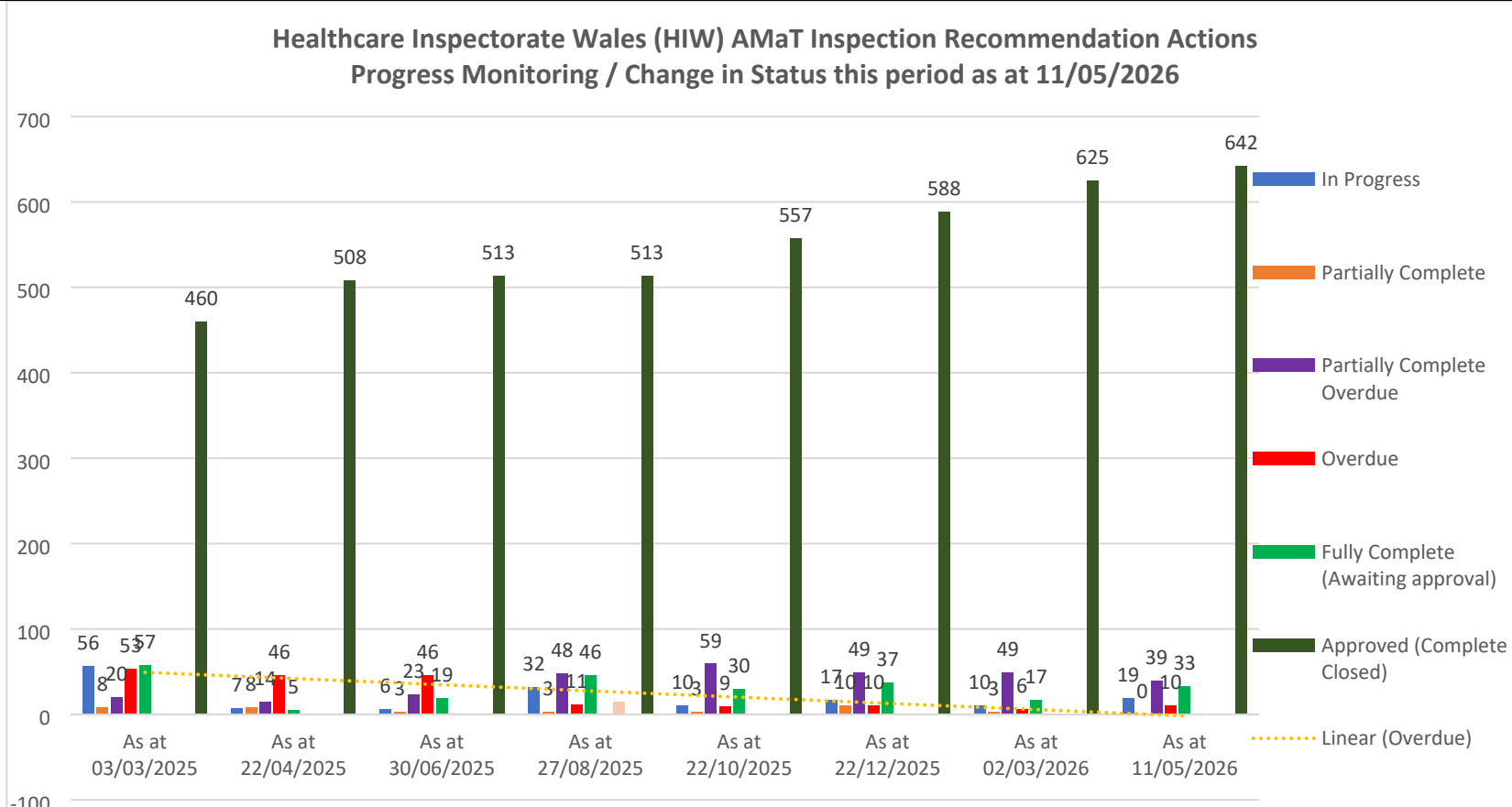
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	18 th May 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 **2nd March 2026 to 11th May 2026**.
- 1.2 This report should be reviewed alongside the previously distributed report which was not discussed at the previous Quality, Safety and Experience Committee at 24th 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 Continued positive levels of progress has been noticed in reducing the numbers of overdue actions (*Graph 1 and 4*). The Quality Assurance and Compliance team will continue to encourage a sustained effort from each Care group to address the partially complete overdue actions alongside the more current actions.
- 2.3 Direct engagement with each individual Care Group has shown an improvement in the number and also the quality of updates noted in the tracker this period. The Quality Assurance and Compliance team will continue to focus on teams where engagement is less to offer further support and encouragement and training as necessary.
- 2.4 Cleansing of historic actions continue to be a priority; however it should be noted that extra engagement from the Care groups and encouragement to reflect on the original recommendation/action has allowed the teams to update a larger number of overdue actions.
- 2.5 A breakdown of the status position with regards to all actions up to the **11th May 2026** is detailed below.
- A total of **744 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 good progress made and **33 actions** have been marked as fully completed awaiting approval.

3. New Inspections / Actions

There has been **1** new Improvement Plans and **32** new actions added for this period bringing the number of open inspections for the Health Board to **15** HIW inspections.

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 Although some Care Groups have been engaging well for this period of updates, further work is required. Teams are requested to review the original recommendation in order to update the actions. The Quality Assurance and Compliance team note that there may be times whereby the original action has been superseded as the Health Board's strategic plans evolve and so updates should reflect this and a review as to whether the original action can now be marked as complete.
- 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 – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-acten.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd)	Whole-systems Perspective



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

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

6. Recommendation

The Quality, Safety & Experience Committee are asked to **NOTE** the contents of this report as well as the report produced for the previous committee meeting to review 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 continue to engage with Care groups directly as well as send further reminders of the AMaT for governance process.
- 7.2 Support continues to be made available 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.

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	22	22	Planned Care Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	2	2	Primary Care & Community Lucie Owen, Nurse Director 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) Colty Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13.11.2024	27	46	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing
Healthcare Inspectorate Wales (HIW)/2025/241	Appendix C - Improvement Plan_Ward 7, Ysbyty Cwm Cynon Hospital	27.01.2025	13	14	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing
Healthcare Inspectorate Wales (HIW)/2025/261	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/264 Appendix C)	20.05.2025	4	8	Diagnostic, Therapies, Pharmacy and Specialities Carl Verrecchia, Service Director
Healthcare Inspectorate Wales (HIW)/2025/264	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HIW)/2025/261 Appendix B)	20.05.2025	24	59	Diagnostic, Therapies, Pharmacy and Specialities Carl Verrecchia, Service Director
Healthcare Inspectorate Wales (HIW)/2025/276	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	18.08.2025	16	24	Children & Families Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2025/277	Appendix C - Improvement Plan_Emergency Department, Royal Glamorgan Hospital (Ref: 03472)	05.08.2025	19	19	Unscheduled Care Deborah Matthews, Nurse Director
Healthcare Inspectorate Wales (HIW)/2026/289	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	12.01.2026	11	32	Mental Health & Learning Disabilities Lloyd Griffiths, Interim Director of Nursing

AMaT Recommendation Actions - Status Key

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

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the H&I 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)	April 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update - Escalated to Executive Director of Nursing, Midwifery & Patient Care and to Care Group DoH for an urgent update on the outstanding action, whilst noting that the roll out is expected to end March 2026.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of Information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	The implementation of Open Eyes will provide optometrists with access to patient information that will promote, simplify and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024	31.12.2025	Partially complete (Overdue)	March, June 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - Working group established. Implemented for Glaucoma. Next phase cataracts. On target for end of March 2026.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Healthcare Inspectorate Wales (HIW)/2017/141/MD10/1	Documents and resource related to FUNB patients are shared between the business Informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PFU Patients with appointments cancelled	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	March, June 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - FUNB list known. CIN recommendation agreed for those on PFU / SOS. Retrospective application of CIN PFU / SOS agreed for FUNB list. Awaiting start date from medical records.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Healthcare Inspectorate Wales (HIW)/2017/141/MD12/1	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A Significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	March, June 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - All outcome forms from OP clinics have PFU / SOS option included. No option for patients to be put on FUNB list. Agreed PFU / 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 Right Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	March, June 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - FUNB strategy agreed through PT programme. Retrospective application of PFU 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 (CARRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete (Overdue)	March, June 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - Ongoing discussions.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/141/MD17/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025, January, March, June 2026 Updates - No update against this recommendation action has been received on these occasions. August 2025 Update (27/8/25) - as of today we are still waiting WG decision re further advice / shared learning.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrists in order to further develop services (such as the soon to be implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	December 2025, January, March, June 2026 Updates - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDH& 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 IPDS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	Partially complete (Overdue)	March, June 2026 Update - No update against this recommendation action has been received on these occasions. December 2025 Update (19/12/25) - Extended 3 part time optometrists whilst workforce review and BC approval.
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ysbyty Cwm Rhonda [Ysbyty Cwm Rhonda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HIW)/2020/139/MD2/1	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM internet site.	Primary Care and Community	01.10.2020	01.10.2020	Overdue	March, June 2026 Update - No update against this recommendation action has been received on these occasions. November 2025 Update (27/11/25) - Head of Quality Assurance and Compliance email to Head of Nursing Primary Care & Community.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MD1/1	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	01.11.2024	01.11.2024	Partially complete (Overdue)	April 2026 Update - Delay remains with regards to medic provision, we are in process of appointing and the aim is to ensure this is completed by end of July 2026. February 2026 Update - Delay in signing off due to medic provision , this has been escalated with a view to conclude at next QSE.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services (Appendix C - PCW Maternity Unit (Ref: 21233))	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Healthcare Inspectorate Wales (HIW)/2022/131/MD1/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Unable to complete	June 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update - Escalated to Executive Director of Nursing, Midwifery & Patient Care for review and guidance to ensure required action is completed.
Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales (HIW)/2023/134/MD2/1	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance:- ED •Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. •An Ia 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 PLS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED - 8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	June 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update (19/02/2026) - improving trajectory-require a further summary for 24th February 2026.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring, bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken. To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October, December 2025, March, June 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 wing for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care and Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024, February, April, June, August, October, December 2025, March, June 2026 - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales (HIW)/2023/155/MD6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of Whiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based SelfStart 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)	April 2026 Update (01/04/2026) - no dedicated stroke specialist Pharmacist, however an allocated Pharmacist available on stroke daily. Senior Principal Pharmacist oversight for USC CSG (ICL), who responds proactively to the needs of the service. RAG rate Amber. February 2026 Update (19/02/2026) - no change from November 2025 update.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD12/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - this has been actioned. RAG rate Green, close and finally approved. February 2026 Update - await training compliance.
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-presenting. Recently reviewed data (as per below "Table removed for AMA7 purposes") shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across Powi and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	June 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update - Improvement in Stroke flow and creating sufficient ring fenced capacity including weekends/out of hours.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Site Manager of the day and the Executive on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - actions completed, escalation policy in place and monitored via ED Huddles/Conference calls etc. Close and finally approved. 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 QSEC.

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)	April 2026 Update (01/04/2026) - currently have a 6 day service, working towards 7 days. Rag rate Amber.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	June 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update -ACP currently 6 day service. Working on 7 day service as part of the transformation work.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	Partially complete (Overdue)	April 2026 Update (01/04/2026) - no change, however a TEAMS communication channel in place that is MDT supports this action and is working effectively to ensure timely transfer to the ASU. Amber rate. February 2026 Update -No change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HIW)/2023/155/MD19/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	April 2026 Update - this work is ongoing in line with Stroke Transformation.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	Partially complete (Overdue)	April 2026 Update (01/04/2026) - no change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that 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/MD21/1	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	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - this action has been progressed and is sustained. Action can be closed and finally approved. 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
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 overnight 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 resourcing the regional Stroke Consultant rota. This would enable us to avoid overnight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Partially complete (Overdue)	April 2026 Update (01/04/2026) - this action is nearing completion-awaiting neurologist to commence employment. Rag Rate Amber. February 2026-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
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this is continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - this action has been progressed and sustained with a number of empty stroke beds/plan to create a ring fenced bed. This has now allowed the team to consider taking some beds out of the acute area to support the transformation work. Action can be closed and finally approved. 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
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 HIL. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	October, December 2025, March, June 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 HIL.
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 of 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)	April 2026 Update (01/04/2026) - No Change. February 2026 Update - No Change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	April 2026 Update (01/04/2026) - No Change. February 2026 Update - No Change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAAP.	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)	April 2026 Update (01/04/2026) - actioned progressed 6 day working, plan to move to 7 day as part of transformation work. RAG Rate Amber. February 2026 Update - No change.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that 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)	April 2026 Update (01/04/2026) - No change, RAG rate Amber. February 2026 Update - Rehabilitation is being reviewed as part of the overall CTM stroke transformation work
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 D28A 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 through 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)	April 2026 Update (01/04/2026) - No change but RAG rating is Amber with training compliance to date Stroke Unit. February 2026 Update - Work ongoing and discussed in monthly Integrated Discharge meetings, compliance monitored (a clear KPI as part of Optimise)
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 D28A in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase uptake for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below ("table removed for AMaF purposes).	Unscheduled Care	01.04.2024	01.04.2024	Partially complete (Overdue)	April 2026 Update (01/04/2026) - action progressing, increase in bed availability due to increase trend in discharge/transfer out of Stroke Unit. RAG Rating Amber. February 2026 Update - partially progressed, supported patient discharge flow Dec, Jan and Feb 2026.
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 actively highlighted through the market stability statement published by the region. A PaCD 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)	April 2026 Update (01/04/2026) - progressing as below, RAG Rating Amber, data evident. February 2026 Update - Hospital @ Home has progressed partially and supported during Dec, Jan and Feb 2026.
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	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - Discharge Lounge not required for Stroke patients as capacity not an issue due to increasing trend of discharges/transfers. If the need arises Ward 1, RGH can be used flexibly in line with the Escalation policy and agreement with CSG. Action can be closed and finally approved. 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)	April 2026 Update (01/04/2026) - CTM UHB Escalation policy approved, RGH Ward 1 can be used flexibly as a surge area to support patient flow following escalation and agreement of CSG. 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.
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 is 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	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - Site Teams can view and proactively allocate to stroke via the EWB-RAG rate green, can close and finally approve. February 2026 Update - No change.
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	April 2026 Update (01/04/2026) - there are no further plans to support construction works in ED PCH. The ambulatory area has been updated including plans to update the Mental Health room in line with legislation-amber rating. February 2026 Update (19/02/2026) -update remains unchanged, as in October 2025.
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	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - Escalation policy updated and approved November 2025, includes pre-emptive transfers and formal escalations to consider other options including surge capacity availability (currently Ward 3 PCH), RAG rate green - can close and finally approve. February 2026 Update (19/02/2026) - No change to October 2025 update.
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	Fully complete (Awaiting approval)	April 2026 Update (01/04/2026) - these plans are no longer being considered. SOP in place for Ambulatory Area including flexibility of appropriate staffing and skill mix to safely manage the are-audit trail in ED electronic huddle documentation implemented December 2025. RAG rate green, can close and finally approve. February 2026 Update (19/02/2026) - No further update as advised in October 2025.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	April 2026 Update (27/04/2026) - Business case being developed in response to the Birthrate Report 2025, currently in draft. Regular finance meetings are in place with Directorate leadership team, the Director of Finance and the Care Group Directors.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	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	Fully complete (Awaiting approval)	April 2026 Update (27/04/2026) - Over the last 18 months, the focus has been on attending streaming events to encourage student midwives to come to work and CTM. We have seen a significant increase in applications from NQM, Band 6, and senior roles. Currently, staffed to establish across CTM. Further BR- review undertaken in November 2025, which is being taken through internal workforce processes.

Healthcare Inspectorate Wales (HWI)/2024/266	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 (HWI)/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)	April 2026 Update (27/04/2026) - MatKris SMOG attended the site escalation meetings - daily and during weekends and out of hours, Internal acute and community safe to start ad safety huddles in place, to review Site safe to start process with the senior team as not currently workable for maternity to ensure appropriate communication and escalation between site and maternity.
Healthcare Inspectorate Wales (HWI)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Colly 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 (HWI)/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	30.04.2025	31.05.2026	In progress	February 2026 Update - New Revised date for completion is 31-05-2026.
Healthcare Inspectorate Wales (HWI)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Colly 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 (HWI)/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	30.06.2025	31.05.2026	In progress	April 2026 Update - Revised date for completion 31-05-2026.
Healthcare Inspectorate Wales (HWI)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ybely 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 (HWI)/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, Ybely Cwm Cynon pharmacy teams screen medication charts and supply medication to the wards and the Principle Pharmacist for Mental Health supports the ward on an ad hoc basis with reviewing medication incidences.	Mental Health & Learning	31.12.2025	31.12.2025	Fully complete (Awaiting approval)	April 2026 Update - this is completed and signed off at QSE. Evidence attached.
Healthcare Inspectorate Wales (HWI)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ybely 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 (HWI)/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	31.12.2025	31.05.2026	In progress	April 2026 Update - revised date to 31-05-26.
Healthcare Inspectorate Wales (HWI)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ybely Cwm Cynon Hospital	12. The health board must ensure that policies are reviewed to ensure they are current.	Healthcare Inspectorate Wales (HWI)/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	31.12.2025	31.05.2026	In progress	April 2026 Update - revised date 31-05-26
Healthcare Inspectorate Wales (HWI)/2025/241	27.01.2025	Appendix C - Improvement Plan_Ward 7, Ybely Cwm Cynon Hospital	13. The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HWI)/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	31.12.2025	31.05.2026	In progress	April 2026 Update - Revised completion date 31-05-2026.
Healthcare Inspectorate Wales (HWI)/2025/261	20.05.2025	Appendix B - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/2025/264 Appendix C).	The employer must ensure that: • The current DRIs are reviewed immediately to ensure that they are appropriate.	Healthcare Inspectorate Wales (HWI)/2025/264/MD2/3	CTM DRI group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRIs. The DRI group will feed into CTM image optimisation team and radiation safety committee.	Diagnostic, Therapies, Pharmacy and Specialities	05.06.2025	05.06.2025	Partially complete (Overdue)	October, December 2025, March, June 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/2025/261 Appendix B)	2. The employer must ensure that training and competency is evidenced prior to duty holder entitlement.	Healthcare Inspectorate Wales (HWI)/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	Fully complete (Awaiting approval)	February 2026 Update - reviewed documentation. October 2025 Update - Documentation ready for sign off, awaiting training records as evidence.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/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 (HWI)/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	Fully complete (Awaiting approval)	April 2026 Update - Authorisation agreed. Guidelines displayed with practitioner name displayed.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/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 (HWI)/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	Fully complete (Awaiting approval)	April 2026 Update - Evidence received and reviewed March 2026. October 2025 Update - Documentation complete, awaiting evidence of training before entitlement sign off.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/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 resaults within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	Healthcare Inspectorate Wales (HWI)/2025/264/MD13/3	Observation and referral form audit will be added to AmaT system to ensure action plans in place, robust analysis and re-audit in an appropriate time frame. Ongoing	Diagnostic, Therapies, Pharmacy and Specialities	31.10.2025	31.10.2025	Partially complete (Overdue)	October, December 2025, March, June 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/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 (HWI)/2025/264/MD15/2	Meeting with MPEs to review baselines and manufacturer recommendations. Will review policy and amend. Ongoing	Diagnostic, Therapies, Pharmacy and Specialities	29.07.2025	29.07.2025	Fully complete (Awaiting approval)	April 2026 Update - Reviewed and amended.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/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 (HWI)/2025/264/MD18/1	CPD session to be delivered on changes to employers procedures to include the difference between justification and authorisation.	Diagnostic, Therapies, Pharmacy and Specialities	30.09.2025	30.09.2025	Fully complete (Awaiting approval)	April 2026 Update - Ongoing. Discussions held with staff across CTM sites.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/2025/261 Appendix B)	19. The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (HMC25 - 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 (HWI)/2025/264/MD19/3	Feedback Friday to be implemented i.e., staff will actively ask patients to give feedback. Once feedback has been gathered 'you said, we did' board will be displayed.	Diagnostic, Therapies, Pharmacy and Specialities	31.08.2025	31.08.2025	Fully complete (Awaiting approval)	April 2026 Update - New promptly system in place across CTM. March 2026 Update - New patient feedback system being launched.
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/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 (HWI)/2025/264/MD20/1	A case has been submitted for additional radiography staff that supports the future workforce model and demand as part of the IMTP investment priorities for 2025-26 across the sites. This will continue to remain the priority for Radiology. To date, no source of funding has been identified. Additional staff have been rostered out of hours at RGH temporarily while services from POW are temporarily relocated.	Diagnostic, Therapies, Pharmacy and Specialities	30.04.2026	30.04.2026	Fully complete (Awaiting approval)	March 2026 Update - Business complete. Will be monitored as part of Radiology IMPT and BCP
Healthcare Inspectorate Wales (HWI)/2025/264	20.05.2025	Appendix C - Immediate Improvement Plan_Diagnostic Imaging Department, Prince Charles Hospital (Ref: 03900) (Link to Healthcare Inspectorate Wales (HWI)/2025/261 Appendix B)	22. The health board is required to reflect on some of the less favourable responses from staff and inform HW of the actions it will take to address these.	Healthcare Inspectorate Wales (HWI)/2025/264/MD22/9	The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways: Wellbeing champions to be established.	Diagnostic, Therapies, Pharmacy and Specialities	31.07.2025	31.07.2025	Fully complete (Awaiting approval)	April 2026 Update - Appointed all sites. February 2026 Update - Chased all sites again Feb 2026
Healthcare Inspectorate Wales (HWI)/2025/276	18.08.2025	Appendix C - Improvement Plan_Maternity Unit, Princess of Wales Hospital (Ref: 03988)	2. Ensure timely pain relief is available postnatally.	Healthcare Inspectorate Wales (HWI)/2025/276/MD2/1	All Wales self-administration policy is currently distributed for comment, once ratification the organisation will support implementation.	Children & Families	30.04.2026	30.04.2026	Overdue	December 2025, March, June 2026 Update - No update against this recommendation action has been received on these occasions.
Healthcare Inspectorate Wales (HWI)/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 (HWI)/2025/276/MD4/1	Videos to be developed to support women and their families how to find maternity departments. Ensure clear signage is displayed to help women and families locate the maternity unit. Estates to review signage across the site to ensure easy access to maternity.	Children & Families	28.02.2026	30.04.2026	Overdue	May 2026 Update (12/05/2026) - Videos currently being filmed and edited by medical illustrators. March 2026 Update (02/03/2026) - 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 Powt to ensure patients/prescribers 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 of POW hospital signs are now in place.
Healthcare Inspectorate Wales (HWI)/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 (HWI)/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	Overdue	March 2026 Update (02/03/2026) - 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. SGRU SharePoint page has now been completed and feedback from staff is positive.
Healthcare Inspectorate Wales (HWI)/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 (HWI)/2025/276/MD12/1	The Maternity Governance team to undertake an engagement event to celebrate the rebranded title of - quality assurance team.	Children & Families	31.01.2026	04.05.2026	Overdue	March 2026 Update (02/03/2026) Update - Quality Assurance Team have reviewed team structure and core responsibilities and presented at unit meeting. 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 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 (HWI)/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 (HWI)/2025/276/MD12/2	Develop an assist me pack which is specific to maternity and neonatal staff to support staff who maybe involved in an incident and the process	Children & Families	31.01.2026	31.01.2026	Partially complete (Overdue)	March 2026 Update (02/03/2026) - assist me back completed in draft. Document shared for comment and due to be presented at the next SWAG meeting in March.
Healthcare Inspectorate Wales (HWI)/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 (HWI)/2025/277/MD4/1	CTMUHB recognises the requirement to continually the ED footprint and its ability to remain fit for purpose in the context of current demand and capacity. Following service reconfiguration as a result of the Critical Incident in Princess of Wales Hospital, a comprehensive review of the current ED footprint will be required to ensure it aligns with evolving service needs. This review should consider patient flow, workforce requirements, infrastructure limitations, and future growth projections to ensure the department remains responsive, safe, and sustainable.	Unscheduled Care	31.03.2026	31.03.2026	Overdue	April 2026 Update (01/04/2026) - as part of Unscheduled Care transformation work (UNITE), STAMP has now been implemented in POWH. 29/03/26. This facilitates the flow out of ED into AMU/EDIC in line with RGH and PCH. Consider care removed from POWH and an Ambulatory Area configured in November 2025, thus supporting 6 Goals initiative and ED's remaining fit for purpose in the context of current demand and capacity. This is in progress (amber rating). January 2026 - Ongoing discussions - for IMTP.
Healthcare Inspectorate Wales (HWI)/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 RCIM (December 2020) regarding security and restraint and ensure that ED staff can access a consistent site security presence.	Healthcare Inspectorate Wales (HWI)/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. Data incident analysis over the past few years shows security porters have been required to manage restraint incidents without back up support from South Wales Police. There are two security porters available to manage violence at any given time and this is to support the hospital site. Next steps: The facilities team are currently undertaking a review of the security team establishment and a training needs analysis to support the increase of security availability at the hospital site. The facilities team are undergoing improvement work to review the current establishment of the security team and implement a training plan for PMVA training.	Unscheduled Care	31.03.2026	31.03.2026	Overdue	April 2026 Update (01/04/2026) - no change from January update. RAG rated Amber. 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 these times -plan to work towards the training package by April 2026 -Senior Nurse for Education in ED will be co-charing the task and finish group to create this package of training.
Healthcare Inspectorate Wales (HWI)/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 RCPC standards, with particular focus on paediatric workforce capacity.	Healthcare Inspectorate Wales (HWI)/2025/277/MD11/1	CTMUHB recognises the importance to audit and revisit the RCPC 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 RCPC standards to benchmark against previous audits prior to implementing the designated paediatric area. Current workforce establishment: 1.6 WTE PEM consultants covering a 6-hour period, 5 days a week. x 1.0 WTE Band 7 Paediatric Lead x 2.0 WTE Band 6 Paediatric nurses x 4.0 WTE Band 5 Paediatric Nurses Additional Information: • Focus on workforce capacity • The RGH ED PEM group will complete benchmarking exercise within the next 3 months.	Unscheduled Care	31.12.2025	31.12.2025	Partially complete (Overdue)	April 2026 Update (01/04/2026) - No change. Amber rating as 3 ED's have appropriate separate Paediatric Areas. Await update as described in January 2026. January 2026 Update - - Update required from PEM group

Healthcare Inspectorate Wales (HWI)/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 (HWI)/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, comprising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTL5 = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An & Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all RNs and HCSW which will align across the 3 ED's. • The PON across the 3 EDs are currently working towards instructor potential to enable and facilitate inhouse training to support training compliance improvements. A trajectory improvement action plan has been made to improve compliance to 100%.	Unscheduled Care	31.03.2026	31.03.2026	Partially complete (Overdue)	June 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update (19/02/2026) - see progression in actions - no further update this month.
Healthcare Inspectorate Wales (HWI)/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 (HWI)/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, comprising of both inhouse and external training. It is important to note that there is currently a delay with booking resuscitation courses via the resuscitation team due to staff shortages amongst the team which is currently affecting course availability. Resuscitation training is a recognised constraint within the Health Board and new ways of working are being explored. Please see attached current training compliance for ED including all available resuscitation courses with a trajectory plan: Current Trauma training Compliance: • MTL5 = 45% • TNCC = 24% • Overall level 2 trauma = 69% (Band 6&7 only) An & Senior Nurse for Professional Education has been appointed (August 2025) who is undertaking a training needs analysis and a study plan for all RNs and HCSW which will align across the 3 ED's. The Practice Development Nurses (PDN) across the 3 EDs are currently working towards instructor potential to enable and facilitate inhouse training to support training compliance improvements. A trajectory improvement action plan has been made to improve compliance to 100%.	Unscheduled Care	31.03.2026	31.03.2026	Partially complete (Overdue)	June 2026 Update - No update against this recommendation action has been received on this occasion. February 2026 Update (19/02/2026) - progression of action as described in January 2025 update.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	1. The health board must ensure all observation panels work as intended to support safe and appropriate observations.	Healthcare Inspectorate Wales (HWI)/2026/289/MD1/1	Faulty observation panel reported to the door manufacturer.	Mental Health & Learning	21.01.2026	21.01.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	1. The health board must ensure all observation panels work as intended to support safe and appropriate observations.	Healthcare Inspectorate Wales (HWI)/2026/289/MD1/2	New observation panel to be fitted.	Mental Health & Learning	01.04.2026	01.04.2026	Fully complete (Awaiting approval)	May 2026 Update - this action has been completed and evidence has been added, the new observation panel has been fitted.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	1. The health board must ensure all observation panels work as intended to support safe and appropriate observations.	Healthcare Inspectorate Wales (HWI)/2026/289/MD1/3	Daily environmental audit in situ. This system supports early identification and reporting of environmental concerns where remedial action maybe required.	Mental Health & Learning	09.03.2026	09.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	1. The health board must ensure all observation panels work as intended to support safe and appropriate observations.	Healthcare Inspectorate Wales (HWI)/2026/289/MD1/4	A spot check against this audit will be completed on a monthly basis over a six month period. This will be reported into Quality, Safety and Experience Group (QSE).	Mental Health & Learning	16.09.2026	16.09.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	2. The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.	Healthcare Inspectorate Wales (HWI)/2026/289/MD2/1	Daily environmental audit in situ. This system supports early identification and reporting of environmental concerns where remedial action maybe required.	Mental Health & Learning	09.03.2026	09.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	2. The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.	Healthcare Inspectorate Wales (HWI)/2026/289/MD2/2	The CAMHS and Specialised Services Directorate hold quarterly Fire and Estates meetings, that feed into the UHB Corporate Facilities meeting for the escalation of any maintenance.	Mental Health & Learning	09.03.2026	09.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	2. The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.	Healthcare Inspectorate Wales (HWI)/2026/289/MD2/3	A spot check against this process will be completed on a monthly basis over a six month period. This will be reported into QSE.	Mental Health & Learning	16.09.2026	16.09.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	2. The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.	Healthcare Inspectorate Wales (HWI)/2026/289/MD2/4	The phase 2 Capital works to improve the Enhanced Care Area (ECA) is in progress.	Mental Health & Learning	31.07.2026	31.07.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	3. The health board must ensure all wards adopt a consistent approach to affixing signage and information without using tape that compromises cleaning.	Healthcare Inspectorate Wales (HWI)/2026/289/MD3/1	Daily environmental audit updated to include: • No tape to be used to secure notices • All notices not stored appropriately (notice board/E-screen) will be moved to the appropriate location.	Mental Health & Learning	09.03.2026	09.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	4. The health board must ensure that key risk-management information is clearly and consistently reflected across all relevant documents, including MySafety Plans, to reduce the risk of important details being missed and to support safe, consistent care delivery.	Healthcare Inspectorate Wales (HWI)/2026/289/MD4/1	Immediate spot check undertaken on relevant documentation including risk management information.	Mental Health & Learning	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	4. The health board must ensure that key risk-management information is clearly and consistently reflected across all relevant documents, including MySafety Plans, to reduce the risk of important details being missed and to support safe, consistent care delivery.	Healthcare Inspectorate Wales (HWI)/2026/289/MD4/2	Monthly WARRN and care-plan audit to be implemented and subject to a six month review, to ensure that YP who are identified to require restrictive practice, have clear risk management actions within the WARRN and a co-produced restraint reduction goal within the care-plan. My Safety Plan is embedded into the care-plan document and specific to what the young person feels best helps them in managing their mental health and any crisis.	Mental Health & Learning	16.09.2026	16.09.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	4. The health board must ensure that key risk-management information is clearly and consistently reflected across all relevant documents, including MySafety Plans, to reduce the risk of important details being missed and to support safe, consistent care delivery.	Healthcare Inspectorate Wales (HWI)/2026/289/MD4/3	Audit findings will be reported via Directorate QSE to ensure that the required level of improvement has been met/ agree if the audit needs to be extended for assurance.	Mental Health & Learning	16.09.2026	16.09.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	5. The health board must ensure that enhanced observation records are completed in full to provide an accurate account of each young person's presentation and to ensure that no safeguarding concerns or changes in risk are missed.	Healthcare Inspectorate Wales (HWI)/2026/289/MD5/1	Monthly Audit of engagement and observation records in situ in order to review completeness and disseminate any learning identified.	Mental Health & Learning	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	5. The health board must ensure that enhanced observation records are completed in full to provide an accurate account of each young person's presentation and to ensure that no safeguarding concerns or changes in risk are missed.	Healthcare Inspectorate Wales (HWI)/2026/289/MD5/2	Nurse In Charge (NIC) checklist to be implemented.	Mental Health & Learning	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	5. The health board must ensure that enhanced observation records are completed in full to provide an accurate account of each young person's presentation and to ensure that no safeguarding concerns or changes in risk are missed.	Healthcare Inspectorate Wales (HWI)/2026/289/MD5/3	NIC checklist to be audited monthly and subject to six month review to further strengthen improvements in this area. Findings will be reported via Directorate QSE.	Mental Health & Learning	16.09.2026	16.09.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	6. The health board must: •Review the current paper record system and implement improvements to ensure information is easy to navigate and in a timely manner. •Consider moving to an electronic patient record system to improve accessibility, enhance consistency and reduce the challenges experienced when reviewing and cross-checking information.	Healthcare Inspectorate Wales (HWI)/2026/289/MD6/1	'At a glance' index to be created to assist with navigation through the patient file.	Mental Health & Learning	01.04.2026	01.04.2026	Fully complete (Awaiting approval)	May 2026 Update - This has been completed and signed off at QSE in April, attached is the evidence showing Patients record Index.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	6. The health board must: •Review the current paper record system and implement improvements to ensure information is easy to navigate and in a timely manner. •Consider moving to an electronic patient record system to improve accessibility, enhance consistency and reduce the challenges experienced when reviewing and cross-checking information.	Healthcare Inspectorate Wales (HWI)/2026/289/MD6/2	MHLD to award contract for electronic record.	Mental Health & Learning	01.05.2026	01.05.2026	Overdue	May 2026 Update - MHSR procurement process has been delayed. The HB is presently awaiting confirmation by Welsh Government of agreed system supplier. It is likely that this will take place by end of 26/27 Q1 (30 June 2026).
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	6. The health board must: •Review the current paper record system and implement improvements to ensure information is easy to navigate and in a timely manner. •Consider moving to an electronic patient record system to improve accessibility, enhance consistency and reduce the challenges experienced when reviewing and cross-checking information.	Healthcare Inspectorate Wales (HWI)/2026/289/MD6/3	The MHLD Care Group will implement a single electronic record for patient notes.	Mental Health & Learning	31.05.2028	31.05.2028	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	7. The health board must ensure that all care and treatment plans fully address the relevant domains of the Mental Health (Wales) Measure, and that these are routinely explored, recorded and translated into clear, measurable actions.	Healthcare Inspectorate Wales (HWI)/2026/289/MD7/1	Due to the regional nature of the ward, Ty Llidard does not act as Care Coordinator under the MHM (2010). This responsibility sits with the Local Authority / Health Boards where the young person resides. Ty Llidard will adopt the National CTP audit on AMaT bi-monthly to ensure all domains of the MHM are completed. Results will be shared with Care Coordinators to support improvements.	Mental Health & Learning	01.05.2026	01.05.2026	Fully complete (Awaiting approval)	May 2026 - action completed and signed off at QSE in April, attached evidence showing care and treatment has been added to AMAT for audits
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	7. The health board must ensure that all care and treatment plans fully address the relevant domains of the Mental Health (Wales) Measure, and that these are routinely explored, recorded and translated into clear, measurable actions.	Healthcare Inspectorate Wales (HWI)/2026/289/MD7/2	A snap shot audit of all CTMUHB patients admitted over the last 12 months will take place to review compliance to the MHM and the results of this audit will be shared widely with the CTMUHB community teams to support any learning identified.	Mental Health & Learning	20.05.2026	20.05.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	7. The health board must ensure that all care and treatment plans fully address the relevant domains of the Mental Health (Wales) Measure, and that these are routinely explored, recorded and translated into clear, measurable actions.	Healthcare Inspectorate Wales (HWI)/2026/289/MD7/3	The findings of the CTMUHB audit and AMAT will be reported into Directorate QSE. This will then form part of regular AMAT audit reporting into QSE.	Mental Health & Learning	20.05.2026	20.05.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	8. The health board must review and update all out-of-date policies and procedures to ensure staff have access to accurate and up-to-date guidance.	Healthcare Inspectorate Wales (HWI)/2026/289/MD8/1	The out-of-date policies identified were all health board corporate policies. Email sent to corporate team to highlight the policies that require review. The MHLD Care Group and Policy Review Group is responsible for the monitoring of all MHLD Policies and procedures. It is also responsible for reporting any corporate policies/procedures found to be out of date.	Mental Health & Learning	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	8. The health board must review and update all out-of-date policies and procedures to ensure staff have access to accurate and up-to-date guidance.	Healthcare Inspectorate Wales (HWI)/2026/289/MD8/2	The MHLD Care Group will reshare the Terms of Reference (TOR) for the MHLD review Group to ensure the process for reporting out of date policies is followed.	Mental Health & Learning	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	9. The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.	Healthcare Inspectorate Wales (HWI)/2026/289/MD9/1	The training identified was regarding meal support. Full Day Meal Support Training is presently being rolled out by the regional Eating Disorder Outreach Service, training compliance is presently 35% and will rise to 53% May 2026 and 85% by December 2026. This will remain a training requirement for all substantive and new MDT staff working in Ty Llidard.	Mental Health & Learning	31.12.2026	31.12.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	9. The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.	Healthcare Inspectorate Wales (HWI)/2026/289/MD9/2	Compliance will be reported and monitored via Directorate QSE	Mental Health & Learning	31.12.2026	31.12.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	9. The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.	Healthcare Inspectorate Wales (HWI)/2026/289/MD9/3	Speciality specific training needs analysis to be completed and considered in line with QNIC standards. Once agreed and embedded, compliance will be reported and monitored via Directorate QSE.	Mental Health & Learning	01.07.2026	01.07.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion. Note: Due Dates - 1st July 2026 completion of analysis. Update on progress in QSE 20th May 2026 and final report in QSE 15th July 2026.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	10. The health board must ensure that the electronic patient information boards are consistently maintained and accurately reflects real-time clinical information.	Healthcare Inspectorate Wales (HWI)/2026/289/MD10/1	Spot check completed to evidence the electronic information / at a glance board has been updated. This is also on the NIC check list.	Mental Health & Learning	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	10. The health board must ensure that the electronic patient information boards are consistently maintained and accurately reflects real-time clinical information.	Healthcare Inspectorate Wales (HWI)/2026/289/MD10/2	The electronic whiteboard user guide has been recirculated to all registered nurses, alongside instruction to self-report any requirement for additional training.	Mental Health & Learning	13.03.2026	13.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	10. The health board must ensure that the electronic patient information boards are consistently maintained and accurately reflects real-time clinical information.	Healthcare Inspectorate Wales (HWI)/2026/289/MD10/3	Audit to be developed to ensure factual completeness of the electronic patient information board. This will be completed monthly over a 6-month period, learning will be disseminated and reported via Care Group QSE for assurance.	Mental Health & Learning	30.09.2026	30.09.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	11. The health board must strengthen incident-reporting processes and ensure the remaining open incidents are addressed promptly. Additionally, ensure all future incidents are logged in a timely manner, that Data entries contain accurate and complete information, and that incidents are reviewed and closed promptly to improve oversight and support learning.	Healthcare Inspectorate Wales (HWI)/2026/289/MD11/1	The Incident Management Framework has been cascaded to all staff responsible for reporting, investigating and closing incidents.	Mental Health & Learning	10.03.2026	10.03.2026	Fully complete (Awaiting approval)	Added to tracker April 2026; this action is marked as 'Complete' as per the plan and will be presented to the Quality, Safety & Experience Committee on Wednesday 3 June 2026 as completed.
Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	11. The health board must strengthen incident-reporting processes and ensure the remaining open incidents are addressed promptly. Additionally, ensure all future incidents are logged in a timely manner, that Data entries contain accurate and complete information, and that incidents are reviewed and closed promptly to improve oversight and support learning.	Healthcare Inspectorate Wales (HWI)/2026/289/MD11/2	A weekly check by the Senior Nurse has been implemented to ensure timely investigation and closure of incidents. And a reminder for timely investigation and closure forms part of daily NIC check list.	Mental Health & Learning	13.03.2026	13.03.2026	Overdue	June 2026 Update - No update against this recommendation action has been received on this occasion.

Healthcare Inspectorate Wales (HWI)/2026/289	12.01.2026	Appendix C - Improvement Plan_Ty Llidard_12, 13 & 14 January 2026 (Ref: 03944)	11. The health board must strengthen incident-reporting processes and ensure the remaining open incidents are addressed promptly. Additionally, ensure all future incidents are logged in a timely manner, that Datix entries contain accurate and complete information, and that incidents are reviewed and closed promptly to improve oversight and support learning.	Healthcare Inspectorate Wales (HWI)/2026/289/MD11/3	The above checks will be implemented in order to review the timeliness of incident reporting with a monthly review for six months into QSE meetings, to monitor the quality. This will also include a review of: • Open Incidents • Incidents under investigation • Incidents awaiting closure This will provide assurance around adherence to the Incident Management Framework.	Mental Health & Learning	16.09.2026	16.09.2026	In progress	June 2026 Update - No update against this recommendation action has been received on this occasion.



Agenda Item

4.8

Quality, Safety & Experience Committee

Highlight Report from the Harm Free Care Agenda

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Becky Gammon – Interim Deputy Executive Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Becky Gammon – Interim Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director 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
	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
TVNs	Tissue Viability Nurses

PU	Pressure Ulcer
QSAG	Quality & Safety Assurance Group
N&H	Nutrition & Hydration
HFC SOG	Harm Free Care Strategic Oversight Group
MDT	Multi-Disciplinary Team

1. Introduction

This highlight report had been prepared to provide the Quality, Safety & Experience Committee with details outlining progress, risks, learning and proposed next steps within the Harm Free Care Agenda.

2. Purpose of this Meeting

The purpose of this meeting is to provide assurance on progress and current updates of the Harm Free Care initiative, currently focusing on the three key workstreams:

1. Inpatient Falls Reduction
2. Nutrition and Hydration
3. Pressure Damage

3. Highlight Report

Alert / Escalate

- The CTMUHB Falls Policy has been comprehensively reviewed and updated and is scheduled for submission for final approval in June 2026.
- There is a recognised risk that learning identified through audits, incidents, and assurance panels is not yet consistently embedded or sustained within frontline practice. Continued focus is being applied to strengthening mechanisms that support the translation of learning into routine care delivery.
- There remains a risk of delayed identification or escalation of emerging harm where intelligence is not fully triangulated or acted upon in a timely manner. In order to minimise and mitigate this risk, the next phase of the Harm Free Care agenda includes the establishment of a Quality and Safety Assurance Group (QSAG). This group will receive assurance from the Chairs of each Harm Free Care Group, supporting a coordinated and systematic approach to risk minimisation and mitigation.
- A Harm Free Care dashboard is currently being piloted. Following this phase, feedback and findings will be reviewed and validated to ensure the data is accurate, reliable, and provides meaningful insight to support quality and safety oversight.



Advise	• Falls - The Inpatient Falls Reduction workstream has focused on strengthening assurance and learning through national audit alignment, enhanced governance oversight, and the delivery of targeted improvement initiatives. This includes learning from the National Audit of Inpatient Falls, progression of deconditioning prevention approaches, policy refresh, and engagement in national improvement programmes, supporting a more systematic approach to harm prevention and early deterioration. • Pressure Ulcer - TVNs worked in collaboration with patients and staff to develop a training video to raise awareness of how to reduce avoidable pressure damage. • The TVN team are representing CTM in the All-Wales work to develop a Wound Care Guidance. • CTMUHB PU assurance panels remain in situ and opportunities to strengthen shared learning are facilitated via the HCFSOG. • A 2026 Clinical Prevalence Audit Plan has been agreed, including a repeat review of Emergency Departments to ensure consistency across sites and evidence improvement and learning since the last audit. • There has been a decrease in the numbers of reported Grade 2 PUs and a reduction in worsening skin damage after hospital admission. • Nutrition and Hydration - CTMUHB Speech and Language representation in the All-Wales Dysphagia standardisation workstream with early actions linked to standardisation of training. The HCFSOG will provide assurance on delivery and progress against the required actions. • Traction with several policies to support N&H activity across CTMUHB continues and monitoring is maintained via the HCFSOG.
Assure	• Ongoing emphasis needed on feedback loops to wards and services to evidence improvement impact. • Sustained and measurable progress across all three primary workstreams: Inpatient Falls Reduction – strengthened governance, national audit alignment, policy refresh and positive external audit assurance. • Pressure Damage – strong prevention focus, assurance panels, co-produced training, national contribution and agreed 2026 prevalence audits. • Harm Free Care continues to strengthen the organisational Quality Management System and learning culture. • A Datix (Risk Management System) user guide to support the correct reporting of N&H related incidents is currently being piloted. Following this pilot phase, feedback and findings will be reviewed and validated to ensure the data is accurately being reported and managed through the Incident



	Management process. Following a successful pilot of the new user guide for reporting nutrition & hydration incidents, it is anticipated that there will be a launch across all sites of the same. This will be monitored and regular audits to ensure accurate reporting and management of all N&H incidents.
Inform	- As part of our Internal Audit 2025/26 Plan, Internal Audit colleagues completed an audit of the health board's Falls Prevention Management during Qtr 4. In common with all health boards, the prevention of hospital falls and the effective management of patients following a fall is an important patient safety challenge for the Health Board. Inpatient falls reduction is one of three workstreams developed by the Health Board in its aim to deliver 'Harm Free Care'. The final audit report has been received and has provided an overall assurance rating of 'Reasonable Assurance, with Substantial Assurance given for the governance arrangements for overseeing falls prevention work. Continued monitoring is required to ensure new and emerging steering groups are embedded into the governance cycles. Development is underway for: - A NEW QSAG, bringing together RADAR, Medicines Management and the Mortality Review Group, with the three workstreams already in place (Falls, PUs, N&H) and this group will be Chaired by the Assistant Director of Quality & Safety. - A NEW Thrombosis and Anticoagulation Group will be developed and will also form part of the workstreams reporting up to the QSAG. - The HCFSOG will provide a single coordinated forum for harm oversight. - A MDT will work to educate and engage with teams during Nutrition and Hydration week.
Appendices	- Appendix 1 – HCFSOG Flowchart (available on request) - Appendix 2 –Terms of Reference for the Harm Free Care Strategic Oversight Group (HCFSOG) (available on request)



4. Assessment

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

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



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

5. Recommendation

5.1 The Quality, Safety & Experience Committee is asked to: **NOTE** the highlights in section 3 of this report and **NOTE** the ongoing work and development of the new groups.

Next steps:

- Formal commencement of the Harm Free Care Strategic Oversight Group
- Integration of all Harm Free Care reporting into agreed governance cycles
- Continued escalation of risks where learning or improvement impact is not assured.



Agenda Item

4.9

Quality, Safety and Experience Committee

MORTALITY INDICATORS AND MORTALITY REVIEWS

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
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
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
HMR	Hospital Mortality Review

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 ME referrals received (as of 6th May 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	5111	189 (4%)	132 (3%)	73 (1%)	4716 (92%)

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	377 (100%)	63%
2025-26	294	228 (78%)	21%
2026-27	5	0 (0%)	0%

- 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 71 HMR cases outstanding. The table below is a breakdown of these cases:

	Number	Percentage
Coroner's Inquest/Investigation	22	31%
Hospital Acquired Covid	7	9.8%
Hospital Acquired Influenza	16	22.5%
Inappropriate Discharge Concerns	12	16.9%
Learning Disabilities Patients	0	0%
Other	14	19.7%

- 1.9 Stage 3 Mortality Review panel continues to be held on a monthly basis via Teams. There are currently 4 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. 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%

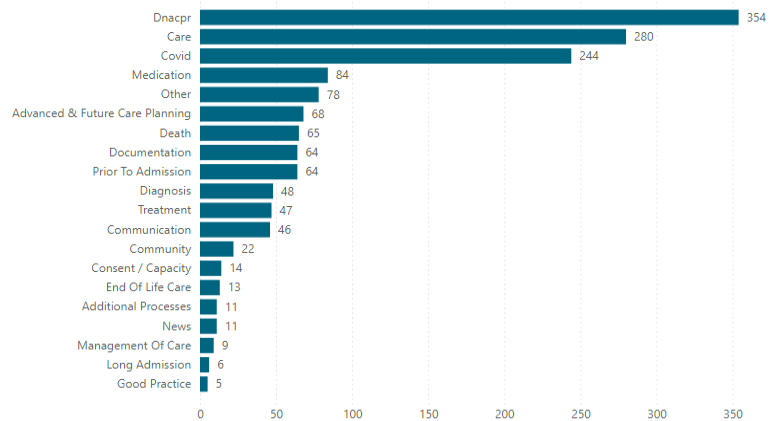
Mortality Rates per Locality:
Merthyr – 1.94%



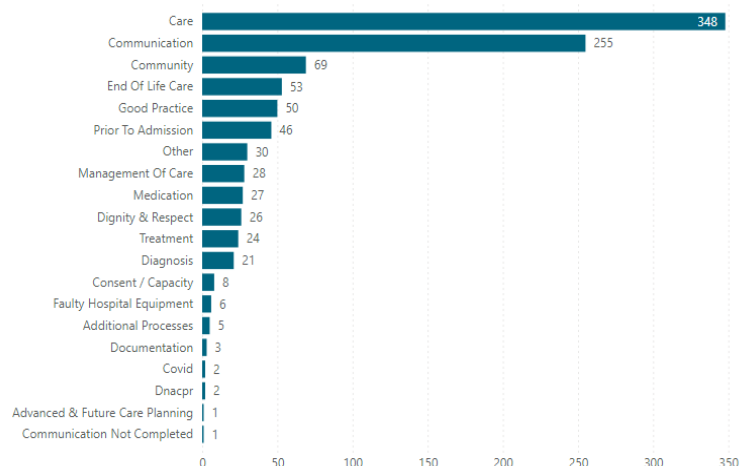
POW – 1.71%
RGH – 2.35%

Bridgend – 1.81%
Rhondda – 2.56%

Themes noted by ME

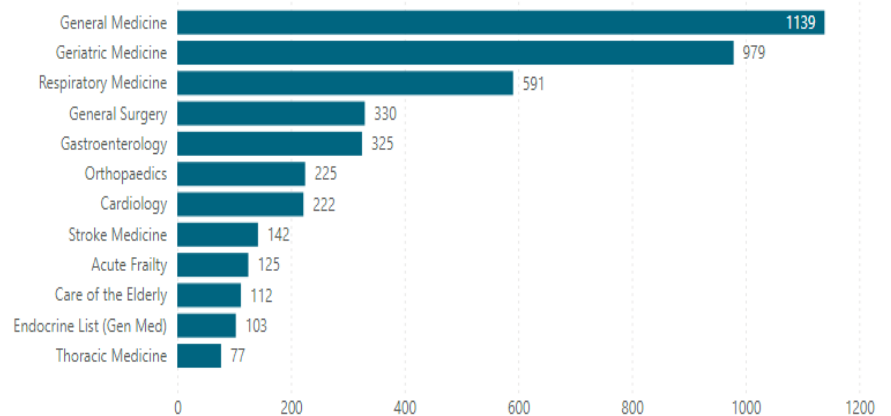


Themes Noted by NOK



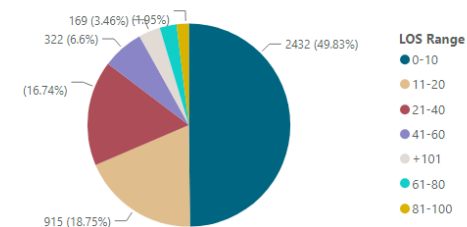


Deaths by Specialty (Top 10)

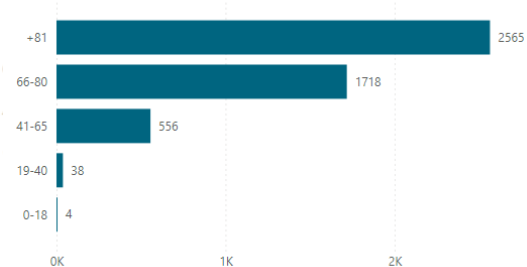


CTM Mortality

Acute Mortality by LOS Category

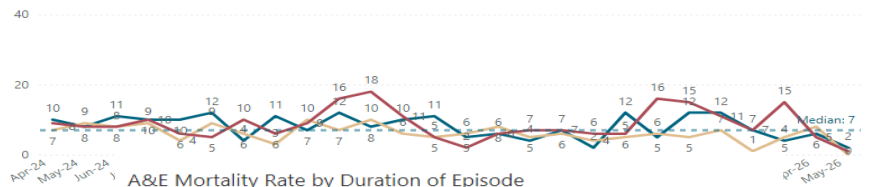


CTM Mortality by Age Group

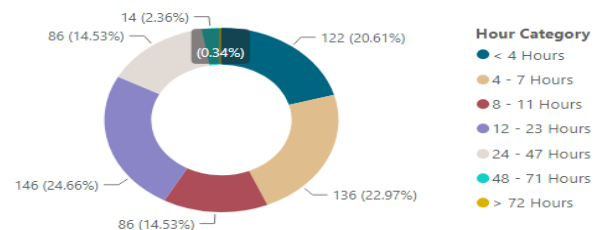


A&E Mortality by Site

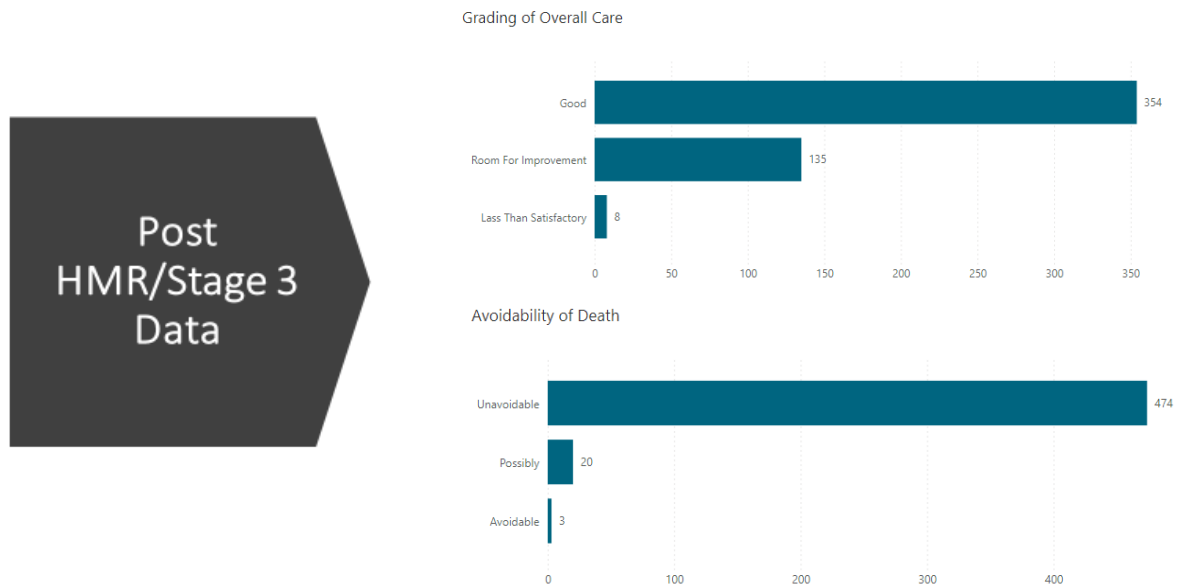
Hospital Prince Charles Hospital Princess Of Wales Hospital Royal Glamorgan Hospital



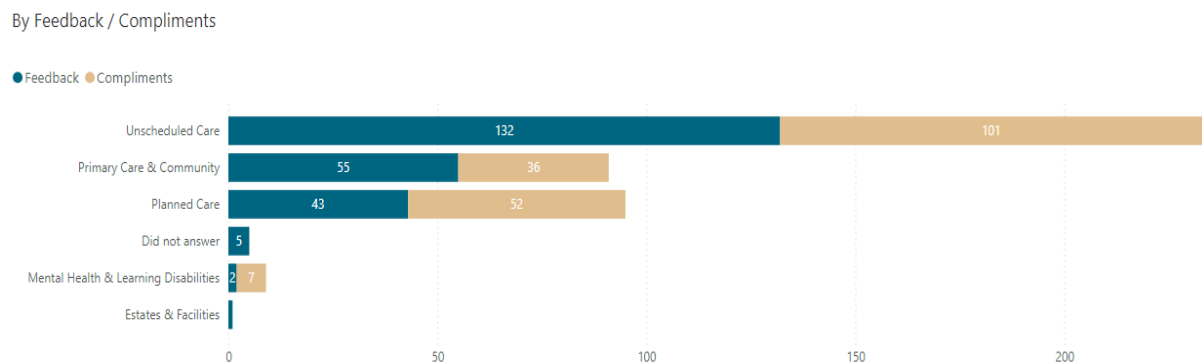
A&E Data



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 Peoples Experience, Operations Lead, AHP Representative and Medical Examiners Service Representative.

The Board meets quarterly, and oversees;

- 1) Data & Dashboard
- 2) Medical Review Process
- 3) Learning from Mortality
- 4) Patient / Family Experience
- 5) Medical Examiner link

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 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	Learning, Improvement & Research



<i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Safe If more than one applies please list below: Effective, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental / Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 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

4.10

Quality, Safety & Experience Committee

Redress Case Management

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Lead for Legal Services
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Lead for Legal Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Nurse Director of Nursing, Midwifery and Patient Services

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
Discussions with key individuals in corporate services and within Care Groups	Click or tap to enter a date.	

Acronyms / Glossary of Terms



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTMUHB	Cwm Taf Morgannwg University Health Board
PTR	Putting Things Right
LTP	Listening to People
PSOW	Public Service Ombudsman for Wales
WRP	Welsh Risk Pool
QL	Qualifying Liability

1. Situation /Background

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2025 supported by the Listening to People (LTP) Guidance 2026, provides the statutory framework in NHS Wales for managing concerns, complaints, and redress where harm may have occurred. Under this process, the Health Board is required to undertake proportionate investigation of incidents to determine whether a breach of duty of care has occurred and, if so, whether this has resulted in qualifying liability (harm). Where both elements are established within the financial threshold, the Health Board may offer redress, including financial compensation, apology, and remedial actions, as an alternative to formal litigation. The process is designed to ensure timely resolution, learning, and transparency, while maintaining a clear distinction between investigation findings and legal liability in higher value or complex cases that fall outside the redress scheme.

The Health Board has experienced sustained delays in the administration and progression of Redress cases, arising from a combination of increased demand, case complexity, and systemic pressures following the introduction of the Duty of Candour and associated governance changes. These delays have been evidenced through missed agreed deadlines, challenges in progressing cases following Regulation 26 reports, and inconsistent communication with legal representatives, which has led to a loss of confidence among claimant solicitor firms managing cases with the organisation. The cumulative impact of these issues has resulted in backlogs across multiple intake years and a perceived lack of timeliness and transparency in the Redress process, prompting escalation of concerns externally.

As a consequence, the Public Services Ombudsman for Wales has proposed an Own Initiative investigation, reflecting concerns from oversight bodies regarding potential maladministration and highlighting the need for significant improvement in performance, governance, and stakeholder engagement within the Redress process (Investigation start letter available via the documents folder on Admincontrol).

2. Specific Matters for Consideration

A key factor contributing to delays in the progression of Redress cases has been the significant and sustained increase in both the volume and complexity of concerns transferred into the Redress process following the introduction of the statutory Duty of Candour in April 2023. This has resulted in a greater number of cases requiring detailed clinical scrutiny, specialist input, and enhanced governance oversight, particularly where consideration of breach, causation, and prognosis necessitates multidisciplinary review.

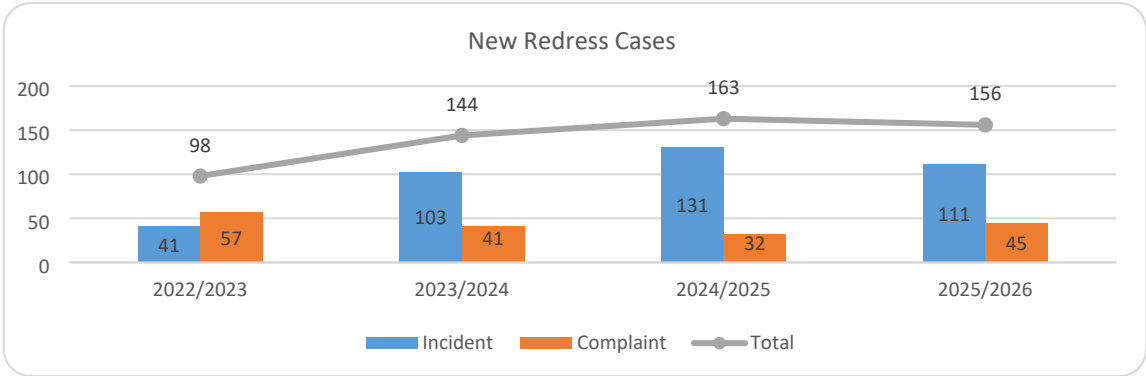
In parallel, the Health Board has implemented major structural and governance changes to strengthen accountability and quality assurance. While these have been necessary improvements, their initial embedding created transitional pressures, with the introduction of Care Group Scrutiny Panels and the transition from a locality-based to a Care Group operating model introducing additional process steps and requiring time for new roles, pathways, and responsibilities to

stabilise. These changes have contributed to slower case progression during the early phases of implementation.

Additionally, clinical capacity constraints have impacted timeliness, with ongoing service pressures limiting clinician availability to provide the detailed input required to progress Redress cases. This has had a direct effect on the ability to form timely Redress decisions, as many cases are dependent on prompt clinical review and expert opinion.

New Redress Activity

The combined effect of these operational, structural and clinical pressures has resulted in a sizeable backlog of Redress cases while new cases continue to enter the system. This is reflected in our internal Redress case activity which highlights that between 2022/2023 and 2025/2026, the organisation received 561 concerns requiring PTR consideration (386 transferred from the incident management process and 175 via the formal complaint process). The trend graph below of annual figures demonstrates a 47% increase in cases being transferred to the Redress process, rising from 98 cases in 2022/2023 to 144 in 2023/2024.



Current Open Redress Cases

Analysis of the current active Redress caseload indicates that the position reflects cumulative, multi-year demand, rather than a single year’s intake or performance. The dataset outlined in the table below represents all live cases currently within the Redress process (427 cases), spanning cohorts from 2021/22 to 2026/27, and therefore includes both legacy cases and more recent activity still progressing through investigation and decision stages.

	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	2026/2027	Total
QL Being Investigated	19	24	50	84	66	5	248
QL Identified	2	2	4	8	45	5	66
Offer made	7	7	8	9	14	8	53
Offer accepted	1	1	5	4	12	3	26
Completed	1	0	0	0	8	0	9
Reimbursement	0	1	2	5	2	0	10
Closed	6	0	1	1	0	0	8
Transferred Out	5	0	0	0	2	0	7

Total	41	35	70	111	149	21	427

The largest active cohorts are 2025/26 (149 cases) and 2024/25 (111 cases), demonstrating sustained inflow alongside a continuing backlog. The majority of cases remain at the investigation stage, with 248 cases recorded as “Qualifying Liability (QL) being investigated”, including 84 from 2024/25 and 66 from 2025/26, illustrating the scale of ongoing casework and the operational pressure across the process.

The profile of the active caseload also reflects improvements in early identification and escalation into Redress, rather than an increase in underlying harm. Cases recorded as QL identified have risen from low single figures in earlier cohorts to 45 in 2025/26, with a further 5 cases already identified in 2026/27, indicating strengthened recognition processes. Progression beyond investigation is evident, with 53 cases having reached the offer stage (including 14 in 2025/26 and 8 in 2026/27) and 26 offers accepted overall, demonstrating movement toward resolution where cases have matured sufficiently. However, the relatively lower volumes of completed (9) and reimbursement (10) cases reflect that a significant proportion of the current caseload remains within earlier stages of the process, rather than indicating reduced throughput. Overall, the active caseload demonstrates a service managing high volumes of complex, multi-year cases concurrently, with the greatest operational pressure continuing to sit within the investigation phase and the most recent high-volume cohorts.

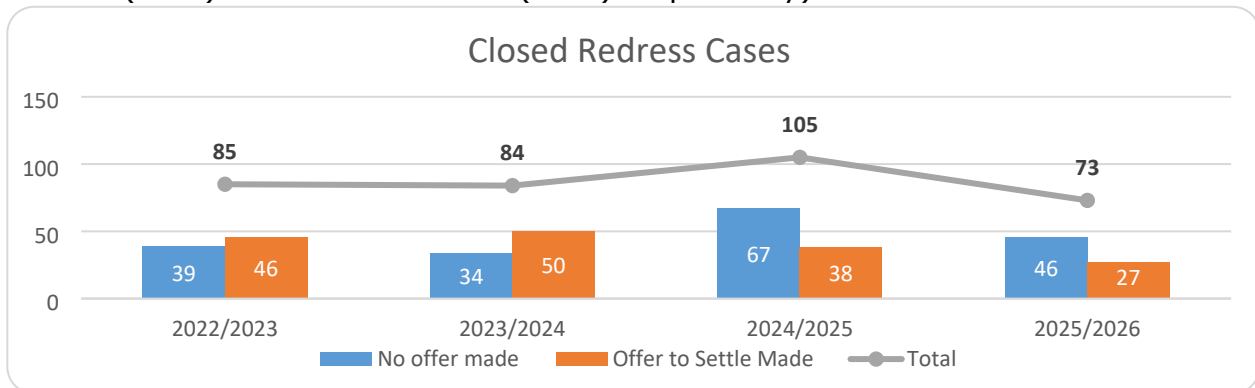
To address the current position, the overarching objective is to reduce the total active Redress caseload and systematically progress historic cases through to resolution, with a particular focus on moving cases out of the “Qualifying Liability (QL) being investigated” stage. This will be achieved through a structured trajectory plan, prioritising the oldest and highest-risk cases for accelerated review, strengthening clinical input to support timely liability and causation decisions, and increasing the rate at which cases progress to “QL identified” and “offer made” stages. The aim is to improve flow across the process, reduce the backlog of long-standing cases, and rebalance the caseload profile toward more timely investigation and resolution, ultimately delivering a sustainable reduction in overall caseload and improved timeliness of Redress outcomes.

Closed Redress Cases

Between 01.04.22 to 31.03.26, the trend (reflected in the chart below) in closed Redress cases shows a broadly stable level of annual case closure, with 85 cases closed in 2022/23, 84 in 2023/24, increasing to a peak of 105 in 2024/25, followed by a reduction to 73 in 2025/26 (total 347 closed cases).

Further analysis of closed Redress cases demonstrates that outcomes are relatively balanced between cases where no offer was made (186 cases) and those progressing to an offer to settle (161 cases), with a total of 347 closed cases. Earlier cohorts (2022/23 and 2023/24) show a higher proportion of cases progressing to settlement, with 46 of 85 cases (54%) and 50 of 84 cases (60%) respectively resulting in offers. In contrast, later cohorts, particularly 2024/25 and

2025/26, show a greater proportion of cases closed without an offer (67 of 105 cases (64%) and 46 of 73 cases (63%) respectively).



This position reflects the variability in case complexity and outcomes, as well as the evolving maturity of cases within each cohort. Overall, the data indicates that while a significant proportion of cases do progress to settlement, a consistent volume are appropriately concluded without an offer, suggesting robust decision-making around liability and causation, supported by clinical and legal review.

Improvement Plan and Actions

A comprehensive Redress improvement and recovery action plan (available via the documents folder on Admincontrol) has been developed and is being implemented to address the identified delays, backlog, and governance challenges within the Redress process. This plan reflects both immediate actions already undertaken to stabilise performance and a programme of sustained improvements to strengthen capacity, governance, and case progression over the longer term.

Actions Already Implemented (Stabilisation and Recovery)

The following actions have been completed to support immediate recovery and strengthen oversight:

- Full review of all open Redress cases to identify priority cases and establish clear next steps for progression
- Implementation of a Redress Tracker and backlog recovery plan to improve visibility, monitoring, and proactive case management
- Reintroduction of weekly Legal Services review meetings to address delays, unblock cases, and maintain momentum
- Direct engagement with legal firms and complainants, including issuing updates to improve transparency and clarify next steps
- Development and approval of a revised end-to-end Redress process and governance framework, including clearer escalation routes and decision-making structures

Actions Underway and Planned (Sustained Improvement)

The following actions are being implemented to support longer-term improvement and system resilience:

- Strengthening workforce capacity and capability through restructuring Legal Services into dedicated Inquests and Claims & Redress functions, with enhanced focus on case management
- Embedding a weekly multidisciplinary Redress/PTR Panel to provide timely legal advice, consistent harm assessment, and support decision-making and case progression
- Further review and optimisation of the end-to-end Redress process to ensure it operates efficiently, is proportionate to case complexity, and consistently supports timely progression and resolution
- Enhancing governance and oversight, including:
 - Introduction of Redress KPIs
 - Development of backlog clearance trajectories
 - Strengthened Executive and Committee reporting arrangements
- Improving administrative and process controls, including:
 - Standardised workflows
 - Optimised use of Datix and tracking systems
 - Strengthened audit and data quality processes
- Enhancing communication and engagement, including:
 - Defined communication plans for each case
 - Clear case ownership
 - Regular, predictable updates aligned to Listening to People requirements

3. Key Risks / Matters for Escalation

The trend in closed Redress cases indicates a period of relative stability followed by an increase and subsequent reduction in closure volumes over the reporting period. A consistent level of closure was achieved in 2022/23 (85 cases) and 2023/24 (84 cases), before rising to a peak of 105 cases in 2024/25, reflecting increased throughput during that period. This was followed by a reduction to 73 cases in 2025/26, suggesting a slowing in closure activity against a backdrop of increasing overall caseload demand.

- **Sustained backlog pressure:** High volumes of cases remain within the system across multiple years, with ongoing inflow exceeding closure rates in recent periods
- **Slowing closure trajectory:** The reduction in closures in 2025/26, following a peak in 2024/25, presents a risk to backlog recovery and overall caseload reduction
- **Pipeline imbalance:** A significant proportion of cases remain within investigation stages, impacting the ability to progress cases to conclusion and maintain flow
- **Timeliness and compliance risk:** Delays in progressing cases increase the risk of missed agreed timelines, external scrutiny, and escalation (e.g. PSOW)



- **Reputational and stakeholder confidence risk:** Continued delays may further impact confidence among complainants, legal representatives, and regulators
- **Capacity and system risk:** Ongoing dependency on clinical input, governance processes, and administrative capacity continues to constrain throughput and requires sustained oversight

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))	Effective Efficient Equitable Person Centred Timely Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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



<i>Have you undertaken a Quality Impact Assessment Screening?</i>	This report outlines key areas of quality across the Health Board	
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	This report relates to the management of the Redress process within the Health Board. Failure to effectively manage the Redress process will result in an increase of cases proceeding to Clinical Negligence Claims which can result in court proceedings and inflate associated costs.	
Enw da / Reputational	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's Redress performance measures may result in impact to the trust and confidence in the Health Boards processes. This can result in an increase in referrals to the Public Service Ombudsman for Wales and solicitor firms not wishing to pursue matters via the redress, opting to progress immediately via the claims route.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

6. Next Steps

- Implementation of improvement actions outlined within the action plan
- Regular update reports on progress to the Quality, Safety and Experience Committee



Agenda Item

5.1

Quality, Safety & Experience Committee

Commissioning Quality Arrangements and Individually Commissioned Packages of Care

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Richard Hughes Executive Director Nursing, Midwifery & Patient Care
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Richard Hughes Executive Director Nursing, Midwifery and Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes Executive Director Nursing, Midwifery and 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		
CTMHB	Cwm Taf Morgannwg University Health Board	



1. Situation / Background

To provide the Committee with assurance that the commissioning quality arrangements previously presented remain robust and appropriate, and to update the Committee on the active review of arrangements for individually commissioned packages of care, including Continuing NHS Healthcare (CHC), Funded Nursing Care (FNC), Section 117 Aftercare and joint commissioning.

The Committee previously received a paper setting out CTMUHB's commissioning quality arrangements, providing assurance that quality, safety, statutory and governance requirements are embedded within formal commissioning agreements and monitoring processes. The details and assurances contained within that paper remain accurate and valid.

Since that time, CTMUHB has commenced an active review of arrangements for individually commissioned packages of care, recognising the scale, complexity, and vulnerability of the population served, as well as the financial significance of this area. This work is ongoing and has not yet concluded.

This paper, therefore, sets out to:

- a) Reaffirm assurance on the overall commissioning quality framework
- b) Update the Committee on the scope, direction and governance of current review activity
- c) Provide assurance that executive leadership and system oversight are in place while the review progresses
- d) Demonstrate alignment with national expectations and statutory duties

CTMUHB commissions a wide range of NHS, independent sector and third-sector services through formal arrangements including Long-Term Agreements, Service Level Agreements, contracts and grants.

As previously reported to the Committee, commissioning arrangements embed explicit requirements relating to:

- a) Quality and safety
- b) Safeguarding
- c) Equality and Welsh Language Standards
- d) Information governance and data protection
- e) Compliance with Welsh legislation, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020

Quality and safety expectations are reflected in commissioning documentation and are supported by monitoring, review, and escalation arrangements that are proportionate to risk and service type.

There has been no material change to the overall commissioning quality framework since the previous paper.

2. Specific Matters for Consideration

Reaffirming Assurance on Commissioning Quality Arrangements

The Committee can continue to take assurance that:

- a) Commissioning documentation remains aligned to statutory and regulatory requirements
- b) Quality and safety requirements are embedded within contractual arrangements
- c) Monitoring and review mechanisms remain in place and operational
- d) Engagement and consultation requirements for service change are established
- e) Executive accountability for commissioning quality is clearly defined

The assurances provided in the previously submitted Commissioning Quality Arrangements paper, therefore, remain valid.

Key Areas of Improvement Being Progressed

While the review remains ongoing, work is actively progressing to strengthen the following areas:

a) Policy and Framework Coherence

Bringing together existing arrangements into a clearer, more coherent Health Board framework to support consistency, clarity and corporate oversight.

b) Process and Documentation Alignment

Reviewing and updating operational guidance to ensure documentation is current, accurate and reflective of existing organisational structures and roles.

c) Panel Governance and Accountability

Strengthening clarity and consistency around panel membership, quoracy, roles and escalation arrangements to support transparent and robust decision-making.

d) Review and Monitoring Arrangements

Clarifying accountability for three-month and annual reviews of care packages to strengthen clinical oversight and reduce quality and safety risk.

e) Financial and Information Governance

Enhancing arrangements for financial accuracy, invoicing, reconciliation and access controls in a high-cost and high-risk area.

f) Corporate Oversight and Reporting

Refreshing governance arrangements to improve visibility of risks, performance and improvement actions through executive and committee structures.

These actions are being progressed alongside ongoing service delivery, while maintaining continuity and safety for individuals and families.

Executive Leadership and Governance

The Executive Director of Nursing, Midwifery and Patient Care is leading this work with Executive colleagues, Care Groups, Finance, Commissioning teams and system partners.

Governance arrangements are in place to ensure:

- a) Risks are identified and managed proactively
- b) Improvement activity is coordinated and prioritised
- c) Alignment with statutory duties and national guidance is maintained
- d) Individuals and families remain central to decision-making

Formal assurance conclusions will be brought forward once the review has been completed and progressed through appropriate governance routes.

Alignment with National Expectations

This work aligns directly with national expectations set out by the Director General for Health, Social Care and Early Years in April 2026, which emphasise the need for immediate local action to review CHC commissioning arrangements and strengthen quality, governance and system working.

The Committee can take assurance that CTMUHB is responding proactively and responsibly to this national direction.

3. Key Risks / Matters for Escalation

3.1 Focus on Individually Commissioned Packages of Care

Individually commissioned packages of care, including CHC, FNC, Section 117 Aftercare and joint commissioning arrangements, represent a particularly complex element of commissioning activity. These packages:

- a) Support individuals with high levels of need and vulnerability
- b) Involve multi-agency decision-making and delivery
- c) Carry significant quality, safety, financial and reputational risk
- d) Require clear accountability for review, monitoring and governance

In response to increasing complexity, demand and national focus on CHC, the Executive Director of Nursing, Midwifery & Patient Care has initiated a dedicated review of local arrangements for this area.

3.2 Status of Current Review Activity

The review of arrangements for individually commissioned packages of care is active and ongoing.

It is being progressed through established executive and operational governance routes and has not yet concluded. No formal conclusions or assurance opinions have been reached at this stage.

The purpose of this update is to ensure Committee visibility and assurance that:

- a) The work is being taken forward with appropriate priority
- b) Clear executive leadership is in place
- c) Risks are being actively identified and managed

3.3 Scope of the Review

The review is examining how individually commissioned packages of care are:

- a) Assessed, approved and commissioned
- b) Governed through panel and escalation arrangements
- c) Monitored and reviewed over time
- d) Supported through financial and information governance processes
- e) Overseen corporately to provide executive and Board-level assurance

3.4 The principal risk relates to the complexity and scale of individually commissioned packages of care while improvement work is ongoing.

This risk is mitigated through:

- a) Active executive oversight
- b) Clear prioritisation of high-risk areas
- c) Continued monitoring through established governance routes

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	A Healthier Wales
	If more than one applies please list below:



150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Person Centred If more than one applies please list below: Efficient Equitable Safe Timely Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Report is for assurance purposes no changes to service
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: All information available in the medium of Welsh or request
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:

- 1) **Note** that the assurances provided in the previously submitted Commissioning Quality Arrangements paper remain accurate and valid.
- 2) **Note** that a detailed review of arrangements for individually commissioned packages of care is currently underway.
- 3) **Receive** assurance that appropriate executive leadership and governance arrangements are in place during this period of review.
- 4) **Note** that further updates will be provided as this work progresses and reaches appropriate assurance points.

6. Next Steps

- 6.1 The review will continue through 2026
- 6.2 Improvements will be embedded as work progresses
- 6.3 A further paper will be brought to the Committee once the review reaches an appropriate assurance milestone

Agenda Item	6.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 24 th March 2026 at 09:00am.
Venue	Virtual via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Patsy Roseblade	Independent Member
	Hayley Proctor	Independent Member
In Attendance	Gethin Hughes	Chief Operating Officer (In-part)
	Richard Hughes	Executive Director of Nursing, Midwifery and Patient Care
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Science
	Hywel Daniel	Executive Director for People (In part)
	Becky Gammon	Interim Deputy Director of Nursing
	Dom Hurford	Executive Medical Director
	Emma Walters	Head of Corporate Governance and Board Business
	Rhian Beynon	Research & Development Manager
	Gaynor Jones	RCN Convenor
	Gareth Watts	Director of Corporate Governance / Board Secretary (In part)
	Deborah Matthews	Nurse Director, Unscheduled Care
	Filipe Leitao	Head of Nursing for Infection, Prevention & Control
	Denise Jenkins	Head of Podiatry & Orthotics
	Robert Richards	Lead Nurse, CAMHS and Specialised Services
	Debbie Jones	Head of Midwifery, Gynae, Integrated Sexual Health and Neonates

	Nigel Downes	Assistant Director of Quality & Safety
	Hannah Wilton	Director of Pharmacy & Medicines Management
	Mohammed Elnasharty	Medical Director - Children & Families Care Group
	Kathrine Davies	Corporate Governance Manager
	Daniel Price	Regional Director, Llais Cymru
	Zoe Ashman	Interim Care Group Nurse Director
	Gary Howell	Clinical Director of Allied Health Professionals
	Sharon Edwards	Corporate Governance Officer
	Sharon O'Brien	Care Group Nurse Director-Planned Care
Meeting Observers	Ceri Derrick	Pharmacist (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. 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: Philip Daniels, Executive Director, Public Health
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 5) that the Committee Members wished to bring forward to the main agenda for discussion. There were no items Members wished to bring forward.

3.	MATTERS ARISING
3.1	Action Log
	P Roseblade highlighted Action Log item 5.1, specifically noting that the point was not about CTM's performance regarding WAST, but rather about the need for triangulation of information. Members noted that this action would be reviewed further outside the meeting.
Resolution	The Committee NOTED the Action Log
Action	Action log item 5.1 to be reviewed further outside the meeting.
3.2	Matters Arising Not Captured on the Action Log
	No further matters were raised
4.	IMPROVING CARE
4.1	Shared Listening & Learning Story – Podiatry Services
	D Jenkins presented a patient story describing a five-year journey of a diabetic patient with complex foot disease. Key points included: • Diabetic foot disease is a major cost and morbidity burden across Wales. • CTM has higher-than-average diabetes prevalence, making prevention and management essential. • The patient had long-standing ulceration, infection and complications • Strong therapeutic relationships, consistent communication, and education enabled the patient to make an informed decision to undergo elective amputation, which he now views positively. • The Value-Based Healthcare (VBHC) inpatient foot project has improved coordinated care from admission to discharge, focused on early intervention, red-flag awareness, and reducing complications. In response to a query raised by L Edwards regarding key learning from the story and whether communication and partnership working were the main themes, D Jenkins advised that communication, relationships, and "what matters to the patient" were fundamental. In response to a query raised by L Edwards as to how this learning could be spread across the organisation and whether early communication helped the patient recognise deterioration, D Jenkins emphasised the importance of clinicians using language patients can understand and added that long-term rapport allowed the patient to feel fully supported, with early education helping to ensure that the patient recognised the red flags and presented promptly. In response to a query raised by G Hughes as to how patient stories could support early education and whether earlier intervention could reduce the need for amputation, D Jenkins highlighted that education must begin at diagnosis, given that diabetes was a lifelong condition and added that foot checks in primary care were vital, with patients requiring simple guidance on risks and prevention. Members noted that the inpatient project now supported ward staff to identify at-risk patients earlier.



	In response to a query raised by P Roseblade as to whether podiatry learning could support Type 2 diabetes prevention messaging, D Jenkins confirmed the availability of an education programme, designed for Type 2 diabetes, covering circulation, neurology, and self-care, which was delivered by the Wellness Improvement Services (WISE) team on behalf of Podiatry and included referral pathways where required. D Hurford raised queries regarding improvements in community foot checks, early detection, and the need for psychological support for patients facing amputation. In response, D Jenkins advised that psychological needs vary, as some patients feel relief post-amputation and added the team ensures patients were informed without feeling directed. In response to a query raised by C Donoghue as to whether the project's funding was time-limited and what its future might be, D Jenkins confirmed funding runs until March 2027. Members noted that the project was initially funded as a one-site proof-of-concept and noted that the project has expanded across the three acute sites, but without recurrent funding, its sustainability is at risk. G Hughes noted that VBHC funding aims to demonstrate that investment in one area delivers savings elsewhere, and the economic case must be evidenced this year to secure future funding. The Committee Chair thanked D Jenkins for the powerful presentation, acknowledging the strong patient-centred practice, the importance of communication and long-term relationships, and the need to consider sustainability of the value-based inpatient foot pathway.
Resolution:	The Listening and Learning Story was NOTED .
Action:	N/A
4.2	Peoples Experience Activity Report
	B Gammon presented the People's Experience Activity Report, highlighting progress, current activity, and key areas of focus across patient experience and the Patient Advisory Liaison Service (PALS). In response to a query raised by K Palmer regarding the current timescales for the Organisational Change Programme (OCP), particularly in relation to PALS, B Gammon advised that the OCP consultation for the Quality & Safety Team (which includes PALS) closed on 18 March and was in the process of being reviewed. Members noted that the senior team structure would be phased in as part of the OCP implementation. In response to a query raised by K Palmer as to whether the PALS service provided support to Community Services as well as Secondary Care, B Gammon advised that whilst PALS does not provide support into community services, the PALS team regularly attends community engagement events, and work closely with the Engagement Team, Communications Team and Charity

	and veterans' organisations. Members noted that whilst the Team provide support across sites, the service was not formally established in primary care. In response to a query raised by P Roseblade regarding what the total whole-time equivalent (WTE) was for the PALS team and whether the posts were difficult to recruit into, B Gammon advised that the PALS team currently has 5.8 WTE, with two vacancies at present. Members noted that whilst the team had not recently had any issues in recruiting into the service, there had been challenges in selecting the right candidates given the patient-facing nature of the role.
Resolution:	The Committee NOTED the report.
4.3	Thematic Spotlight Presentation – Winter Wrap Up D Matthews, S O'Brien and F Leitao presented an overview of the winter pressures experienced across the Health Board. The update covered ambulance handovers, emergency care pressures, planned care impacts, boarding, delayed transfers, infection-prevention challenges and the cumulative effect on patient experience and staff well-being. K Palmer raised a concern about what is being done to support staff given there was clear pressure and fatigue along with whether it has been recognised that the Royal Glamorgan Hospital (RGH) appeared to be under particular strain. R Hughes explained that staff wellbeing and sickness pressures would be addressed with a strengthened executive focus and that RGH pressures had been recognised and would form part of future service/pathway planning. In response to a query raised by K Palmer as to how Hospital at Home was being factored into the wider transformation, R Hughes advised that Hospital at Home was strategically important with further work planned over the coming months to maximise its role in admission avoidance. H Proctor expressed concern that boarding was becoming the norm and queried what would happen when escalation was already at maximum. H Proctor further highlighted the issue of surgical patients remaining in Recovery due to the unavailability of ward beds, and asked what thresholds trigger a move from monitoring to intervention. In response, R Hughes and S O'Brien reiterated that boarding remains a last resort but acknowledged that pressures have increased. D Hurford reinforced that although boarding was not acceptable, community mortality risk must also be considered when balancing decisions and supported further discussion while emphasising the need to understand system-wide risk. R Hughes added that Recovery delays are linked to wider flow pressures and advised that, while the Escalation Framework was helpful, improvements were needed in out-of-hours adherence, consistency of decision-making and overall concordance, with work underway to strengthen oversight.



	P Roseblade sought clarification on several points within the presentation slides, including the meaning of “probable compliance” in the sepsis audit slide and the specific intention behind the reference to “support further developments.” P Roseblade also expressed concern regarding delays in discharges to the local authority (Pathway 3). In response, C Donoghue asked R Hughes to consider the queries raised and consider whether a response could be provided outside the meeting or whether any updates needed to be presented to the next meeting for further assurance. B Gammon also noted that to add to the Hospital at Home model and ongoing work with Infection, Prevention and Control and admission prevention, the team had been able to extend its reach into Primary Care this year. Members noted that this had enabled the introduction of champions across nursing and care homes and strengthened collaboration with GPs and pharmacists, which was expected to have a positive impact next winter. C Donoghue thanked the presenters for a thorough and honest account of winter pressures, noting key concerns around staff strain, boarding impacts, ED overcrowding, delayed transfers of care, and the sustainability of system-wide escalation. C Donoghue and R Hughes agreed to summarise the emerging themes and bring back a structured, high-level follow-up for future Committee discussion. R Hughes further suggested that such a review could usefully become an annual process.
Resolution:	The Committee • NOTED the report • Agreed continued 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, subject to the approval of any resource issues • Recommend that IPC winter learning is embedded into annual preparedness planning, with earlier escalation triggers aligned to epidemiological patterns observed this year.
Action:	Summarise the emerging themes from the winter wrap up and bring back a high level follow up
Action:	Consideration to be given as to whether the Winter Pressures Wrap up should be presented on an annual basis.
4.4	Report from the Clinical Executives
	R Hughes and his Clinical Executive Director colleagues presented the report and highlighted the key matters for Members attention. K Palmer asked whether psychological support could be incorporated into long term pain management, particularly if medication such as gabapentin was being reduced, to which D Hurford confirmed that psychological support was

	already part of the chronic pain pathway, delivered through WISE psychology services and internal pain teams. D Hurford explained that psychological therapy cannot directly replace gabapentin but was a key component of a multi-disciplinary approach and often works alongside medication review. In response to a query raised by P Roseblade as to why one of the newly appointed Associate Medical Director roles was interim, whereas others were substantive, D Hurford explained that the role was interim because the appointed individual also holds a Care Group Director position, and the interim arrangement allows both the individual and the organisation to test the balance of responsibilities before confirming the post permanently, adding that the individual was performing exceptionally well. P Roseblade sought clarification on what the consequences were when the coroner issues a Schedule 5. R Hughes explained that a Schedule 5 notice was issued when the organisation misses the deadline for providing evidence or statements to the coroner. Members noted it effectively gives the Health Board an additional period to submit the outstanding information while also noting that the number of Schedule 5 notices has reduced as compliance has improved.
Resolution:	The Committee NOTED the reports
4.5	CARE GROUP HIGHLIGHT REPORTS
4.5.1	Unscheduled Care
	D Matthews presented the Unscheduled Care update and highlighted the key matters for Members attention. In response to a query raised by C Donoghue as to when the Committee should expect to see improvement in resuscitation training compliance, D Matthews confirmed that the improvement plan was already in progress and that measurable progress should be apparent within two to six months. K Palmer sought clarification on whether there were any other areas of mandatory training, beyond resuscitation, where compliance remained below target. D Matthews confirmed that no additional training areas were currently escalated as concerns. In response to a query raised by K Palmer as to what the Committee should reasonably expect in relation to reducing falls and pressure damage, and whether these trends were likely to remain stable or improve over the next year, D Matthews advised that both falls and pressure damage continue to be monitored daily and, while current patterns remain stable, some incidents are unavoidable given the frailty and mobilisation needs of the patient population. Members noted that work was underway to strengthen the distinction between avoidable and unavoidable harm, which will help set clearer expectations. L Edwards highlighted concerns regarding oral care and hygiene. In response, D Matthews agreed that this was an important area for improvement and

	indicated her intention to spread the learning, particularly around enabling staff to understand how to clean the palate properly with patient compliance. R Hughes advised that he had commissioned a whole-scale review of the organisation's current approach to training, including how it is structured, delivered and monitored, which will help shape how training compliance is improved going forward. R Hughes added that forthcoming work through the Improving Care Board and the Harm-Free Care programme will support the Committee in understanding "<i>what good looks like</i>" by providing clearer benchmarks, expectations and a more consistent framework for assessing quality and safety performance.
Resolution:	The Committee NOTED the report.
4.5.2	Planned Care
	Sharon O'Brien presented the Planned Care update and highlighted the key matters for Members attention. An update on the Audit Wales Eye Care Review was also included, showing progress against historic actions. P Roseblade asked for clarification on the communication and language complaints shown in the Planned Care dashboard and queried whether this related to patients' spoken language needs or something else. S O'Brien confirmed that these complaints do not relate to different spoken languages or access to translation and related primarily to the communication around waiting list delays along with clarity of information provided to patients and the use of clinical or technical terminology that patients had found difficult to understand. S O'Brien highlighted that early resolution work had significantly reduced waiting-list-related concerns. P Roseblade asked whether the Committee could receive a further update on Ophthalmology, noting that it had been an area of historical concern. It was agreed and confirmed that a more detailed ophthalmology update will be brought to a future meeting, given the interest and importance of the Audit Wales Eye Care review.
Resolution:	The Committee NOTED the report.
Action:	A further ophthalmology update to be brought to a future meeting given the interest and importance of the Audit Wales Eye Care review.
4.5.3	Children & Young People
	D Jones presented the Children & Young People report and highlighted the key matters for Members attention. K Palmer sought clarification on the location and timescales related to the Maternity Priority Unit (triage) and whether the issue was specific to Prince Charles Hospital (PCH). D Jones confirmed that whilst the triage area at PCH does have environmental and space challenges, both sites do have maternity triage in place. D Jones added that potential alternative spaces had been reviewed during recent site walkarounds, with the aim of identifying a workable solution by the summer.



	K Palmer asked for further detail on the Special School Nursing risk, particularly why it remained at a score of 20. R Hughes advised that the special school nursing risk was subject to a broader national review and local work is ongoing. R Hughes advised that the current risk score may reduce following further assessment, but a full review with the Care Group will take place over the coming weeks.
Resolution:	The Committee NOTED the report
Action:	N/A
4.5.4	Primary Care & Community
	Z Ashman presented the Primary Care & Community update, highlighting several key issues and developments across the service. In response to a query raised by P Roseblade as to what aspects of the new dental contract were causing concern and leading practices to return their contracts, Z Ashman explained that the new contract includes additional performance monitoring requirements and more stringent conditions, which some practices do not wish to sign up to. Z Ashman added that similar patterns were occurring across Wales and England and reassured the Committee that the position was being closely monitored. K Palmer asked about the challenges with the GP Out-of-Hour's system, including issues arising from the shift to LocumNest and whether there were any interim mitigations while national solutions are awaited. D Hurford advised that whilst a new provider for the OOH system was being finalised and that changes were imminent, he could not give specific detail at this stage. D Hurford assured the Committee that work was actively progressing to stabilise the service.
Resolution:	The Committee NOTED the report
4.5.5	Mental Health & Learning Disabilities
	R Richards presented the Mental Health & Learning Disabilities update on behalf of the Care Group and highlighted current pressure points and areas of improvement. K Palmer noted that Ward 14 at Princess of Wales Hospital (POW) had previously appeared highly pressured and queried whether the high number of incidents reported on the ward were linked to staffing issues or other concerns. R Richards confirmed that Ward 14, like many adult inpatient mental health wards, continues to experience high acuity and consistent full occupancy, which contributes to the volume of incidents and advised that there were no staffing shortages at present. L Edwards confirmed that themes and trends from Ward 14 are reviewed regularly through the Care Group Quality, Safety, Risk & Experience Committee, and updates can be shared with Members if required.
Resolution:	The Committee NOTED the report.
4.5.6	Diagnostics, Therapies, Pharmacy & Sciences (DTPS)

	H Wilton presented the DTSP update, highlighting several significant risks and developments across the Care Group. H Proctor expressed concern that pharmacists were being asked to prescribe outside their scope of practice and asked whether staff were being sufficiently supported. H Proctor also highlighted the need to consider full patient pathway impacts when introducing additional weekend clinics. H Wilton agreed with the concerns raised and confirmed that pharmacists had sustained this pressure for some time prior to escalating and added that staff had been encouraged to raise a DATIX each time they were asked to work outside their scope. Members noted that Primary Care senior leads had acted immediately once notified of this situation with the team ensuring all staff are supported and noted that the issue is now being closely monitored. In relation to additional clinics, H Wilton acknowledged the concern and confirmed services must ensure all affected parts of the pathway are informed and prepared. D Hurford highlighted significant concern about the LIMS programme, describing the risk to CTM as high. H Wilton agreed, noting that LIMS was a major strategic risk and that the full options appraisal will outline risks and mitigations. L Edwards confirmed that concerns about LIMS had been escalated nationally, with regular meetings between Directors of Digital, Chief Executives and the Welsh Government.
Resolution:	The Committee NOTED the report.
Action:	N/A
4.6	Quality Dashboard Report
	N Downes presented the Quality Dashboard Report covering the period 1 January – 28 February 2026 and highlighted the key matters for Members attention. In response to a query raised by K Palmer as to why there were a high number of NRIs (Nationally Reportable Incidents) recorded in the Children & Families Care Group, and whether the committee would receive further detail on the reasons behind this, N Downes confirmed that the Children & Families team had experienced a greater volume of NRIs during the period and proposed that the Care Group include some commentary on this within its next highlight report to provide context and assurance In response to a request made by K Palmer, N Downes confirmed that the latest Regulation 28 report had been issued and agreed to circulate it to Committee members. In response to a query raised by K Palmer regarding the Mental Health metrics noting that 32 out of 75 restrictive practices were not care-planned and whether this was a concern, N Downes advised this required further exploration and added that restrictive practices, their planning, and their appropriateness

	would be reviewed with the MHL D Care Group, with detail to be fed back through future reporting. R Hughes added that the review would help ensure the dashboard more clearly distinguishes planned against unplanned restrictive interventions. P Roseblade advised that she had previously asked how themes relating to communication within complaints were captured and analysed, and sought assurance that improvements were underway. N Downes confirmed that work was ongoing to analyse communication-related themes more systematically, which was being strengthened through both Listening to People implementation and the Quality & Safety Organisational Change Process, with an aim to improve learning loops across the organisation. R Hughes informed the Committee that he and the Chief Executive would be meeting with the Public Services Ombudsman for Wales later that day regarding concerns over delayed redress cases, and a further update would be provided to the Committee and Independent Members once outcomes were known.
Resolution:	The Committee NOTED the report.
Action:	Regulation 28 report to be circulated
Action:	To receive further clarification on NRI levels in the Children & Families Care Group Highlight report at the next meeting
Action:	To review restrictive practices, including their planning and appropriateness, with the MHL D Care Group, and provide feedback through future reporting.
Action:	To provide an update to the Committee and Independent Members on the outcomes of discussions with the Public Services Ombudsman for Wales regarding concerns over delayed redress cases.
4.7	Healthcare Inspectorate Wales (HIW) Improvement Plan Tracker Report
	The HIW Improvement Plan Tracker Report was not discussed during the meeting due to time constraints. It was agreed that there would be a full discussion at the next QSEC meeting in June, where it would be received on the main agenda for deeper scrutiny. R Hughes also asked members to review the Tracker Report and submit any specific questions in advance of the next meeting, so that these can be fully addressed in the June discussion.
Resolution:	The Committee NOTED the report is deferred.
Action:	Consideration be given by members to specific questions relating to the tracker so they can be addressed at the next committee
4.8	Mortality Indicators and Mortality Reviews
	The Mortality Indicators and Mortality Reviews Report was not discussed during the meeting due to time constraints. D Hurford clarified the paper itself would remain unchanged but would welcome committee discussion on • Variation between acute sites and localities, and • The reasons CTM is not achieving 28-day Stage 2 mortality reviews

Resolution:	The Committee NOTED the report would be deferred
4.9	CTMUHB's NHS Research & Development Framework Assessment 2026 R Beynon presented the CTMUHB NHS Research & Development Framework Assessment, explaining that the updated self-assessment reflects progress made since the baseline assessment in 2024. The assessment outlines CTM's position against the ten pillars of the NHS Wales R&D Framework, highlighting organisational strengths, areas for further development, and key strategic objectives. Members noted the updated assessment would be submitted to Welsh Government and would form the basis of CTM's discussion at the Annual Review meeting scheduled for 29 July. In response to a query raised by L Edwards as to how the feedback from the Welsh Government Annual Review would be reported back into CTM's governance structures and whether the Committee would receive the outcomes. R Beynon confirmed that the assessment informs the Annual Review discussion with Health & Care Research Wales and Welsh Government. Following the meeting, formal feedback is provided in writing, and this will be shared with both the Improving Care Board and QSEC, in line with existing reporting cycles.
Resolution:	The Committee APPROVED the submission of CTMUHB's NHS R&D Framework assessment 2026 to Health Care and Research Wales.
Action:	Formal feedback to be provided at future meeting.
4.10	Organisational Risk Register E Walters provided a verbal update on the Organisational Risk Register, advising that due to ongoing staffing gaps within the Corporate Governance Team, work had prioritised the Board Assurance Framework and strategic risk updates. E Walters advised that whilst the Organisational Risk Register had not been refreshed for this cycle, Directorates were continuing to update their risks on Datix.
Resolution:	The Committee NOTED the update
5.	CONSENT AGENDA
5.1	FOR APPROVAL
5.1.1	Unconfirmed Minutes of the Meeting held on 20th January 2026 The Unconfirmed Minutes of the Committee Meeting held on 20 th January 2026 were APPROVED .
5.1.2	Policies for Approval – ALL Wales Top Up Policy Top Up Policy Papers were APPROVED .
5.2	FOR NOTING
5.2.1	Non-Routine Committee Business (Forward Plan) The Committee NOTED the Forward Plan.
5.2.2	Health Inspectorate Wales (HIW) Improvement Plan tracker Report The Committee NOTED the report.
5.2.3	Organ Donation Sub Committee Highlight Report The Committee NOTED the report.
5.2.4	Highlight Report from the JCC Quality, Safety and outcomes Sub Committee



	The Committee NOTED the report.
6.	CLOSE OUT BUSINESS
6.1	Committee Highlight Report to the Board – Verbal
	The Chair and Committee noted the update to the Committee Highlight Report. E Walters confirmed that key issues raised during the meeting—particularly winter pressures, staff wellbeing, and escalation concerns—would be reflected in the Alert/Escalate section for the upcoming Board meeting. The Chair advised she would provide a verbal update to the Board at its March 2026 meeting on significant issues emerging from the meeting.
6.2	Meeting Feedback
	C Donoghue advised that she welcomed feedback outside this meeting
6.3	Any Other Business
	There was no other business to report.
7.	PRIVATE / CLOSED SESSION BUSINESS
	There were no items requiring discussion in closed session on this occasion.
8.	DATE & TIME OF THE NEXT MEETING
	Wednesday 3 rd June 2026 at 9:00am



Agenda Item

6.1.2

Quality, Safety & Experience Committee

Unlicensed Medicines Policy

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Huw Carson- principal Pharmacist- Quality and Safety
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Hannah Wilton- Director Medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Approval	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Medicines Management Quality and Safety Group	February 2026	Approved
DTPS QSRE	March 2026	Approved
OMB	March 2026	Approved
Acronyms / Glossary of Terms		

1. **Situation /Background**

This report seeks approval for the updated Unlicensed Policy. The policy is an update of the previous unlicensed policy as part of general review, with additional clarifications around communication with primary care and improved governance around purchasing unlicensed medication during periods of national shortages.

2. **Specific Matters for Consideration**

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

Name Title	Date Consulted/Completed
Equality Impact Assessment	
Informal Consultation with interested parties	Multiple rounds of consultation with different pharmacy teams (QC, logistics, governance, clinical services)
Formal Consultation	Consultation with pharmacy team Consultation with Medical Directors
Committee – For approval	Approved by Medicines Management Quality and Safety Meeting, and DTPS QSRE- March 2026 OMB March 2026

- 2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
- 2.3 Organisational values and behaviours have been reflected within the policy.



3. **Key Risks / Matters for Escalation**

- 3.1 In response to the consultation the following amendments have been made:
- 3.1.1 multiple minor amendments to flow



- 3.1.2 following consultation with Medical Director, Primary Care- clarification on the route of communication from GPs back to initiating consultants

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 Prosperous 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	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Review of current policy



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

5. Recommendation

5.1 The Committee is asked **APPROVE** the Policy

6. Next Steps

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

Unlicensed Medicines Policy

Document Type:	Clinical Policy
Ref:	CTM-MM-UoM-12
Author:	Huw Carson- Principal Pharmacist, Quality and Safety Iwan Wyn Griffith- Principal Pharmacist, Quality Assurance
Executive Sponsor:	Executive Medical Director
Approved By:	OMB
Approval / Effective Date:	18/03/26
Review Date:	18/03/29
Version:	2.0

Target Audience:

People who need to know about this document in detail	All staff involved in prescribing, administration or supply of medication
People who need to have a broad understanding of this document	Managers of the above staff
People who need to know that this document exists	Senior Health Board staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: Outcome: This policy has been screened for relevance to Equality. No potential negative impact has been identified.
Welsh Language Standard	No
Date of approval by Equality Team:	
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

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Summary

This document lays out the procedures for handling unlicensed medicines within the CTM UHB, including prescribing, procurement, receipt, quality assessment, supply and administration.

The processes described in this document apply only to **products which do not have a UK product licence / marketing authorisation**. This process **does not** apply to medicines used outside of their product licence / marketing authorisation (i.e. “off-label” use).

i. Policy Statement

The policy provides a framework to ensure the use of unlicensed medicines within the Health Board is consistent, efficient and safe and is in line with current regulations.

The processes described in this document apply only to **products which do not have a UK product licence / marketing authorisation (MA)**. They do *not* apply to medicines used outside of their product licence / marketing authorisation (i.e. “off-label” use).

This policy does not cover the use of:

- Clinical trials i.e. Investigational Medicinal Products (‘IMPs’)
- Medicines made available through ‘Early Access Medication Schemes’

ii. Scope of Policy

This policy is intended for use by all healthcare professionals (HCPs) employed by, or working for, Cwm Taf Morgannwg University Health Board (CTMUHB) who are involved with prescribing, purchasing, receipt, quality assessment, supply and administration of unlicensed medicines.

The policy covers the use of medicines without a UK Marketing Authorisation i.e. product licence (unlicensed medicines).

iii. Aims and Objectives

Liability for issues arising from the use of unlicensed medicines will be accepted by CTMUHB if the agreed policy and approved procedures are followed.

In exceptional circumstances, some unlicensed medicines may be kept as ‘stock’ in a clinical area. It is recognised that this approach is not in keeping with the principles of [MHRA Guidance Note 14](#). However, where an unlicensed medicine is being used to treat a cohort, i.e. a group of patients where a UK licensed medicine is temporarily unavailable, it is important to maintain a system that allows for the timely treatment of patients ‘out of hours’. This policy identifies how this risk should be managed.

iv. Responsibilities

The Chief Executive has overall responsibility for policies within Cwm Taf Morgannwg University Health Board.

The Director of Corporate Services & Governance has delegated responsibility for the corporate implementation, co-ordination and monitoring of compliance with legislation and national guidance in relation to the use of unlicensed medicines to the **Clinical Director, Medicines Management** as the lead Clinical Directorate.

All users will understand and adhere to their responsibilities for prescribing, purchasing, manufacturing, dispensing and administration of unlicensed/ off label medicines in line with the policy and procedures

The Board is responsible for the strategic elements, taking into account all related legal and NHS requirements and for the development and coordination of effective governance within the Health Board and with its partners.

Managers at all levels within the Health Board are responsible for continuing compliance within their areas and ensuring that this policy is built into local processes.

Clinicians / Prescribers- Prescribers must consider patient clinical need and safety when prescribing unlicensed medicines. The BNF and BNF for Children (BNF-C) state that “Prescribing unlicensed medicines or medicines outside the recommendations of their Marketing Authorisation alters (and probably increases) the prescribers’ professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines and also inform the patient or the patient’s carer that the prescribed medicine is unlicensed”.

When prescribing an unlicensed medicine the prescriber must:

- be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy, and that there is no suitable licensed alternative that would meet the patient’s needs;
- take responsibility for prescribing the medicine and for overseeing the patient’s care, monitoring and any follow up treatment, or make sure that arrangements are in place for another suitable prescriber to do so;
- make a clear, accurate and legible record of all medicines prescribed and, where common practice is not being followed, the reasons for prescribing an unlicensed medicine.
- ensure patients are fully informed and provided with sufficiently detailed information regarding the unlicensed medicine.
- ensure prescribing falls within their defined scope of practice / area of competence

Guidance from the General Medicine Council (GMC) on prescribing unlicensed medicines and for prescribing medicines for use outside the terms of their product licence or MA should be followed (see appendix 1).

Pharmacists / Pharmacy Staff- It is the duty of Pharmacists and Pharmacy Technicians to assist prescribers in ensuring that an unlicensed medicine is only used where there is no appropriate licensed alternative.

Additional responsibilities placed on Pharmacy staff in relation to unlicensed medicine include:

- Ensuring cost effective medicines are used.
- Ensuring effective governance arrangements are in place in relation to procurement and supply, including quality assessment of the medicinal product and it’s packaging to consider its appropriateness for use.
- Where possible, sourcing unlicensed medicines that are on a National Procurement Contract, as the quality and cost will have been considered with the suppliers.
- Ensuring appropriate reporting of Adverse Drug Reactions (ADRs) through the Yellow Card monitoring scheme.

Shared Responsibility

The pharmacy team should work closely with the prescriber, and the patient where appropriate, to identify the most appropriate product if a prescriber decides that an unlicensed medicine is required to establish optimal treatment. This will ensure an informed decision is taken in the context of the options available.

The pharmacy team should be involved in monitoring the treatment and the response to it. Safety and efficacy of the unlicensed medicine is not assured to the same degree as for a UK licensed medicine. The patient's condition and their 'special clinical need' may change with time and the care environment. Therefore, the choice of medicine should be regularly reviewed to ensure that it remains appropriate and that continued prescribing of an unlicensed medicine remains justified.

Professional standards:

- All medical and non-medical prescribers should follow their respective regulatory bodies' standards of proficiency, as well as the principles of prescribing as detailed by the competency framework for all prescribers published by the Royal Pharmaceutical Society⁹.
- In addition, medical prescribers should follow guidance on prescribing unlicensed medicines issued by the General Medical Council¹⁰ and other nationally recognised sources.
- Non-medical prescribers should follow their relevant professional bodies' standards^{5, 11-18} as they are individually professionally accountable to their respective professional regulatory bodies and must act in accordance with the relevant code of ethics and conduct.
- It is expected that all pharmacists acting outside the role of an independent prescriber and pharmacy technicians following this policy will also comply with the professional standards set out by the General Pharmaceutical Council⁵

vi. Equality Impact Assessment Statement

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

1. Principles

The Medicines and Healthcare products Regulatory Agency (MHRA) is the UK's medicines and medical devices regulator. Following a rigorous assessment process, every marketed medicinal product in the UK is issued with a Great Britain Marketing Authorisation (MA) number also known as a Great Britain Product Licence (PLGB) number by the MHRA. The MA/PLGB number must be displayed on each medicines pack, and its presence provides a guarantee of quality. The majority of medicines used within CTMUHB have a MA issued by the MHRA and are used within the terms of that MA. The terms of a product's MA set out the indication(s) for use, patient group(s), dosing and method of administration which have been approved by the MHRA.

The MHRA accept that a licensed medicinal product does not exist to meet every clinical situation. The purpose of this policy is to provide a framework to ensure the use of unlicensed medicines within the Health Board is consistent, efficient and safe and is in line with current regulations.

<u>Licensed Medicines</u>	Medical treatment should always use UK licensed medicines wherever possible. A medicinal product can generally only be placed on the market when it has been assessed by the Medicines and Healthcare products Regulatory Agency (MHRA) to meet the <i>quality, safety</i> and <i>efficacy</i> standards for its intended use, and has been granted a UK Marketing Authorisation (MA) by the MHRA. A UK licensed medicine has a Marketing Authorisation that appears on the packaging in the format PL/12345/12340 or PLGB 12345/12345.
<u>Unlicensed Medicines</u>	Any medicine that meets the definition of a medicine but does not have a UK Marketing Authorisation granted by the MHRA is an unlicensed medicine. Licensed medicines undergo full evaluation by the MHRA as part of the licensing process. Pharmaceutical <i>efficacy, safety and quality</i> are assessed and assured. Unlicensed medicines fall outside of the MHRA medicines licensing process i.e. they are not assessed by the MHRA, so prescribers and pharmacists must take additional steps to assure themselves of the quality, safety and efficacy of all the unlicensed medicines that they prescribe, purchase, supply and administer. Unlicensed medicines may only be prepared and supplied under an exemption from the Human Medicines Regulations 2012 (SI 2012/1916).

Examples of Unlicensed Medicines

- UK manufactured 'Specials' (unlicensed medicines manufactured in the UK by the holder of a "Specials" Manufacturing Authorisation (MS) licence)
- Imported medicines (which may or may not be licensed in countries outside of the UK)
- Medicines made under Regulation 174 of the Human Medicines Regulations
- Medicines made under 'Section 10' exemption of the Medicines Act 1968
 - e.g. aseptically prepared injectable medicines
 - extemporaneously prepared non-sterile medicines

Reasons for using an Unlicensed medicine

Most medical treatment is given by prescribing licensed medicines, which provides a high level of assurance of *quality, safety* and *efficacy*. Unlicensed medicines should be prescribed and supplied ONLY if the prescriber is satisfied that the patient has a “special clinical need” which cannot be met by any available licensed medicine. It does not include reasons of cost, convenience or operational needs.

Options to explore before deciding to use an unlicensed medicine are:

- using an alternative licensed presentation of the same drug molecule
- using an alternative licensed medicine
- using a licensed medicine “off-label”

In many cases, an unlicensed medicine is already established in use for patient groups with the same ‘special clinical need’. Nevertheless, those involved should ensure they are satisfied that the unlicensed medicine is still appropriate.

Who can prescribe Unlicensed Medicines

The following HCPs can prescribe unlicensed medicines (subject to accepted good clinical practice):

- Doctors,
- Dentists,
- Independent Nurse and Pharmacist Prescribers,
- Providing it is in accordance with the patient’s clinical management plan - supplementary prescribers (can be a Pharmacist, Nurse, Midwife, Optometrist, Physiotherapist, Radiographer, Chiropodist/Podiatrist).

There must be authoritative clinical evidence and guidance to support such prescribing decisions. The non-medical independent prescriber must accept professional, clinical and legal responsibility for unlicensed prescribing and follow the Health Board Non-Medical Prescribing procedure.

All supplementary prescribers may prescribe unlicensed medicines, subject to accepted clinical good practice and clinical competence, and provided they form part of the patient’s agreed clinical management plan.

2. Process for prescribing Unlicensed Medicines

Requests for new unlicensed medicines may come either directly from clinicians or be prompted by a shortage of a UK-licensed product. The process to be followed will depend on whether the request for the unlicensed medicine is a:

2.1	"patient-specific approval" request	Patient specific request
2.2	"blanket approval" request	Request to treat a group of patients with a common 'special clinical need'
2.3	"a drug shortage"	In the event of the temporary unavailability of a UK licensed medicine (a UK drug shortage)

The clinician requesting a new unlicensed medicine must complete the relevant 'unlicensed medicine approval form' and submit it to Pharmacy. The form completed will depend on whether the unlicensed medicine is to be administered:

- To an individual named patient ("**patient-specific approval**") – the Consultant who is overseeing the prescription should sign the completed form (in appendix 2) and submit to the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy for approval of use for the specified patient.
- To a defined cohort of patients ("**blanket approval**") – the Clinical Director responsible for the clinicians prescribing/working within this specialist area should sign the completed form (in appendix 2) and submit to the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy. If approved, the form will be submitted to the Formulary and Interface Pharmacist for consideration by ATMG under the Health Board's clinical governance processes. Blanket approvals are valid for 2 years from the date of approval.
- In the event of the temporary unavailability of a UK licensed medicine ("**a drug shortage**"). Medicines Management team to complete form (in appendix 3) and submit to Director of Medicines Management and Deputy Medical Director for approval.

2.1 “One off” patient-specific request

1. The prescriber, along with patient, make a decision that only an unlicensed medicine would meet the patient’s ‘special clinical need’.
2. This decision should be documented in the patient’s medical notes
3. Pharmacy should be involved at the earliest stage to advise on suitable products (see Section 2.5)
4. Prescriber writes a prescription for an unlicensed medicine
5. The prescriber must inform the patient of the medicine’s unlicensed use/ classification. The Patient Information Leaflet for Unlicensed Medicines (Appendix 4 and 5) can be used for this.
6. Clinical justification for the medicine’s use must be specified in Section A of the ‘Request and Risk Assessment (RRA) form’, Parts 1A, 2 and 3 (Appendix 2), which the prescriber must complete. This must include evidence for its proposed use.
7. The ‘Request and Risk Assessment (RRA) form’ must be completed by the prescriber detailing clinical justification for the medicine’s use. The Consultant who is overseeing the patient’s treatment should sign the completed RRA form and submit to the appropriate to the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy.
8. At this point the specialist pharmacist for this clinical area may be consulted (if not already involved) by the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy, to ensure that no licenced product exists which could be used instead. The relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy ,must sign the bottom of Section A of the RRA form at this point (ensuring this policy for medicines without a Marketing Authorisation is followed and due consideration of “special patient need” under Medicines for Human Use 2012 is given).
9. A clinical check of the prescription by a clinical pharmacist must be performed when the completed RRA and prescription is received.
10. The CTMUHB Formulary process applies to medicines that fall within this policy. If the medicine is not listed in the CTM formulary:
 - a. If cost is less than £5k per annum/ per patient follow the non-formulary process. The completed Non-Formulary Form should be passed to the procurement pharmacy technician alongside the completed RRA form.
 - b. If the cost is ≥£5k/ annum, follow IPFR process
11. The completed unlicensed medicine RRA form with all the required signatures (prescriber and the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy) will then be passed to a procurement pharmacy technician, along with the prescription with clinical approval from the ‘clinical checker’ to action under Purchasing Process.

Under normal circumstances, requests for new unlicensed medicine should be completed in advance of a prescription being written. However, for patient-specific requests in an emergency, a completed form may be supplied retrospectively. It is not appropriate to permit retrospective approval for new cohort/blanket requests as these would not be applicable to emergency situations.

The responsibility for determining the “special clinical need” of the patient lies with the prescriber (although it will also be reviewed and approved by the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy). The special clinical need must not relate to reasons of cost, convenience, or operational needs.

2.2 Blanket approval to treat a group of patients with a common 'special clinical need'

1. The prescriber makes a decision that only an unlicensed medicine would meet the patient cohorts' special clinical need.
2. Pharmacy should be involved at the earliest stage to advise on suitable products (see Section 2.5)
3. Clinical justification for the medicine's use must be specified in Section A of 'Request and Risk Assessment (RRA) form', Parts 1B, 2 and 3 (Appendix 2), which the prescriber should complete. This must include evidence for its use (see Section 2.4)
4. The 'Request and Risk Assessment (RRA) form' must be completed by the prescriber detailing clinical justification for the medicine's use. The Consultant who is overseeing the request should sign the completed form and submit to the appropriate Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy or their nominated deputy.
5. At this point the specialist pharmacist for this clinical area may be consulted (if not already involved) by the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy to ensure that no licenced product exists which could be used instead. The relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy must sign the bottom of Section A of the RRA form at this point (ensuring this policy for medicines without a Marketing Authorisation is followed and due consideration of "special patient need" under Medicines for Human Use 2012 is given).
6. The relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy must forward to the 'Access to Medicines Group' for Health board approval.

If cohort proposal is accepted, when there is a clinical need to use the medicine

1. The prescriber, along with patient, make a decision that only an unlicensed medicine would meet the patient's special clinical need.
2. This decision should be documented in the patient's medical notes
3. Prescriber writes a prescription for an unlicensed medicine
4. The prescriber must inform the patient of the medicine's unlicensed use. The Patient Information Leaflet for Unlicensed Medicines (Appendix 4 and 5) can be used for this.
5. A clinical check by a clinical pharmacist must be performed when prescription is received.
6. Completed prescription with clinical approval from the 'clinical checker' will then be passed to a procurement pharmacy technician to action under Purchasing Process.

It is not appropriate to permit retrospective approval for new cohort/blanket requests as these would not be applicable to emergency situations.

The responsibility for determining the "special clinical need" of the cohort lies with the prescriber (although it will also be reviewed and approved by the relevant Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy and ratified by Access to Medicines Group). The special clinical need must not relate to reasons of cost, convenience, or operational needs.

A number of unlicensed medicines are held as ward 'stock' within the Health Board. Clinical Directors are expected to be aware of these and to authorise their use via a "blanket" unlicensed medicine approval form (see above and Appendix 2). The specialist pharmacist is responsible for reviewing and updating the list of unlicensed medicines held in their clinical areas.

2.3 In the event of the temporary unavailability of a UK licensed medicine (drug shortage)

Where a drug shortage has Health Board wide impact, individual patient approval would delay access to treatment and be a burdensome process for prescribers e.g. salbutamol nebuliser shortage.

In this instance:

1. Medicines Management to convene shortage group
2. Unlicensed form (Form for Health Board Use of an Unlicensed Medicine Where There Is a Temporary Unavailability Of a UK Licensed Medicine (A UK Drug Shortage) - see Appendix 3) to be completed by medicines management and submitted to the Chair of the 'Access to Medicines Group', in conjunction with the Clinical Director of Pharmacy and Medicines Management
3. The Chair of the 'Access to Medicines Group', in conjunction with the Clinical Director of Pharmacy and Medicines Management will authorise the risk assessment on behalf of the health board.
4. Clinicians/prescribers will be informed that a risk assessment had been completed on behalf of the health board via the shortage notification dissemination process.

2.4 What evidence is needed

Evidence to support use of unlicensed medicines

Acceptance of liability for the use of a product without a UK Market Authorisation by CTMUHB will depend on the concept of "peer group support". This will be based on the use of published evidence, standard text and specialised text. As part of this process, the unlicensed medicine approval forms require that evidence is submitted to support the use of the requested unlicensed medicine. The onus is on the clinician to provide sufficient evidence to support the request; the appraising Pharmacist may request further evidence if needed.

Indications for use which are supported by the BNF and/or the BNF-C may be documented on the unlicensed medicine approval form as "peer group approved as per BNF/BNFC" OR "peer group approved as per NICE guidance" and further evidence will not be required. This only applies where there is no UK-licensed product available for the indication. It is not applicable to products where an unlicensed option is listed alongside UK-licensed products.

Peer group support may also be demonstrated by published guidelines, consensus statements and position statements issued by relevant clinical and professional bodies. Where such documents are used to support an unlicensed medicine request, these must be fully referenced and either electronically linked or have a copy submitted with the form.

Paediatric unlicensed medicine use

The use of unlicensed medicines and off-label prescribing is common practice in paediatrics. Often medicines do not have a licence for use in children; additionally, medicines may not be available in suitable formulations for administration to children e.g. liquid presentation. The use of unlicensed medicines or licensed medicines for unlicensed applications is frequently necessary in paediatric practice when there are no suitable alternatives. Such uses are usually informed and guided by a respected and responsible body of professional opinion.

The Royal College of Paediatrics and Child Health have issued a position statement relating to the use of unlicensed medicines and off-label medicines in paediatrics whilst the Neonatal and Paediatric Pharmacists Group provides useful information relating to the use of standardised liquid formulations for children.

2.5 Identifying & Choosing an Appropriate Medicinal Products

Once the patient's requirements have been established, there may be a number of different options for providing treatment.

In general, the options for choosing the most appropriate product can be listed as a broad hierarchy:

- using a UK licensed medicine "off-label"
- using an imported medicine licensed in another suitable country e.g. EU country, USA, Canada, Australia, New Zealand, Japan, etc.
- using a UK manufactured 'Special'
- using a medicine prepared under "Section 10 exemption"
- manipulating a licensed dose form or using a licensed dose form via an unlicensed route

Once the patient's special clinical needs are understood, it is confirmed that no appropriate licensed medicine is available and all potentially suitable unlicensed medicines have been identified, an option appraisal will identify the optimal treatment for the patient at that time. The prescriber and the pharmacist should make a joint decision to ensure the medicine:

- meets the needs of the patient (consider efficacy and safety)
- is of the appropriate quality
- is available at the time when it is required and will continue to be available

The prescriber and the pharmacist will also need to ensure that appropriate information is available:

- for the patient, as unlicensed medicines are not always supplied with information leaflets and there may be specific risks that need to be explained and discussed
- for the healthcare professional who will administer the medicine, and for those who will be responsible for continuing treatment.

In rare cases, it may be decided that no suitable medicine can be made available, and the most appropriate decision is to withhold treatment.

Where possible, the decision should be a shared decision with the patient and/or carer and reflect the patient's needs, values and preferences.

2.6 Pharmacist Responsibility

Pharmacists share responsibility with the prescriber for supplying an unlicensed medicine to a patient. The clinical pharmacist has professional responsibility to liaise with the prescriber and the patient to ensure that an unlicensed medicine is (and remains) the most appropriate choice of treatment.

The clinical pharmacist must be able to demonstrate due diligence with regards to the patient's safety, and that the product meets the special clinical need of the patient.

It is the pharmacist's professional duty to assist prescribers in ensuring that an unlicensed medicine is only used where there is no appropriate licensed alternative, in line with current RPS, GMC and MHRA guidance. It is also the professional responsibility of the prescriber and pharmacist to follow prudent prescribing principles to ensure that prescribing and supply of medicines is appropriate and cost effective.

Pharmacists should only clinically approve a prescription for an unlicensed medicine when:

- A 'special clinical need' exists for that patient.
- No licensed medication exists that can meet that 'special clinical need' (even if use is "off label").
- The decision to initiate is appropriately documented.
- It is approved for use in the Health Board.
- Patient is appropriately informed.

2.7 Patient information

The prescriber and the clinical pharmacist will also need to ensure that appropriate information is available for the patient (or carer), as unlicensed medicines are not always supplied with information leaflets, and there may be specific risks that need to be explained and discussed.

The prescriber should ensure the following key points are covered:

- explain/reiterate the nature of the product (licensed vs. unlicensed);
- explain/reiterate the need for unlicensed product and where relevant explain the unavailability of licensed preparation;
- explain/reiterate the expected length of treatment and timescale for review, if provided, on prescriber's notes;
- explain timescales for obtaining future supplies, including potential differences with other licensed medicines the patient may be using;
- discuss any special storage requirements;
- The prescriber should also provide a suitable Patient Information Leaflet (PIL) (see appendix 4 and 5) or if not available a copy of the [All Wales Medicines Strategy Group \(AWMSG\) bilingual patient information](#) leaflets to provide information regarding the use of unlicensed medicine's or off-label use of medicines.

There are exceptions to this where it may not be practical or necessary to draw attention to the product license e.g. medication used in emergencies or where there is no realistic alternative treatment and such information is likely to cause distress.

In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population. Clinicians must always answer questions from patients, or their parents or carers, about medicines fully and honestly.

In exceptional circumstances, if a prescriber intends to prescribe unlicensed medicines where this is not routine practice or if there are suitably licensed alternatives available, the prescriber should explain this to the patient and give reasons for doing so.

2.8 Continuing Supply

The initiating HCP should take responsibility for prescribing the unlicensed medicine and oversee the patient's care, monitoring and any follow up treatment or ensure that arrangements are in place for another suitably qualified prescriber to assume these responsibilities.

Consideration could be made as to whether transfer of prescribing and monitoring responsibility is appropriate, or whether these need to be maintained within secondary care. The agreement of the patient's primary care prescriber must be obtained before prescribing is transferred to ensure continuity of therapy. The GMC advises that the prescriber should have the necessary knowledge and experience of the patient and medicine to prescribe. Unlicensed medicine use must be accurately recorded when transferring between care settings, and ongoing use monitored. The prescribing team must be fully informed about the use of the unlicensed medicine and provided with all necessary prescribing information or supporting evidence for use. The indication and rationale for the unlicensed medicine must be recorded in the patient's record.

Medicines initiated and dispensed within secondary care remain the responsibility of the initiating consultant or prescriber until timely, accurate and adequate communication on treatment and diagnosis is received by primary care

When a General Practitioner (GP) is asked to continue prescribing a product initiated in secondary care, prescribing responsibility rests with the GP signing the prescription. As a minimum the below information should be communicated to the GP/ primary care professional:

- Patient details
- Medicine – name, strength, form (including pack size, manufacturer information and brand name)
- Dose
- Indication
- Evidence for the use of the medicine including if listed in the BNF or BNF for children
- Anticipated duration of therapy
- Relevant comments on diagnosis
- Monitoring required

Where prescribing responsibility for a patient is transferred it is required that sufficient information is provided to allow the new prescriber to identify the use of the drug as unlicensed/ off-label, the special clinical need of the patient that requires such use. This information needs to contain full details of the drug regime to ensure safe prescribing. For those patients admitted to hospital this information should be clearly added to the electronic discharge letter.

A GP is under no obligation to accept prescribing recommended by secondary care and should only do so if they have full confidence in prescribing the drug. If the GP does not wish to continue such treatment it will remain the responsibility of the initiating prescriber.

A GP can prescribe an unlicensed medicine / licensed medicine for off-label use but in doing so must meet the requirements of a clinician / prescriber. GPs remain professionally accountable for their judgements in prescribing of unlicensed medicines or off-label use of licensed medicines and still have the discretion to choose whether to prescribe an unlicensed medicine / off-label.

If a GP chooses to decline to prescribe the unlicensed medicine, the decision to decline should be made clearly in writing by an established method (such as email or letter) to the initiating specialist, asking them to continue to prescribe the unlicensed medicine.

When initiating an unlicensed medicine, continuity of supply and the risk to the patient of disrupted or unreliable supply should be carefully considered. Where appropriate and possible, information should be provided to inform the Community Pharmacy or practice dispensary on where the unlicensed medicine can be obtained (appendix 6). An appropriate level of notice and time should be provided for the Community Pharmacist to source, order and receive the unlicensed medicine as timescales may vary widely depending on the manufacturer, wholesaler, or importer:

- details of supplier/manufacturer of the product supplied in hospital should be shared;
- Pharmacy staff should liaise with Community Pharmacists regarding supply timelines of individual medicine manufacturers and ensure prescribing intervals are aligned.
- CTMUHB cannot supply unlicensed medicines to Community Pharmacies. Community Pharmacists should be referred directly to the supplier of the unlicensed medicine.
- In an emergency, the Community Pharmacist should be referred to the Secondary Care Procurement Pharmacist or nominated deputy.

Supplies of unlicensed medicine's ordered at the request of a consultant will be recorded by Pharmacy. Supplies made to individual patients will be recorded on the Pharmacy computer system. The issue of "specials" will be recorded on the Pharmacy computer system.

2.9 Monitoring & Reviewing

The optimal treatment for the patient may change over time as circumstances change, for example the patient's 'special clinical needs', the care setting and the availability of alternative or newly licensed medicines.

Unlicensed medicines do not undergo any evaluation by the MHRA as part of a licensing process and ongoing pharmacovigilance. Therefore, the *quality, safety* and *efficacy* of unlicensed medicines should be continually monitored and reviewed by the clinicians and clinical pharmacists involved in the care of the patient, as well as the pharmacy team purchasing the medicine.

3. Procurement of Unlicensed Medicines

The process of purchasing an unlicensed medicine is usually more complicated than purchasing licensed medicines, especially when they are being purchased for the first time.

It may be necessary to identify and evaluate a number of purchasing options in collaboration with the prescriber and potential suppliers.

The approach may differ depending on whether an entirely new product or an existing formulation is to be purchased, and whether there is a local or national purchasing contract already in place. Nevertheless, considerations will include:

- the required characteristics of the medicine as defined in a 'purchasing/ product specification' e.g. drug, strength, form, route of administration/ presentation, excipients, flavour, smell, appearance, etc.
- identification of a suitable manufacturer or supplier/ importer
- assessment of the quality of the medicine and the supplier
- checking medicines on receipt

It may be necessary to work with the prescriber to define which characteristics are essential and which are desirable in case a medicine with all the requirements cannot be found. Standardised formulations should be purchased wherever practicable.

The purpose of a 'purchasing/ product specification' is to ensure all parties are clear about exactly what is required. It may take the form of a purchasing/ product specification prepared by the purchaser and accepted by the manufacturer/ supplier, or a finished product specification accepted by the purchaser.

Purchasers must ensure that unlicensed medicines are sourced from reputable suppliers with the correct MHRA licences i.e. 'Specials' MS licence, WDA(H) licence, etc.

3.1. Procurement process

1. On receipt of the completed RRA form Section A, the procurement pharmacy technician will source the unlicensed medicine from one of the following suppliers:
 - CTM Approved 'Specials' manufacturers specified in Appendix 7 "List of Approved Purchases"
 - MHRA 'Specials' manufacturers (list can be found [Human and veterinary medicines: register of licensed manufacturing sites - GOV.UK](#))
 - Wholesalers of 'Specials'
 - Licensed Importers of Unlicensed Medicines

Note: NHS Pro-File <http://www.pro-file.nhs.uk/Login.aspx> can be consulted to find a suitable supplier.

2. If the only available supplier is not listed in the list of approved suppliers above, the procurement pharmacy technician must consult with the CTM procurement lead pharmacist and consider if an alternative product, which is available from an authorised supplier, could be used. If not, the CTM procurement lead pharmacist will consult with the UHB QA pharmacist to decide if the new supplier can provide sufficient evidence to be considered as an approved supplier. Alternatively, a Specification Sheet can be completed and submitted to an approved supplier to detail the health board's requirements of the medicine and negotiations commenced to procure it.
3. When details of product and supplier are agreed the procurement pharmacy technician will complete RRA form Section B Part 2 with details of the medicine and supplier.
4. RRA form Section B Part 2 will then be passed to the clinical pharmacist originally requesting the product to complete the clinical signature section.
5. RRA form Section B Part 3 will then be passed to the operational lead pharmacist or a senior pharmacist to complete the risk assessment and sign to authorise the purchase of the medicine.
6. If the risk assessment score is below 14 the form will be returned to the procurement pharmacy technician to process the order. If the risk assessment is equal to or above 14 the procurement lead pharmacist must consult with the UHB QA pharmacist to discuss the potential risks of purchasing the product. The product will only be purchased if deemed safe to be used in the Health Board and the Pharmacy Site Lead would need to sign the RRA form part 2.
7. When both part 1 and part 2 of the RRA form have been completed with clinical and procurement pharmacists' signatures the procurement pharmacy technician will then produce a purchase order via the pharmacy system and send to the supplier.
8. A copy of the completed RRA form will be scanned and saved in the RRA folder in the unlicensed medicine section on the Procurement Teams Channel to provide a library of completed forms for future scrutiny.

3.2 Notes

Authorised Suppliers

The NHS does not maintain a single list of "approved suppliers". Some manufacturers of "Specials" are evaluated or audited as part of regional or national frameworks. In some cases, "Specials" manufacturers may have been audited by Regional Quality Assurance specialists. This does not constitute approval, but the report may inform the decision-making process when the Health Board decides on the suitability of a supplier.

The Health Board will keep a list of approved suppliers of unlicensed medicines based on information from NWSSP Procurement Services and historically used suppliers who have demonstrated a high level of quality. If a new supplier needs to be created, the logistics team will advise on the process.

Obtaining an alternative medicine

If a supplier is no longer able to supply the unlicensed medicine, or an alternative, similar medicine is supplied, RRA form Part 2 must be completed again and the product risk-assessed in the same way as before. This additional form must be saved with the original form.

Historically ordered products

This procedure will apply to all newly purchased medicines, however a retrospective review of all unlicensed medicines must be made based on the procedure to ensure patient safety.

If the unlicensed medicine has been purchased previously for another patient, then the previous RRA form can be referred to in an effort to aid the completion of the new form, BUT, a new RRA form MUST be completed for EVERY patient prescribed the medicine.

Ongoing Governance

Regular review of the use of unlicensed medicines is essential and so the specialist pharmacist for the area where the medicine is used will use their close links with the prescribers and directorate meetings to ensure the unlicensed medicine remains the best therapeutic option, and no comparable licensed medicine exists.

4. Quality Assessments of Unlicensed Medicines

Unlicensed Medicines have not been evaluated for *quality*, *safety* and *efficacy* by the MHRA, so it is essential that the purchaser takes additional steps to gain assurance that the medicine is:

- of an appropriate pharmaceutical quality
- meets the purchasing specification and is suitable for the patient
- labelled and packaged in a way that minimises the risk of medication error

Quality assessments should be undertaken **before** a medicine is purchased for the first time and should be periodically reviewed to ensure that there have been no changes.

Ideally, an unlicensed medicine i.e. 'special' manufacturer or importer of an unlicensed medicine will be able to provide a finished product specification that provides all the details required to enable a quality assessment to be performed. In practice, this is not always the case, so additional information may need to be requested.

If a supplier of an unlicensed medicine is reluctant to provide the requested information, this should be a cause for concern and consideration should be given to purchasing elsewhere.

UK Specials

In most cases, a certificate of analysis or certificate of conformity should be provided with the unlicensed medicines received. This should be checked for completeness and that it corresponds to the batches received. Some manufacturers make these available on their websites, rather than as a hard copy.

Certificates of analysis include the results of finished product testing. These should be checked against the manufacturer's finished product specification.

Certificates of conformity confirm only that the batch has been manufactured in accordance with GMP and that it has been released by an approved Releasing Officer. Certificates of conformity do not include any information on product end testing results. As a result, a certificate of analysis is preferable to a certificate of conformity.

Imported Medicines

The information needed depends on the type and origin of the imported medicine.

The MHRA requires importers to notify them of their intention to import medicines that are unlicensed in the UK. The MHRA may object to importation if there is no evidence of 'Special Clinical Need', if there are concerns about the pharmaceutical quality of the medicine, or if there are clinical safety issues.

The MHRA does not take any responsibility for the efficacy, safety and quality of any imported medicine, which is the responsibility of the purchaser and prescriber.

If considering purchasing an imported medicine, then we must ensure that the medicine meets standards of manufacturing that are equivalent to those for UK licensed medicines. For imported

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Policy Title: Unlicensed Medicines Policy

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medicines, this means obtaining information about the supplier (i.e. the importer), and the Marketing Authorisation (licence) of the medicine in another country.

The UK importer is usually unrelated to the manufacturer or Marketing Authorisation Holder (MAH) of the medicine, so as with the supplies of licensed medicines, it is essential to undertake bona fide checks on the importer.

Importers of unlicensed medicines must have an appropriate MHRA WDA(H) licence.

Once all available information has been received from the supplier and evaluated, a conclusion can be made about the quality of the medicine.

The information obtained and the outcome of the evaluation i.e. quality assessment should be documented and should include an overall conclusion about the suitability of the medicine for the patient or patient group. This quality assessment will be used to inform the purchasing decision and, where necessary, local risk mitigation measures.

5. Receiving Unlicensed Medicines

Unlicensed medicines should be quarantined on receipt until they can be checked by a suitably competent person e.g. purchasing pharmacist, QA pharmacist, for compliance with the “QA List of Approved Unlicensed Medicines Purchases” or the completed RRA record/ purchasing specification. [Note, only unlicensed medicines purchased for the first time need to be quarantined]

1. On receipt of the unlicensed medicine, stores staff will check the details against the delivery note and check if the medicine has been added onto the QA List of Approved Unlicensed Medicines Purchases (See logistics Teams Channel). If it has not been previously quality assessed, the stores staff will complete an Unlicensed Medicine - Record of Purchase form (Appendix 8) and ensure that the medicine will be placed in the designated QA area to await check by the QA pharmacist. The pharmacy computer system will be updated to reflect this. Only items appearing on the QA List of Approved Unlicensed Medicines Purchases can be placed in the areas allocated for specials/unlicensed products without a QA check.
2. Stores staff will notify the QA pharmacist via email that the medicine needs a QA check.
3. Referring to the completed RRA form Part 2, the QA pharmacist will conduct the required product quality assessment as soon as possible.
4. If the QA pharmacist has any doubts regarding the suitability of the unlicensed medicine, these must be discussed with the procurement team and the Pharmacist involved in prescribing i.e. requesting the product.
5. Once a quality assessment has been carried out, the stores staff will be informed of the medicine’s suitability, and the medicine will be moved to the allocated specials/unlicensed medicine storage area. The pharmacy computer system must be updated accordingly.
6. Stores staff will then notify the dispensary team of the availability of the medicine.
7. The QA Pharmacist will update the ‘QA List of Approved Unlicensed Medicines Purchases’ accordingly.

5.1 Notes- Lack of over-labelling on purchased imported medicines

Should an imported medicine be received in livery in a language other than English, with no clear way to identify it i.e. labelling is not easy to understand, confirmation of the product specification can be found by referring to the original RRA form. This will be useful if such a product is dispensed and the Accredited Checker is unsure of the details of the product. Any item supplied to a ward or department as a stock item must have suitable labelling in English. In this instance advice must be sought from the QA pharmacist.

6. Dispensing/ Supply of Unlicensed Medicines

1. When unlicensed medicines are received, their location should be based on whether they are on the 'QA List of Approved Unlicensed Medicines Purchases'.
 - a. For items appearing on 'QA List of Approved Unlicensed Medicines Purchases', once a record of the received 'product details' has been made on the pharmacy computer system, the product may be transferred to its dispensary/ stores location.
 - b. Items not appearing on 'QA List of Approved Unlicensed Medicines Purchases' must be quarantined to await QA assessment and approval. Only after QA release can these items be transferred to their dispensary/ stores locations.
2. When stores staff put the unlicensed medication on the shelf, they must check if there are any to-follows outstanding for it. These must be actioned immediately.
3. If the unlicensed medicine is to be placed on a ward as 'stock', a copy of the Unlicensed Medicine Reconciliation Record (Appendix 9) must be distributed with it. Note, if an unlicensed medicine is dispensed, then the pharmacy computer system will automatically record details of the patient and batch number for audit purposes.
4. All issues (i.e. supply) of unlicensed medicines must be recorded either manually on 'Unlicensed Medicine Reconciliation Record' or electronically on the pharmacy computer system (for audit/ traceability purposes – refer to 'Health Board Unlicensed Medicines Policy'). Manual and/ or electronic records of issue must include details of the name of the unlicensed medicine supplied, form, strength, quantity supplied, date supplied, **batch number** and patient details (where relevant).
5. When giving out the medicine, the patient should be counselled regarding the unlicensed nature of the product along with any other necessary counselling points that relate to the medicine. Although it is the responsibility of the prescriber to inform the patient/carer of the unlicensed nature of the medicine, pharmacy staff are able to re-confirm this or offer any additional advice at the point of giving out the medicine.

7. Administration of Unlicensed Medication

There is limited information outlining the responsibilities of HCPs who administer unlicensed medicines. The Nursing and Midwifery Council (NMC) (2015) Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates outlines the responsibilities with regards to medicines administration.

Any registered HCP responsible for administering an unlicensed medicine must have access to the patient's clinical records, where the prescriber must have documented a treatment plan, including their reasons for prescribing an unlicensed medicine, utilising relevant professional or regulatory body guidance. Any healthcare professional administering unlicensed/ off-label medication should be satisfied they have sufficient information to safely administer the medicine to ensure it is appropriate for the patient and to enable them to administer the unlicensed medicine safely (AWMSG (2023) Understanding Unlicensed Medicines).

Any ambiguities, or concerns, regarding a direction for the administration of a medicine should be raised with the prescriber, or a Pharmacy professional, without delay (RPS (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings).

7.1 Adverse Drug Reactions

- Suspected adverse drug reactions to medication must be reported to the MHRA via the Yellow Card Scheme.
- Yellow Card reports for unlicensed medication should state the manufacturer and that the product is unlicensed.
- All healthcare professionals are responsible for completing Yellow Card reports.

7.2. Patient Group Directions

A registered nurse may administer an unlicensed medication with informed consent against a patient specific direction and not a patient group direction (PGD).

PGD legislation **does not** allow for unlicensed medicines to be supplied and/or administered. Any action resulting in unlicensed administration e.g. crushing tablet formulations, mixing medicines (refer to NEWT guidelines / Handbook of Drug Administration via Enteral Feeding Tubes) may invalidate PGDs.

The MHRA states that "the mixing of two separate medicinal products will result in a new, unlicensed product if one product cannot be described as a vehicle for the administration of the other (e.g. as a reconstitution or diluting agent). Therefore, mixing of medicines is not permitted under a PGD."

A registered nurse may administer off-label medication against a patient specific direction or a patient group direction. Off-label use of a licensed medicine is permitted under a PGD. However, this should only occur when clearly justified by best clinical practice. Any PGD for the off-label use of a licensed medication should clearly state when the product is being used outside the terms of its Marketing Authorisation and why this use is recommended with reference to the supporting evidence or guidance. Consideration should be given to informing the patient or their carer that the use is off-label.

8. Information, Instruction and Training

Clinical Directors and/or Directorate Management Teams will ensure that prescribers within the Directorate are aware of this policy and the list of unlicensed medicines held as stock for use in clinical areas.

Pharmacy managers will ensure that Pharmacy staff are aware of the policy and their responsibilities.

The Procurement Pharmacist will ensure that members of the Pharmacy procurement team are aware of the policy and their responsibilities.

Specialist pharmacists will lead discussions and review of the unlicensed stock held in their areas with the Clinical Directors of their specialties.

9. Main Relevant Legislation

A list of the relevant statutory provisions which influence the organisation's operation in relation to the policy.

- Medicines Act 1968
- Human Medicines Regulations 2012
- NHS Wales Governance e-manual. Standard 15: Medicines Management.
- MHRA Guidance Note No.14: The supply of unlicensed medicinal products ("specials"). Revised May 2014
- Good practice in prescribing and managing medicines and devices. General Medical Council.
- Standards and guidance. The General Dental Council.
- Standards for pharmacy professionals. General Pharmaceutical Council. May 2017
- Nursing and Midwifery Council. The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates.
- Standards of Proficiency. Health and Care Professions Council.
- Code of professional conduct: standards for conduct, performance and ethics. Health and Care Professionals Council.
- Practice guidance for physiotherapist supplementary and/or independent prescribers in the safe use of medicines. Chartered Society of Physiotherapy
- Good Practice in Prescribing and Medicines Management for Podiatrists. The College of Podiatry.
- GOC Standards Framework. General Optical Council.
- College of Optometrists' Code of Ethics and Guidelines for Professional Conduct.
- The Welsh Risk Pool. NHS Wales Shared Services Partnership.
- Non-Medical Prescribing in Wales Guidance. NHS Wales.
- Freedom of Information Act 2000
- Equality Impact Assessment – The Equality Act 2010
- Health Impact Assessment
- Privacy Impact Assessment

10. References

Policies must be based on sound evidence and be appropriately referenced.

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3. Medicines, Ethics and Practice. Edition. Royal Pharmaceutical Society
4. Non-Medical Prescribing in Wales Guidance. NHS Wales. May 2017. Available at <http://www.awmsg.org/docs/awmsg/medman/Non%20Medical%20Prescribing%20in%20Wales%20Guidance.pdf> Accessed 8th April
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8. British National Formulary and British National Formulary for Children. Available at <https://www.medicinescomplete.com/#/> (Subscription required) Accessed 30th May 2023
9. A Competency Framework for all Prescribers. July 2016. Royal Pharmaceutical Society. Available at <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf?ver=2019-02-13-163215-030> Accessed 30th May 2023
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13. Standards of Proficiency 2013. Health and Care Professions Council. Available at <https://www.hcpc-uk.org/standards/standards-of-proficiency/> Accessed 8th April 2019
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17. GOC Standards Framework. General Optical Council. Available at https://www.optical.org/filemanager/root/site_assets/standards/goc_standards_framework_43114.pdf Accessed 8th April 2019

18. College of Optometrists' Code of Ethics and Guidelines for Professional Conduct. Available at <https://guidance.college-optometrists.org/home/> Accessed 30th May 2023

Other sources

- General Medical Council. Prescribing unlicensed medicines. 2021. Available at: [Prescribing unlicensed medicines - ethical guidance - GMC \(gmc-uk.org\)](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care#paragraph-76)
- Royal College of Paediatrics and Child Health. 2020. The use of unlicensed medicines or licensed medicines for unlicensed applications in paediatric practice. [The use of unlicensed medicines or licensed medicines for unlicensed applications in paediatric practice \(nppg.org.uk\)](https://www.rcpch.ac.uk/resources/unlicensed-medicines)
- Pharmaceutical Services Negotiating Committee. Who can prescribe what? 2022. Available at: <https://psnc.org.uk/dispensing-and-supply/prescription><https://psnc.org.uk/dispensing-and-supply/prescription-processing/receiving-a-prescription/who-can-prescribe-what/processing/receiving-a-prescription/who-can-prescribe-what/> .
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- Understanding Unlicensed Medicines. All Wales Medicines Strategy Group. 2023. Available at: awttc.nhs.wales/files/guidelines-and-pils/understanding-unlicensed-medicines-pdf/unlicensed-medicines-pdf/
- MHRA. Yellow Card Monitoring Scheme. [Yellow Card | Making medicines and medical devices safer \(mhra.gov.uk\)](https://www.mhra.gov.uk/yellow-card)

Appendix 1 GMC Guidance for prescribing unlicensed medicines

Guidance from the General Medical Council (GMC) Good Practice in Prescribing and Managing Medicines and Devices (2021)

General Medical Council (2021) Good practice in prescribing and managing medicines and devices: Prescribing unlicensed medicines, p103-109 <http://www.gmc-uk.org/guidance/>

Prescribing unlicensed medicines

103 In this guidance, the term ‘unlicensed medicine’ is used to describe medicines, which are used outside the terms of their UK licence or that have no licence for use in the UK.³³ Unlicensed medicines are commonly used in some areas of medicine, such as in paediatrics, psychiatry and palliative care. They are also used, albeit less frequently, in other areas of medicine.

104 You should usually prescribe licensed medicines in accordance with the terms of their licence. However, you may prescribe unlicensed medicines where, on the basis of an assessment of the individual patient, you conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient.

105 Prescribing unlicensed medicines may be necessary in the following instances.

- a. There is no suitably licensed medicine that will meet the patient’s need. Examples include – but are not limited to – where:³⁴
 - i. there is no licensed medicine applicable to the particular patient, for example, if the patient is a child and a medicine licensed only for adult patients would meet the needs of the child
 - ii. a medicine licensed to treat a condition or symptom in children would nonetheless not meet the specific assessed needs of the particular child, but a medicine licensed for the same condition or symptom in adults would do so
 - iii. the dosage specified for a licensed medicine would not meet the patient’s need
 - iv. the patient needs a medicine in a formulation that is not specified in an applicable licence.
- b. A suitably licensed medicine that would meet the patient’s need is not available. This may arise where, for example, there is a temporary shortage in supply.
- c. The prescribing forms part of a properly approved research project.
- d. There is a serious risk to public health and the MHRA has temporarily authorised the sale or supply of an unlicensed medicine, such as a vaccine or treatment, in response.³⁵
- e. A prescription only medicine that is unlicensed in Northern Ireland has been supplied under the Northern Ireland MHRA Authorised Route (NIMAR).³⁶

106 When prescribing an unlicensed medicine, you must:

- a. be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy
- b. take responsibility for prescribing the medicine and for overseeing the patient’s care, monitoring and any follow up treatment, or make sure that arrangements are in place for another suitable doctor to do so
- c. make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an unlicensed medicine.

Information for patients about the licence for their medicines

107 You must give patients, or their parents or carers, sufficient information about the medicines you propose to prescribe, to allow them to make an informed decision.

108 Some medicines are routinely used outside the terms of their licence, for example in treating children. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population.³⁷ In the case of a medicine supplied under NIMAR, it’s not usually necessary to draw attention to it being unlicensed in Northern Ireland. This is because the medicine will be licensed in Great Britain and have met the MHRA’s requirements for safety, quality and efficacy. You must always answer questions from patients, or their parents or carers, about medicines fully and honestly.

109 If you intend to prescribe unlicensed medicines where it’s not routine or if there are suitably licensed alternatives available, you should explain this to the patient, and give your reasons for doing so.

Appendix 2: Request for use of an Unlicensed Medicine and Risk Assessment (RRA) Form



Section A: For use by Clinician

Part 1

- For a request to use of an Unlicensed Medicine for an Individual Named Patient complete part 1A
- For a request for Use of an Unlicensed Medicine for a Specified Clinical Area complete part 1B

Part 1A- For a request to use of an Unlicensed Medicine for an Individual Named Patient

Patient name:		Hospital number	
Date of Birth:		/NHS Number:	

Part 1B- For a request for Use of an Unlicensed Medicine for a Specified Clinical Area

Clinical Specialty:		Care group:	
Patient cohort details:			

Part 2 Unlicensed Medicine details and indication

Product Name (& brand if known):	
Form/ Route of administration:	
Strength and pack size:	
Dosage (dose and frequency):	
Anticipated duration of treatment:	
Clinical Indication:	
Is the unlicensed medicine/use formulary approved? Y ☐ / N ☐ If 'No', has a non-formulary request form been completed? Please send a copy of this form to CTM.AccessMeds@wales.nhs.uk	

Part 3 Evidence

Indication for Use:
Please provide details of indication, and why an UK licensed medicine cannot be used i.e. the patient's "special clinical need" for an unlicensed medicine:
What are the risks to the patient of not using this medicine?

Summary of evidence available for indication (please also attach copies/ links to evidence):
What are the serious and common side effects of this unlicensed medicine? Is any monitoring required
Give details of contraindications and any other risks to the patient. Include precautions in use (including pharmaceutical precautions) or cautions
Are alternative treatments available? Y ☐ / N ☐ <i>(If Y please complete the following information)</i>
What alternative treatments for this condition have been tried?
What is the reason for preferred use of this unlicensed medication? What are the proposed benefits to the patient?
Will there be any primary care implications? (e.g. need for continuation of prescribing in primary care, including via a shared care protocol) If so, describe:

The ultimate responsibility for prescribing any drug lies with the doctor who signs the prescription and is professionally accountable for his/her judgement. Doctors have a duty in common law to take reasonable care and to act in a way consistent with practice of a responsible body of their peers of similar professional standing. In situations where the product is not licensed or where the product is used outside its licensed indications, the manufacturer carries no legal liability should an untoward event arise, putting a greater responsibility on individual prescribers and the Health Board. The manufacturer is only likely to be found liable if harm results from a defect in the product. If use of this product is deemed to have significant risks, the request will be referred to the Medical Director. The purpose of this policy is to provide an internal means of assessing the use of these products, thereby safeguarding patients against the risk of injury as well as minimising the likelihood of claims against the Health Board.

Declaration by Consultant

1. I have read the above and understand that the named product is an unlicensed medicine within the UK.
2. I accept responsibility for fully informing the patient of the fact that the product is unlicensed and has no UK Market Authorisation. I will initiate each prescription for the patient and obtain their consent.
3. Providing the above has been undertaken, I understand that this prescription and its consequence will be covered for vicarious liability under terms of my contract with the Health Board.

Requesting Consultant Details

Name		Signature	
Job title		Date	
Clinical Speciality		Care Group	

Blanket approvals must be authorised by Care Group Clinical director

Name		Signature	
Job title		Date	

Pharmacy approval

Deputy Head of Pharmacy (or their nominated deputy), or in their absence a Head of Pharmacy

Name		Signature	
Job title		Date	

Section B: Pharmacy Use Only

Part 1: Formulary

Is the drug on the HB formulary	Y ☐ / N ☐
If not, is the net drug cost > £5000 per year	Y ☐ / N ☐ If yes an IPFR will be required for individual patients and formulary proposition for a cohort of patients

Part 2: Procurement

Is the Supplier a.....:

A UK NHS 'Specials' Manufacturer	Y ☐ / N ☐	MS Licence Number: _____
A UK commercial 'Specials' Manufacturer	Y ☐ / N ☐	MS Licence Number: _____
A Wholesaler of UK 'Specials'	Y ☐ / N ☐	MS Licence Number: _____ WDA(H) Licence Number: _____
A Wholesaler of Imported Medicines	Y ☐ / N ☐	WDA(H) Licence Number: _____

For Imported Unlicensed Medicines

Country of Origin:	
Is the medicine licensed in the country of origin?	Y ☐ / N ☐ If Y- record product license number:
Does this country have a Mutual Recognition Agreement with the UK for the manufacture of medicinal products?	Y ☐ / N ☐
What language is used on the product label?	Language: _____ If not in English, is it over-labelled in English? Y ☐ / N ☐
Is an English translation of the SPC and/or Patient Information Leaflet available?	Y ☐ / N ☐

Product Specification

Is a 'Product Specification' available from the supplier?	Y ☐ / N ☐	Is a Certificate of Analysis available?	Y ☐ / N ☐
		Is or Certificate of Conformance available?	Y ☐ / N ☐
Is the product available "off the shelf"?	Y ☐ / N ☐ If No, what is the quoted importation time? _____		

Part 3: Quality Assessment. Risk Level Assignment: Scoring Guidelines

Supplier	Score	
MHRA licensed Importer ('Preferred Supplier') – Copy of most recent MHRA “non-objection” to import (including conditions) should be supplied	1 3 (if no import confirmation)	
MHRA licensed ‘Specials’ Manufacturer ('Approved Manufacturer')	1	
Other MHRA licensed ‘Specials’ Manufacturer	2	
Supplier not manufacturer (e.g. wholesalers)	3	
Registered Pharmacy (i.e. Extemporaneous Preparation Or ‘Section 10 exemption’ preparation)	4	
Origin	Score	
EU/ Switzerland/ Australia/ Canada/ Japan/ New Zealand/ USA (licensed in country of origin)	1	
UK based MHRA licensed ‘Specials’ Manufacturer	2	
EU/ Switzerland/ Australia/ Canada/ Japan/ New Zealand/ USA (not licensed in country of origin)	4	
Elsewhere (licensed in country of origin)	4	
Elsewhere (not licensed in country of origin)	5 (HIGH)	
Product Certification	Score	
Licensed in country of origin (EU/ Switzerland/ Australia/ Canada/ Japan/ New Zealand/ USA)	0	
Certificate of Analysis and TSE Statement available (if UK ‘special)	1	
Certificate of Conformity (i.e. no final product testing) and TSE Statement available (if UK ‘special’)	3	
No certification available (no product testing performed)	5 (HIGH)	
Packaging & Labelling	Score	
English (SPC/PIL available)	0	
English (no SPC/ PIL available)	2	
Foreign language but easy to read critical data	3	
Foreign language – requires over labelling in English (translated SPC/ PIL required)	4	
Route of Administration	Score	
Topical to intact skin (non-sterile)	1	
Mucous membranes, broken skin, oral (non-sterile)	2	
Intravenous, Intramuscular or Subcutaneous Injection	3	
Intrathecal Route	4	
Therapeutic Agent	Score	
Established therapeutic agent – no special problems	0	
Recognised therapeutic agent – minor problems or little experience of use	2	
Novel/ unrecognised therapeutic agent of unusual use	3	
Recognised therapeutic agent with known problems	4 (HIGH)	
OVERALL QUALITY RISK SCORE:		
LOW (0 – 5)	MEDIUM (6 – 14)	HIGH (> 14)

Supply and Cost	
Are there any problems associated with continuity of supply? If so provide details	Y ☐ / N ☐
Any additional information required by supplier / manufacturer e.g. consultant letter. Provide details	Y ☐ / N ☐
What are the costs involved in obtaining this medicine? (If cost is less than £5k per annum/ per patient follow the non-formulary process. If the cost is ≥£5k/ annum, follow IPFR process)	
Initial Requesting Clinical Pharmacist	
Name and Signature:	Date:
Authorised by Procurement Lead Pharmacist or Pharmacy Technician	
Name and Signature:	Date:
Quality Assurance	
Quality Assessment Risk Score	
Authorised by CTMUHB QA Pharmacist (Name and Sig.):	Date:

Appendix 3: Form for Health Board Use of an Unlicensed Medicine Where There Is a Temporary Unavailability of a UK Licensed Medicine (A UK Drug Shortage)



FOR COMPLETION BY MEDICINES MANAGEMENT ONLY

Section A

Shortage details

Name of shortage Product:	
CPhO shortage number:	

Unlicensed Medicine details

Product Name (and brand if known):	
Form/ Route of administration:	
Strength and pack size:	
Dosage (dose and frequency):	
Anticipated duration of treatment:	
Clinical Indication for use (if applicable):	
Is the unavailable licensed medicine on the formulary? Y ☐ / N ☐ If 'No', is this unlicensed product needed If it is please complete a non-formulary request form and send to CTM.AccessMeds@wales.nhs.uk	
Cost of licensed product:	
Cost of unlicensed product:	
Comment on cost difference:	

From completed by (Medicines Management Only):

Name		Signature	
Job title		Date	

Approved on Behalf of Health Board

MUST only be completed by:

- Clinical Director Medicines Management or
- Deputy Medical Director (Chair of Access to Medicines Group) ONLY

Name		Signature	
Job title		Date	

Section B: Pharmacy use only

Part 1: Formulary

See section A

Part 2: procurement

Is the Supplier a.....:

A UK NHS 'Specials' Manufacturer	Y ☐ / N ☐	MS Licence Number: _____
A UK commercial 'Specials' Manufacturer	Y ☐ / N ☐	MS Licence Number: _____
A Wholesaler of UK 'Specials'	Y ☐ / N ☐	MS Licence Number: _____ WDA(H) Licence Number: _____
A Wholesaler of Imported Medicines	Y ☐ / N ☐	WDA(H) Licence Number: _____

For Imported Unlicensed Medicines

Country of Origin:	
Is the medicine licensed in the country of origin?	Y ☐ / N ☐ If Y- record product license number: _____
Does this country have a Mutual Recognition Agreement with the UK for the manufacture of medicinal products?	Y ☐ / N ☐
What language is used on the product label?	Language: _____ If not in English, is it over-labelled in English? Y ☐ / N ☐
Is an English translation of the SPC and/ or Patient Information Leaflet available?	Y ☐ / N ☐

Product Specification

Is a Product Specification available from the supplier?	Y ☐ / N ☐	Is a Certificate of Analysis available?	Y ☐ / N ☐
		Is or Certificate of Conformance available?	Y ☐ / N ☐
Is the product available "off the shelf"?	Y ☐ / N ☐	If No, what is the quoted importation time? _____	

Part 3 Quality Assessment. Risk Level Assignment: Scoring Guidelines

Supplier	Score
MHRA licensed Importer ('Preferred Supplier') – Copy of most recent MHRA “non-objection” to import (including conditions) should be supplied	1 3 (if no import confirmation)
MHRA licensed 'Specials' Manufacturer ('Approved Manufacturer')	1
Other MHRA licensed 'Specials' Manufacturer	2
Supplier not manufacturer (e.g. wholesalers)	3
Registered Pharmacy (i.e. Extemporaneous Preparation Or 'Section 10 exemption' preparation)	4
Origin	Score
EU/ Switzerland/ Australia/ Canada/ Japan/ New Zealand/ USA (licensed in country of origin)	1
UK based MHRA licensed 'Specials' Manufacturer	2
EU/ Switzerland/ Australia/ Canada/ Japan/ New Zealand/ USA (not licensed in country of origin)	4
Elsewhere (licensed in country of origin)	4
Elsewhere (not licensed in country of origin)	5 (HIGH)
Product Certification	Score
Licensed in country of origin (EU/ Switzerland/ Australia/ Canada/ Japan/ New Zealand/ USA)	0
Certificate of Analysis and TSE Statement available (if UK 'special')	1
Certificate of Conformity (i.e. no final product testing) and TSE Statement available (if UK 'special')	3
No certification available (no product testing performed)	5 (HIGH)
Packaging & Labelling	Score
English (SPC/PIL available)	0
English (no SPC/ PIL available)	2
Foreign language but easy to read critical data	3
Foreign language – requires over labelling in English (translated SPC/ PIL required)	4
Route of Administration	Score
Topical to intact skin (non-sterile)	1
Mucous membranes, broken skin, oral (non-sterile)	2
Intravenous, Intramuscular or Subcutaneous Injection	3
Intrathecal Route	4
Therapeutic Agent	Score
Established therapeutic agent – no special problems	0
Recognised therapeutic agent – minor problems or little experience of use	2
Novel/ unrecognised therapeutic agent of unusual use	3
Recognised therapeutic agent with known problems	4 (HIGH)
OVERALL QUALITY RISK SCORE:	
LOW (0 – 5)	MEDIUM (6 – 14)
HIGH (> 14)	

Supply and Cost	
Are there any problems associated with continuity of supply? If so provide details	Y ☐ / N ☐
Any additional information required by supplier / manufacturer e.g. consultant letter. Provide details	Y ☐ / N ☐
What are the costs involved in obtaining this medicine? If cost is less than £5k per annum/ per patient follow the non-formulary process. If the cost is ≥£5k/ annum, follow IPFR process	
Initial Requesting Clinical Pharmacist	
Name and Signature:	Date:
Authorised by Procurement Lead Pharmacist or Pharmacy Technician	
Name and Signature:	Date:
Quality Assurance	
Quality Assessment Risk Score	
Authorised by CTMUHB QA Pharmacist (Name and Sig.):	Date:

Appendix 4: Patient Information Leaflet for Unlicensed Medicines

Patient Information Leaflet for Unlicensed Medicines

This leaflet has been designed to give you important information and to answer some common queries that you may have

Why there is a need for this leaflet?

In the UK most medicines are 'licensed' but some are not. This leaflet explains why medicines are licensed and why some useful medicines do not have licences.

You will have been given this leaflet by your doctor or pharmacist because the medicine prescribed for you is not 'licensed' or is being used for a reason not covered by the licence.

We want to reassure you that we have thought very carefully about the best medicine for you. This leaflet should answer any questions you may have about this.

What are unlicensed medicines?

Before a medicine is allowed to be marketed in the UK, drug companies must ask the Medicines and Healthcare Products Regulatory Agency (MHRA), a part of the Department of Health, for a 'licence' for the medicine.

The company has to show the MHRA that the medicine works well, does not have too many side effects and has been made to a high standard.

How are medicines tested?

To be sure that a medicine works and is safe, medicines are first tried on volunteer groups of patients in what is called a 'clinical trial'. The information from the trials, together with details of how the medicine is made, how the medicine is to be used, and the leaflets to be provided to doctors and patients are all given to the MHRA for approval. If approved, the medicine is given a 'licence'. This will specify the purposes for which the medicine is to be used and, sometimes, the categories of patients it is intended to be used for

Why don't all medicines have a licence?

There are many reasons why, but they can be put into two main groups:

1. Medicines are used for illnesses, conditions, diagnostic tests or age groups not covered by their license. Sometimes the license is for one illness but doctors find it works very well for another illness. The clinical trial may only have been performed with a set age group of patients but doctors find it works very well for other age groups too. This is often called 'off label' use.
2. Medicines that have no license at all. They may be:
 - Medicines licensed in other countries.
 - Medicines made when it is too expensive to obtain a license
 - Medicines prepared to order so the medicine is suitable for the patient, e.g. liquids made from tablets.
 - Medicines ready-made for use in hospitals, to reduce risks of infection or errors in preparation.
 - Medicines that are still in 'clinical trial', but which have been shown to be of benefit in treating disease
 - Some items are marketed as foods or cosmetics and will not have a 'license'.

How will I know that my medicine is not licensed?

Your doctor or pharmacist should tell you or when you read the information leaflet with the medicine you may notice that the information is not quite as expected. The leaflet may not talk about your particular illness or condition or it may say that it should not be used for your age group.

Unlicensed medicines may be made to order and may take longer to obtain. Pharmacy can provide information on this to you, your GP or your local community pharmacy if required.

How do I know that these medicines are safe and will work?

Doctors think carefully about prescribing such medicines and will have read information and taken recommendations from other specialists to confirm that the medicine would be right for you.

Pharmacists will confirm that the medicine is appropriate for you. In addition, all unlicensed medicines used within the Health Board and supplied by the Health Board's Pharmacy Department are checked by specialist pharmacy staff to ensure that they are made to a high standard.

Should I be worried about taking these medicines?

Doctors and pharmacists have a lot of experience with medicines, whether licensed or not, and will have thought very carefully about the best medicine for you. If you are worried please talk to your doctor or pharmacist. They can tell you more about the medicine. They can also tell you about all the treatments available and why they think this is the best one.

Where do I obtain further supplies of unlicensed medicines?

Your GP may or may not be prepared to continue supply of an unlicensed medicine. They are not obliged to. In the event that your GP is not prepared to continue supply, further supplies may be obtained by contacting your hospital prescriber to provide another prescription to be dispensed by the hospital pharmacy department.

What to do if I want more information?

Please talk to your doctor or pharmacist – they may have a special information leaflet.

Produced by:

Medicines Management, Cwm Taf Morgannwg University Health Board

Royal Glamorgan Hospital Tel No 01443 443443

Prince Charles Hospital Tel No 01685 721721

Princess of Wales Hospital Tel No 01656 752382

Appendix 5: Taflen Wybodaeth i Gleifion ar gyfer Meddyginiaethau Didrwydded

Nod y daflen hon yw rhoi gwybodaeth bwysig i chi ac i ateb rhai ymholiadau cyffredin all fod gyda chi.

Pam mae angen y daflen hon?

Yn y DU mae'r rhan fwyaf o feddyginiaethau wedi'u 'trwyddedu', ond dydy hyn ddim yn wir am bob un. Mae'r daflen hon yn esbonio pam mae meddyginiaethau'n cael eu trwyddedu a pham nad oes gan rai meddyginiaethau defnyddiol drwyddedau.

Byddwch wedi cael y daflen hon gan eich meddyg neu fferyllydd oherwydd nad yw'r feddyginiaeth gawsoch chi ar bresgripsiwn 'wedi'i thrwyddedu', neu mae'n cael ei defnyddio am reswm nad yw wedi'i gynnwys yn y drwydded.

Rydyn ni am eich sicrhau ein bod wedi meddwl yn ofalus iawn am y feddyginiaeth orau i chi. Dylai'r daflen hon ateb unrhyw gwestiynau sydd gyda chi am hyn.

Beth yw meddyginiaethau didrwydded?

Cyn y bydd meddyginiaeth yn cael caniatâd i gael ei marchnata yn y DU, rhaid i gwmnïau cyffuriau ofyn i'r Asiantaeth Rheoleiddio Meddyginiaethau a Chynhyrchion Gofal Iechyd (MHRA), rhan o'r Adran Iechyd, am 'drwydded' ar gyfer y feddyginiaeth.

Mae'n rhaid i'r cwmni ddangos i'r MHRA bod y feddyginiaeth yn gweithio'n dda, bod dim gormod o sgil effeithiau a'i bod wedi'i gwneud i safon uchel.

Sut caiff meddyginiaethau eu profi?

Er mwyn sicrhau bod meddyginiaeth yn gweithio a'i bod yn ddiogel, caiff meddyginiaethau eu rhoi ar brawf yn gyntaf ar grwpiau gwirfoddol o gleifion mewn 'treial clinigol'. Mae'r wybodaeth o'r treialon, ynghyd â manylion am sut mae'r feddyginiaeth yn cael ei gwneud, sut mae'r feddyginiaeth i fod i gael ei defnyddio, a'r taflenni sydd i'w rhoi i feddygon a chleifion i gyd yn cael eu rhoi i'r MHRA i'w cymeradwyo. Os caiff y feddyginiaeth ei chymeradwyo, bydd yn cael 'trwydded'. Bydd hon yn nodi at ba ddibenion y mae'r feddyginiaeth i'w defnyddio ac, weithiau, y categorïau o gleifion sydd i fod i'w defnyddio.

Pam nad oes gan bob meddyginiaeth drwydded?

Mae yna lawer o resymau pam, ond gellir eu rhoi mewn dau brif grŵp:

3. Mae'r meddyginiaethau'n cael eu defnyddio ar gyfer salwch, cyflyrau, profion diagnostig neu grwpiau oedran sydd ddim yn dod o dan eu trwydded.

Weithiau mae'r drwydded ar gyfer un salwch ond mae meddygon yn gweld ei bod yn gweithio'n dda iawn ar gyfer salwch arall. Efallai mai dim ond gyda grŵp oedran penodol o gleifion y cafodd y treial clinigol ei gynnal, ond mae meddygon yn canfod ei fod yn gweithio'n dda iawn ar gyfer grwpiau oedran eraill hefyd. Yr enw ar hyn yw 'all-drwydded' neu 'off-label' yn Saesneg.

4. Meddyginiaethau sydd heb drwydded o gwbl. Gallan nhw fod yn:
 - Feddyginiaethau sydd wedi'u trwyddedu mewn gwledydd eraill;
 - Meddyginiaethau sy'n cael eu gwneud pan fydd yn rhy ddrud i gael trwydded;

- Meddyginiaethau sydd wedi'u paratoi yn ôl archeb fel bod y feddyginiaeth yn addas i'r claf, e.e. hylifau wedi'u gwneud o dabledi;
- Meddyginiaethau parod i'w defnyddio mewn ysbytai, i leihau'r risg o haint neu gamgymeriadau wrth baratoi;
- Meddyginiaethau sy'n dal mewn 'treial clinigol', ond lle mae wedi ei dangos bod y feddyginiaeth o fudd i drin afiechyd;
- Caiff rhai eitemau eu marchnata fel bwydydd neu gosmetigau a fydd dim 'trwydded' gyda nhw.

Sut bydda i'n gwybod nad yw fy meddyginiaeth wedi'i thrwyddedu?

Dylai eich meddyg neu fferylllydd ddweud wrthyh chi, neu pan fyddwch yn darllen y daflen wybodaeth gyda'r feddyginiaeth efallai y byddwch yn sylwi nad yw'r wybodaeth yn union fel y disgwylioch chi. Efallai na fydd y daflen yn sôn am eich salwch neu gyflwr penodol neu efallai y bydd yn dweud na ddylid ei defnyddio ar gyfer eich grŵp oedran.

Mae modd gwneud meddyginiaethau didrwydded yn ôl archeb a gall gymryd mwy o amser i'w cael. Gall y fferyllfa roi wybodaeth am hyn i chi, i'ch meddyg teulu neu i'ch fferyllfa gymunedol leol os oes angen.

Sut ydw i'n gwybod bod y meddyginiaethau hyn yn ddiogel ac y byddan nhw'n gweithio?

Mae meddygon yn meddwl yn ofalus am bresgripsiynu meddyginiaethau o'r fath a byddan nhw wedi darllen gwybodaeth ac wedi cymryd argymhellion gan arbenigwyr eraill i gadarnhau y byddai'r feddyginiaeth yn iawn i chi.

Bydd fferyllwyr hefyd yn cadarnhau bod y feddyginiaeth yn briodol i chi. Yn ogystal, mae'r holl feddyginiaethau didrwydded sy'n cael eu defnyddio a'u rhoi i bobl yn y Bwrdd Iechyd Prifysgol gan yr Adran Fferylliaeth yn cael eu gwirio gan staff fferyllol arbenigol i sicrhau eu bod yn cael eu gwneud i safon uchel.

Ddylwn i boeni am gymryd y meddyginiaethau hyn?

Mae gan feddygon a fferyllwyr lawer o brofiad gyda meddyginiaethau, p'un a ydyn nhw wedi'u trwyddedu ai peidio, a byddan nhw wedi meddwl yn ofalus iawn am y feddyginiaeth orau i chi. Os ydych chi'n poeni, siaradwch â'ch meddyg neu fferylllydd. Gall ddweud mwy wrthyh chi am y feddyginiaeth. Gall hefyd ddweud wrthyh chi am yr holl driniaethau sydd ar gael a pham mae'n meddwl mai dyma'r un orau.

Ble galla i gael cyflenwadau pellach o feddyginiaethau didrwydded?

Mae'n bosibl y bydd eich meddyg teulu yn barod i barhau i roi meddyginiaeth ddidrwydded i chi. Fodd bynnag, does dim rhaid iddyn nhw wneud hynny. Os na fydd eich meddyg teulu yn barod i barhau â'r cyflenwad, gellir cael cyflenwadau pellach trwy gysylltu â'ch presgripsiynydd ysbyty i ysgrifennu presgripsiwn arall i'w ddosbarthu i chi gan adran fferylliaeth yr ysbyty.

Beth i'w wneud os ydw i eisïau mwy o wybodaeth?

Siaradwch â'ch meddyg neu fferylllydd - efallai y bydd taflen wybodaeth arbennig gyda nhw.

Cynhyrchwyd gan:

Y Gyfarwyddiaeth Rheoli Meddyginiaethau, Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Ysbyty Brenhinol Morgannwg Rhif ffôn 01443 443443

Ysbyty'r Tywysog Siarl Rhif ffôn 01685 721721

Ysbyty Tywysoges Cymru Rhif ffôn 01656 752382

Appendix 6: Primary Care Medication Information

To the patient/carer: Please give one copy to your GP and one to your Community Pharmacy

(addressograph or patient details)

Dear Dr _____, your patient was

started on an unlicensed medication

On ____/____/____.

The details of the medication are as follows:

Name of medication (including brand name)* ¹	
Form and strength of medication	
Pack size	
Dose and frequency	
Indication	
Supplier* ²	
Evidence for the use of the medicine including if listed in the BNF or BNF for children	
Anticipated duration of therapy	
Monitoring required	

*¹ GP -This item may not be listed on your practice computer system; if so the prescription should be handwritten.

*² Pharmacist -This item may be difficult to obtain from your usual suppliers so we have included details above of the supplier used by hospitals in Cwm Taf Morgannwg LHB.

An interim supply has been made by the hospital for _____ days supply)

A further appointment has been made for _____

I confirm that the patient has been counselled on the treatment and the side effects

Signature	Print name	Grade
	Contact details	

It is important that the patient continues to receive their medication in the same form and strength as originally prescribed to ensure continuity of care and reduce any risk.

If you have any queries please contact the relevant hospital pharmacy department:

Royal Glamorgan Hospital - Dispensary 01444 443443 ext 74053

Prince Charles Hospital - Dispensary 01685 728691

Princess of Wales Hospital – Dispensary 01656 752382

Appendix 7: List of Approved Unlicensed Medicines Purchases

The list of approved unlicensed medicines purchases will be stored on the CTM Logistics Teams Channel.

Items NOT appearing on this list must be quarantined on receipt, and require approval/ release by the QA Pharmacist/ suitable deputy

Appendix 8: Unlicensed Medicine Purchase Record

Unlicensed Medicine Purchase Record

Unlicensed Medicine – Record of Purchase and Receipt			
Purchasing Department		POWH ☐ / PCH ☐ / RGH ☐ / YCR ☐	
Product Details (Name, Form, Strength, Unit Size)			
Manufacturer			
Supplier			
Date Ordered		Quantity Ordered	
Date Received		Quantity Received	
Manufacturer's Batch Number			
Manufacturer's Expiry			
Product Details (incl. BN and Expiry) recorded on pharmacy computer system		Yes ☐ / No ☐ Signature:	
Product on 'List of Approved Purchases'?		Yes ☐ / No ☐ (If No – Date submitted for QA Review: _____)	
Certificate of Analysis or Conformity?		Yes ☐ / No ☐ / To Follow	
QA REVIEW OUTCOME			
Section A of RRA form completed		☐	
Section B of RRA form completed		☐	
PIL Available		☐	
Product is ACCEPTABLE		☐	
<u>Comments:</u> (e.g. over labelling or review by UHB QA Pharmacist required)			
Name, signed and dated		Added to Approved List ☐	



Agenda Item

6.1.3

Quality, Safety & Experience Committee

Ventilation Policy

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Approval	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Ventilation Safety Group - Approved	24/02/2026	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	01/04/2026	ENDORSED FOR APPROVAL
Operational Management Board	15/04/2026	ENDORSED FOR APPROVAL



Acronyms / Glossary of Terms

WHTM	Welsh Health Technical Memorandum
WHBN	Welsh Health Building Note
IPC	Infection Prevention and Control

1. Situation / Background

- 1.1 This Policy has been developed to introduce a structured procedure for the Management and Control of critical ventilation systems in compliance with current guidelines contained in Welsh Health Technical Memorandum (WHTM) 03-01 and relevant legislation.
- 1.2 The Policy specifies the management responsibilities for ensuring compliance with WHTM 03-01, safe systems of work, the reduction of hazards in the working and patient environments and day to day management of ventilation systems within CTMUHB.
- 1.3 The objective is to ensure the organisation takes all reasonable precautions to ensure ventilation systems are managed correctly for the safety of patients and staff.

2. Specific Matters for Consideration

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

Name Title	Date Consulted/Completed
Equality Impact Assessment	Updated 01/04/26
Informal Consultation with interested parties	Ventilation Safety Group completed 24/02/26
Formal Consultation	Available on Sharepoint policies page – closed 25/03/26
Committee – For approval	OMB approved on 15/04/26

- 2.2 Implementation of this policy will:

- Ensure critical ventilation systems and air handling equipment is suitable for its intended use and is maintained to satisfactory performance levels;
- Contribute to the overall Infection Prevention and Control agenda within the Health Board;
- Comply with Health and Safety legislation requirements;
- Maintain the health, comfort and environment for all patients, staff and public, by ensuring adequate ventilation exists and it is fully functional.

- 2.3 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
- 2.4 The membership of the CTM Ventilation Safety Group have been engaged in the consultation
- 2.5 Organisational values and behaviours have been reflected within the policy.



3. Key Risks / Matters for Escalation

- 3.1 In response to the consultation process the following amendments have been made:
- Responsibilities of different groups have been updated and clarified (including IPC responsibilities as per WHBN 00-09)
 - The list of critical ventilation plant has been updated to accompany the policy, incorporating Local Exhaust Ventilation plant
 - Latest CTM policy template used.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Whole-systems Perspective



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

5. Recommendation

- 5.1 The Quality, Safety & Experience Committee are asked **to APPROVE** the changes to the Ventilation Policy.

6. Next Steps

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

Ventilation Policy

Document Type:	Non Clinical Organisational Wide Policy
Ref:	EST10
Author:	Paul Lewis, Head of Assets, Governance and Technical Services. Supported by the Ventilation Safety Group.
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	Quality & Safety Committee
Approval / Effective Date:	(00/00/0000)
Review Date:	(00/00/0000)
Version:	2.0

Target Audience:

People who need to know about this document in detail	Director of Nursing, Medical Director, Heads of Nursing, Theatre Managers, Head of Estates, Head of Capital, Infection Prevention & Control Committee, Ventilation Safety Group members, Authorised Persons for Ventilation Systems.
People who need to have a broad understanding of this document	(For example: Board Members, Management Board. Senior Leaders. Board Committees.)
People who need to know that this document exists	(For example: All staff involved in the development of Health Board Policies.)

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 01/04/26 Outcome: Neutral
Welsh Language Standard	No
Date of approval by Equality Team:	N/A
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care



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INTRODUCTION

1. POLICY STATEMENT

Ventilation is used extensively in healthcare premises for both the comfort of occupants in buildings and to closely control the environment and air movement of the space that it serves, in order to contain, control and reduce hazards to patients and staff from airborne contaminants, dust and harmful micro-organisms.

The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of ventilation systems. Cwm Taf Morgannwg University Health Board will ensure that all ventilation/air handling units (AHU's), are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Welsh Health Technical Memoranda (WHTM) or similar, to ensure that such equipment does not pose a health or operational risk to either, staff, patients or members of the public.

2. SCOPE OF POLICY

The policy applies to all properties owned and maintained by the Health Board, including properties leased, rented or occupied under lease or any other occupancy agreement. The policy covers the maintenance of all ventilation/air handling equipment within Cwm Taf Morgannwg University Health Board, to ensure a safe environment for both patients, staff and the public.

The policy does not cover natural ventilation, or naturally ventilated areas.

3. DEFINITIONS

For the purpose of this document the following definitions apply:

- 3.1 The Environment** - Relates to the total space of an occupier's surroundings when in a healthcare premises, whether they are a patient, member of staff or a visitor. This includes the fabric of the building and related fixtures, fittings and services such as air and water supplies.
- 3.2 Ventilation** - Is a means of removing and replacing the air in a space. This can be achieved simply, by opening windows and doors etc. Mechanical ventilation systems provide a more controllable method. Basic systems consist of a fan attached to distribution ductwork; more complex systems may include the ability to heat and filter the air passing through them. Ventilation equipment is used to remove smells, dilute contaminants and ensure that a supply of "fresh" air enters a space.
- 3.3 Air Handling (Ventilation) Systems (AHU's)** – can have the ability to heat, cool, humidify, dehumidify and filter air (note - systems may perform

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some but not all of these functions). AHU's allow the climate within a space to be controlled at a specific level, regardless of changes in the outside air conditions or the activities within the space. Within the healthcare environment there are two classes of ventilation system, Critical systems and Non-critical systems. Examples are given below.

3.4 Air Cooling Systems

Air cooling systems recirculate and cool the air within a space, do not use fresh air and therefore are **not** classified as Ventilation Systems. There are two categories of air cooling systems:

Equipment Cooling systems.

Equipment air cooling systems are designed to reduce risk of over temperature for specialised purposes, such as cooling IT equipment in server rooms and data centres, or providing controlled temperatures for pharmacy drug storage.

Comfort Cooling systems.

Comfort cooling is primarily designed with people in mind. Applications for cooling systems must be pre-approved by the Ventilation Safety Group prior to procurement.

3.5 Critical Systems – Certain clinical and non-clinical areas within a healthcare establishment are considered critical to its ability to provide healthcare.

WHTM 03-01 Part B sets a requirement for annual verification and performance testing. The results of which are to be reviewed by the Ventilation Safety Group (VSG).

Typically, ventilation systems serving the following are considered critical (however this list is not exhaustive):

- operating suites of any type including rooms used for image-guided surgical procedures and their recovery areas;
- airborne isolation facilities, both source and protective;
- critical care areas and neonatal units;
- invasive treatment, endoscopy and bronchoscopy rooms;
- containment level 3 laboratory;
- pharmacy aseptic preparation facility;

- inspection, assembly and packing (IAP) room in a sterile services department;
- MRI, CAT and other types of emerging imaging technologies that require particularly stable environmental conditions to remain within calibration;
- any system classified as an LEV system under the COSHH Regulations (Control of Substances Hazardous to Health Regulations);
- any other system that clearly meets the definition that "a loss of service from such a system would seriously degrade the ability of the premises to deliver optimal healthcare"

A list of critical ventilation plant maintained by Estates is held, this includes the following information:

- Hospital / Location
- Description of system
- Date of last inspection
- Date inspection due
- Contact person
- Report author and document reference
- Condition (and notes)
- Hyperlink to report

The critical ventilation plant list is a live document maintained and managed by Ventilation APs supported by Estates Admin, it is the responsibility of APs to update the list as required. The list is located within the CTM Estates W:Drive and a link is provided at Appendix A.

3.6 Non Critical System - Non critical systems are general ventilation and general extract systems in buildings.

3.7 Annual Authorising Engineers (AE) Report - A summary of annual verification progress and standards met.

4. AIMS AND OBJECTIVES

The Policy has been developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all critical ventilation systems/air handling units in use within the organisation. The Policy will not only ensure the organisation complies with the law, it also fosters confidence amongst both public and staff that the organisation takes its responsibilities regarding maintenance of these systems seriously.

Implementation of this policy will:

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- 4.1** Ensure critical ventilation systems and air handling equipment is suitable for its intended use and is maintained to satisfactory performance levels;
- 4.2** Contribute to the overall Infection Prevention and Control agenda within the Health Board;
- 4.3** Comply with Health and Safety legislation requirements;
- 4.4** Maintain the health, comfort and environment for all patients, staff and public, by ensuring adequate ventilation exists and it is fully functional.

5. RESPONSIBILITIES

5.1 Managerial Responsibilities

The Health Board has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without risk to staff, patients or members of the public.

5.2 The Chief Executive

The Chief Executive (Management (Duty Holder) has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Health Boards ventilation systems. In particular he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity. Management is defined as the owner, occupier, employer, general manager, chief executive or other person who is ultimately accountable for the safe operation of premises.

5.3 Designated Person (DP) for Ventilation (as defined by WHTM 03-01)

The Designated Person for Ventilation as defined by WHTM 03-01 Part A is responsible for delivering the policy aims and aspirations. The Designated Person provides the essential senior management link between the organisation and professional support.

They should:

- Set out the standards and quality of service to be provided;
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy;
- Appoint an Authorising Engineer for Ventilation (AE(V));
- The Designated Person should also provide an informed position at board level and confirm the appointment of the following staff in writing.

5.4 Head of Estates and Assistant Head of Estates / Staff responsible for critical ventilation systems in their departments

The Head of Estates (and Assistant Head) / Staff responsible for critical ventilation systems in their departments is responsible for ensuring that all ventilation/air handling systems contained in the Critical Ventilation Plant Asset List (link at Appendix 1) are inspected, serviced, verified, maintained and tested in a safe manner without hazard to staff, patients or members of the public.

The Head of Estates and Assistant Head / Staff responsible for critical ventilation systems in their departments shall oversee that:

- Critical systems as identified above in 3.5 are subjected to testing by an Authorised Person;
- Systems identified in 5.12 should ensure that certification is made available for inspection by Authorised Persons;
- Maintain a register of Authorised Persons;
- Ensure that appropriate reactive and planned preventative arrangements are put in place to deliver to the aims of this policy to the standards set in WHTM 03-01.
- Have in place a procedure for assessing Competent Persons;
- Maintain a register of Competent Persons;
- Ensure that only individuals assessed as being competent and included on the register are used by sub-contractors. I.e. it is the individual not the contractor that needs to be assessed;
- Ensure that competent persons undertake regular maintenance on other ventilation systems and equipment;
- Ensure that the policy and procedures are implemented by a range of in-house or contracted services;
- Audit the effectiveness of the arrangements and arrange corrective action;
- Report any deficiencies which cannot be addressed within delegated limits of resource and authority;
- Ensure that critical ventilation systems are independently verified in accordance with WHTM 03-01 Part B requirements;
- Arrange for any adverse incident to be investigated by the Authorising Engineer and for the dissemination of related advice.

5.5 Senior Operations Manager

The Senior Operations Manager is responsible for the direct management and delivery of the above duties in 5.4, with oversight and support from Head of Estates / Assistant Head of Estates.

5.6 Maintenance

Maintenance procedures will conform to the principles set out in WHTM 03-01 Part B Specialised Ventilation in Healthcare Premises, L8 the Approved Code of Practice on the Prevention and Control of Legionella, WHTM 04-01 the Control of Legionella, Hygiene, safe hot water, cold water and drinking water systems, manufactures instructions and any subsequent legislation or guidelines.

5.7 Project Managers

Have the responsibilities to ensure that:

- All new installations meet the latest legal and technical standards;
- A suitably qualified person is involved in the design of all new installations, designs are scrutinised by the Lead Infection Prevention Control Specialist, the ventilation safety group and the Authorising Engineer or Performance Standards Engineer. Commissioning, witnessing and performance checks are undertaken and documented;
- All new installations are assessable and maintainable without resort to specialist access equipment or the need for removal of finishes/infrastructure;
- That maintenance teams have comprehensive operations and maintenance manuals (O&M), handed over on completion of schemes;
- That appropriate training and familiarisation is provided to in house and contract teams;
- That all new designs or major modification to existing systems are reviewed by the Ventilation Safety Group, the Authorising Engineer or Performance Standards Engineer prior to the commencement of work;
- That all new installations are independently validated prior to contract completion;
- That all variations from the standards set out within WHTM 03-01 Part A are listed and agreed in writing by the Ventilation Safety Group, the Authorising Engineer and Head of Estates prior to implementation.

Installation and Refurbishment - Any new ventilation/air handling system must be designed, installed and commissioned by suitably qualified personnel. They will be compliant with the requirements set out in WHTM 03-01 Part A, any other relevant statutory legislation and must be appropriate for the area for which it was designed.

When new ventilation/air handling systems are commissioned, full information concerning their designed mode of operation, together with full details of all maintenance procedures must be provided as part of the commissioning process.

In areas being refurbished, the IPC team must be involved as part of a multidisciplinary team in line with Welsh Health Building Note (WHBN) 00-09: Infection control in the built environment.

Derogations and alternative design strategies

Any derogations or alternative design strategies from WHTM 03-01 should be subject to the scrutiny and agreement in writing by the VSG. The reason for the derogation or alternative design strategy and limits to its application should be recorded.

Designers proposing a derogation or alternative design strategy must be able to supply a body of evidence that their proposal will provide a degree of safety no less than if the guidance in this document had been followed.

Note: The foregoing guidance is not intended to prevent the use of new technology or stifle design innovation but rather to ensure that what is being proposed will result in a facility that is fit for purpose when used. It will not be enough to state that the derogation or alternative design strategy proposed has been used elsewhere. There should be evidence that what is being proposed has been successful elsewhere.

On new build facilities, there should not be any derogations from the guidance given in the WHTMs and WHBNs.

Derogations should not be accepted by the VSG unless absolutely necessary or fully justified.

5.8 Authorising Engineer (Ventilation) AE(V)

The AE(V) is defined as a person designated by Management to provide independent auditing and advice on ventilation systems, to review documentation on verification and validation and witness the process as necessary.

They shall:

- Provide a service in accordance with WHTM 03-01;
- Advise on technical compliance with WHTM 03-01 Part A and B;
- Advise on interpretation of WHTM 03-01 Part A and B;
- Assess and make recommendations for the appointment of Authorised Persons;
- Monitor the performance of the service and provide a triannual audit and annual verification reports to the Designated Person and Head of Estates;
- Investigate any adverse incident and report on any findings;
- Advise on the consequences of any proposed variation from the standards given within WHTM 03-01.

5.9 Authorised Person (Ventilation) AP(V)

The AP(V) will be an individual possessing adequate technical knowledge and having received appropriate training, appointed in writing by the Designated Person (in conjunction with the advice provided by the AE(V)), who is responsible for the practical implementation and operation of Management's safety policy and procedures relating to the engineering aspects of ventilation systems.

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5.10 Competent Person CP(V)/Maintenance Person

The CP(V) is defined as a person designated by Management to carry out maintenance and periodic testing of ventilation systems. Undertakes work on systems as designed by engineering managers. In particular:

- Carry out planned preventative routines (PPM) and repairs as instructed by the Head of Estates and provide feedback on performance and maintenance issues;
- To ensure all health and safety, COSHH, Health Board policies and procedures and risk assessments are adhered to at all times;
- To leave work area clean and tidy;
- To report any maintenance defects or required changes to PPM routines or asset data;
- Record work carried out on individual ventilation systems, in system log books;
- Ensure that appropriate records are kept for maintenance, testing and verification work, in a format readily retrievable for audit purposes.

5.11 Infection Prevention Control Team (IPCT)

The IPCT function will adhere to the duties / requirements set out in Welsh Health Building Note (WHBN) 00-09: Infection control in the built environment and WHTM 03-01.

IPCT (also Infection Control Doctor / Consultant Microbiologist) will provide input into Estates on Capital projects and schemes, on infection control matters. They will require assurance that appropriate action is taken internally and externally by Consultants and Contractors commissioned and controlled by the organisation, to thereby reduce any risk of cross infection.

The IPCT will:

- Advise, monitor and investigate infection control and microbiological performance issues, and highlight to the Ventilation Safety Group when infection route may be connected to ventilation systems;
- Support and advise Estates and the Ventilation Safety Group regarding the undertaking of microbiological tests (by an accredited laboratory) when required and within IPC scope;
- Provide infection control support to Estates staff as required in relation to infection control issues related to ventilation systems.

5.12 Persons responsible for other specialist ventilation systems

Eg. Pathology, Containment Level 3 (CL3) Microbiological Safety Cabinets, Pharmacy Aseptic Suite (as covered by MHRA requirements), Afos Benches (example dissection benches).

Pathology ventilation systems should be managed in accordance with the requirements of the COSHH Regulations and the relevant HSE requirements, published as the following documents:

- Management and operation of microbiological containment laboratories (HSE 2019)
- Sealability of Microbiological Containment Level 3 and 4 Facilities (HSE undated)
- Safe working and the prevention of infection in clinical laboratories and similar facilities (HSE 2003)

Managers of specialist critical ventilation systems (outside of Estates) must provide copies of annual verification reports to the Ventilation Safety Group, IPCC and the Authorising Engineer. Attend the Ventilation Safety Group, and report on maintenance standards for the relevant ventilation systems. Departments will include but not limited to:

- Manager responsible for the Aseptic Suite;
- Manager responsible for Pathology specialist ventilation systems such as Afos benches, Extracts;
- Manager responsible for Mortuary Specialist Ventilation maintenance.

Managers are responsible for ensuring that their end users are competent in the operation and use of the systems under their control.

5.13 User

A User is the person responsible for the management of the unit in which the ventilation system is installed (for example head of department, operating theatre manager, laboratory manager, production pharmacist, head of research or other responsible person).

The user shall: Report plant failures, report any ventilation system local alarms, under performance or ventilation concerns, suspicious odours or abnormal environmental conditions. Approve permission to disconnect requests when planned maintenance works are scheduled. For Estates maintained systems this should be via the Estates Helpdesk Service, for other locally managed systems this would be via locally agreed procedure.

Purchase of any mobile local ventilation, air conditioning or filtration units must be pre-approved by the Ventilation Safety Group.

5.14 Contractor

The Contractor is the person or organisation responsible for the supply of the ventilation equipment, its installation, commissioning, validation, verification or decommissioning. This person may be a representative of a specialist ventilation organisation or a member of the general manager/chief executive's staff.

5.15 Ventilation Safety Group (VSG)

The management of the ventilation systems for CTMUHB will be overseen by the Ventilation Safety Group (VSG). The role and responsibility of the VSG are defined below. The VSG will be part of a healthcare organisation's governance structure, reporting to the Capital and Estates Health Safety and Risk Group by exception from high risks reported through highlight reports, and report to the appointed ventilation designated person at Board level. It will be led and chaired by a person who has appropriate management responsibility, knowledge, competence and experience (for example the Designated Person).

The VSG will be a multidisciplinary group and should typically comprise of the following:

- An Authorising Engineer/independent adviser for ventilation AE(V);
- An Infection Prevention and Control person;
- Authorised Person(s) for ventilation services AP(V);
- Estates (operations and projects) staff;
- Clinicians and specialist departments (for example, theatres, critical care areas, pharmacy, medical microbiology, nursing, decontamination);
- Personnel from the finance department with accountability for capital and revenue evaluation;
- Other stakeholders as appropriate;
- Co-opted expertise (for example, ventilation designers, consultants and suppliers).

The VSG remit is to assess all aspects of ventilation safety and resilience required for the safe development and operation of healthcare premises. It will inform the following areas:

- The design process for new healthcare premises;
- The design process for modifications to existing premises;
- The commissioning and validation process;
- Operational management and maintenance;
- Annual verification and performance testing;
- Review plant non-conformances to WHTM as picked up via audit and or verification reports;
- Prioritising the plant replacement programme;
- Decommissioning and removal of redundant equipment.

It is important that decisions affecting the resilience, safety and integrity of the ventilation systems and associated equipment are not taken without the agreement of the VSG. The VSG are to ensure that appropriate expertise and competence is available when making such decisions.

Whenever significant building projects are undertaken, the VSG will consider its effects on the existing ventilation system air intakes. These may need to be protected from airborne dust during construction by the fitting of temporary

additional filtration. There will also be a need to identify any risks to construction personnel who may be working in the vicinity of extract air discharges.

When construction or alteration work is undertaken inside an occupied building, its effects on the occupiers should be considered. The VSG should be consulted, and they may require that the area be sealed off from the occupied parts of the building and that a temporary extract be provided to maintain the worksite at a negative pressure to prevent the spread of dust into the rest of the building.

6. INFORMATION, INSTRUCTION AND TRAINING

All staff, whether working for the Health Board or as partners who have duties under this policy should receive appropriate training. This training is specified in detail in the WHTM 03-01.

Staff working on critical ventilation systems within Health Board properties must be trained and approved to suitable standards for Ventilation Authorised Persons (APs) and or Ventilation Competent Persons (CPs) as per the requirements of HTM 03-01.

7. SPECIFIC HEALTH AND SAFETY ASPECTS

Those engaged in the service and maintenance of ventilation systems may be at risk. Hazards should be identified, the risk evaluated and suitable control measures implemented to ensure the risk is reduced to the lowest reasonably practicable level.

Extract ventilation systems from, for example, pathology departments, mortuaries, laboratories, source protected isolation facilities and other areas containing a chemical, biological or radiation hazard, may present specific hazards and levels of risk. Again, the hazards should be identified, the risk evaluated and suitable control measures implemented to ensure the risk is reduced to the lowest reasonably practicable level. In these cases the means by which the systems can be rendered safe to work on would require the implementation of a permit-to-work on the system.

Some specialised units may have access restrictions (pharmacy aseptic suites). Estates or contract staff may require additional training or to be accompanied when entering the unit.

Mortuary ventilation equipment to be verified annually to WHTM 03-01 to satisfy the requirements of the Human Tissue Authority (HTA). Estates provide monthly air flow readings to Pathology.

8. REVIEW, MONITORING AND AUDIT ARRANGEMENTS

The Designated Person (DP) for Ventilation will maintain an audit cycle for monitoring and review of compliance of this and other Estates policies within the Health Board.

8.1 Triennial Authorised Engineers (AE) Ventilation Systems Audit Report:

A triennial performance report will be presented and discussed at the Health Board Ventilation Safety Group. The ventilation plant verification report will contain key performance indicators to confirm:

- Any critical systems are clearly identified.
- Where they exist, that appropriate validation checks have been undertaken.
- That any non-conformance on systems is clearly documented and deemed satisfactory.
- That required plant investments are designed, installed and commissioned in line with current legislation.
- Highlight any non-compliance from the WHTM, either to be remedied or agreed as Derogation by the Ventilation Safety Group.

8.2 Annual Authorising Engineers (AE) Report.

A summary of annual verification progress and standards met. Will include the following for example:

- Compliance and standards met
- Which plant verified
- Governance levels
- Issues raised
- Authorised Persons status (including new APs)

9. IMPLEMENTATION/POLICY COMPLIANCE

It is the policy of the organisation to comply with NHS, WG, UK and EU statutory and other legislative requirements in relation to the use and management of ventilation systems. The legislation and Health Service guidance documents that must be considered in the development and maintenance of this policy are listed in section 13 – Main Relevant Legislation:

10. RETENTION OR ARCHIVING

In line with the Health Board's Policy on Records, all Engineering / Building records will be kept for the lifetime of the premises. All other records will be retained in line with the relevant Department requirements, if not dictated by the Health Board's Policy.

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11. NON CONFORMANCE

There is a requirement of all staff to comply with the provisions of the Ventilation Safety Policy and, where requested, to demonstrate such compliance.

12. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

13. MAIN RELEVANT LEGISLATION / STANDARDS

- The Health and Safety at Work etc. Act 1974;
- The Control of Substances Hazardous to Health (COSHH) Regulations 2002;
- Managing for Health and Safety (HSG65) 2013;
- Workplace (Health, Safety and Welfare) Regulations 1992;
- Provision and Use of Workplace Equipment Regulations 1998;
- Approved Code of Practice on the Prevention or Control of Legionella (L8);
- Welsh Health Technical Memorandum (WHTM) 03-01. Part A and B Specialised Ventilation in Healthcare Premises;
- Welsh Health Technical Memorandum (WHTM) 00 Policies and Principles of Healthcare Engineering;
- Welsh Health Technical Memorandum (WHTM) 04-01 Part A, B & C Safe Water in Healthcare Premises.
- Welsh Health Building Note (WHBN) 00-09: Infection control in the built environment
- Building Regulations Part F
- Management and operation of microbiological containment laboratories (HSE 2019)
- Sealability of Microbiological Containment Level 3 and 4 Facilities (HSE undated)
- Safe working and the prevention of infection in clinical laboratories and similar facilities (HSE 2003)
- CIBSE guidance relevant to ventilation systems.
- COVID-19 ventilation guidance and alerts.
- Cwm Taf Morgannwg Health Board Aspergillus Policy (IPC).

APPENDIX

- List of Critical Ventilation Plant / Critical Asset List

W Drive: (specify file pathway)

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

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

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
11 March 2025	Request made by an Independent Member at the January 2025 QSEC for this report to added to future meeting agenda's	Executive Director of Nursing	WAST Produced Quality Report	USC Care Group to provide a report on the joint working with WAST looking at the People's Experience and Quality of care as this is work that is undertaken jointly with the central team and sits within USC portfolio.	USC Care Group Nurse Director	Executive Director of Nursing	20 May 2025 22 July 2025 Now November 2025 Now June 2026	In progress An update on the current position has been included in the Clinical Executives Report being presented to the June 2026 meeting
22/07/2025	Request made at the July meeting for this item to be brought back to a meeting in 2026	Interim Executive Director of Nursing	Listening & Learning Story - Carers	This matter to be revisited given that the Committee had been made aware that there were issues that needed to be addressed, with further discussion required as to what could be done to address the issues	Carers Lead	Interim Executive Director of Nursing	July 2026	In progress Date to be confirmed with Carers Lead
23 September 2025	Request made at the meeting held on 23 September 2025	QSEC Committee Chair	Listening & Learning Story - Domestic Violence	Head of Safeguarding to return to the Committee in one year to provide more evidence in relation to learning points	Head of Safeguarding	Executive Director of Nursing	22 September 2026	In progress Scheduled for September 2026
23 September 2025	Request made at the meeting held on 23 September 2025	QSEC Committee Chair	Planned Care - Care Group Highlight Report	Outcome and impact of the splitting of the Anaesthetics, Critical Care & Theatres and Trauma & Orthopaedics Directorate to be presented to the Committee after the trial period of 12 Months	Planned Care Group Nurse Director	Executive Director of Nursing	22 September 2026	In progress Will be presented to the September 2026 meeting
16 December 2025	Request made at agenda planning session held on 16 December	QSEC Committee Chair & Executive Lead	Spotlight Presentation - Hospital at Home	To be presented to Committee for discussion	Chief Operating Officer	Chief Operating Officer	24 March 2026 Was June 2026 Now July 2026	In progress Will be deferred to the July 2026 meeting
13 January 2026	Reference made in the Clinical Executives Report presented to the January 2026 meeting	Interim Executive Director of Nursing	Maternity & Neonatal Services Performance Report for 2025/2026 plus	To be presented to the Committee for discussion	Director of Midwifery	Director of Midwifery	24 March 2026 Now July 2026	In progress March 2026 Care Group Highlight Report states that this is not

			outcome of the national assessment					yet available until later in the year.
20 January 2026	Captured as an action at the January 2026 meeting	Executive Medical Director	Physicians Associates	Report to be presented to a future meeting of the Committee in relation to Physicians Associates outlining training, governance and patient communication.	Executive Medical Director	Executive Medical Director	22 September 2026	In progress Scheduled for the September 2026 meeting
10 February 2026	Request made at the agenda planning session held on 10 February 2026	Executive Director of Nursing	Welsh Risk Pool and Medical Negligence Claims – Quality Update	To be presented to the Committee for discussion	Executive Director of Nursing	Executive Director of Nursing	3 June 2026 Now 22 September 2026	In progress This will now be presented to the September 2026 meeting
10 March 2026	Email request received from the Assistant Head of Assets, Governance and Technical Services	Assistant Head of Assets, Governance and Technical Services	Ventilation Policy	To be presented to the Committee for approval	Assistant Head of Assets, Governance and Technical Services	Executive Director of Finance	3 June 2026	On agenda This item is on the agenda for the 3 June 2026 meeting
31 March 2026	Email request received from the Principal Pharmacist- Quality and Safety. Medication Safety Officer	Principal Pharmacist- Quality and Safety. Medication Safety Officer	Unlicensed Medicine Policy	To be presented to the Committee for approval	Principal Pharmacist- Quality and Safety. Medication Safety Officer	Executive Medical Director	3 June 2026	On agenda This item is on the agenda for the 3 June 2026 meeting
13 April 2026	Email request received from the Medical Directors Business Manager	Executive Medical Director	Update: Explosion of Pacemaker at Glyntaff Crematorium	To be presented to the Committee for information only	Executive Medical Director	Executive Medical Director	3 June 2026	On agenda This item is on the agenda for the 3 June 2026 meeting
28 April 2026	Request made at agenda planning that this item is added to the agenda for the July meeting	Executive Director of Nursing	Sexual Health Safeguarding Update	To be presented to the Committee for discussion	Head of Safeguarding	Executive Director of Nursing	21 July 2026	In progress Scheduled for the July 2026 meeting
28 April 2026	Request made at agenda planning that this item is added to the agenda for the July meeting	Executive Director of Nursing	Winter Wrap Up – Themes and Trends	To be presented to the Committee for discussion	Executive Director of Nursing	Executive Director of Nursing	21 July 2026	In progress Scheduled for the July 2026 meeting
28 April 2026	Request made at agenda planning that this item is added to the agenda for the September meeting	Committee Chair	Eye Care Update	To be presented to the Committee for discussion	Planned Care Nurse Director	Executive Director of Nursing	22 September 2026	In progress Scheduled for the September 2026 meeting
14 May 2026	Email request received from the Lead for Legal Services asking for this item to be added to the agenda for the June 2026 meeting	Lead of Legal Services	Redress Case Management	To be presented to the Committee for discussion	Lead for Legal Services	Executive Director of Nursing	3 June 2026	On agenda This item is on the agenda for the 3 June 2026 meeting
27 May 2026	Email request received from the PCC Advisor	PCC Advisor	Pharmaceutical Needs Assessment	To be presented to the Committee for endorsement	PCC Advisor	Executive Medical Director	3 June 2026	On agenda

								This item is on the agenda for the 3 June 2026 meeting
Completed Items								
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	Completed - Superseded The Committee receives Highlight Reports from the RADAR Committee. The End of Life Care Steering Group has also recently been launched
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	Completed An update was included in the MHL D Highlight Report received at the meeting held on 24 March 2026
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	Completed Received at 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	Completed Received at the March 2026 meeting as part of the Winter Wrap Up report
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	Completed This item was received at the March 2026 meeting
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	Completed This item was received at the March 2026 meeting
3 February 2026	Committee Referral made at the February 2026 meeting of the	Audit, Risk & Assurance Committee	Audit Wales Report on Eye Care Services	The Committee raised concerns on reading the report with regard	Care Group Director of Nursing	Chief Operating Officer	24 March 2026	Completed This was included in the Planned Care

	Audit, Risk & Assurance Committee			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.				Group Highlight Report for discussion at the March 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: Carolyn Donoghue, IM University	Committee Vice Chair Kath Palmer, Vice Chair	Executive Leads for Agenda Planning 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 BAE	
Shared Listening & Learning Story	Executive Director of Nursing	All Regular Meetings	R		R			R Defer to July	R Falls Story		R		R		X	R	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											R		X	R	No	N/A	Strategic Risk 2	
Outcome reports – Board Member Patient Safety Walkabouts	Executive Director of Nursing	Twice per annum.						R					R		X	R	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 BAE
Peoples Experience Activity Report <i>(to include an annual update on CTM Carers End of Year Progress Report)</i>	Executive Director of Nursing	All Regular Meetings	R		R			R	R Not required		R		R		X	R	No	N/A	Strategic Risk 2
Thematic Spotlights – Learning and Improvement Outcomes	Lead Clinical Executive	All Regular Meetings	R Compassionate Care		R Quality Impact of the new Escalation Framework & Hospital at Home			R Not required	R Nutrition & Catering & Hospital at Home		R TBC		R TBC		X	R	N/A	N/A	Will be assigned to a strategic risk dependent on topic
Report from the Clinical Executives <i>(to include bi-annual updates on Coroners Inquests – activity & lessons learnt)</i>	Clinical Executives	All Regular Meetings	R		R			R	R Not required		R		R		X	R	N/A	N/A	It is anticipated that this report will crosscut several strategic risks.
Care Group Highlight Reports	Care Group Nurse Directors/Care Group Medical Directors	All Regular Meetings	R		R			R	R Not required		R		R		X	R	N/A	N/A	Each Care Group Highlight Report will crosscut several of the strategic risks
Quality Dashboard Report <i>To include an addendum relating to Ombudsman activity</i>	Executive Director of Nursing	All Regular Meetings	R		R			R	R Not required		R		R		X	R	N/A	N/A	Strategic Risk 2
Ombudsman’s Letter & Annual Report	Executive Director of Nursing	Annually									R				R	X	EMB	Yes	Strategic Risk 2
Organisational Risk Register <i>Risks assigned to the QSEC</i>	Director of Corporate Governance/Board Secretary	All Regular Meetings	R		R Verbal			R	R Not required		R		R		X	R	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	R		R Consent			R Main	R Not required		R Main		R		R	R (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			R Deferred to June			R					R		X	R	Yes - EMB	N/A	• Strategic Risk 2
Infection, Prevention and Control Annual Report	Executive Director of Nursing	Annually									R				X	R	N/A	N/A	• Strategic Risk 2
Putting Things Right Annual Report	Executive Director of Nursing	Annually									R				R	X	N/A	N/A	• Strategic Risk 2
Safeguarding & Public Protection Report	Executive Director of Nursing	Annually											R		X	R	N/A	N/A	• Strategic Risk 2
Nurse Staffing Levels Wales Act	Executive Director of Nursing	Twice Per Annum						R N/A as went to May Board					R		X	R	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							R						R	X	N/A	N/A	• Strategic Risk 2
Cancer Services Annual Report	Executive Medical Director	Annually						R							R	X	EMB	N/A	• Strategic Risk 2

RADAR Committee Highlight Annual Report <i>ICB x 2 – Clinical Exception Report then at QSEC</i>	Executive Medical Director	Annually plus exception reporting	R					R							R	X	Improving Care Board	N/A	Strategic Risk 2
Improving Care Strategic Goal aligned to Committee Business Contd. - Delivering Safe and Compassionate Care - Developing new models of care - Digital Transformation for patients and staff - Ensuring timely access to care																			
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting 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	R						R						R	X	EMB	Yes	Strategic Risk 2
Individual Patient Funding Request Annual Report	Executive Director of Public Health	Annually									R				R	X	N/A	N/A	Strategic Risk 2
Radiation Safety Committee Annual and Mid-Year Updates	Executive Director of Allied Health Professionals & Health Science	Twice Per Annum						R					R		R	X	N/A	N/A	Strategic Risk 2
Human Tissue Act Authority – Progress Report	Executive Medical Director	Twice Per Annum	R						R						R	X	EMB	N/A	Strategic Risk 2
Anti-Microbial Resistance Reports	Executive Medical Director	Twice Per Annum						R					R		R	X	N/A	N/A	Strategic Risk 2
Harm Free Care Agenda	Executive Director of Nursing	Twice Per Annum						R					R		X	R	N/A	N/A	Strategic Risk 2
Annual Duty of Quality Report	Executive Director of Nursing	Annually							R						X	R	EMB	Yes	Strategic Risk 2
Consent to Examination for Treatment Annual Report	Executive Medical Director	Annually						R							R	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 BAE	
Health Inequalities Population Inequality Service Inequality <i>(Quality & Safety impact of services we currently run – differential in quality)</i>	Executive Director of Public Health	Twice Per Annum						Defer to July							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 <i>Quality Reporting Process – Annual Appraisal</i>	Executive Director of Nursing	Annually							 Now June						X		N/A	N/A	- Strategic Risk 2 - Strategic Risk 11
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Director of Nursing	Annually						 An update is included in the Commissioned Services Report							X		N/A	N/A	- Strategic Risk 2 - Strategic Risk 11

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

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

CTMUHB Board Assurance Framework Dashboard

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee
1.	Improving Care, Sustaining our Future   Click Here for Risk 1a Click Here for Risk 1b	a) Enough capacity to meet elective demand b) Enough capacity to meet emergency demand	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee
2.	Improving Care, Sustaining our Future   Click Here for Risk 2	Ability to deliver improvements which transform care and enhance outcomes	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee
3.	Sustaining our Future, Improving Care and Inspiring People    Click Here for Risk 3	Enough workforce to deliver the activity and quality ambitions of the organisation <i>(Including Culture, Values and Behaviours)</i>	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee
4.	Creating Health, Sustaining our Future   Click Here for Risk 4	Effective Community and Partner Engagement in service changes and developments	Director of Communication, Engagement & Fundraising	Strategic Development Committee
5.	Improving Care, Sustaining our Future   Click Here for Risk 5	Delivery of a digital and information infrastructure to support organisational transformation	Director of Digital	Operational Delivery Committee and Strategic Development Committee
6.	Improving Care, Sustaining our Future   Click Here for Risk 6	Ability to maintain a safe and fit for purpose estate infrastructure	Executive Director of Finance	Operational Delivery Committee
7.	Sustaining our Future, Creating Health   Click Here for Risk 7	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee
8.	Creating Health, Sustaining our Future   Click Here for Risk 8	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee
9.	Sustaining our Future  Click Here for Risk 9	Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)	Executive Director of Finance	Operational Delivery Committee
10.	Sustaining our Future, Improving Care   Click Here for Risk 10	Ability to develop a fit for the future estate to reflect our future clinical service model	Executive Director of Finance	Strategic Development Committee
11.	Creating Health, Sustaining our Future, Improving Care    Click Here for Risk 11	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee



Agenda Item

6.2.3

Quality, Safety & Experience Committee

Cancer Services Annual Report

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Tanya Williams – Cancer & Urology Services Senior Manager David Williams – Cancer & Outpatients Improvement Manager Dawn Casey – Macmillan Lead Cancer Nurse Rhian Collins - Deputy Head of Dietetics
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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



Acronyms / Glossary of Terms

CTMUHB	Cwm Taf Morgannwg University Health Board
SCP	Suspected Cancer Pathway
CWT	Cancer Waiting Times
PTR	Putting Things Right
HB	Health Board
OPA	Outpatient Appointment
MDT	Multi-Disciplinary Team
HEIW	Health Education and Improvement Wales
CNS	Clinical Nurse Specialist
WCISU	Welsh Cancer Intelligence and Surveillance Unit
AHP	Allied Health Professional
MUO/CUP	Malignancy of undefined origin/Cancer of unknown primary



1. Situation / Background

1.1 This report provides an annual update on cancer services across CTMUHB.

2. Specific Matters for Consideration

2.1 Impact of non-compliance with the suspected cancer waiting time measure.

3. Key Risks / Matters for Escalation

3.1 Continued failure to meet the suspected cancer waiting time performance measure.

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

Impact Assessment



Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below) Cancer performance is a key Welsh Government priority	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below) Additional funding will be required to meet current cancer waiting time performance target	

5. Recommendation

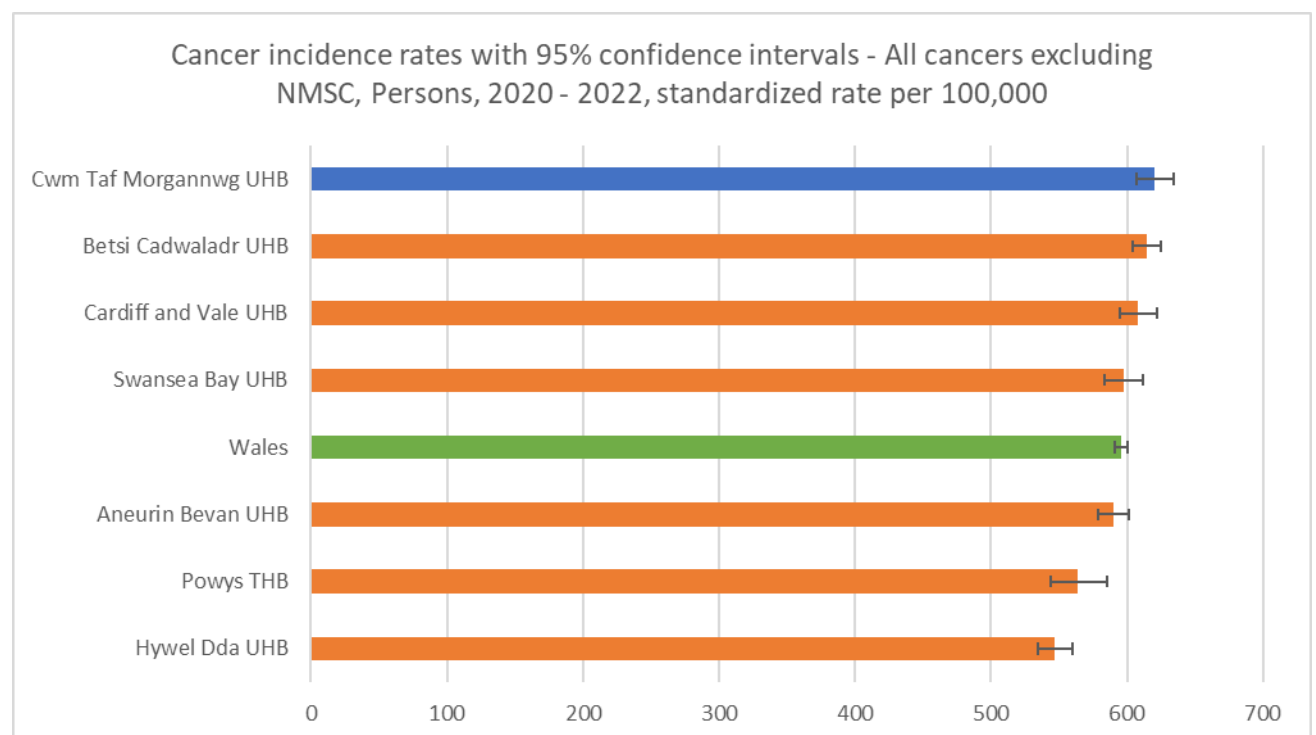
- 5.1 The Committee are asked to **NOTE** and **CONSIDER** the contents of this report.

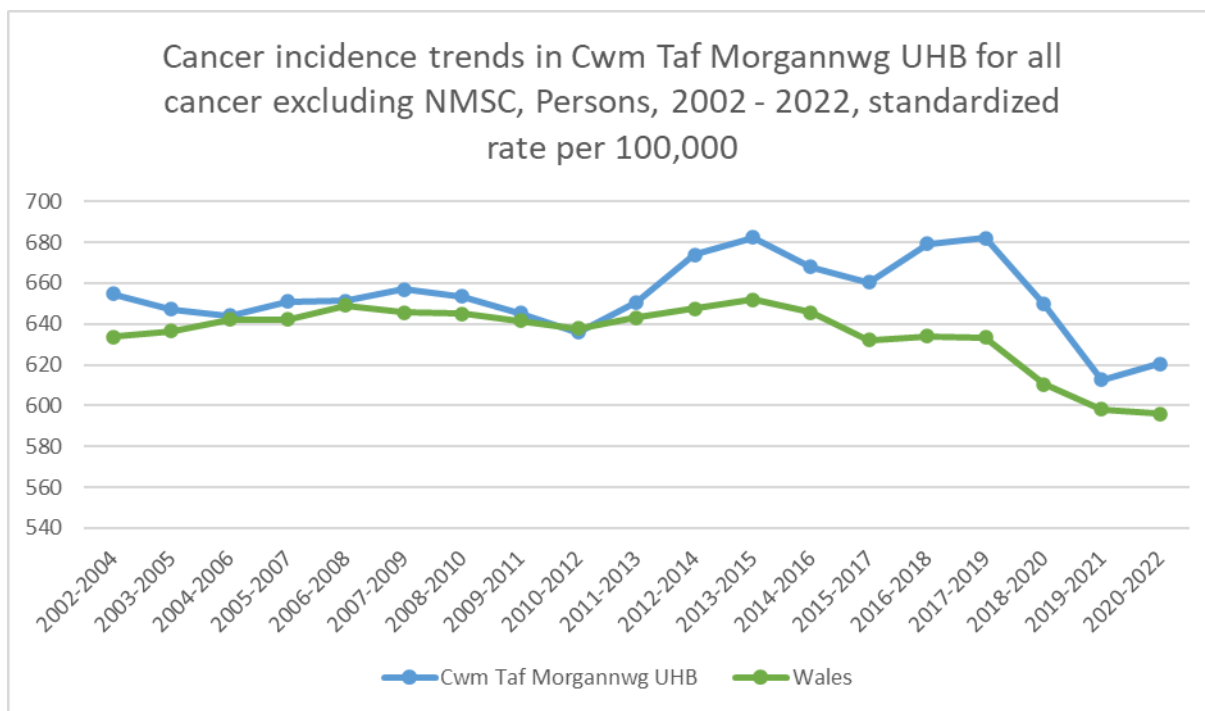
Annual Cancer Report 2025/2026

1.0 Introduction

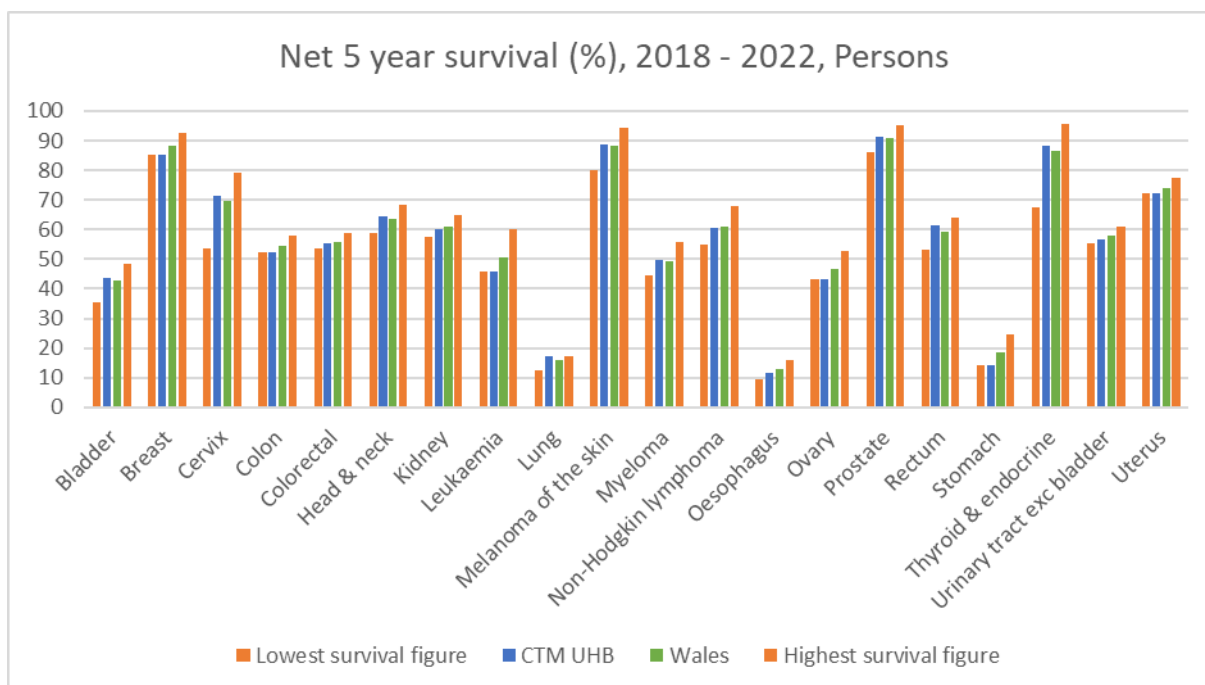
This annual report provides an overview of the challenges faced by our cancer teams, in delivering the National Optimal pathway and our progress made during 2025/2026.

2.0 Cancer landscape across CTMUHB





Each year around 3,900 people across CTMUHB are diagnosed with cancer. Cancer incidence has remained at a higher rate in CTMUHB than for Wales overall.



The latest published cancer survival figures from WCISU show for people diagnosed with cancer in Wales during 2018 to 2022, 75% survived one year from diagnosis and 60% survived five years from diagnosis, after accounting for other causes of death.

Improvements in cancer survival have stalled, with trends remaining broadly flat up to 2018-2022. This levelling off began before the pandemic, from the 2015-2019 period.

One-year cancer survival has recovered significantly following the COVID-19 pandemic. Looking at single years of diagnosis, one-year cancer survival fell by 4 percentage points between 2019 and 2020, around the onset of the COVID-19 pandemic. By 2022, it had recovered to pre-pandemic levels

The analysis showed that Cwm Taf Morgannwg survival figures were not statistically different to the all Wales figures for any major tumour site.

3.0 Performance

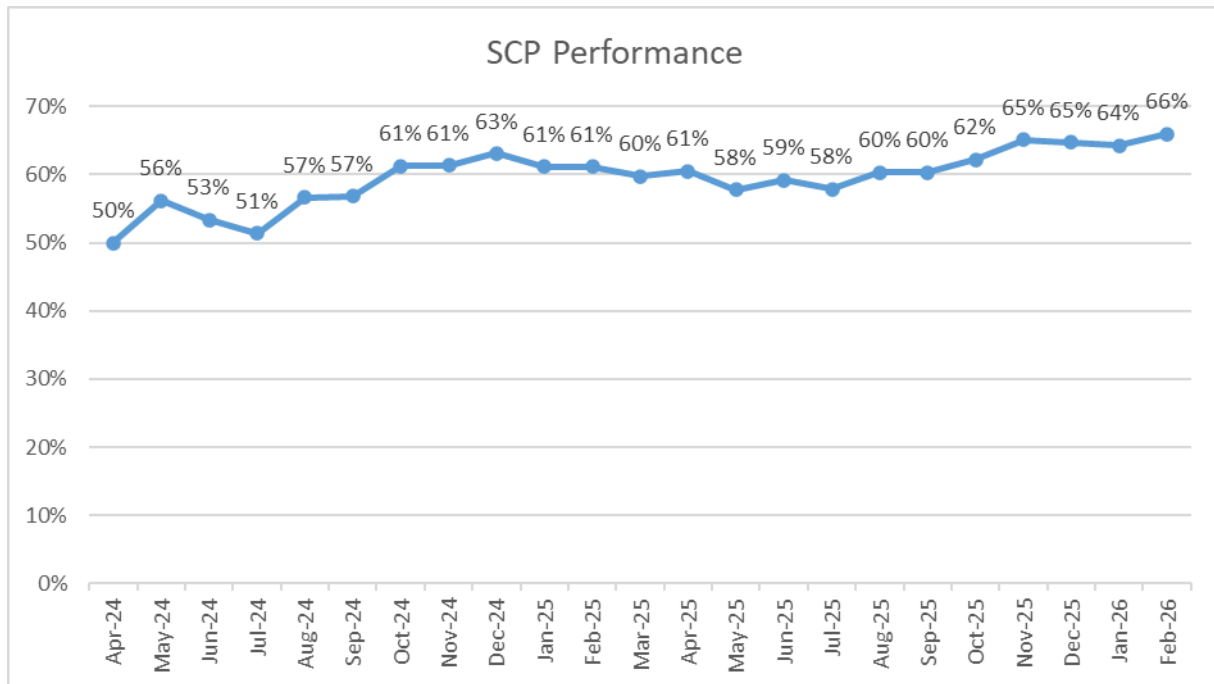
3.1 Referrals

Referral numbers have increased by 0.4% over the last 12-month period compared to the previous 12 months.

Tumour Site	2024/2025	2025/2026	Vol Diff	%Diff
Brain/CNS	52	48	-4	-8.3%
Breast	4,093	4,289	196	4.6%
Children's	41	33	-8	-24.2%
Gynaecological	5,461	5,141	-320	-6.2%
Haematological (exc acute leukaemia)	480	548	68	12.4%
Head and neck	4,013	3,781	-232	-6.1%
Lower GI	5,499	5,730	231	4.0%
Lung	1,265	1,334	69	5.2%
Other	2,109	1,822	-287	-15.8%
Sarcoma	82	43	-39	-90.7%
Skin (exc BCC)	5,488	6,172	684	11.1%
Upper GI	3,495	4,097	602	14.7%
Urological	5,757	4,958	-799	-16.1%
Total	37,835	37,996	161	0.4%

3.2 Cancer Performance

The current Cancer Waiting Times target is 75%.

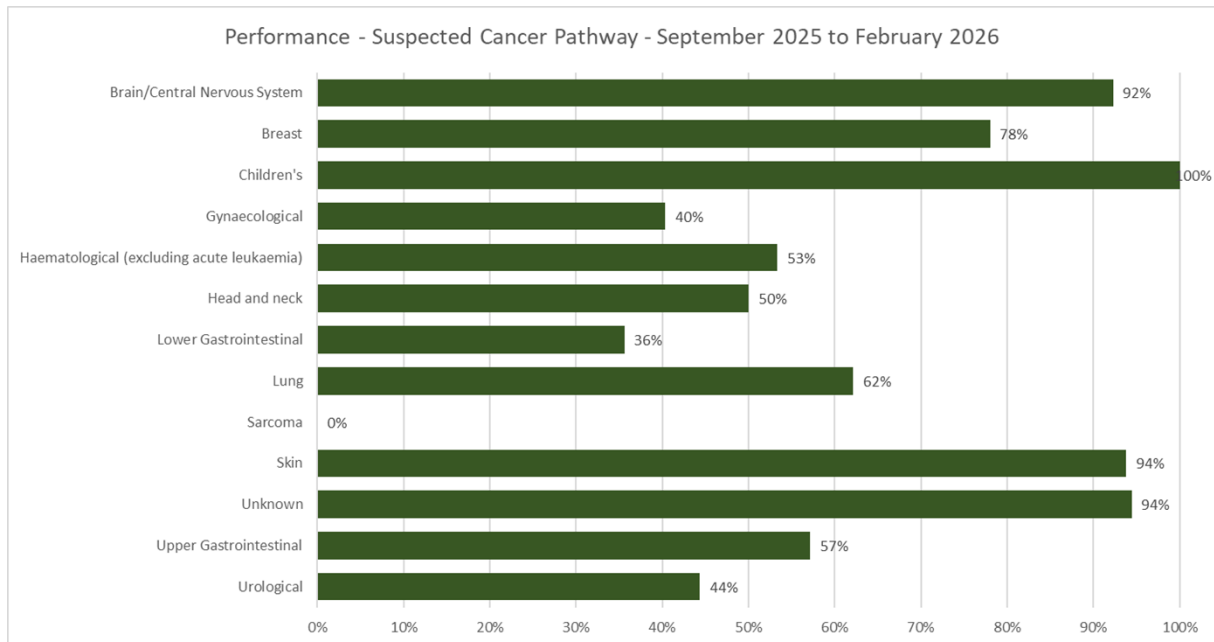


Although there have been continued improvements, CTMUHB has not achieved the SCP CWT target in any month over the last 12-month period.

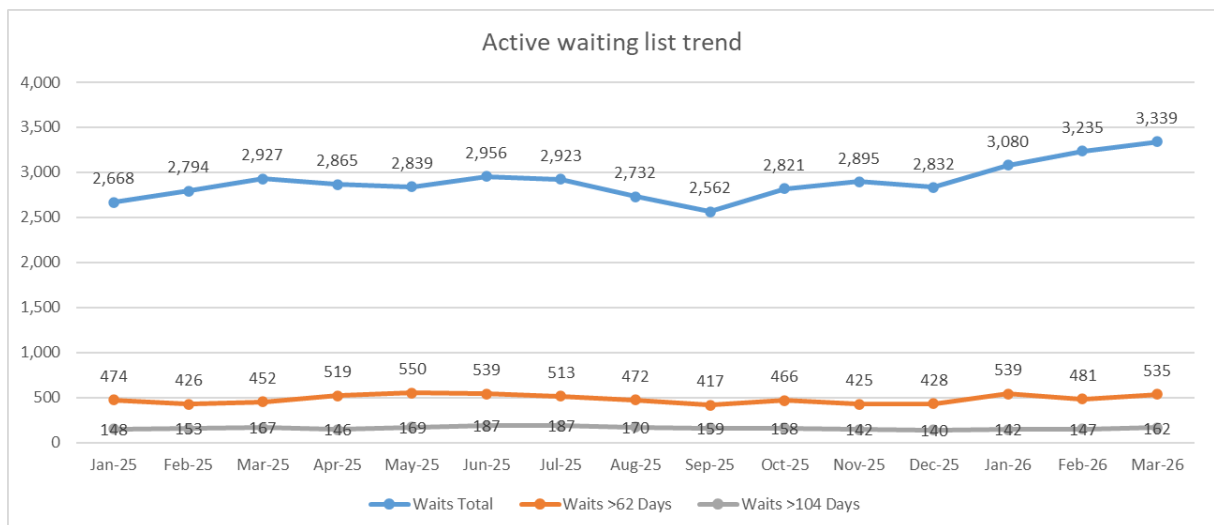
The improvements seen in cancer performance during 2025/26 have been acknowledged by Welsh Government, with cancer services at CTMUHB being de-escalated from enhanced monitoring and scrutiny (level 3) to routine arrangements (level 1).

CTMUHB's performance has gradually increased over the last 12 months. In comparison to all other acute HB's throughout Wales, CTMUHB has moved to have highest average performance for the last 6 months of published data.

Performance - Suspected Cancer Pathway – September 2025 to February 2026	
Aneurin Bevan	58.9%
Betsi Cadwaladr	52.6%
Cardiff & Vale	57.3%
Cwm Taf Morgannwg	63.7%
Hywel Dda	62.8%
Swansea Bay	56.6%
Wales	58.7%



Of the major tumour sites, both the Breast and Skin tumour sites are above the 75% cancer waiting time target. All other tumour sites have failed to achieve it; although performance varies, as illustrated above.



The waiting list and backlog volumes have increased over the last 12 months. Bottlenecks specifically at radiology, endoscopy, pathology and specialty specific diagnostics account for the bulk of the diagnostic challenges.

Fundamental to improving cancer performance is investment in diagnostics and the continuation of backlog clearance.

4.0 Quality Assurance of Cancer

4.1 Quality Assurance Framework

The quality assurance framework is available as a dashboard and is reviewed on a quarterly basis, reporting to the cancer programme board. The trends are noted, and an additional deep dive is undertaken when changes are identified. This year anomalies have been reviewed in upper and lower gastrointestinal cancer pathway. Nothing of concern has been identified.

The annual cancer audits are also reviewed and reported, along with the action plans. These are also discussed at the HB clinical effectiveness meeting.

An annual review of patients who were treated for cancer within 12 months of a cancer downgrade is also undertaken.

There remain challenges around the key worker reporting, following the transition from CANISC. These have been raised with the NHS Executive.

The number of patients who have died on a cancer pathway is also reviewed. Nothing of note.

A review of compliance with the National Optimal pathways has been undertaken this year and an action plan created.

A Health Board wide cancer patient experience survey is also available to provide us real time feedback on the services. Complimenting the less frequent National patient experience information.

4.2 Cancer Harm reviews

Since 2023, Welsh Government, no longer require a separate process for cancer harm reviews. Reverting to the standard duty of candour process. The breaches are routinely reviewed to look for learning and themes, but not added to Datix.

There have been 164, 146-day breaches between April 2025 and March 2026. Fifty-six have been reviewed and no harm found. All cancer harms on the current system have now been reviewed and closed. There are 165 harm reviews remaining on the historical system.

4.3 Ongoing reviews of CTMUHB organisational cancer risk

As a result of improvements in the suspected cancer pathway performance, the overarching risk score for cancer has been reduced to 16.

5.0 Workforce

5.1 Macmillan partnership

Macmillan have stopped the funding for the Welfare benefits advice service provision. The closure of this service has been challenging and will impact on patient's financial situation.

5.2 Prehabilitation Team

The prehabilitation team funded via therapies are supporting people diagnosed with cancer to optimise their physical and psychological health prior to surgery. The team consists of a Physiotherapist, Dietitian, Occupational Therapists, two Therapy assistant practitioners and a clinical co-ordinator.

The prehabilitation service provides assessment and intervention to patients with lung, colorectal, Upper Gastrointestinal (UGI), hepatopancreatobiliary (HPB), and gynaecological cancers. In 25/26, the service received 719 new referrals and had more than 2500 individual contacts with patients.

6.0 Improvement and innovation

Improvement and innovation are crucial in reducing variation across our system and in making strides forward to improve our cancer outcomes. Recently completed and ongoing work streams and projects to support our aims include:

- Sustained improvements in prostate biopsy waiting times have been achieved through redesigned processes that strengthen demand and capacity alignment, supported by robust weekly monitoring to enable timely and responsive service adjustments.
- Bowel Screening Wales activity - Increase from 6.25 core weekly colonoscopy lists to 8 weekly lists.
- Formalised breast pain pathway for all CTM patients.
- Velindre Cancer Centre Satellite Radiotherapy Unit opened in Nevill Hall July 2025 – providing treatment closer to home for CTM patients.
- Funding secured for advanced communications skills course for Cancer professionals within Health Board and the Prehabilitation learning visit to Canada.
- The field of genomics and liquid biopsies continues to expand. The lung team and Acute oncology service (MUO/CUP) have been involved in the QuickDNA research. Other teams are exploring new developments and innovations.
- Established provision of Expiratory Muscle Strength Training (EMST) for head and neck cancer patients experiencing late effects dysphagia with confirmed aspiration. This has demonstrated a positive impact on Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS). Research project to further investigate this commenced in 2026.
- Upper GI Stent Research Project evaluating QoL changes pre and post oesophageal stent and whether there is any correlation with the type of stent placed- data collection complete.
- Provided multi-disciplinary facilitation of parenting with cancer workshops. Developed booklet for palliative care wards on supporting children accessing the units.

- Increased psychological support to staff by providing reflective practice sessions to upskill staff to manage difficult situations both personally and with patients

7.0 Challenges

There are several long-standing challenges across the HB.

- Achieving the SCP target which is largely attributed to the increased complexity of patients, their treatment and capacity shortfalls in key diagnostic areas.
- Providing a sustainable pathology, radiology, and Endoscopy service (Including Bowel Screening Wales activity). Collectively this relates to workforce, capacity, and demand with both internal and regional solutions required to resolve.
- Achieving performance and backlog clearance in line with target trajectories.



Agenda Item

6.2.4

Quality, Safety & Experience Committee

Bi-Annual Report CTM Radiation Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon Donovan, Professional Head of Radiography
Cyflwynydd yr Adroddiad / Report Presenter	Lauren Edwards, Executive Director of AHPs and Health Science
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
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CAVUHB CTMUHB DEXA Scan DRLS EPs	Cardiff and Vale University Health Board Cwm Taf Morgannwg University Health Board Bone Density Scan (DEXA) Diagnostic Reference Levels Employer Procedures



HIW	Healthcare Inspectorate Wales
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IOFBLPA	Intra Orbital Foreign Body
MEG	Laser Protection Advisor
MRSE	Medical Exposure Group
NRW	Magnetic Resonance Safety Expert
PCH	Natural Resources Wales
POW	Prince Charles Hospital
RGH	Princess of Wales Hospital
RIS	Royal Glamorgan Hospital
RPA	Radiology Informatic System
RPSC	Radiation Protection Advisor
RPS	Radiation Protection Service, Cardiff
RSC	Radiation Protection Supervisor
RPG	Radiation Safety Committee
PACS	Radiation Protection Group
QA	Picture Archive System
	Quality Assurance

1. Purpose

- 1.1 This report has been prepared to provide the Committee with details of the key matters considered by the Radiation Safety Committee (RSC) at its meeting on 30th April 2026. Minutes are available on request.
- 1.2 Key highlights from the meeting are reported in section 5.
- 1.3 The Committee is requested to **NOTE** the report.

2. Specific Matters for Consideration

- 2.1 The meeting on 30th April was the second RSC meeting to be held in the new format of RPG and MEG.
- 2.2 Both RPG and MEG provided an Alert, Advise & Assure report format. The new format brought the reports together for each modality in CTMUHB and avoided duplication. It enabled colleagues to attend the group that is most appropriate to them, or both if required. A required attendance list was generated, and Teams links were sent for each meeting to ensure the required attendees were in attendance. This meeting was productive and will continue to report into the Quality, Safety and Experience Committee (QSEC).

2.3 Highlight Report

Alert / Escalate

CAVUHB Radiation Protection Services (RPS) have identified compliance risks within the DEXA service against IR(ME)R 2017, notably the absence of Employer's Procedures and associated governance arrangements. Strengthened oversight and support from Radiology and RPS are recommended. A multidisciplinary meeting between Rheumatology (DEXA service leads), Radiology, and Medical Physics is scheduled for 27/5/26 to address these issues, with Rheumatology representatives from POW and RGH to be invited to future Radiation Safety Committee meetings to ensure ongoing compliance and oversight.

Theatres PCH confirmed they had put the Mini C-Arm, compact medical imaging device, back into use in November 2025 without notifying the RSC committee. This directly contravenes instructions given in October's meeting 2025 meeting of the RSC, where it was documented that before the Mini C Arm at Theatres PCH could be reintroduced into service following repairs, Radiology would need to be alerted to ensure testing could be undertaken.

The Mini C-Arm has been withdrawn from service pending a joint assessment by RPS Velindre and the equipment manufacturer. Both parties are required to attend site concurrently to complete the necessary QA testing. The unit will not be returned to clinical use until formal written assurance is received from RPS Velindre. The air handling system in the POW Nuclear Medicine (Gamma camera) room remains unreliable, with elevated temperatures increasing humidity and causing QA failures that can result in 24-hour service downtime. As a fully centralised service, this represents a single point of failure with potential to disrupt diagnostic pathways including oncology, impacting the timeliness of diagnosis and treatment. The issue remains under continuous oversight with Estates, with ongoing monitoring and escalation.



Advise

The absence of a Laser Protection Advisor (LPA) creates risks to compliance and reduces specialist oversight of laser safety, with potential implications for staff and patient safety. This is recorded on the risk register, with mitigation underway through securing LPA support via a SLA with Medical Physics CAVUHB. The MRI RGH chiller remains an issue as it is intermittently failing to function. The MRI scanner will not operate if the chiller fails, as the temperature in the MRI scanning room would increase and imaging must cease to protect the magnet. The resulting risk would be delays to imaging of patients and the potential impact on care and treatment decisions. There are currently work arounds in place that are proving to be effective; however, a longer-term solution needs to be agreed. Escalated to Estates on 6th May 2026.

POW Radiology have purchased a metal detector for use in MRI when patients following an incident whereby a patient concealed a razor blade on his person. This was a near miss and a safety alert. Site lead and MRI superintendent are in conversation with the Radiology Quality manager around the governance and protocol for its use. The Magnetic Resonance Safety Expert (MRSE) is also listing this for discussion on the All-Wales MRI safety meeting.

An intra-orbital foreign body (IOFB) was not identified during MRI pre-screening at RGH, presenting a potential patient safety risk. The patient confirmed the metallic object had been removed. The patient also confirmed he had undergone an MRI scan in POW previously following an IOFB X ray. The IOFB report stated that there was an IOFB in situ. No patient harm was identified. The issue has been escalated through Radiology governance, and work is underway at an all-Wales level to strengthen screening processes, including revised documentation from the MRI safety expert. This was confirmed at the RPG meeting on 30/4/26, with further review planned following full implementation of the new Radiology Information System (RIS) across Wales.

The All-Wales Radiology Informatic System (RIS) does not clearly differentiate between medical and non-medical referrers, reducing effective safety netting of IR(ME)R duty holders requesting examinations outside their scope of practice. This has been escalated to the All-Wales Quality Forum and national programme to identify interim mitigations and share learning across Health Boards.

Additionally, radiation dose is not currently captured within Philips PACS, presenting an IR(ME)R governance risk. A manual workaround is in place to maintain dose recording and



	oversight. Following a meeting held on 13/5/26, the details of all PACS-connected ionising equipment has been submitted to the dose management team to support system configuration and resolution. The Radiology Quality Manager reported 37 IR(ME)R incidents over six months, equating to a very low rate (0.023%) across approximately 162,000 ionising procedures, though opportunities for improvement remain. A bi-monthly Radiology Patient Safety Week will be introduced to reduce radiation incidents, emphasising “pause, check, and get it right first time.” Time pressure and rushing have been identified as a contributing factor. Impact will be monitored through audit and reported via the radiology governance framework.
Assure	An Ultrasound Governance Group has been established and met April 30th to agree its Terms of Reference and future meeting schedule. The group will ensure alignment with the All-Wales Ultrasound Governance Framework, overseeing implementation of national standards, compliance, and local risk and training needs, while reporting through Health Board governance structures via RSC. Additional RPSs have been trained on all sites within Radiology. This strengthens assurance through improved oversight and consistent compliance with local rules and IRR, supporting safe and standardised practice. Lead aprons have been screened across Radiology and Theatres, achieving over 80% compliance, with actions in place to improve further. This strengthens regulatory compliance, reduces the risk of staff exposure from defective PPE. Attendance at the MRI Safety Meeting has improved, with strong representation across all relevant staff groups, strengthening oversight and reinforcing safe practice through shared learning. Radiation Monitoring Badge return rates are strong, with Cardiology at 99% and Radiology at 90%, against a 95% target for Radiology by October 2026. This demonstrates good compliance with IRR requirements and supports effective monitoring of staff radiation exposure, enabling timely identification and management of risks. Achieving the new target will further improve compliance.



	The EPs for the mini-C Arm in POW have been revised to reflect the 2024 amendments and to ensure alignment with IR(ME)R standards. The document aims to provide a robust, compliant framework for local practice across departments. Resilience has improved in the Nuclear Medicine team with an additional RSAC licence holder and an additional nuclear medicine MPE joining the team. Adding qualified duty holders reduces single-point dependency and supports continuity of oversight.
Inform	No pending inspections or anything to inform.

3. Recommendations

4.1 Quality, Safety and Experience Committee are asked to NOTE the report.



Agenda Item

6.2.7

Quality, Safety & Experience Committee

**RADAR Programme
– Outline of Activities, Areas of Focus and Roles**

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Dr Richard Jones & Vanessa Jones Co-Clinical Leads for RADAR
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Dr David Deekollu AMD Quality & Safety (Chair of RADAR Group) / Dr Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

1. Situation / Background

The RADAR (Recognition of Acute Deterioration and Resuscitation) committee provides CTM's framework for early recognition and response to deterioration across adult, paediatric, maternity and neonatal services across primary, community and secondary care. Its aim is to reduce avoidable or preventable deterioration and cardiac arrests by improving systems and training staff.

1.1 Core Team

- Clinical Lead for RADAR
- Interim Lead Nurse — operational lead for Outreach & Resuscitation
- Interim Senior Nurse — Outreach
- Senior Nurse — Resuscitation
- RADAR Committee meets four-monthly
- Locality RADAR groups meet four-monthly
- Care Group link via attendance and structured reporting to QSRE (Quality Safety Risk and Experience) groups

1.2 Early Warning Systems & Response systems

RADAR has standardised our Early Warning Scoring systems by fully implementing NEWS2, PEWS, NEWTT2, and MEWS, (National Early Warning Score 2, Paediatric Early Warning Score, Newborn Early Warning and Treatment Tool 2 and Maternal Early Warning Score) embedding Rapid Response teams and establishing 24/7 Outreach support across acute sites.

We undertake regular Quality assurance of deterioration and arrests via rapid response, early warning score and cardiac arrest audits and participate in the National Cardiac Arrest Audit.

1.3 Digital Transformation (Next Phase of NerveCentre Rollout)

Digital transformation planned through NerveCentre rollout, enabling electronic observations, automated escalation, sepsis screening, AKI alerts, fluid balance monitoring and documentation of patient/family concern.

Implementation of the national Call4Concern (patient-and family-initiated escalation) programme in progress across ALL inpatient areas during 2026.

- Current systems reliant on paper
- Next phase will convert to fully digital workflows, including:
- Electronic EWS (Early Warning Score) recording and escalation
- Sepsis screening tools
- Fluid balance monitoring
- AKI (Acute Kidney Injury) alerts and monitoring

- Documentation of patient/family concern (Call4Concern)

This applies across adult, paediatric, maternity and neonatal services.

1.4 Resuscitation, Cardiac Arrest Governance & Mortality Outcomes

NCAA + CARM (National Cardiac Arrest Audit and Monthly Cardiac Arrest Review meeting)

- Updated CTM Resuscitation Policy in place
- Ongoing participation in national benchmarking:
- National Cardiac Arrest Audit (NCAA)
- CARM plus feedback from mortality reviews

Key Findings

Cardiac Arrest Outcomes

- ROSC (Return of Spontaneous Circulation) rates comparable to national averages but variable between sites
- Survival to discharge for shockable rhythms lower than expected

Pre-Arrest Care & Escalation

- Evidence of delayed recognition and escalation in a proportion of cases
- Rapid Response capacity constraints contributing to deterioration prior to arrest

Advance Care Planning

- Lack of DNACPR/TEP (Do Not Attempt cardiopulmonary Circulation/Treatment escalation Plan) identified in several cases, leading to inappropriate calls
- Inconsistent documentation and decision-making across sites

Team Performance

- Variability in leadership, role allocation and team functioning during arrests

Mortality Themes (CARM)

- Deterioration management and escalation delays contribute to avoidable harm
- Data triangulates with NCAA (National Cardiac Arrest Audit) findings

Actions Underway

- Strengthening pre-arrest detection and Rapid Response systems
- Cross-site comparative review of key arrest metrics:
 - Time to CPR
 - Time to first shock (for shockable rhythms)
 - Location of arrest (ward/ED/critical care)
 - Rapid Response involvement pre-arrest
- Standardisation of arrest team leadership and debriefing across sites to reduce variability in team performance
- Simulation-based training for cardiac arrest team leaders
- Enhanced governance review processes
- More focus on Advance Care Planning

1.5 Training & Workforce

- Mandatory resuscitation training programme ongoing

Constraints

- Limited training space (particularly RGH)
- DNA rate ~16%
- Poor staff preparation
- ESR competency misalignment affecting compliance reporting

Actions Underway

- ☐ Targeted analysis of DNAs to identify themes
- ☐ Strengthened booking and reminder processes, including clearer expectations for attendance and escalation of repeat DNAs to line managers

1.6 Sepsis Programme

CTM-wide multidisciplinary Sepsis Programme being developed in line with updated NICE guidance, including standardised pathways, staff education and public awareness work.

Programme Components

Public Awareness

- Planned campaigns to improve recognition of sepsis symptoms by patients and families
- Supports earlier presentation and escalation
- Aligns with patient empowerment principles
 - Working with UK Sepsis trust
 - Good support from Comms team

Alignment with National Guidance

- Pathways being updated in line with current NICE sepsis guidance
- Standardisation of screening, risk stratification and treatment across CTM

Staff Education

- Education programme planned for recognition, escalation and management of sepsis
- Integration with EWS (Early Warning Score)systems and deterioration pathways

Safety-Netting

- Emphasis on clear discharge advice and escalation instructions for at-risk patients
- Paediatric team working hard to standardise. ED being urged to follow suit.

Sequencing Requirements

- Call4Concern implementation must be prioritised first as a mandatory national requirement

- Sepsis programme development is dependent on:
- Successful C4C/PFIE (Patient and Family Initiated Escalation) implementation
- Digital systems to support screening and monitoring

Current Constraint

- Programme cannot fully develop due to absence of dedicated project management support
- RADAR teams lack capacity to deliver concurrent large-scale change programmes

Sepsis delays remain a recurring theme in incident reviews and mortality analyses.

1.7 Advance Care Planning: DNACPR, TEP & ACP

Continued development of Advance Care Planning (DNACPR and Treatment Escalation Plans) to promote appropriate escalation and patient-centred decision-making.

- TEP implementation progressing slowly
- DNACPR/ACP issues frequently contribute to inappropriate escalation and avoidable harm
- No formal governance work stream or oversight

1.8 Acute Kidney Injury

AKI bundle introduced to support early recognition and management of acute kidney injury.

- AKI recognised as a key deterioration marker
- Work aligned with Welsh Kidney Network guidance

ROUNDUP AKI Bundle (recently introduced)

Standardised bedside tool to improve early recognition and management of AKI:

- Repeat blood tests
- Obstruction assessment
- Urinalysis
- NEWS/clinical deterioration assessment
- Fluid status optimisation
- Urine output monitoring
- Medication review

2. Specific Matters for Consideration

2.1 Call4Concern / Patient & Family-Initiated Escalation (WHC/2026/001)

Mandatory national programme with no additional Welsh Government funding.

Key Requirements for CTM

RADAR Programme-
Outline of Activities, Areas
of Focus and Roles

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By 31 July 2026

- Twice-daily documentation of patient wellness/family concern in all acute inpatient areas
- PFIE system enabling direct activation of senior clinical review

By 30 Sept 2026

- Demonstrate reliable twice-daily documentation

By 31 Dec 2026

- Extend to non-acute inpatient settings

3. Key Risks / Matters for Escalation

- Workforce pressure on Outreach and clinical teams.
- Infrastructure requirements for escalation (especially mental health, maternity and paediatrics).
- Cultural change needed to empower patients and families.
- Fragile response to deterioration - single-practitioner Outreach model potential prone to overload. Times of high demand lead to escalation friction, delays and poor outcomes.
- Lack of formal ACP/DNACPR strategy - need for a dedicated improvement programme across Primary and Secondary care to tackle the overtreatment, inappropriate escalation and misuse of resources that result from a lack of Advance Care Planning. Need decision as to if in RADAR remit or another group.
- Programme management capacity - limited project management support limits delivery of multiple mandated programmes in parallel, resulting in slow progress on the Sepsis Programme and risk of non-compliance with national expectation.

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: All areas
	Not Applicable



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

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



<i>Impact Assessment Screening?</i>	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below) Ask for PMO involvement that the Exec Nurse and Medical Director are looking into to assist work	

5. Recommendation

The Committee are being asked to **NOTE** the report



Agenda Item

6.2.8

Quality, Safety & Experience Committee

**Update: Explosion of Pacemaker at Glyntaff
Crematorium**

Dyddiad y Cyfarfod / Date of Meeting	03/06/2026
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Rebecca Hopson, Pathology Quality & Governance 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 / Forum Individuals	Date	Outcome
ELG	16/03/2026	Noted

Acronyms / Glossary of Terms	
RCTCBC	Rhondda Cynon Taff County Borough Council
QAP	Qualified Attending Practitioner
MCCD	Medical Certificate of Cause of Death
EWN	Early Warning Notification



1. Situation and Background

- 1.1 On Tuesday February 24th the Health Board received notification from the RCTCBC Bereavement Services Manager & Registrar informing that an explosion of a pacemaker had occurred during a cremation at Glyn Taff Crematorium.
- 1.2 During the cremation process, cremator technicians reported hearing a loud bang from the cremator. Once the cremation was complete, an inspection of the remains was undertaken and a hazardous implant (pacemaker) was discovered within the cremated remains.
- 1.3 All cremation paperwork was subsequently checked and was found to state that no hazardous implant was present. It is a legal and safety requirement that the Qualified Attending Practitioner (QAP) responsible for completing the MCCD records the presence of a pacemaker (or other explosive device), along with a form completed by the family/funeral director (Crem1)
- 1.4 In this instance the QAP was a member of the CTM surgical team who missed that the deceased patient had a pacemaker in situ when scrutinising the patients' medical records.
- 1.5 On this occasion it is fortunate that there was no damage and no-one at the crematorium was harmed. However, this type of explosion has the potential to cause significant damage and poses a severe risk to staff and public at the crematorium.

2. Current Status

- 2.1 There was a request to undertake a RAPID review of the incident, however advice received was the incident did not fall under the umbrella of the CTM Patient Safety Incident Management Framework. In light of this a multidisciplinary review meeting was arranged between relevant stakeholders (Surgery, Cardiology, Pathology, Human Tissue Authority (HTA) Designated Individual, Primary Care).
- 2.2 The Review meeting took place on Monday 9th March and was primarily led by the Assistant Clinical Director of Surgery as the directorate responsible for the patients care and completion of the MCCD.

3. Key Risks and Matters for Noting

- 3.1 The patients' medical records indicated that there was a pacemaker in situ, however this was not picked up by the QAP who completed the MCCD. The presence of the device was not noted on the MCCD which is the primary source of identifying if a device is present, and as a result subsequent documentation did *not* indicate the presence of a device.



- 3.2 The introduction of the new Medical Examiner Services (MES) legislation in September 2024 has introduced additional challenges to the death certification process in relation to identifying explosive devices. The identification of a pacemaker or other device is primarily the responsibility of the QAP completing the MCCD, it is felt that in future there should be fail safes in place after this point, including an additional level of scrutiny from the MES.
- 3.3 There is potential for this incident to have significant consequences in terms of harm to staff and public, financial impact (a new cremator can cost up to £1.2 million) and reputational damage. This has highlighted that there may be a potential gap in the incident management framework for this type of incident that would ensure the correct level of escalation and proportionate investigation.

4. Actions

- 4.1 7-minute briefing to be compiled for Health Board Learning, covering the importance of fully scrutinising Welsh Clinical Portal (WCP)/GP records/Paper notes and Radiology records when completing the MCCD to ensure certainty around devices being present/not present.
- 4.2 Healthcare professionals with access to WCP (in particular Cardiologists and Cardiac Physiologists as well as any other specialties who insert potentially explosive devices) to utilise a tick box that is available on WCP to note that the patient has an implanted potentially explosive device, this will then add an alert/warning message to the patient record going forward. Process to be communicated to all users of WCP. The absence of this note should not be taken as assurance there is no device present however.
- 4.3 Health Board MES QR notification form to be updated specifically noting the necessity to identify whether a pacemaker (or other potentially explosive device device) is present.
(Wording now agreed for insertion into QR form imminently to help raise awareness of importance of this task).
- 4.4 Resident doctor induction programme to be updated in relation to the learning from this incident, highlighting the importance of thorough scrutiny of medical records when completing the MCCD.
(Discussions already underway, suggestion to present this as a session 'it couldn't possibly happen to me' during induction to highlight this incident. Plan to update for August induction)
- 4.5 A formal letter to be sent from the Health Board Medical Director to the MES highlighting the challenges faced since the introduction of the MES legislation in September 2024, due to removal of Crem4/5 forms (which previously required physical checks), including how the MES could further support by providing an additional level of scrutiny.



- 4.6 Review system of scrutinising cases, and completion of Crem1 form at Glyntaff Crematorium.
- 4.7 Contact patient safety colleagues to determine if any further escalation is required in relation to this incident (such as EWN).
(Patient safety contacted).

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	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	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? /	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required



Quality Have you undertaken a Quality Impact Assessment Screening?		
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐ Outcome for Equality (delete as appropriate): NEUTRAL Outcome for Welsh Language (delete as appropriate): NEUTRAL	No: ☒ If no, please include rationale below: Not required
Cyfreithiol / Legal	Yes (Include further detail below) Blood Bank has a legal requirement to comply with BSQR	
Enw da / Reputational	Yes (Include further detail below) Concern/complaint received from a patient; notifiable to regulators	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below) Refer to staffing risk outlined in the report	

6. Recommendation

The Committee are being asked to **NOTE** the report and support actions set out.